NCCD | National Council on Crime & Delinquency

From the Field
Why it Takes Courage to be Data Driven

By Raelene Freitag, Director of Social Service Practice

Making data-driven decisions may seem like the safest, least controversial way to function as a worker or an administrator in child protective services. After all, when you can back up your decisions with solid data, who can fault you?

As it turns out, many people can fault you. Each decision has a formal or informal "review chain" consisting of people who are in positions to question a decision they did not make. For workers, this always includes their supervisors and typically other professionals and family members involved in the case. If someone complains, the worker's review chain extends to managers, administrators, and, if something adverse happens AFTER the decision, the press and community. For administrators, their review chain also includes political appointees, politicians, community advocacy groups, the press, and the public at large. These review chains include individuals with varying knowledge of, interest in, and commitment to data-driven decision making. These individuals, along with the workers or administrators making the decisions, operate under conditions full of well-documented cognitive biases.

A fundamental benefit of data-driven decision making is the interruption of our naturally occurring cognitive biases. This type of decision making causes us to slow down and check the data against our perceptions. When review chain members do not slow down, nothing prevents them from judging the decisions of workers and administrators solely through the lens of one or more cognitive biases. When the data-driven decision does not align with the decision that would have been made without the data, the worker or administrator will be in for some heat. It takes courage to hold firm to the specific actions and larger policies that incorporate data into decision making.

As an example, this is the classic situation of dissonance between a worker decision and what the review chain contends the worker should have done: A worker decides to NOT open (or keep open) a case, and subsequently, an adverse event occurs. The review chain members (and often the worker, second guessing him/herself) review the decision and one or more cognitive biases strongly influence the thinking. A few examples follow.

- Hindsight bias. This is pretty obvious. When the review chain already knows the outcome, they may have a distorted sense that had they been involved with the situation before the adverse event, they would have known all along what was going to happen.

- Identifiable victim bias. This child, whose photograph haunts us from the newspaper page, draws passionate conviction that we should have done something. Sadly, most child protection agencies face serious gaps between available resources, the actual time investment required to effectively intervene in any one family, and the fact that there are hundreds (in larger systems, thousands) of children just like this child. Yet, seldom is there public outcry that child protection agencies should be resourced properly to serve ALL families in danger and at high risk.

© 2016 by NCCD, All Rights Reserved

- Regressive bias. This is a cognitive error that often directly conflicts with data. Regressive bias refers to a tendency to overestimate high risk and underestimate low risk. Combined with hindsight bias, the family that already experienced an adverse event will look to review chain members as a family who, prior to the adverse event, was obviously high risk and something should have been done. If the worker estimated the family's risk with an actuarial tool, which assigned low or moderate risk, and if the administrator supports policies that direct the child protection agency's scarce resources to higher-risk families, the decision to close the case would now be challenged by review chain members who are certain that a case should have been opened.

Here is where courage is needed. One alternative is to accept the subconsciously biased review chain reasoning. The worker can take on unrelenting guilt. The administrator can fire the worker, winning praise from the review chain for such decisive correction of an obvious mistake. In the future, workers at this agency will be more likely to remove and open a case than to leave children with their families and close cases. This is influenced by zero-risk bias (investing intensively to lower an already small risk, while allowing more prevalent, higher risk to drift upward) and the availability heuristic (being unduly influenced by recent and emotionally charged events). This alternative, which is chosen far too often, contributes to unnecessary removals, burgeoning caseloads that swamp workers' abilities to work effectively with any one case, and the long-term tragic but well-hidden impact on children and families. A headline will never report, for example, the thousands of children who were removed unnecessarily, are less likely to graduate school, more likely to experience teen pregnancy, and more likely to become involved in the juvenile justice system.[1]

In a data-driven system, however, the system first equips itself with a reliable and valid actuarial risk assessment tool. Granted, these are not "predictors," nor are they perfect. Still, they outperform unaided judgment and other ways to estimate risk; it is the best tool a worker and an administrator can have. Next, the system works for high-fidelity use of the tool. Even a good tool fails if used incorrectly, and correct use takes effort. Third, the system has in place reasonable policies around how risk level will be used (and how it will not be used: risk level should never be used to guide removal decisions). These policies should take into account the resources available to the agency, alternative resources in the community, the community's tolerance for risk, and the distribution of risk levels and number of families at each risk level.

In the rare event that an adverse event happens after closing the case of a low- or moderate-risk family, the worker and administrator need to courageously hold onto the practice and policy that best serves the most families.

Most severe, adverse events occur among higher-risk families. Sometimes these events happen after a case is closed for a high-risk family. Why does a worker close a high risk case? Sometimes it is because the worker cannot open a case or keep a case open. If a family refuses, the only way to open a case is to obtain a court order. Often, there is not enough available evidence to do this. Sometimes the worker feels helpless to open a case if the family is reluctant to accept services. Courageous leadership is needed to reduce unserved high- and very high-risk families. Several ways to do this follow.

[1] Doyle, J. J. (2007, December). Child protection and child outcomes: Measuring the effects of foster care. *The American Economic Review, 97*(5), 1583–1609.

© 2016 by NCCD, All Rights Reserved

- Make it a priority that every worker truly understands risk and can effectively talk about risk with families. When voluntary intervention is the only option, effective strategies to help families understand that they are at risk and that they have the support and ability to reduce their risk are essential.

- Make it a priority that every worker has the practice skills and the time to use them to build partnerships with families that increase the chances of families being motivated to do something to lower their risk.

- Work tirelessly with community partners to develop alternatives to child protection intervention for higher-risk families so that if child protection itself is not an option, they can get help to reduce their risk in other ways.

- Advocate, with data, for sufficient resources for the CPS agency to provide a level of intervention for higher-risk families that can demonstrably reduce adverse outcomes. (A workload study and evaluation study can help.)

Quite often, these adverse events happen among higher-risk cases that are open. How can this happen? Take a hypothetical CPS agency that has resources to serve 100 families effectively and has 100 high- or very high-risk families. If the workers and agency feel pressure to open low or moderate risk cases, one of the following three things could happen.

- Decisions are made to not open higher-risk families. Of course, this actually increases the overall chance of an adverse event.

- More cases are opened overall without a change in resources, meaning that each family gets less of a worker's time. This means more chances of overlooking important information, reduced ability to form a working partnership with the family that is a foundation for change, and ultimately a reduction in the ability of services to every family to have a positive results.

- Agency resources are increased in order to effectively serve all families, including lower- and moderate-risk families. This means an increased budget, which translates to either reductions in other county or state services or an increase in taxes.

Using data to make sound decisions about case opening and service level often puts a worker and administrator at odds with review chain members. Yet, sticking to data-informed policy; advocating for agency and community resources to support the policy; equipping workers with the knowledge, skills, and time needed to follow the policy; and data feedback loops to ensure fidelity to the practice and policy take courage and can lead to better outcomes.

© 2016 by NCCD, All Rights Reserved