

INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

February 2014



INTEGRATING SAFETY, PERMANENCY AND WELL-BEING: A view from the field



Preface

This series of papers, *Integrating Safety, Permanency and Well-Being in Child Welfare*, describes how a more fully integrated and developmentally specific approach in child welfare could improve both child and system level outcomes. The papers were developed to further the national dialogue on how to more effectively integrate an emphasis on well-being into the goal of achieving safety, permanency and well-being for every child.

The overview, *Integrating Safety, Permanency and Well-Being: A View from the Field* (Wilson), provides a look at the evolution of the child welfare system from the 1970s forward to include the more recent emphasis on integrating well-being more robustly into the work of child welfare.

The first paper, *A Comprehensive Framework for Nurturing the Well-Being of Children and Adolescents* (Biglan), provides a framework for considering the domains and indicators of well-being. It identifies the normal developmental trajectory for children and adolescents and provides examples of evidence-based interventions to use when a child's healthy development has been impacted by maltreatment.

The second paper, *Screening, Assessing, Monitoring Outcomes and Using Evidence-based Practices to Improve the Well-Being of Children in Foster Care* (Conradi, Landsverk and Wotring), describes a process for delivering trauma screening, functional and clinical assessment, evidence-based interventions and the use of progress monitoring in order to better achieve well-being outcomes.

The third paper, *A Case Example of the Administration on Children, Youth and Families' Well-Being Framework: KIPP* (Akin, Bryson, McDonald, and Wilson), presents a case study of the Kansas Intensive Permanency Project and describes how it has implemented many of the core aspects of a well-being framework.

These papers are an invitation for further thinking, discussion and action regarding the integration of well-being into the work of child welfare. Rather than being a prescriptive end point, the papers build developmentally on the Administration on Children, Youth and Families' 2012 information memorandum *Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* and encourage new and innovative next steps on the journey to support healthy development and well-being.

Acknowledgments

This publication was produced by Paltech, Inc. under the Technical Support and Product Development for the Children's Bureau and its Grantees, contract number HHSP23320095648WC with the U.S. Department of Health and Human Services (HHS). The author of this publication was Charles Wilson, MSSW, of the Chadwick Center for Children & Families at Rady's Children's Hospital—San Diego

Disclaimer

The views, opinions, and content expressed herein are those of the authors and do not necessarily reflect the views, opinions, or policies of HHS or Paltech. No official support of or endorsement by HHS or Paltech for these opinions or for particular interventions, programs, practices, tools, instruments, software, or resources is intended or should be inferred.

Reflection

As our response to abuse and neglect of children has evolved over 50 years, child welfare across the United States has undergone a fundamental transformation. Today, the forces shaping the future of child welfare are shifting in a way that not only will produce change, but may bring dramatic improvement to the lives of children and families touched by the system. Alignment of vision, science, management, and leadership is taking place and is reshaping the culture of child welfare at all levels across the country.

At the heart of the change is the full integration of the three federal child welfare goals established by Congress in 1997 in the Adoption and Safe Families Act: safety, permanency, and well-being. An emphasis on safety and permanence is not new. These two goals have been at the center of child welfare practice since the 1970s. It is an understanding of the need to address children's social and emotional well-being emerging in research and practice that is driving the transformation.

For this author, the meaningful integration of social and emotional needs of children with safety and permanence is revolutionary. I began working in child welfare in 1972 in rural Florida and continued in Memphis, Tennessee, as a child protective services intake worker. At that time, my primary goal was clear: physically protect children and keep them safe. I knew the stakes were high. If I did not perform my job, a child could be seriously injured or die. My colleagues and I took this responsibility seriously. We had few tools at our disposal. We could remove children from dangerous environments and send parents to general mental health providers or parenting classes. In the absence of empirical evidence, child welfare systems operated in good faith to assure the best interests of the child.

Some might argue that, due to this single-minded focus on physical protection that resulted in removing children from maltreating caregivers, we resorted to placing children in foster care far too often. As a result, the foster care population rose steadily. By 1998 there were more than 550,000 children in out-of-home care (AFCARS, 1998).

As the foster care population grew, children experienced frequent moves, loss of connections with siblings and parents, changes in schools, and little predictability. The system bulged at the seams. Murmuring concerns in the 1970's about the role and effectiveness of child welfare increased in volume and spawned a national debate.

Child welfare leaders and their critics increasingly recognized that foster care alone was an insufficient response to abuse and neglect. We needed to do more. Children needed a permanent family either with their original caregivers or formed through adoption and guardianship. At this time, the overriding tension inherent in child welfare was born: balancing a child's physical safety with the child's fundamental need to grow up in a family environment. Foster care was perceived as a temporary solution and permanency became the central child welfare focus.

The mission of child welfare grew more complex: keep children safe, keep them at home, and, if that was not possible, place them for adoption or guardianship. In the age of aggressive permanency planning, reducing the number of children in foster care became the dominant metric of success. Implicit in this shift was the notion that foster care itself was less than ideal and diminishing children's prospects for the future. Advocates and former foster youth effectively and accurately depicted the shortcomings of a system that relied primarily on substitute care during a vulnerable child's formative years. These efforts combined with increasingly sophisticated perma-

nency practices led to a decrease in the use out-of-home placement and increased efforts to move children who were in foster care to permanency quickly. Successful child welfare systems were considered to be those that reduced the number of children in state custody.

Financial concerns also played a role. As the foster care rolls grew in the nineteen-eighties, child welfare expenses ballooned. The field sought practices that contained costs by constraining the population's growth without compromising the safety of children. The emphasis on permanency and shrinking the size of the out-of-home population led to a dramatic reduction in the number of children in foster care. This began in the 1990s and gained momentum in the year 2000 and beyond. Between 1998 and 2012, the number of children in foster care dropped by a dramatic 27 percent nationwide (AFCARS, 2012).

This decline was driven in part by federal legislation emphasizing permanency as a child welfare priority. *The Adoption and Safe Families Act of 1997* went further, though, than holding states accountable for children's safety and permanency. It also required a focus on well-being. While few appreciated the implications in 1997, the role of child welfare was exponentially expanded. This new focus meant that it was no longer good enough to achieve physical safety and secure a permanent placement. Child welfare was obligated to address the well-being of children. No one was quite sure what this meant. Some suggested that care was adequate as long as foster children went to school, saw a doctor when they were sick, visited a dentist each year, and received mental health services. Others suggested that achieving safety and permanency amounted to meeting a child's well-being needs.

At this point, the application of science and data began to play a role in shaping the philosophy and practice of child welfare. Those studying children who had been in foster care discovered that reunification did not necessarily yield better outcomes. Children returning home, in many cases, appeared to fare worse in school and function less successfully in society than those who were not reunified. Those children were more likely to be arrested and to exhibit behavior problems (Tausig, Clyman, & Landsverk, 2001; Bellamy, 2008). Research also indicated that placing children in permanent adoptive homes was not a panacea. Children placed for adoption require mental health services at largely undiminished rates years after placement (Simmel, et al., 2007). Clearly, something more than physical safety and a permanent home was needed.

It was time to consider the concept of well-being—its parameters, nuances, and, most importantly, its application to children who have experienced significant trauma. The Administration on Children, Youth, and Families began to articulate a vision of social and emotional well-being. If fulfilled, children served by the child welfare system would have improved lives. This vision of social and emotional well-being went beyond simple metrics of doctor visits or school attendance and posed a challenge: what can we do to build children's capacity to function in a complex world and negotiate the challenges of life?

During this same period, we began to more fully appreciate the vital importance of the first years of life and the value of intervening early in a child's development. This was matched with a growing understanding of the impact of traumatic stress on the body and the brain, especially for young children (Perry, et al, 1995; Pynoos, et al, 1997; van der Kolk, 1997; Shonkoff & Garner, 2012).

Another movement was underway in child welfare at this time. Child welfare leaders began to ask the question, "What evidence do we have that what we do really works?" Learning from a similar movement in medicine a decade earlier, systems began to introduce evidence-based practices

designed to achieve positive impacts on the lives of the children and families into child welfare services. In the space of less than ten years, evidence-based practices moved from the university laboratory into the mainstream of child welfare and mental health systems. This offered frontline workers new tools to achieve safety, permanency and well-being nationwide. We could have only dreamt of this opportunity in the 1970s.

The interaction between the three goals is mutually compatible and synergistic. Few can question the logic that a child better able to regulate emotions and successfully navigate complex social interactions and who can build and maintain positive relationships with adults will have more opportunities for successful permanent placement. There also is a decreased risk for maltreatment. The three goals of safety, permanency and well-being are intertwined and jointly reinforce one another.

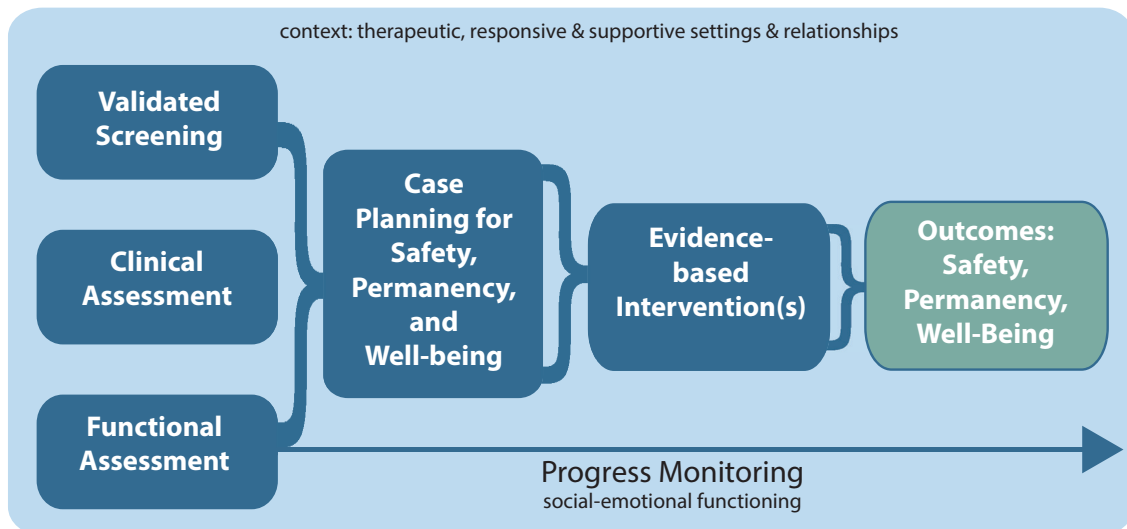
Child welfare systems that take advantage of emerging opportunities to improve outcomes for vulnerable children will require new approaches and capacity. This reflection provides an introduction to three papers that describe ways to better integrate safety, permanency, and well-being and demonstrate how these approaches can make a difference for children and families.

Three Papers

The first paper, by Anthony Biglan, presents a framework for understanding and achieving well-being for children and youth, including those who have experienced trauma. Guided by such a framework, child welfare and its complementary systems can ensure children and families get the right intervention, at the right time, and with the right support to change their developmental and life trajectories for the better.

In the second paper of this series, John Landsverk and colleagues explore essential steps in this process, outlining the embedding of screening and assessment in a comprehensive, evidence-based/evidence-informed service delivery system. (See Figure 1 below.) Child welfare needs a screening and assessment system that identifies the social and emotional needs of children, just as it needs a safety and risk assessment system. Identification of trauma symptoms, mental health concerns, and functional needs can then be linked to comprehensive and trauma-informed mental health assessment to identify a child's strengths and needs, which then leads to the selection of an evidence-based or evidence-informed intervention best suited to that child and family to achieve better outcomes.

Figure 1



However, it is clear that having evidence-based practices available is not enough. The practices must fit the unique needs of the community. To determine what practices are needed, it is important to use data to develop a multidimensional profile of the population to inform strategic decisions. This information can drive the purchase of services that will have the greatest positive impact on the social and emotional needs of the children served, enhancing their safety and creating opportunities for real permanence. In the final paper, Becci Akin and colleagues discuss one state's experience in mining multiple data sources to guide the selection of an evidence-based intervention to address long-term foster care.

The three papers in this series mark a moment in child welfare's evolution, articulating how systems can better integrate safety, permanency, and well-being to achieve dramatically improved outcomes for children, youth, and families. As the past has shown, building a better system is an ongoing journey and there is always progress to be made. Research will continue to deepen our understanding of children and families and encourage innovations. We owe it to our young people, our society, and ourselves to keep moving forward.

INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

February 2014



A COMPREHENSIVE FRAMEWORK for Nurturing the Well-Being of Children and Adolescents



Preface

This series of papers, *Integrating Safety, Permanency and Well-Being in Child Welfare*, describes how a more fully integrated and developmentally specific approach in child welfare could improve both child and system level outcomes. The papers were developed to further the national dialogue on how to more effectively integrate an emphasis on well-being into the goal of achieving safety, permanency and well-being for every child.

The overview, *Integrating Safety, Permanency and Well-Being: A View from the Field* (Wilson), provides a look at the evolution of the child welfare system from the 1970s forward to include the more recent emphasis on integrating well-being more robustly into the work of child welfare.

The first paper, *A Comprehensive Framework for Nurturing the Well-Being of Children and Adolescents* (Biglan), provides a framework for considering the domains and indicators of well-being. It identifies the normal developmental trajectory for children and adolescents and provides examples of evidence-based interventions to use when a child's healthy development has been impacted by maltreatment.

The second paper, *Screening, Assessing, Monitoring Outcomes and Using Evidence-based Practices to Improve the Well-Being of Children in Foster Care* (Conradi, Landsverk and Wotring), describes a process for delivering trauma screening, functional and clinical assessment, evidence-based interventions and the use of progress monitoring in order to better achieve well-being outcomes.

The third paper, *A Case Example of the Administration on Children, Youth and Families' Well-Being Framework: KIPP* (Akin, Bryson, McDonald, and Wilson), presents a case study of the Kansas Intensive Permanency Project and describes how it has implemented many of the core aspects of a well-being framework.

These papers are an invitation for further thinking, discussion and action regarding the integration of well-being into the work of child welfare. Rather than being a prescriptive end point, the papers build developmentally on the Administration on Children, Youth and Families' 2012 information memorandum *Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* and encourage new and innovative next steps on the journey to support healthy development and well-being.

Acknowledgments

This publication was produced by Paltech, Inc. under the Technical Support and Product Development for the Children's Bureau and its Grantees, contract number HHSP23320095648WC with the U.S. Department of Health and Human Services (HHS). The author of this publication was Anthony Biglan, Ph.D., Senior Scientist of the Oregon Research Institute.

Disclaimer

The views, opinions, and content expressed herein are those of the authors and do not necessarily reflect the views, opinions, or policies of HHS or Paltech. No official support of or endorsement by HHS or Paltech for these opinions or for particular interventions, programs, practices, tools, instruments, software, or resources is intended or should be inferred.

Introduction

This is the first in a series of three papers entitled *Integrating Safety, Permanency and Well-Being* written for the Administration on Children, Youth and Families at the U.S. Department of Health and Human Services to further dialogue regarding the more robust integration of well-being with the safety and permanency pillars of child welfare services. This paper presents a framework for ensuring the successful and healthy development of young people who have been maltreated or are at risk to be maltreated. Much research evidence about child and adolescent development has accumulated in the past 30 years, making it increasingly clear that it is both possible and necessary to integrate safety and permanency with efforts intended to ensure young people's successful development and well-being (Administration for Children & Families, 2012).

The Problem of Child Abuse and the Need for Comprehensive Strategies

The harm child abuse does to a child is far more pervasive than previously believed. Recent biological studies of the effects of maltreatment indicate that, beyond its immediate physical harm, abuse causes significant effects on children's cognitive, social, behavioral, and physical development. Shonkoff, Boyce, and McEwen (2009) review evidence showing that maltreatment and related stressors such as poverty, family conflict, and parental substance abuse can produce latent effects on children's health and behavior that are not detected until much later. In addition, the cumulative effect of repeated exposure to stress produces myriad effects including "...coronary artery disease, chronic pulmonary disease, cancer, depression, and drug abuse (p. 2253)," as well as teenage pregnancy and obesity. Thus, preventing maltreatment and treating those who have been maltreated will have benefits that extend throughout the life of the individual and to those around the individual.

Even after maltreatment has ended and children are safe and have achieved permanency, it is likely that many will require further assistance to address their well-being and developmental needs. Recent neuroscience findings show that maltreatment has an impact on brain functioning in ways that affect emotional regulation and executive functioning. Evidence-based interventions can help children develop these self-regulatory capacities, control emotions and inhibit impulses in the interest of achieving longer term outcomes to include being successful at home, in school, at work, in the community and in relationships. In the absence of effective interventions, academic and employment challenges and social rejection are common, which, taken together, contribute to the development of numerous problems including drug abuse and delinquency (Biglan, Brennan, Foster, & Holder, 2004).

Comprehensive family support is also needed to help children heal and recover after abuse has occurred and to prevent maltreatment. Much child abuse is never reported or detected. For example, Theodore et al. (2005) found in phone surveys that rates of parental discipline practices considered abusive were 40 times greater than that of official child physical abuse reports. This implies that universally available strategies are needed to prevent and address child abuse among families who may never be identified (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009).

When families do come to the attention of child welfare, targeted and intensive interventions can be provided to increase family capacity and functioning while simultaneously promoting healing and recovery for children. Importantly, most children are never removed from their caregivers, and the majority of those who enter foster care return home. Within this overall context of parental and family relationships, children's well-being and developmental needs can and must be met. In sum, there are strong reasons for all of the agencies and organizations with responsibility

for child and adolescent development, such as child welfare, to develop integrated, coordinated approaches to helping families and caregivers increase the quality of their nurturance. Increasing the nurturing capacity of parents and caregivers can prevent maltreatment from occurring and buffer children from negative long-term effects of maltreatment in order to help them get back on track developmentally. This is critically important in child welfare as child abuse and neglect often occurs in a relationship context.

A Developmental Framework for Promoting Well-Being

The Administration on Children, Youth and Families, in its *Promoting Social and Emotional Well-being for Children and Youth Receiving Child Welfare Services*, called on the child welfare field to embed a developmentally specific focus on well-being in all areas of its work (ACF, 2012). In child welfare and in other child and family serving systems, prevention and neurobiological science is increasingly informing this emphasis on promoting healthy development in the social/emotional, behavioral, cognitive, and physical domains. This focus on healthy development, rather than on preventing specific child-level problems, has been prompted by several lines of research. First, it has become clear that psychological, behavioral, and health problems tend to be inter-related, so that a young person with a problem such as substance abuse is highly likely to have other problems, ranging from academic failure and depression to risky sexual behavior (Biglan et al., 2004; Boles, Biglan, & Smolkowski, 2006). Second, most problems arise in environments that fail to nurture young people's positive social behavior and values (Biglan et al., 2004). Third, analysis of the ingredients of most evidence-based preventive interventions shows that they have preventive effects because they foster development of prosocial behaviors and values that are incompatible with problems (Biglan, Flay, Embry, & Sandler, 2012).

Caring and Productive Young Adults

One way to think about how to nurture development is to imagine the caring and productive 19-year-olds envisioned in the Institute of Medicine's report on preventing mental and behavioral health problems (National Research Council & Institute of Medicine, 2009). They will be high school graduates pursuing further education: anything less than that would likely result in a life of under employment and low-paying jobs (Bynner & Parsons, 1997). To succeed in school, they will have developed the self-management skills and social relations that enable them to complete schoolwork, get support from others, and avoid conflict. They will be physically healthy and not obese, have a healthful diet, and exercise regularly. These skills and activities will be in place because they have developed self-regulation or executive functions enabling them to persist in the face of challenges and cope with distress without having to avoid or suppress it (Vohs & Baumeister, 2011). Finally, the caring young adults that their families and communities nurture will be strongly committed to helping others and contributing to their community's well-being.

Nurturing these qualities, throughout infancy, childhood and adolescence, will have additional advantages. Young people with these characteristics are unlikely to have any of the psychological, behavioral, or health problems that are so costly to young people and society: antisocial behavior, substance abuse, risky sexual behavior, or depression. Indeed, most of what has been learned about the environments that promote these positive qualities comes from prevention research that set out to prevent one or more of the most common and costly psychological and behavioral problems (NRC & IOM, 2009).

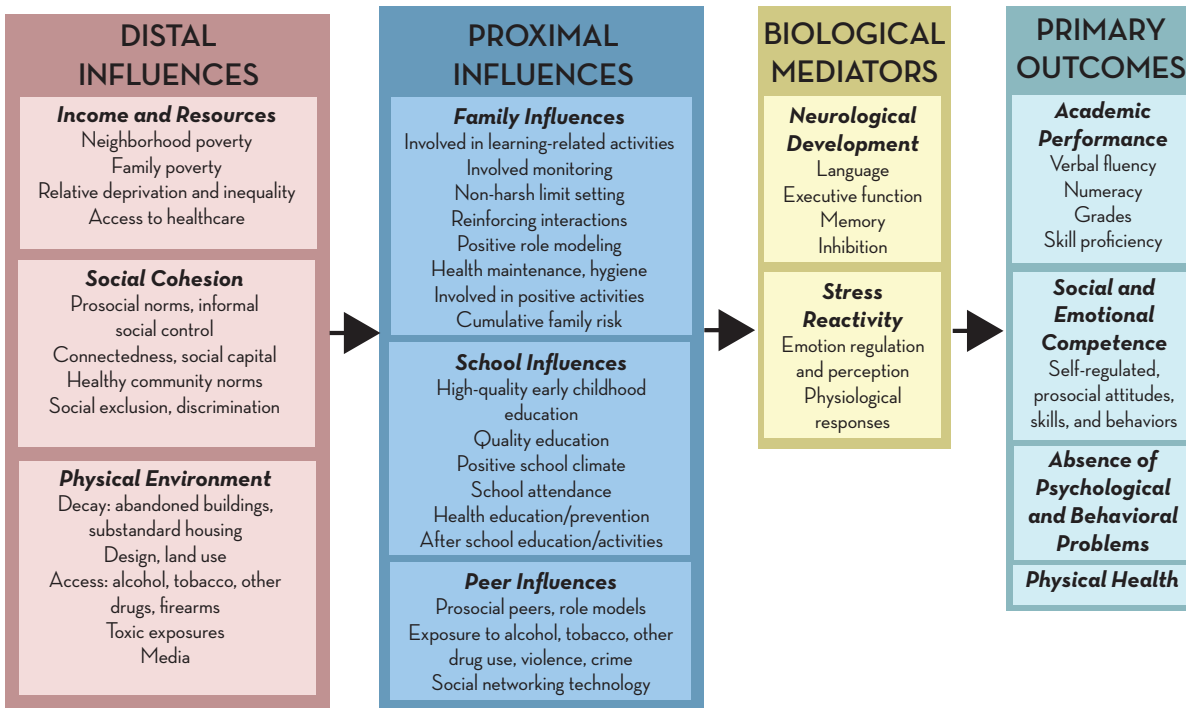
For their own well-being and for the good of society, children and young adults' healthy development requires a constellation of behaviors, values, and attitudes that involve working for the well-being of others and striving to develop themselves. Because of its centrality to the well-being of individuals and groups, this constellation has come to be called prosociality by a growing number of behavioral scientists (Biglan & Cody, 2013; Caprara, Alessandri, & Eisenberg, 2012; Wilson, O'Brien, & Sesma, 2009). If they are in nurturing and prosocial environments, they have fewer behavioral problems (Caprara, Barbaranelli, Pastorelli, Bandura, & Zimbardo, 2000; Kasser & Ryan, 1993; Sheldon & Kasser, 1998; Wilson & Csikszentmihalyi, 2008), do better in school (Caprara et al., 2000), have more and better friends (Clark & Ladd, 2000), and are healthier (Biglan & Hinds, 2009).

Nurturing Development from Pregnancy through Adolescence

Prevention scientists have identified a set of programs, policies, and practices that can ensure positive well-being outcomes for most young people—if we can reach them with these interventions. Key ingredients of these interventions are that they make young people's environment more nurturing (Biglan et al., 2012). They (a) reduce socially and biologically toxic conditions; (b) teach, promote, and richly reinforce executive functions such as self-regulation and positive interactions/relationships with others; (c) limit opportunities for problem development; and (d) promote the pragmatic pursuit of prosocial values. Because children and youth who have experienced maltreatment are more likely to develop social/emotional, behavioral, and mental health problems than other children, it is important that interventions containing these essential ingredients be available in order to help bring them back onto a healthy developmental track. Examples of evidence-based interventions that contain these essential ingredients and promote positive development are provided later in this paper.

Figure 1 presents a framework for thinking about what is needed for all children, including those who have experienced maltreatment and trauma. It is adopted from an analysis by Komro, Flay, Biglan, and the Promise Neighborhoods Research Consortium (2011) of the last 30 years of developmental research. At every phase of development—from pregnancy through adolescence—young people need to develop cognitively, to develop social and emotional competence, and to be physically healthy. We also need to prevent them from developing any of the many psychological, behavioral, or health problems that can harm them and be costly to those around them and the society in general.

Figure 1: PNRC Model



The three most important proximal influences on young people’s development are the family, school, and peers. Effective community efforts to ensure successful development must ensure that these environments are nurturing, as just described. Families, schools, and peers, however, exist in a larger social context that affects the likelihood that they will be nurturing. As Figure 1 shows, more distal influences are also important, including the economic resources of families, schools, and neighborhoods. So is the degree of social cohesion in the neighborhood and community—the degree to which there are strong prosocial norms, positive social relations, and minimal social exclusion or discrimination. Finally, the quality of the physical environment, including physical decay of buildings; access to weapons, alcohol, tobacco, and other drugs; and access to nutritious food can have a strong influence on developmental outcomes.

Table 1 below shows the essential outcomes to be nurtured in the cognitive, social/emotional, behavioral, and physical domains across the developmental stages from prenatal/birth through adolescence. It is important to note that the each of the indicators of these outcomes identified within the table is measurable. (See also Appendix 1 of the ACYF well-being framework; 2012.) Thus, it is possible to assess whether a child is on target developmentally across each of the domains. Advances in the use of valid and reliable screening and functional assessment tools also allow for on-going progress monitoring to determine if the interventions employed are helping to return the child to on target developmental functioning. Paper 2 in this series, *Screening, Assessing, Monitoring Outcomes and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare* (Conradi, Landsverk & Wotring), provides more in-depth information about the use of screening and functional assessment tools to determine a child’s developmental trajectory in the cognitive, social/emotional, behavioral and physical domains.

After Table 1 are descriptions of each developmental phase in more detail, including outcomes and the major proximal influences at each stage. Examples are provided of interventions that have been shown to promote positive development and well-being during each developmental stage. As noted previously, these interventions can meet many of the needs of children who have experienced abuse and neglect by reducing socially and biologically toxic conditions, reinforcing self-regulation and positive relationships, limiting opportunities for problem development and

promoting prosocial values. The lists of interventions in each section are not exhaustive or prescriptive. It is worth noting that most of the example interventions noted in this paper are targeted or intensive rather than universal and are designed to remediate and to prevent further problems from occurring given the abuse and neglect encountered.

Additional evidence-based and evidence-informed interventions can be explored in databases such as the National Registry of Evidence-based Programs and Practices. The appendix to this document provides resources for exploring evidence-based interventions.

Table 1. Key outcomes by developmental phase

Developmental phase	Outcome Domain			
	Cognitive development	Social & emotional competence	Psychological and behavioral development	Physical health
<i>Prenatal-infancy (birth to age 2)</i>	Language development; executive functioning	Social/emotional development; attachment	Self awareness develops; behavioral development	Birth weight; physical and motor skill development; injuries
<i>Early childhood (3-5)</i>	language and early literacy development (e.g., picture naming, rhyming, letter naming); executive functioning	Self-regulation; emotional symptoms; social relations; prosocial behavior, skills, attitudes	Self-concept develops; behavioral development; attentional and hyperactivity difficulties; conduct problems	Physical development; injuries; asthma-like illness; diet; physical activity; height/weight percentiles; oral health
<i>Childhood (6-11)</i>	Reading proficiency; mathematics proficiency (at or above grade level); executive functioning	Same as above, plus: gradual shift in control from parents to child; peers assume a more central role	Same as above, plus: self-concept becomes more complex; disruptive and aggressive behavior; depressive symptoms	Same as above, plus: strength and athletic skills improve
<i>Early adolescence (12-14)</i>	Same as above, plus intellectual development, abstract thinking	Same as above, plus: central role of peer group, identity formation	Same as above, plus: violent behaviors; drug use; risky sexual behaviors	Same as above, plus: more rapid physical growth and changes; puberty and reproductive maturity; self-inflicted injuries; type 2 diabetes; STDs; any pregnancy injuries; self-inflicted injuries; diet; physical activity; BMI; type 2 diabetes; STDs; unplanned pregnancy, repeat pregnancy
<i>Adolescence (15-19)</i>	Executive functioning; intellectual development; critical and rational thinking; high school graduation	Same as above, plus: moral development; intimacy development	Same as above	

Pregnancy and the First Two Years of Life

Milestone outcomes. The first step on the road to adult well-being is being born healthy. This requires that mothers have good nutrition and do not smoke, drink, or take drugs (Olds, Henderson, Tatelbaum, & Chamberlin, 1986) and are not stressed (Coussons-Read, 2012). During the first two years of life, infants develop the rudiments of self-regulation, as they become able to calm themselves.

Other key milestones in infancy include the development of fine and gross motor skills that are the foundation for physical competence, the rudiments of language, and attachment and positive interactions with others, which are the basic building blocks of social competence (Greenspan & Greenspan, 1985; Lerner & Ciervo, 2003; NRC & IOM, 2000). This development requires patient parents who are skilled at soothing their baby when she is distressed.

Support for new parents and their infants. A number of programs help families who are at risk of having problems during pregnancy and the first two years of their child's life. The most extensively evaluated among these is the Nurse-Family Partnership, in which a nurse provides support to poor, first-time mothers during pregnancy and the first two years of the baby's life. Three randomized trials offered evidence that the program reduced child-abuse and neglect, prevented children from developing disruptive behavior disorders, increased the time between the mother's first pregnancy and her second, and improved the mother's economic situation (Olds, Hill, O'Brien, Racine, & Moritz, 2003). A long-term follow-up of the program showed that it even reduced the likelihood that the children whose mothers had received the program would be arrested at age 15 (Olds, 2008; 2010). A cost-benefit analysis (Aos et al., 2011) showed that the program yields more than \$3 in benefits to recipients and taxpayers for every dollar invested in it. The IOM report on prevention (NRC & IOM, 2009) reviewed additional programs of this sort.

Another intervention showing promise in improving the language and social development of infants born into high-risk families is Play and Learning Strategies I (PALS; Landry, Smith, & Swank, 2006). The program teaches parents responsive parenting skills designed to strengthen the parent-child bond and promote early language, cognitive, and social development. It uses videotaped examples of parents and children interacting in order to demonstrate parenting skills. Then parents are given opportunities to discuss and practice the skills.

Early Childhood (ages 2 to 5)

Milestone outcomes. During early childhood the basic foundation of language, numeracy, and preliteracy skills are established and children begin to develop the self-regulatory and social skills that are vital to the further development of most every other skill. For example, children who do not learn to restrain their first impulsive responses in stressful situations may act aggressively or refuse to cooperate with adults in ways that harm their relationships with others and prevent them from learning from adults or their peers (Denham et al., 2003). Such restraint is shaped by hundreds of interactions in which others reinforce self-regulated behavior (e.g., Agran, Blanchard, Wehmeyer, & Hughes, 2001). Thanks to such socialization, children become better able to cooperate with others: an important step in developing prosociality.

Empathy is also foundational for success in life (Eisenberg, Miller, Shell, McNalley, & Shea, 1991). Children develop empathy as they learn to take the perspective of others through hundreds of interactions in which they are asked about what they see, hear, or are doing, and what they see and hear others doing (McHugh & Stewart, 2012).

At the same time, young children must develop steadily increasing fine and gross motor skills, be physically active, have a healthful diet, and not be overweight. To the extent that we ensure these cognitive, social, verbal, and physical developments, we will prevent diverse psychological and behavioral problems (NRC & IOM, 2009). In particular, it is important to prevent aggressive social behavior, since it is a major pathway toward academic failure, social rejection, delinquency, substance abuse, and even depression (Biglan et al., 2004).

Influencing the development of young children. Families, preschools, and childcare settings influence young children's development. It is vital that communities ensure these environments nurture every young child. Families need to actively and positively engage children. Parents can patiently and skillfully engage children by following their children's lead and actively teaching them through playful interactions in which the children's attention to any given thing is the basis for the parents to extend the children's knowledge. Parents must keep harsh and inconsistent discipline to a minimum by using mild but effective consequences for problem behavior, anticipating and preventing situations that would evoke misbehavior, and richly reinforcing the children's active, positive engagement with others and their world.

Children in foster care are often removed from their homes and communities and placed into the homes of others who temporarily become their primary caretakers. They can experience multiple placement moves during their time in care. Multiple placements are associated with poorer outcomes for children (Dregan & Gulliford, 2012; Newton, Litrownik, & Landsverk, 2000) and are more likely when children have significant behavior problems (Newton et al., 2000). However, interventions that support effective parenting or caregiving can significantly reduce both the likelihood of removal from home and multiple placements, and can increase the chances of reunification at the same time that they improve children's well-being (Price et al., 2008).

Family interventions. Table 2 lists examples of family interventions that have been shown to help families and other caregivers strengthen the nurturing conditions that young children need. These interventions have multiple benefits. They help families and other caregivers replace harsh and inconsistent discipline with much more positive ways of supporting children's development. Parents learn to reinforce children's positive behavior through attentive and engaging interactions and, when needed, use rewards such as stickers and fun activities. They learn how to use mild negative consequences like timeout, if necessary.

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P; Fisher, Burraston, & Pears, 2005; Fisher, Ellis, & Chamberlain, 1999) provides intensive training and support to caregivers, children in foster care, and the parents or others who might provide a permanent placement for the child. Caregivers receive 12 hours of intensive training, receive support and supervision via daily phone calls, and have back-up assistance and consultation available around the clock. When provided for young children in foster care, the program has been shown to reduce child behavior problems (Fisher et al., 2005), reduce blunted hypothalamic-pituitary-adrenal (HPA) axis functioning (Fisher, Gunnar, Dozier, Bruce, & Pears, 2006), and reduce caregiver stress (Fisher & Stoolmiller, 2008).

Trauma-Focused Cognitive Behavior Therapy has been shown in at least two randomized trials to benefit families of children who have been diagnosed with PTSD due to sexual abuse (Cohen & Mannarino, 1996; Cohen, Deblinger, Mannarino, & Steer, 2004). The program helps children who have been abused develop skills in expressing and coping with feelings, and recognizing relationships among thoughts, feelings, and behavior. The program gradually exposes the chil-

dren to increasingly intense reminders of their traumatic experiences and helps them talk and write about and share these descriptions with their parents. Evaluations of the program indicate that, compared with alternative treatments, it produces significantly lower levels of depression, shame, and behavior problems among children. Parents were less distressed and more supportive toward their children.

Table 2: Evidence-based family interventions for early childhood

Program	Outcomes affected
<p><i>Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)</i></p> <p>Fisher, Burraston, & Pears, 2005; Fisher, Ellis, & Chamberlain, 1999</p>	<ul style="list-style-type: none"> • Reduced child behavior problems • Improved HPA axis functioning • Reduced caregiver stress • Reduction in number of placements
<p><i>Incredible Years</i></p> <p>Barrera et al., 2002; Gardner, Hutchings, Bywater, & Whitaker, 2010; Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, in press; Lees & Ronan, 2008; Webster-Stratton & Reid, 2010</p>	<ul style="list-style-type: none"> • Increases praise and use of non-violence discipline and decreases criticism, harsh discipline, negative commands • Reduces parental depression and increases parental self-confidence • Increases involvement with teachers and schools • Increases communication, problem-solving strategies, conflict management, social behavior, and play skills • Reduces conduct problems at home and school
<p><i>Family Check-Up (FCU)</i></p> <p>Dishion & Stormshak, 2009; Dishion, Nelson, & Kavanagh, 2003; Dishion, Stormshak, & Siler, 2010; Lunkenheimer et al., 2008; Moore, Dishion, & Shaw, 2012; Shaw, Dishion, Supplee, Gardner, & Arnds, 2006; Stormshak & Dishion, 2009; Van Ryzin, Stormshak, & Dishion, 2012</p>	<ul style="list-style-type: none"> • Prevents behavioral and emotional disorders • Reduces family conflict and problem behavior • Prevents substance abuse • Motivates parenting monitoring • Increases parents' positive behavior support • Decreases depression, improves self-regulation, and increases youth school engagement
<p><i>Triple P</i></p> <p>Nowak & Heinrichs, 2008; Prinz et al., 2009; Sanders, Cann, & Markie-Dadds, 2003</p>	<ul style="list-style-type: none"> • Improves the quality and effectiveness of parents' interactions with their children • Prevents child abuse and resulting foster care placement • Reduces children's uncooperative and aggressive behavior

Table 2: Evidence-based family interventions for early childhood

Program	Outcomes affected
<i>Play and Learning Strategies II (PALS) for young children</i>	<ul style="list-style-type: none"> • Improves parents' skill in developing children's verbal and cognitive skills
Landry et al., 2006; Landry, Anthony, Swank, & Monseque-Bailey, 2009; Landry, Swank, Anthony, & Assel, 2011	<ul style="list-style-type: none"> • Improves children's vocabulary and their engagement when others read to them

School interventions. Substantial evidence indicates that a high-quality preschool can significantly and cost-effectively improve a child's cognitive and social skills and prevent development of behavioral and academic problems (Pianta, Barnett, Burchinal, & Thornburg, 2009). To nurture young children's social, language, and literacy development, adults must provide a safe and structured environment characterized by sensitive and engaging interactions, including teacher-led instruction and opportunities for children to lead in play (Burchinal et al., 2008; 2009; Pianta & Stuhlman, 2004). Verbal stimulation, engagement, and feedback in less structured interactions are vital to reinforcing and extending children's cognitive and literacy development (Burchinal et al., 2008). Unfortunately, a sizable gap in quality exists between conditions tested in randomized trials and those in typical preschools (Pianta et al., 2009). Thus, recent research has focused on how to improve preschools' quality.

Landry and colleagues provide the best-developed and most extensively evaluated strategy for improving preschool quality. Landry et al. (2009) developed a facilitated online professional development training that emphasizes language and literacy development. In a randomized trial involving 158 preschools across four states, they found that the training program significantly improved the quality of teaching and led to improvements in children's phonological awareness, expressive vocabulary, and language competence. In a randomized trial in a large sample of Texas preschools, Landry et al. (2011) subsequently showed that these methods improved most aspects of teaching and children's competence. Other studies show that mentoring and feedback can improve the quality of preschool and childcare environments (Lonigan, Farver, Phillips, & Clancy-Menchetti, 2011; Rusby, Smolkowski, Marquez, & Taylor, 2008; Wasik & Hindman, 2011).

Childhood (ages 6 through 11)

Milestone outcomes. In this period a child must begin to develop the key reading and arithmetic skills that form the basis for virtually all later learning. Children who do not learn to read in early elementary school will not be able to read to learn in later grades. Children who are not reading at grade level by grade 3 are at high risk of never learning to read adequately (Fiester & Smith, 2010). They are likely to have increasing academic problems in school as they progress. Those problems not only affect later learning, they make development of behavioral and psychological problems more likely.

Emotional regulation and social development are also vital. Children with problems controlling their emotions are likely to act impulsively in ways that interfere with making and keeping friends and with their effective participation in the classroom (Graziano, Reavis, Keane, & Calkins, 2007; Kashdan & Rottenberg, 2010; Spinrad et al., 2006). It is also essential that children are not uncooperative or aggressive at home and in school, as these behaviors predict social rejection and academic failure (Walker, Colvin, & Ramsey, 1995).

Finally, it is important that children be physically healthy, are not overweight, stay physically active, and eat healthful foods.

Key influences on development. Families, of course, continue to have a critical influence on children’s development. As with early childhood, it is vital during this stage that parents remain involved with their children on a daily basis, listening to them, and supporting their cognitive and social development. Increasingly, parents should monitor their children’s activities outside the home and set limits that prevent them from becoming involved in risky behavior. It continues to be essential that parents richly reinforce children’s desirable behavior through their attention, interest, and love and use mild, consistent methods of discipline, such as timeout, when discipline becomes necessary.

Supports for families. Families having trouble maintaining this kind of nurturing environment need access to supportive, evidence-based family interventions that can help them strengthen their family life. Table 3 lists examples of interventions shown to help families become more nurturing during childhood. These programs are similar to and in some cases the same as the programs listed above for families of young children. They reliably improve families’ nurturance and reduce children’s aggressive behavior.

Table 3: Examples of evidence-based interventions for childhood

Program	Outcomes affected
Families	
<p><i>Parent Management Training-Oregon (PMTO)</i></p> <p>Forgatch, Patterson, & DeGarmo, 2005; Forgatch, Patterson, DeGarmo, & Beldavs, 2009; Ogden, Forgatch, Askeland, Patterson, & Bullock, 2005</p>	<ul style="list-style-type: none"> • Reduces coercive discipline practices and increases warm and positively reinforcing relationships among family members • Reduces children’s aggressive and uncooperative behavior
<i>Incredible Years</i>	See Table 2
<i>Triple P</i>	See Table 2
Schools: Instruction	
<p><i>Response to Intervention</i></p> <p>Burns, 2007; Fuchs & Fuchs, 2006; Jimerson, Burns, & VanDerHeyden, 2007</p>	<ul style="list-style-type: none"> • Identifies academic and behavioral needs of individual students • Uses data to inform the problem-solving process • Designs and modifies instruction to meet student needs • Evaluate the effectiveness of instruction at different levels of the system • Regularly assesses students’ progress in learning and behavior so teachers can identify which students need more help, which are likely to make good progress without extra help, and which need their learning accelerated • Conducts brief progress monitoring assessments to determine if students are progressing adequately

Table 3: Examples of evidence-based interventions for childhood

Program	Outcomes affected
<p><i>Direct Instruction</i></p> <p>Barrera et al., 2002; Engelmann, 2007; Engelmann, Becker, Carnine, & Gersten, 1988; Gunn, Biglan, Smolkowski, & Ary, 2000; Smolkowski et al., 2005; Stockard & Engelmann, 2010</p>	<ul style="list-style-type: none"> • Increases the ability of all children to learn • Children improve academically and in terms of their self images • Teachers are able to succeed with adequate training and materials, regardless of circumstance • Low performers and disadvantaged learners are able to catch up to their higher-performing peers • DI minimizes the chance of students’ misinterpreting the information being taught and maximizes the reinforcing effect of instruction
<p><i>Cooperative Learning</i></p> <p>Johnson, Johnson, & Hulobec, 2008; Johnson, Johnson, & Smith, 1991; 1998; Wenzel, 2000</p>	<ul style="list-style-type: none"> • Students learn significantly more, remember it longer, and develop better critical-thinking skills • Students enjoy Cooperative Learning more than traditional lecture classes, and are more likely to attend class and finish the course. • Students develop the skills necessary to work on projects too difficult and complex for any one person • Prepares students to assess outcomes linked to accreditation
<p>Schools: Social</p>	
<p><i>Good Behavior Game (GBG)</i></p> <p>Embry, 2002; Kellam et al., 2008; Poduska et al., 2008</p>	<ul style="list-style-type: none"> • Reduces disruptive behavior and increases cooperation in classrooms • Children who received Good Behavior Game (only in first or second grade had fewer drug abuse problems, antisocial behavior, or suicidality as young adults, compared with those who did not receive GBG
<p><i>Positive Behavioral Intervention and Support (PBIS)</i></p> <p>Bradshaw, Koth, Bevans, Ialongo, & Leaf, 2008; Bradshaw, Koth, Thornton, & Leaf, 2009; Bradshaw, Mitchell, & Leaf, 2010; Horner et al., 2009; Horner & Sugai, 2000; Metzler, Biglan, Rusby, & Sprague, 2001; Sugai & Horner, 2002</p>	<ul style="list-style-type: none"> • Reduces discipline problems in schools. • Increases academic engagement and achievement.

Table 3: Examples of evidence-based interventions for childhood

Program	Outcomes affected
<p><i>Positive Action</i></p> <p>Beets et al., 2008; Flay & Allred, 2003</p>	<ul style="list-style-type: none"> • Reduces disruptive behavior, prevents substance use, and improves academic achievement • Teaches youth specific positive actions in the physical, emotional, intellectual, and social domains of life • Helps youth identify positive feelings and treat others the way they want to be treated
<p><i>Promoting Alternative Thinking Strategies (PATHS)</i></p> <p>Domitrovich, Cortes, & Greenberg, 2007; Kam, Greenberg, & Kusche, 2004</p>	<ul style="list-style-type: none"> • Improves children’s social competence, reduces social withdrawal, and prevents the development of aggressive social behavior, anxiety, and depression

School interventions. Table 3 also lists examples of the instructional approaches and social and behavior interventions that can effectively support children’s development. As noted above, it is vital that children learn to read in elementary school, because programs to remediate reading deficiencies later are seldom available. Effective reading instruction requires that students learn how to decode the phonemes in words and blend them with sufficient skill and speed in order to comprehend what they are reading (Gunn et al., 2000).

At the same time, schools must create a climate that promotes positive social behavior and minimizes the use of punishment from adults and bullying and harassment from other students. Table 3 lists interventions that have proven valuable in helping children develop positive, cooperative social behavior. Each intervention has been shown in rigorous randomized trials to reduce aggressive behavior and contribute to children’s social and academic development. As the value of these interventions becomes clearer, more schools are adopting them. For example, Positive Behavioral Intervention and Support (PBIS) is now in more than 15,000 schools across the nation and the Good Behavior Game (GBG) is being implemented throughout the province of Manitoba and in more than 20 U.S. school districts.

Early Adolescence (ages 12-14)

Milestones outcomes. In early adolescence, problems not effectively addressed in childhood tend to escalate. During this time, grades can fall off and the rates of substance use, delinquency, risky sexual behavior, and depression increase. This is not to say that every adolescent will have problems at this time. It is more that problems begin to emerge among children who are already having academic, social, and behavioral challenges.

Cognitive and academic skill development must continue during early adolescence. Adolescents must be at or beyond grade level in their subjects. Falling behind, especially when middle schools emphasize academic competition, can undermine early adolescents’ interest in school (Roeser & Eccles, 1998) and influence them to seek reinforcement through association with other youth who are having difficulty in school (Biglan et al., 2004).

Good peer relationships are critical at this stage. Young people whose friends value education and prosocial activities will be supported in their own commitment to these values. Conversely, early

adolescents who have few friends or have conflict with peers will be more likely to form friendships with rejected and deviance prone peers (Dishion, 2000; Dishion & Piehler, 2007). Finally, as in other periods of development, it is vital the early adolescents be physically active, eat a healthful diet, and not be overweight.

Influences on development. Families and schools continue to be the most important influences. It is vital that there are places where young people's prosocial behavior is richly reinforced and conflict and coercion are minimized. This is also the stage when heightened monitoring of young people's behavior and setting effective limits on risky behavior is essential. Richardson and colleagues (Richardson et al., 1989; Richardson, Radziszewska, Dent, & Flay, 1993) found that early adolescents who were at home unsupervised after school were at greater risk to use substances, engage in other risky behaviors, become depressed, and be less successful at their academic achievements. The risk was especially high if they were spending this time with other youth. This is one reason why the use of after-school programs is growing.

Obviously, it is impossible for some parents to be home at these times. However, parents who communicate well with their children and establish consistent cooperation can monitor what their children are doing at home in the afternoon, and can ensure that they do homework and chores, as well as play and relax safely.

An additional important influence during this period is puberty. During the onset of puberty young people learn how to establish relationships with potentially intimate partners.

Family interventions. Table 4 lists examples of family-based interventions for families with early adolescents. These interventions have been shown in randomized trials to strengthen the quality of parenting and prevent the development of diverse problems.

School interventions. Table 4 also lists examples of evidence-based school interventions of two types. The first are school wide interventions that have been shown to ensure that the social environment of the school minimizes harassment and bullying and teaches and reinforces positive behavior. Both PBIS and Positive Action are beneficial and are being implemented widely.

Of particular interest in this case is Cognitive Behavior Intervention for Trauma in Schools (Jaycox, Kataoka, Stein, Langley, & Wong, 2012). It is a program designed to help children in school settings who have been exposed to violence, including maltreatment. It provides a series of 10 class sessions for groups of 8 to 10 students (Jaycox, Langley, & Dean, 2009). The sessions focus on helping students to change "maladaptive thoughts," promote positive behavior, and enlist support from peers and adults. Stein et al. (2003) reported a randomized control trial of this program for sixth-grade children in two Los Angeles middle schools who had been exposed to violence and had PTSD symptoms. Students received the 10-session program immediately or in a wait-list control condition. At three-month follow-up, those who had received the program had fewer PTSD symptoms, lower levels of depression, and lower scores on a measure of psychological dysfunction.

The second type of intervention consists of a classroom-based program designed to prevent one or more specific problem, such as tobacco use, substance use more generally, or risky sexual behavior. In addition to the two examples listed in Table 4, there is a growing body of evidence for the value of several different school-based programs to prevent teenage pregnancy and risky sexual behavior (Kirby, 2007).

Table 4: Examples of evidence-based interventions for early adolescence

Program	Outcomes affected
Family interventions	
<p><i>Strengthening Families</i></p> <p>Kumpfer, Molgaard, & Spoth, 1996; Molgaard, Kumpfer, & Spoth, 1994; Spoth & Molgaard, 1999</p>	<ul style="list-style-type: none"> • Reduces problem behaviors, delinquency, and alcohol and drug abuse in children • Improves social competencies and school performance • Decreases child maltreatment as parents strengthen bonds with their children and learn more effective parenting skills
<p><i>Family Check-Up</i></p>	<p>See Table 2</p>
<p><i>Communities that Care</i></p> <p>Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004; Hawkins et al., 2008; 2012</p>	<ul style="list-style-type: none"> • Exposure to targeted risk factors increased less rapidly in Communities That Care than in control communities • Eighth graders were less likely to initiate delinquent behavior, to initiate the use of alcohol, to initiate cigarette use, or to initiate the use of smokeless tobacco (ST) • Less likely to use alcohol or ST in the past 30 days and less likely to have been binge drinking in the past two weeks • Eighth-grade students committed 31% fewer different delinquent behaviors than students in the control communities
School-based interventions	
<p><i>Parents and Children Against Tobacco (PACT)</i></p> <p>Gordon, Biglan, & Smolkowski, 2008</p>	<ul style="list-style-type: none"> • Influenced parents to discourage children’s tobacco use • Promotes not smoking by associating not smoking with social acceptance. • Decreased smoking prevalence and use of smokeless tobacco in the prior month at two-year follow-up. • Developed an intervention manual to help other communities replicate the study

Table 4: Examples of evidence-based interventions for early adolescence

Program	Outcomes affected
<p><i>Life Skills Training</i></p> <p>Botvin, Griffin, Diaz, & Ifill-Williams, 2001; Botvin, Griffin, & Nichols, 2006; Engberg & Morral, 2006; Griffin, Botvin, & Nichols, 2006; NC-CDPHP, 2009; Spoth, Randall, Trudeau, Shin, & Redmond, 2008; Thornton, Craft, Dahlberg, Lynch, & Baer, 2000</p>	<ul style="list-style-type: none"> • Decreases substance use • Teaches substance use resistance, anxiety reduction, and stress management • Significantly cuts tobacco, alcohol, and marijuana use initiation; reduces smoking, drinking, drunkenness, inhalant use, and polydrug use; prevents cigarette, marijuana, and immoderate alcohol use • Reduces violence and delinquency • Has a direct, positive effect on the cognitive, attitudinal, and personality factors that play a part in substance use • Emphasizes communication skills, general social skills, dating skills, and assertiveness • Teaches and provides practice in making social contacts, giving and receiving compliments and other feedback, effective listening, being persistent, having self-awareness, feelings toward others, communication, conversation, and creative thinking. • Teaches communication skills to avoid misunderstandings, clarifying, asking questions, paraphrasing, and being specific • Emphasizes reflecting on actions taken, types of responses, consequences, decision-making, awareness of persuasive tactics, refusal responses, self-respect, planning, and goal setting • Increases interpersonal and communication skills

Adolescence (ages 15-19)

Key outcomes. Among the sentinel outcomes in adolescence are graduation from high school and preparedness for, and interest in, further education. In the social realm, adolescents need to have formed strong ties with a set of prosocial friends and be skilled in maintaining respectful, safe, healthy, and supportive romantic relationships. However, as noted above, children in foster care often experience placement moves that disrupt their formation of friendships. As in earlier periods, teens should not be involved in antisocial behavior, substance abuse, or risky sexual behavior, and should have no problems with depression, anxiety, or other psychological problems, such as schizophrenia. Aspects of physical health that may be a particular concern at this age include eating healthfully, engaging in regular physical activity, not self-inflicting injuries, or having STDs, obesity, or diabetes.

Family interventions. By this age most youth are doing just fine but a small subgroup of adolescents has developed multiple problems (Biglan et al., 2004). For this reason the most prominent

interventions are designed to remediate problems among youth who already have problems and to prevent further ones from developing. Three such programs have been extensively evaluated.

Multidimensional Treatment Foster Care (Chamberlain, 2003) was originally developed for adjudicated youth, but is now in widespread use for children placed in foster care due to abuse or neglect. Unlike much foster care, however, these foster care placements provide intensive skills training for the adolescent and the foster parents, and around the clock support of the family. Foster parents closely monitor adolescents activities and provide a structured behavioral program that is designed to reinforce appropriate academic and social behavior and limit opportunities for and involvement in problem behavior. A series of randomized trials have shown that, compared with usual care conditions, the program significantly reduces recidivism and pregnancies and increases school attendance and homework completion (Chamberlain, Leve, & DeGarmo, 2007; Leve & Chamberlain, 2007; Leve, Chamberlain, & Reid, 2005).

Multisystemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) is a similarly intensive intervention that keeps adolescents in their homes and works with entire families. As the name implies, it focuses on all systems within which the adolescent lives—home, school, peers, and community. It tries to ensure that adolescents are closely monitored and that parents and schools increase reinforcement and support for appropriate behavior and prevent opportunities for problem behavior such as unsupervised involvement with deviant peers. Numerous randomized trials have evaluated the program. It has shown value in reducing recidivism among delinquent youth, reducing substance abuse, reducing emotional and behavioral disturbances among youth with emotional disorders, and in reducing abuse in families that have been found to be abusing children or adolescents (Multisystemic Therapy, 2013).

Functional Family Therapy (Alexander, Waldron, Robbins, & Neeb, 2013) is an intensive family intervention in which a therapist works with the family typically for eight or more sessions. Alexander et al. (2013) characterize treatment in terms of five processes: establishing engagement with the family, developing family motivation to change, clarifying typical sequences of interactions in the relations among family members, facilitating behavior change of individuals and change in the interactions of family members, and supporting the generalization of learned skills to a wider number of settings. The program has been evaluated in at least 19 randomized trials involving adolescents with problems including delinquency, substance abuse, and alcohol abuse. It has generally been found to produce bigger reductions in these problems than interventions with which it has been compared. The evidence indicates that it does so by improving family functioning and reducing parental depression (Alexander et al., 2013).

Cost-Benefit Analyses

Several economic experts have conducted cost-benefit analyses for the programs detailed in Tables 2 through 4 and the ones identified in the previous section. Based on their reports, most programs have proven return on investment. (See Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; O’Neill, McGilloway, Donnelly, Bywater, & Kelly, 2013.)

For example, the Washington State Institute for Public Policy reports \$25.61 in benefits per \$1 spent in implementing Life Skills Training (Washington State Institute for Public Policy, 2004) and Pennsylvania State University reports \$25.72 in benefits per \$1 spent, with an estimated \$16,160,000 in potential economic benefit statewide (Jones, Bumbarger, Greenberg, Greenwood, & Kyler, 2008).

Another source for cost-benefit analyses is the Blueprints programs website: (<http://www.blueprintsprograms.com/>).

Convergence

Traditionally, approaches to ensuring successful youth development and well-being have been fragmented. Different organizations have worked on different aspects of the same problem with little coordination and without a shared understanding of what young people need. Education has worked on ensuring young people's academic skills, but has typically given social and emotional development much less attention. Agencies addressing child abuse have typically done so as though this problem could be solved with a focus on safety and permanency. Organizations exist to prevent teenage pregnancy but often focus narrowly on sexual activity, as though it has nothing to do with coercive family and social environments. Criminal justice deals with delinquency, but rarely intervenes in families to prevent delinquency from developing. Drug abuse treatment treats drug abuse, but not mental illness, while mental health treatment is provided by other agencies, as if problems like depression and anxiety are unrelated to drug abuse. And few of these efforts take into account the effect of maltreatment and trauma on the developing brain architecture and stress response system, which are significant causes of derailed development across all domains of well-being.

All of this is changing thanks to the accumulation of a huge amount of evidence about neuro-biological, behavioral, and psychological development. Increasingly diverse organizations are coming together around a coordinated and integrated strategy that is helping communities significantly increase the proportion of young people who develop the skills, interests, and health habits they need to become productive and caring members of their community. As these coordinated efforts spread and are refined, we will see a steady decline in the rates of most of the psychological and behavioral problems that impose heavy costs on young people, their families, and their communities.

The core insights that guide these efforts are (a) the recognition that throughout development children and adolescents need warm, sensitive, reinforcing families, schools, and communities that minimize punishment, conflict, and coercion and (b) the evidence that providing these conditions can prevent the entire range of psychological, behavioral, and health problems.

Now that tested and effective school and family interventions are available to ensure these nurturing conditions, it is clear that every community organization that has responsibility for child or adolescent well-being should make it their highest priority to work with all other relevant organizations on ensuring that these nurturing conditions increasingly characterize life in the community. With the strategic use of resources, it is possible to achieve dramatic improvements in the well-being of our young people with enormous societal benefits.

Reference List

- Administration for Children & Families. (2012). *Information memo: Promoting social and emotional well-being for children and youth receiving child welfare services*. Log No. ACYF-CB-IM-12-04. U.S. Department of Health and Human Services.
- Agran, M., Blanchard, C., Wehmeyer, M., & Hughes, C. (2001). Teaching students to self-regulate their behavior: The differential effects of student-vs. teacher-delivered reinforcement. *Research in Developmental Disabilities, 22*, 319-332.
- Alexander, J. F., Waldron, H. B., Robbins, M. S. & Neeb, A. A. (2013) *Functional Family Therapy for Adolescent Behavior Problems*. Washington, DC: American Psychological Association.
- Aos, A, Lieb, R., Mayfield, J., Miller, M., & Pennucci, P. (2004) *Benefits and costs of prevention and early intervention programs for youth*. Olympia, WA US: Washington State Institute for Public Policy. Available at <http://www.wsipp.wa.gov/rptfiles/04-7-3901.pdf>.
- Aos, S., Lee, S., Drake, E., Pennucci, A., Klima, T., Miller, M., & Burley, M. (2011). *Return on investment: Evidence-based options to improve statewide outcomes* (Document No. 11-07-1201). Olympia, WA US: Washington State Institute for Public Policy.
- Barrera, M. Jr., Biglan, A., Taylor, T., Gunn, B., Smolkowski, K., Black, C., & Fowler, R. (2002). Early elementary school intervention to reduce conduct problems: a randomized trial with Hispanic and non-Hispanic children. *Prevention Science, 3*, 83-94.
- Beets, M. W., Flay, B. R., Vuchinich, S., Acock, A. C., Li, K. K., & Allred, C. (2008). School climate and teachers' beliefs and attitudes associated with implementation of the positive action program: A diffusion of innovations model. *Prevention Science, 9*, 264-275.
- Biglan, A., Brennan, P. A., Foster, S. L., & Holder, H. D. (2004). *Helping adolescents at risk: Prevention of multiple problem behaviors*. New York, NY US: Guilford.
- Biglan, A., & Cody, C. (2013). Integrating the human sciences to evolve effective policies. In D. S. Wilson, J. M. Gowdy, & J. B. Rosser (Eds.), *Evolution as a general theoretical framework for economics and public policy* (Supplementary issue). *Journal of Economic Behavior and Organization, S90*, S152-S162.
- Biglan, A., Flay, B. R., Embry, D. D., & Sandler, I. (2012). Nurturing environments and the next generation of prevention research and practice. *American Psychologist, 67*, 257-271.
- Biglan, A., & Hinds, E. (2009). Evolving prosocial and sustainable neighborhoods and communities. *Annual Review of Clinical Psychology, 5*, 169-196.
- Boles, S., Biglan, A., & Smolkowski, K. (2006). Relationships among negative and positive behaviours in adolescence. *Journal of Adolescence, 29*, 33-52.
- Botvin, G.J., Griffin, K.W., & Nichols, T.R. (2006). Preventing youth violence and delinquency through a universal school-based prevention approach. *Prevention Science, 7*, 403-408.
- Botvin, G.J., Griffin, K.W., Diaz, T., & Ifill-Williams, M. (2001). Drug abuse prevention among minority adolescents: Posttest and one-year follow-up of a school-based prevention intervention. *Prevention Science, 2*, 1-13.
- Bradshaw, C. P., Koth, C. W., Bevans, K. B., Ialongo, N., & Leaf, P. J. (2008). The impact of school-wide positive behavioral interventions and supports (PBIS) on the organizational health of elementary schools. *School Psychology Quarterly, 23*, 462-473.

- Bradshaw, C. P., Koth, C. W., Thornton, L. A., & Leaf, P. J. (2009). Altering school climate through school-wide Positive Behavioral Interventions and Supports: Findings from a group-randomized effectiveness trial. *Prevention Science, 10*, 100-115.
- Bradshaw, C. P., Mitchell, M. M., & Leaf, P. J. (2010). Examining the effects of schoolwide positive behavioral interventions and supports on student outcomes: Results from a randomized controlled effectiveness trial in elementary schools. *Journal of Positive Behavior Interventions, 12*, 133-148.
- Burchinal, M., Howes, C., Pianta, R., Bryant, D., Early, D., Clifford, R. et al. (2008). Predicting child outcomes at the end of Kindergarten from the quality of pre-Kindergarten teacher-child interactions and instruction. *Applied Developmental Science, 12*, 140-153.
- Burchinal, M., Kainz, K., Cai, K., Tout, K., Zaslow, M., Martinez-Beck, I. et al. (2009). *Early care and education quality and child outcomes* (Research to Policy Brief) (Rep. No. 2009-15). Washington, DC US: Office of Planning, Research, and Education.
- Burns, M. K. (2007). Reading at the instructional level with children identified as learning disabled: potential implications for Response-to-Intervention. *School Psychology Quarterly Journal, 22*, 297-313.
- Bynner, J. M., & Parsons, S. (1997). *It doesn't get any better: the impact of poor basic skills on the lives of 37 year olds*. London, UK: Basic Skills Agency.
- Caprara, G. V., Alessandri, G., & Eisenberg, N. (2012). Prosociality: The contribution of traits, values, and self-efficacy beliefs. *Journal of Personality and Social Psychology, 102*, 1289.
- Caprara, G. V., Barbaranelli, C., Pastorelli, C., Bandura, A., & Zimbardo, P. G. (2000). Prosocial foundations of children's academic achievement. *Psychological Science, 11*, 302-306.
- Catalano, R.F., Haggerty, K.P., Oesterle, S., Fleming, C.B., & Hawkins, J.D. (2004). The importance of bonding to school for healthy development: Findings from the social development research group. *Journal of School Health, 74*, 252-261
- Chamberlain, P. (2003). *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional treatment foster care model*. Washington, DC: American Psychological Assn.
- Chamberlain, P., Leve, L. D., & DeGarmo, D. S. (2007). Multidimensional Treatment Foster Care for girls in the juvenile justice system: 2-year follow-up of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 75*, 187-193.
- Clark, K. E., & Ladd, G. W. (2000). Connectedness and autonomy support in parent-child relationships: Links to children's socioemotional orientation and peer relationships. *Developmental Psychology, 36*, 485-498.
- Cohen, J. A., Mannarino, A. P. (1996). A treatment study for sexually abused preschool children: initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 42-50.
- Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*, 393-402.
- Coussons-Read, M. E. (2012). The psychoneuroimmunology of stress in pregnancy. *Current Directions in Psychological Science, 21*, 323-328.
- Denham, S. A., Blair, K. A., DeMulder, E., Levitas, J., Sawyer, K., Auerbach-Major, S., et al. (2003).

- Preschool emotional competence: Pathway to social competence. *Child Development*, 74, 238–256.
- Dishion, T. J. (2000). Cross-setting consistency in early adolescent psychopathology: Deviant friendships and problem behavior sequelae. *Journal of Personality*, 68, 1109-1126.
- Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The Family Check-Up for high-risk adolescents: Motivating parenting monitoring and reducing problem behavior. In J. E. Lochman & R. Salekin (Eds.), Behavior oriented interventions for children with aggressive behavior and/or conduct problems [Special issue]. *Behavior Therapy*, 34, 553-571.
- Dishion, T. J. & Piehler, T. F. (2007). Peer dynamics in the development and change of child and adolescent problem behavior. In A. S. Masten (Ed.), *Multilevel dynamics in developmental psychopathology: Pathways to the future* (pp. 151-180). New York, NY US: Taylor & Francis/ Erlbaum.
- Dishion, T. J., & Stormshak, E. A. (2009). A school-based family-centered intervention to prevent substance use: The Family Check-Up. In J. Bray & M. Stanton (Eds.), *Blackwell handbook of family psychology* (pp. 499-514). Malden, MA US: Blackwell Publishing.
- Dishion, T. J., Stormshak, E. A., & Siler, C. (2010). An ecological approach to interventions with high-risk students in schools: Using the Family Check-Up to motivate parents' positive behavior support. In M. R. Shinn, H. M. Walker, & G. Stoner (Eds.), *Interventions for achievement and behavior in a three-tier model including response to intervention*. Bethesda, MD US: National Association of School Psychologists.
- Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *The Journal of Primary Prevention*, 28, 67-91.
- Dregan, A. A., & Gulliford, M. C. (2012). Foster care, residential care and public care placement patterns are associated with adult life trajectories: Population-based cohort study. *Social Psychiatry And Psychiatric Epidemiology*, 47, 1517-1526.
- Eisenberg, N., Miller, P. A., Shell, R., McNalley, S., & Shea, C. (1991). Prosocial development in adolescence: A longitudinal study. *Developmental Psychology*, 27, 849-857.
- Embry, D. D., (2002). The Good Behavior Game: A best practice candidate as a universal behavioral vaccine. *Clinical Child and Family Psychology Review*, 5, 273-297.
- Engberg, J., & Morral, A.R. (2006). Reducing substance use improves adolescents' school attendance. *Addiction*, 101, 1741-1751.
- Engelmann, S. (2007). *Teaching needy kids in our backward system: 42 years of trying*. ADI Press.
- Engelmann, S., Becker, W.C., Carnine, D., & Gersten, R. (1988). The direct instruction follow-through model: Design and outcomes. *Education and Treatment of Children*, 11, 303-317.
- Fiester, L., & Smith, R. (2010). *Early warning! why reading by the end of third grade matters: A KIDS COUNT Special Report from the Annie E. Casey Foundation*. Baltimore, MD US: Casey Foundation.
- Fisher, P. A., Burraston, B., & Pears, K. C. (2005). The Early Intervention Foster Care Program: Permanent placement outcomes from a randomized trial. *Child Maltreatment*, 10, 61–71.
- Fisher, P. A., Ellis, B. H., & Chamberlain, P. (1999). Early Intervention Foster Care: A model for preventing risk in young children who have been maltreated. *Children's Services: Social Policy, Research, and Practice*, 2, 159–182.

- Fisher, P. A., Gunnar, M. R., Dozier, M., Bruce, J., & Pears, K. C. (2006). Effects of a therapeutic intervention for foster children on behavior problems, caregiver attachment, and stress regulatory neural systems. *Annals of the New York Academy of Sciences*, 1094, 215–225.
- Fisher, P. A. & Stoolmiller, M. (2008). Intervention effects on foster parent stress: Associations with child cortisol levels. *Development & Psychopathology*, 20, 1003-1021.
- Flay, B. R., & Allred, C. G. (2003). Long-term effects of the Positive Action program: A comprehensive, positive youth development program. *American Journal of Health Behavior*, 27, S6-S21.
- Forgatch, M. S., Patterson, G. R., & DeGarmo, D. S. (2005). Evaluating fidelity: Predictive validity for a measure of competent adherence to the Oregon Model of Parent Management Training. *Behavior Therapy*, 36, 3-13.
- Forgatch, M. S., Patterson, G. R., DeGarmo, D. S., & Beldavs, Z. G. (2009). Testing the Oregon delinquency model with nine-year follow-up of the Oregon divorce study. *Development & Psychopathology*, 21, 637-660.
- Fuchs, D., & Fuchs, L. S. (2006). Introduction to Response to Intervention: What, why, and how valid is it? *Reading Research Quarterly*, 41, 93-99.
- Gardner, F., Hutchings, J., Bywater, T., & Whitaker, C. (2010). Who benefits and how does it work? Moderators and mediators of outcome in an effectiveness trial of a parenting intervention. *Journal of Clinical Child & Adolescent Psychology*, 39, 568-580.
- Gordon, J., Biglan, A., & Smolkowski, K. (2008). The impact on tobacco use of branded youth anti-tobacco activities and family communications about tobacco. *Prevention Science*, 9, 73-87.
- Graziano, P. A., Reavis, R. D., Keane, S. P., & Calkins, S. D. (2007). The role of emotion regulation in children's early academic success. *Journal of School Psychology*, 45, 3-19.
- Greenspan, S., & Greenspan, N. T. (1985). *First feelings: milestones in the emotional development of your baby and child*. New York, NY US: Penguin Books.
- Griffin, K.W., Botvin, G.J., & Nichols, T.R. (2006). Effects of a school-based drug abuse prevention program for adolescents on HIV risk behaviors in young adulthood. *Prevention Science*, 7, 103-112.
- Gunn, B., Biglan, A., Smolkowski, K., & Ary, D. (2000). The efficacy of supplemental instruction in decoding skills for Hispanic and non-Hispanic students in early elementary school. *Journal of Special Education*, 34, 90-103.
- Hawkins, J. D., Brown, E. C., Oesterle, S., Arthur, M. W., Abbott, R. D., & Catalano, R. F. (2008). Early effects of Communities That Care on targeted risks and initiation of delinquent behavior and substance use. *Journal of Adolescent Health*, 43, 15-22.
- Hawkins, J. D., Oesterle, S., Brown, E. C., Monahan, K. C., Abbott, R. D., Arthur, M. W., Catalano, R. F. (2012). Sustained decreases in risk exposure and youth problem behaviors after installation of the Communities That Care prevention system in a randomized trial. *Archives of Pediatrics and Adolescent Medicine*, 166, 141-148.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents* (2nd ed.). New York, NY US: Guilford.
- Horner, R. H., & Sugai, G. (2000). School-wide behavior support: An emerging initiative. *Journal of Positive Behavior Interventions*, 2, 231-232.

- Horner, R. H., Sugai, G., Smolkowski, K., Eber, L., Nakasato, J., Todd, A. W. et al. (2009). A randomized, wait-list controlled effectiveness trial assessing school-wide positive behavior support in elementary schools. *Journal of Positive Behavior Interventions*, *11*, 133-144.
- Hurlburt, M.S., Nguyen, K., Reid, J., Webster-Stratton, C., & Zhang, J. (2013). Efficacy of the Incredible Years group parent program with families in Head Start who self-reported a history of child maltreatment. *Child Abuse & Neglect*, Available at <http://dx.doi.org/10.1016/j.chiabu.2012.10.008>.
- Jaycox, L. H., Langley, A., & Dean, K. L. (2009). Support for Students Exposed to Trauma: The SSET Program. Santa Monica, CA: RAND Corporation. Downloaded 7/23/13 from http://www.rand.org/pubs/technical_reports/TR675.
- Jaycox, L. H., Kataoka, S. H., Stein, B. D., Langley, A. K., & Wong, M. (2012). Cognitive Behavioral Intervention for Trauma in Schools. *Journal of Applied School Psychology*, *28*, 239-255.
- Jimerson, S. R., Burns, M. K., & VanDerHeyden, A. M. (Eds.). (2007). *Handbook of response to intervention: The science and practice of assessment and intervention*. New York, NY US: Springer.
- Jones, D., Bumbarger, B.K., Greenberg, M.T., Greenwood, P., & Kyler, S. (2008). *The economic return on PCCD's investment in research-based programs: A cost-benefit assessment of delinquency prevention in Pennsylvania*. Philadelphia, PA US: Pennsylvania State University: The Prevention Research Center for the Promotion of Human Development.
- Johnson, D., Johnson, R., & Hulobec, E. (2008). *Cooperation in the classroom*. Edina, MN US: Cooperative Learning Institute and Interaction Book Company.
- Johnson, D. W., Johnson, R. T., & Smith, K. A. (1991). *Active learning: Cooperation in the college classroom*. Edina, MN US: Interaction Book Company.
- Johnson, D. W., Johnson, R. T., & Smith, K. A. (1998). Cooperative learning returns to college: what evidence is there that it works? *Change*, *30*, 26-35.
- Kam, C. M., Greenberg, M. T., & Kusche, C. A. (2004). Sustained effects of the PATHS curriculum on the social and psychological adjustment of children in special education. *Journal of Emotional and Behavioral Disorders*, *12*, 66-78.
- Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review*, *30*, 467-480.
- Kasser, T., & Ryan, R. M. (1993). A dark side of the American dream: Correlates of financial success as a central life aspiration. *Journal of Personality and Social Psychology*, *65*, 410-422.
- Kellam, S. G., Brown, C. H., Poduska, J. M., Ialongo, N. S., Wang, W., Toyinbo, P. et al. (2008). Effects of a universal classroom behavior management program in first and second grades on young adult behavioral, psychiatric, and social outcomes. *Drug and Alcohol Dependence*, *95*, S5-S28.
- Kirby, D. (2007). *Emerging Answers: Research findings on programs to reduce teen pregnancy*. Washington, DC: National Campaign To Prevent Teen Pregnancy.
- Komro, K. A., Flay, B. R., Biglan, A., & The Promise Neighborhoods Research Consortium (2011). Creating nurturing environments: a science-based framework for promoting child health and development within high-poverty neighborhoods. *Clinical Child and Family Psychology Review*, *14*, 111-134.

- Kumpfer, K. L., Molgaard, V., & Spoth, R. (1996). The Strengthening Families Program for prevention of delinquency and drug use in special populations. In R. Dev Peters, & R. J. McMahon (Eds.), *Childhood disorders, substance abuse, and delinquency: prevention and early intervention approaches*. Newbury Park, CA US: Sage.
- Landry, S. H., Anthony, J. L., Swank, P. R., & Monseque-Bailey, P. (2009). Effectiveness of comprehensive professional development for teachers of at-risk preschoolers. *Journal of Educational Psychology, 101*, 448-465.
- Landry, S. H., Smith, K. E., & Swank, P. R. (2006). Responsive parenting: Establishing early foundations for social, communication, and independent problem-solving skills. *Developmental Psychology, 42*, 627-642.
- Landry, S. H., Swank, P. R., Anthony, J. L., & Assel, M. A. (2011). An experimental study evaluating professional development activities within a state funded pre-kindergarten program. *Reading and Writing, 24*, 971-1010.
- Lees, D. G., & Ronan, K. R. (2008). Engagement and effectiveness of parent management training (Incredible Years) for solo high-risk mothers: A multiple baseline evaluation. *Behaviour Change, 25*, 109-128.
- Lerner, C., & Ciervo, L. A. (2003). *Healthy minds: nurturing children's development from 0 to 36 months*. Washington, DC US: Zero to Three Press and American Academy of Pediatrics.
- Leve, L. D., & Chamberlain, P. (2007). A randomized evaluation of Multidimensional Treatment Foster Care: Effects on school attendance and homework completion in juvenile justice girls. *Research on Social Work Practice, 17*, 657-663.
- Leve, L. D., Chamberlain, P., & Reid, J. B. (2005). Intervention outcomes for girls referred from juvenile justice: Effects on delinquency. *Journal of Consulting and Clinical Psychology, 73*, 1181-1185.
- Lonigan, C. J., Farver, J. M., Phillips, B. M., & Clancy-Menchetti, J. (2011). Promoting the development of preschool children's emergent literacy skills: A randomized evaluation of a literacy-focused curriculum and two professional development models. *Reading and Writing, 24*, 305-337.
- Lunkenheimer, E. S., Dishion, T. J., Shaw, D. S., Connell, A., Gardner, F., M., Wilson, M. N., & Skuban, E. (2008). Collateral benefits of the Family Check-Up on early childhood school readiness: Indirect effects of parents' positive behavior support. *Developmental Psychology, 44*, 1737-1752.
- McHugh, L. & Stewart, I. (2012). *The self and perspective taking: Contributions and applications from modern behavioral science*. Oakland, CA US: New Harbinger Publications.
- Metzler, C. W., Biglan, A., Rusby, J. C., & Sprague, J. R. (2001). Evaluation of a comprehensive behavior management program to improve school-wide positive behavior support. *Education and Treatment of Children, 24*, 448-479.
- Molgaard, V., Kumpfer, K. L., & Spoth, R. (1994). *The Iowa Strengthening Families Program for Pre and Early Teens*. Ames, IA US: Iowa State University.
- Moore, K. J., Dishion, T. J., & Shaw, D. S. (2012). The Family Check-Up in early childhood: A public health intervention to prevent long-term behavioral and emotional disorders. *Child Welfare and Technology, 5*, 17.
- Multisystemic Therapy (2013). *MST research at a glance: Published MST outcome, implementation, and benchmarking studies*. Available online at <http://mstservices.com/outcomestudies.pdf>.

- National Center for Chronic Disease Prevention and Health Promotion (2009, July 29). *Fact Sheet: Student Health and Academic Achievement*. Retrieved from the Center for Disease Control website: http://www.cdc.gov/HealthyYouth/health_and_academics/#5.
- National Research Council & Institute of Medicine (2009). *Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Washington, DC US: The National Academies Press.
- National Research Council & Institute of Medicine. (2000). *From neurons to neighborhoods: the science of early childhood development*. Committee on Integrating the Science of Early Childhood Development. Edited by J. P. Shonkoff & D. A. Phillips. Board on Children, Youth and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC US: NAP
- Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect*, 24, 1363-1374.
- Nowak, C., & Heinrichs, N. (2008). A comprehensive meta-analysis of Triple P-Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*, 11, 114-144.
- O'Neill, D., McGiloway, S., Donnelly, M., Bywater, T., & Kelly, P. (2013). A cost-effectiveness analysis of the Incredible Years parenting programme in reducing childhood health inequalities. *The European Journal of Health Economics*, 14, 85-94.
- Ogden, T., Forgatch, M. S., Askeland, E., Patterson, G. R., & Bullock, B. M. (2005). Implementation of parent management training at the national level: The case of Norway. *Journal of Social Work Practice*, 19, 317-329.
- Olds, D. L. (2008). Preventing child maltreatment and crime with prenatal and infancy support of parents: The nurse-family partnership. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 9, 2-24.
- Olds, D. L. (2010). The nurse-family partnership: From trials to practice. In A. J. Reynolds, A. J. Rolnick, M. M. Englund, & J. A. Temple (Eds.), *Childhood programs and practices in the first decade of life: A human capital integration* (pp. 49-75). New York: Cambridge University Press.
- Olds, D. L., Henderson, C. H. Jr., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of Nurse Home Visitation. *Pediatrics*, 77, 16-28.
- Olds, D. L., Hill, P. L., O'Brien, R., Racine, D., & Moritz, P. (2003). Taking preventive intervention to scale: The nurse-family partnership. *Cognitive and Behavioral Practice*, 10, 278-290.
- Pianta, R. C., & Stuhlman, M. W. (2004). Teacher-child relationships and children's success in the first years of school. *School Psychology Review*, 33, 444-458.
- Pianta, R. C., Barnett, W. S., Burchinal, M. R., & Thornburg, K. R. (2009). The effects of preschool education: What we know, how public policy is or is not aligned with the evidence base, and what we need to know. *Psychological Science in the Public Interest*, 10, 49-88.

- Poduska, J. M., Kellam, S.G., Wang, W., Brown, H., Ialanga, N.S., & Toyinbo, P. (2008). Impact of the Good Behavior Game, a universal classroom-based behavior intervention, on young adult service use for problems with emotions, behavior, or drugs or alcohol. *Drug and Alcohol Dependence*, 95, S29-S44.
- Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of a foster parent training intervention on placement changes of children in foster care. *Child Maltreatment*, 13, 64-75.
- Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P System Population Trial. *Prevention Science*, 10, 1-12.
- Richardson, J. L., Dwyer, K. M., McGuigan, K., Hansen, W. B., Dent, C. W., Johnson, C. A. et al. (1989). Substance use among eighth-grade students who take care of themselves after school. *Pediatrics*, 84, 556-566.
- Richardson, J. L., Radziszewska, B., Dent, C. W., & Flay, B. R. (1993). Relationship between after-school care of adolescents and substance use, risk taking, depressed mood, and academic achievement. *Pediatrics*, 92, 32-38.
- Roeser, R. W., & Eccles, J. S. (1998). Adolescents' perceptions of middle school: Relation to longitudinal changes in academic and psychological adjustment. *Journal of Research on Adolescence*, 8, 123-158.
- Rusby, J. C., Smolkowski, K., Marquez, B., & Taylor, T. K. (2008). A small-scale randomized efficacy trial of CareScapes: enhancing children's social development in child care homes. *Early Childhood Research Quarterly*, 23, 527-546.
- Sanders, M. R., Cann, W., & Markie-Dadds, C. (2003). The Triple P-Positive Parenting Programme: A universal population-level approach to the prevention of child abuse. *Child Abuse Review*, 12, 155-171.
- Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to prevention of early conduct problems: 2-year effects of the Family Check-Up in early childhood. *Journal of Consulting & Clinical Psychology*, 74, 1-9.
- Sheldon, K. M., & Kasser, T. (1998). Pursuing personal goals: Skills enable progress, but not all progress is beneficial. *Personality and Social Psychology Bulletin*, 24, 1319-1331.
- Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities. *Journal of the American Medical Association*, 301, 2252-2259.
- Smolkowski, K., Biglan, A., Barrera, M., Taylor, T., Black, C., & Blair, J. (2005). Schools and Homes in Partnership (SHIP): Long-term effects of a preventative intervention focused on social behavior and reading skill in early elementary school. *Prevention Science*, 6, 113-125.
- Spinrad, T. L., Eisenberg, N., Cumberland, A., Fabes, R. A., Valiente, C., Shepard, S. A. et al. (2006). Relation of emotion-related regulation to children's social competence: A longitudinal study. *Emotion*, 6, 498-510.
- Spoth, R., & Molgaard, V. (1999). Project Family: A partnership integrating research with the practice of promoting family and youth competencies. In T.R. Chibucos & R. Lerner (Eds.), *Serving children and families through community-university partnerships: success stories* (pp.127-137). Boston, MA US: Kluwer Academic.

- Spoth, R.L., Randall, G., Trudeau, L., Shin, C., & Redmond, C. (2008). Substance use outcomes 5½ years past baseline for partnership-based, family school prevention interventions. *Drug and Alcohol Dependence*, 96, 57-68.
- Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *JAMA: The Journal of the American Medical Association*, 290, 603-611.
- Stockard, J., & Engelmann, K. (2010). Academic kindergarten and later academic success: The impact of Direct Instruction. *Journal of Behavioral Assessment and Intervention for Children*, 1, 2-24.
- Stormshak, E. A., & Dishion, T. J. (2009). A school-based family-centered intervention to prevent substance abuse: The Family Check-Up. *American Journal of Drug and Alcohol Abuse*, 35, 227-232.
- Sugai, G., & Horner, R. (2002). The evolution of discipline practices: School-wide positive behavior supports. *Child & Family Behavior Therapy*, 24, 23-50.
- Theodore, A. D., Chang, J. J., Runyan, D. K., Hunter, W. M., Bangdiwala, S. I., & Agans, R. (2005). Epidemiologic features of the physical and sexual maltreatment of children in the Carolinas. *Pediatrics*, 115, e331-e337.
- Thornton, T.N. Craft, C.A., Dahlberg, L.L., Lynch, B.S., & Baer, K. (2000). *Best practices of youth violence prevention: A source-book for community action*. Atlanta, GA US: Centers for Disease Control and Prevention.
- Van Ryzin, M. J., Stormshak, E. A., & Dishion, T. J. (2012). Engaging parents in the Family Check-Up in middle school: Longitudinal effects on family conflict and problem behavior through the transition to high school. *Journal of Adolescent Health*, 50, 627-633.
- Vohs, K. D., & Baumeister, R. F. (2011). *Handbook of self-regulation: Research, theory, and applications (2nd ed.)*. New York, NY US: Guilford.
- Walker, H. M., Colvin, G., & Ramsey, E. (1995). *Antisocial behavior in school: Strategies and best practices*. Belmont, CA US: Brooks/Cole.
- Washington State Institute for Public Policy. (2004). *Benefits and cost of prevention and early intervention programs for youth (04-07-3901)*. Olympia, WA US: Washington Legislature.
- Wasik, B. A., & Hindman, A. H. (2011). The morning message in early childhood classrooms: Guidelines for best practices. *Early Childhood Education Journal*, 39, 183-189.
- Webster-Stratton, C., & Reid, M. (2010). Adapting The Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system. *Journal of Children's Services*, 5, 25-42.
- Wenzel, T. (2000) . Cooperative student activities as learning devices. *Analytical Chemistry*, 72, 293A-296A.
- Wilson, D. S., & Csikszentmihalyi, M. (2008). Health and the ecology of altruism. In S. G. Post (Ed.), *The Science of Altruism and Health*. Oxford, UK: Oxford University Press.
- Wilson, D. S., O'Brien, D. T., & Sesma, A. (2009). Human prosociality from an evolutionary perspective: Variation and correlations at a city-wide scale. *Evolution and Human Behavior*, 30, 190-200.

Appendix: Resources

Best Evidence Encyclopedia (BEE) — <http://www.bestevidence.org/>
Blueprints for Healthy Youth Development — <http://www.blueprintsprograms.com/>
California Evidence-based Clearinghouse for Child Welfare — <http://www.cebc4cw.org/>
Coalition for Evidence-based Policy — <http://toptierevidence.org>
Find Youth Info — <http://findyouthinfo.gov>
Florida Center for Reading Research (FCRR) — <http://www.fcrr.org/>
Identifying and Implementing Education Practices Supported by Rigorous Evidence:
A User Friendly Guide — <http://www2.ed.gov/rschstat/research/pubs/rigorousetid/index.html>
The Center for Substance Abuse Prevention (CSAP) — <http://www.samhsa.gov/prevention/>
The National Institute on Drug Abuse (NIDA) — <http://www.drugabuse.gov/>
The National Registry of Evidence-based Programs and Practices (NREPP) — <http://www.nrepp.samhsa.gov/>
The Office of Justice Programs Crime Solutions — <http://www.crimesolutions.gov/>
The Office of Juvenile Justice and Delinquency Prevention (OJJDP) Model Programs Guide—
<http://www.ojjdp.gov/mpg/>
The U.S. Department of Education (USDOE) — <http://www.ed.gov/>
The White House Office of National Drug Control Policy (ONDCP) — <http://www.whitehouse.gov/ondcp>
Vanderbilt Kennedy Center — <http://kc.vanderbilt.edu/site/default.aspx>
What Works Clearinghouse (WWC) — <http://ies.ed.gov/ncee/wwc/>
IES Practice Guides — http://ies.ed.gov/ncee/wwc/publications_reviews.aspx

INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

February 2014



SCREENING, ASSESSING, MONITORING OUTCOMES
and Using Evidence-Based Interventions to Improve the
Well-Being of Children in Child Welfare



Preface

This series of papers, *Integrating Safety, Permanency and Well-Being in Child Welfare*, describes how a more fully integrated and developmentally specific approach in child welfare could improve both child and system level outcomes. The papers were developed to further the national dialogue on how to more effectively integrate an emphasis on well-being into the goal of achieving safety, permanency and well-being for every child.

The overview, *Integrating Safety, Permanency and Well-Being: A View from the Field* (Wilson), provides a look at the evolution of the child welfare system from the 1970s forward to include the more recent emphasis on integrating well-being more robustly into the work of child welfare.

The first paper, *A Comprehensive Framework for Nurturing the Well-Being of Children and Adolescents* (Biglan), provides a framework for considering the domains and indicators of well-being. It identifies the normal developmental trajectory for children and adolescents and provides examples of evidence-based interventions to use when a child's healthy development has been impacted by maltreatment.

The second paper, *Screening, Assessing, Monitoring Outcomes and Using Evidence-based Practices to Improve the Well-Being of Children in Foster Care* (Conradi, Landsverk and Wotring), describes a process for delivering trauma screening, functional and clinical assessment, evidence-based interventions and the use of progress monitoring in order to better achieve well-being outcomes.

The third paper, *A Case Example of the Administration on Children, Youth and Families' Well-Being Framework: KIPP* (Akin, Bryson, McDonald, and Wilson), presents a case study of the Kansas Intensive Permanency Project and describes how it has implemented many of the core aspects of a well-being framework.

These papers are an invitation for further thinking, discussion and action regarding the integration of well-being into the work of child welfare. Rather than being a prescriptive end point, the papers build developmentally on the Administration on Children, Youth and Families' 2012 information memorandum *Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* and encourage new and innovative next steps on the journey to support healthy development and well-being.

Acknowledgments

This publication was produced by Paltech, Inc. under the Technical Support and Product Development for the Children's Bureau and its Grantees, contract number HHSP23320095648WC with the U.S. Department of Health and Human Services (HHS). The authors of this publication were Lisa Conradi, Psy.D. and John Landsverk, Ph.D., of the Chadwick Center for Children and Families at Rady Children's Hospital – San Diego; and James R. Wotring, M.S.W., of the National Technical Assistance Center for Children's Mental Health at Georgetown University.

Disclaimer

The views, opinions, and content expressed herein are those of the authors and do not necessarily reflect the views, opinions, or policies of HHS or Paltech. No official support of or endorsement by HHS or Paltech for these opinions or for particular interventions, programs, practices, tools, instruments, software, or resources is intended or should be inferred.

Introduction

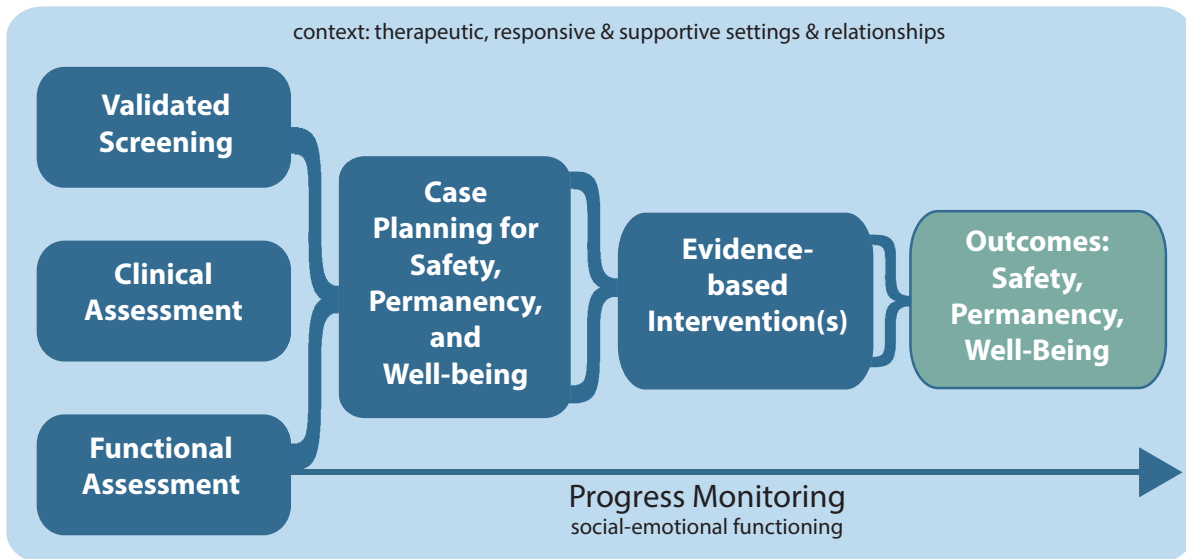
This is the second in a series of three papers informed by the well-being framework developed by the Administration on Children, Youth and Families (U.S. Department of Health and Human Services, 2012). It addresses three critical components of a well-functioning response to the social, emotional and behavioral needs of vulnerable children and their families involved with the child welfare system:

1. universal screening for mental health and trauma symptoms that can assist the decision to refer for clinical assessment and treatment;
2. clinical and functional assessment together with outcome measurement and management; and
3. selection and use of evidence-based interventions (EBI) in response to clinical needs observed in the assessment process that have the potential for relief of symptoms/conditions and improvement in psychosocial functioning.

The figure below depicts how the three critical components are related and lead to better outcomes for children and families. The first step is conducting a reliable and valid universal screening. This screening can both collect information on the trauma and related behavioral health needs for children in child welfare and assist in referring children to a more comprehensive clinical assessment conducted by a mental health provider. Next, this information is used to inform case planning efforts with a focus on activities that support safety, permanency and well-being. This includes the referral of a child to an evidence-based practice or practices to meet the child's unique needs.

A functional assessment, which focuses on assessing a child's functional capacity such as relationships at home and school, can be conducted at any point during this process. It may be conducted by child welfare at the beginning of the case with periodic follow-ups, or within the context of a clinical assessment.

Throughout this process, data are collected for continuous quality improvement purposes including informing the child's progress and providing aggregate level information to contribute to system improvements. Course corrections at both the client level, such as referral to different treatment practices, and at the system level, such as scaling up or down the service array, can be made, as needed.



Implementing the three components mentioned in the first paragraph requires the cooperation and expertise of community child welfare and mental health services systems, data-informed planning, and services at the organizational level. Data informed planning begins with careful selection of target populations and concludes with on-going progress monitoring at both the individual child level and the system level. Additionally, evaluation and outcome measurement are critical to ensuring that improvements in social and emotional well-being, safety, and permanence are achieved and maintained.

Component One: Universal Screening for Mental Health and Trauma Symptoms and Referral for Clinical Assessment

Children involved in the child welfare system, especially those who have been placed in foster care, are particularly vulnerable because they have experienced one or more traumatic events that brought them into contact with the system. These traumatic effects can have long lasting consequences on child development across the well-being domains (i.e., social/emotional, behavioral, cognitive, and physical) (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011; Lou, Anthony, Stone, Vu, & Austin, 2008). These children are more likely to display trauma-related symptoms and mental and behavioral health issues that can negatively impact their ability to build and maintain stable and healthy relationships, interfere with their ability to cope with challenging situations, and negatively disrupt their self-concept (Cook et al., 2005; Stein et al., 2001).

Traditionally, child welfare caseworkers, supervisors, and administrators have focused primarily on ensuring children are safe from abuse and neglect and secondarily on ensuring permanent homes for children. It was not until recently that the short and long-term effects of the abuse and neglect and a child's trauma history have been seen as equally important considerations for organizing services to help a child heal and recover from trauma and mental and behavioral health challenges. Indeed, there is a growing understanding that safety and permanency can be enhanced if a child's well-being needs are addressed.

Additionally, the importance of screening for trauma among children in the child welfare system has received increased attention. In December, 2011, the Child and Family Services Improvement

and Innovation Act of 2011 (P.L. 112-34) amended title IV-B of the Social Security Act, to require states to screen for “emotional trauma associated with a child’s maltreatment and removal from the home.” This important legislation suggests policy makers recognize that screening for trauma plays a critical role in assisting child welfare systems to meet their goals of safety, permanency, and child well-being.

The early identification of trauma and mental and behavioral health issues in children known to the child welfare system is critical. Effective identification through the use of standard, valid, and reliable screening tools paired with case planning efforts can help child welfare caseworkers organize effective early intervention that includes referring children for mental health assessment and treatment. This also can support other case management efforts to build a child’s resilience and relational capacity and support the child’s well-being. Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is designed to ensure children receive comprehensive preventive and speciality health care services. EPSDT can be used to fund screening and assessment activities for eligible children known to child welfare (Sheldon, Tavenner, & Hyde, 2013; Teich, Buck, Graver, Schroeder & Zheng, 2003).

The first step in a comprehensive effort is effective screening and identification of a child’s history of trauma, an assessment of their trauma-related symptoms, and an assessment of the child’s mental and behavioral health strengths and needs. The language for screening and assessment may be used interchangeably and the distinction may seem arbitrary. For purposes of this paper, screening refers to a brief, focused inquiry to determine whether an individual has experienced specific traumatic events or reactions to trauma and if any specific mental or behavioral health needs should be referred for a more comprehensive clinical assessment.

A functional assessment, described in component two below may be conducted concurrently with a screening to assess critical areas related to developmental functioning. This assessment also may be conducted within the context of a clinical assessment. Screening is often completed by individuals on the front-line with children and families, such as child welfare workers, pediatricians, or school personnel. A screening is not diagnostic in nature, nor is it meant to determine the severity of a child’s difficulty. It simply determines a child’s present needs and if a more comprehensive assessment is necessary.

There are a number of reasons why screening for a child’s trauma needs and mental and behavioral health needs is helpful. Screening provides information on broad symptoms the child may be experiencing that may warrant a more comprehensive assessment. Furthermore, although workers already may be gathering this information, they may not understand the usefulness of what they are collecting. Screening assists caseworkers to identify the types of events or situations that may trigger a child’s traumatic memories or symptoms. The workers can share this information with the foster parent or caregiver to help them manage difficult behaviors. Screening can also assist in case planning and referral to the appropriate EBIs.

A referral for a comprehensive clinical assessment is indicated for those children who have trauma needs identified during screening. This assessment includes a more in-depth exploration of the nature and severity of the traumatic events, the impact of those events, and trauma-related symptoms and functional impairment. This assessment is used to understand whether a child is on target developmentally in the social/emotional and behavioral well-being domains and to drive treatment planning and on-going progress monitoring.

A good assessment usually occurs over 2-3 sessions or more and includes a clinical interview; use of objective measures; behavioral observations of the child; and collateral contacts with the family, caseworkers, and others. The assessment covers basic demographics; family history; a comprehensive trauma history including events a child has experienced or witnessed; a complete developmental history; an overview of the child's problems/symptoms; and relevant contextual history, such as behavior and progress in school; as well as interactions with other systems. The information gathered from the clinical assessment facilitates the selection of the most appropriate treatment for a child's unique needs.

Identifying and Selecting Measures for Screening and Assessment Purposes

Prior to selecting a tool or measure to use for screening or assessment, a number of key questions should be considered at the systemic and client level. Key questions to consider at the systemic level include:

1. What is the purpose of the tool? Is it being used to facilitate case decision-making or to inform clinical practice?
2. What type of research has been conducted on the tool? Does it have established reliability, validity, and norms?
3. What are the budget and the cost for the tool?
4. How are data from the measure scored and stored? Do we need to work with information technology to create a system that stores the information gathered? Are we able to provide feedback to the caseworker or clinician in an efficient and timely manner?
5. How is the information shared? Are we able to share the information across the child welfare and mental health systems?
6. What staff do we have available to administer the tool? What is their level of education and experience? How much extra time is involved in completing a screening and using the information for case and/or treatment planning purposes?
7. Does the tool track change over time and allow us to see if the child has improved?

The questions to consider at the client level include:

1. Is the child old enough and able to answer questions about personal history?
2. Can the child read or will a computer read the question to the child?
3. Is the caregiver a reliable informant?
4. If the worker is completing the screening, do the case files provide enough information?
5. With whom will the information be shared?
6. Will the results inform case and/or treatment planning?

The available screening and assessment tools each present their own unique set of strengths and challenges. Many tools have been reviewed in online relevant databases. (Examples include the California Evidence-Based Clearinghouse for Child Welfare at <http://www.cebc4cw.org> and the

National Child Traumatic Stress Network Measures Database at <http://www.nctsn.org/resources/online-research/measures-review>.) Tools may be completed by the child, by the caregiver regarding the child, or by a provider to assist case planning decisions. Each type is described below.

Child-Completed Tool: This tool may be used if a child has the developmental capacity to read and complete answers (usually ages 8 and above but the age varies significantly). The questions/items are administered in an interview format to the child either verbally or in writing. One benefit to this strategy is that the child may have the opportunity to verbalize responses. Training and support on asking questions in a sensitive manner is critical since a caseworker or clinician may be asking highly personal and sensitive questions. The child may be sharing experiences for the first time, or may be hesitant to share them. In situations when it is difficult for the child to share experiences, it also may be difficult for the caseworker or clinician to hear about them. Examples of child-completed tools include the Trauma Symptom Checklist for Children (Briere, 1996); the UCLA PTSD Reaction Index, Adolescent Version (Steinberg, Brymer, Decker, & Pynoos, 2004); the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001); and the Youth Self-Report (Achenbach & Rescorla, 2001).

Caregiver-Completed Tool: For infants, toddlers, and young children (ages 0-8) or children with developmental delays, it may be appropriate to have a caregiver complete a tool. They can either provide written responses to questions/items, or respond during an interview by a caseworker or clinician. This strategy is particularly helpful in detecting exposure to trauma for young children who cannot verbalize information. For older children (ages 9-18), caregiver-completed tools can provide helpful information about functioning. A possible challenge is identifying an informant able to provide reliable information on a child's history and symptoms. A child's biological parent may be cautious about sharing detailed information about the child's traumatic experiences, since this may impact decisions about placement, visitation, and reunification. However, foster parents may not know the child's trauma history and may over- or under-report trauma symptoms based on their experiences fostering other children in their care. Examples of caregiver-completed tools include the Trauma Symptom Checklist for Young Children (Briere, 2005), the Child Behavior Checklist (Achenbach & Rescorla, 2001), the Pediatric Symptom Checklist (Jellinek, et al., 1988), and the Strengths and Difficulties Questionnaire (Goodman, 1997).

Provider-Completed Tool: A tool can be completed by the caseworker or clinician as he or she reviews and integrates all available information on a child. The information may include court reports, interviews with caregivers and teachers, other questionnaires, and behavioral observations. This strategy is particularly useful for helping the caseworker or clinician make sense of information available about children in all age groups including infants and toddlers. However, without asking the child or caregiver specific questions, they may not have a complete picture of the child's unique experiences. One example of a provider completed tool is the Child Welfare Trauma Referral Tool (Taylor, Steinberg, & Wilson, 2006).

Identifying a specific tool or measure is challenging. It must be useful, reliable and valid, provide helpful information, and translate easily into case planning without adding an undue burden to the caseworker or costs to the system. There is no one tool or measure that universally meets the needs of all children served by a child welfare system. Also, it is important to conduct a cost-benefit analysis when considering a tool. While one tool may have sound psychometric qualities, it may be cost prohibitive or require that caseworkers or clinicians have a certain level of training

and experience. Another tool may be easy for caseworkers or clinicians to complete but may not have sound psychometric properties or generate useful information that assists in case planning efforts. Strategies that may assist agencies in successfully choosing screening and assessment tools include the following: researching available tools and identifying several that meet their needs; asking staff to pilot test various measures; embedding trauma screening practices into the existing system in a more formalized manner; and having multiple strategies available based on the age of the child and education level of the workforce.

Component Two: Functional Assessment, Outcome Measurement, and Progress Monitoring

Functional Assessment

Functional assessment involves periodic evaluation of a child's well-being using standardized, valid and reliable measurement tools. These tools are not diagnostic; rather, they provide individual-level data on a child's strengths and needs to inform case planning. Functional assessment tools can be administered by a range of professionals, depending on the requirements of the particular tool and can involve child, caregiver and/or professional reporters. Functional assessment gathers information on key indicators across well-being domains, such as a child's relationship with peers, school and home behavior, and whether a child is on track developmentally. These indicators are described in the first paper in this series. Functional assessment provides critical information on a child's relational capacity, the ability to develop positive relationships in the future. Functional assessment data can inform broader outcomes monitoring and system-level decisions about service array planning and contracts (adapted from Sheldon, Tavenner, & Hyde, 2013).

The use of a standardized functional assessment tool generally involves professionals gathering information from a child, caregiver, and others involved in the child's life, such as teachers or day care providers. Functional assessment can be conducted within the context of a clinical assessment or by child welfare at the onset of the case to assist in case planning efforts. The information includes questions about social/emotional, behavioral, cognitive and physical domains, and/or symptoms a child/youth may be demonstrating. The use of the data from a functional assessment tool can assist in matching EBIs with the needs of the child/youth. For example, if the score on a particular tool indicates a youth may be experiencing depression, cognitive behavior therapy for depression may need to be considered. For youth who score high with behavioral problems, an intervention such as Functional Family Therapy or the Parent Management Training Oregon-Model may be considered.

Outcome Measurement and Progress Monitoring

Measuring success by tracking child-level well-being outcomes allows systems to ensure that services are achieving desired improvements in children's health and functioning. At the child level, these data allow matching specific characteristics and needs of individual children with appropriate, responsive interventions. At the system level, staff can use an iterative process of reviewing aggregated data to tailor and refine an array of services to address the needs of the population (adapted from Sheldon, Tavenner, & Hyde, 2013).

Monitoring well-being and functional outcomes and progress over time allows an objective review using data to determine what types of interventions are working for different populations. These

interventions can assist children in returning to a normal developmental trajectory and also can help to reduce symptoms, such as depression, anxiety, and traumatic stress reactions. Monitoring progress also allows for adjustments in the treatment process. For example, if a child's functioning or well-being is not improving, the treatment selected may be inappropriate or not implemented with fidelity. A medication may need to be administered in conjunction with an EBI. If psychotropic medication is being used, it should be monitored closely to determine if the treatment approach is working and to ensure management of side effects. In other instances, trauma identified later may need to be considered in the treatment approach. Regardless of the circumstance, monitoring progress with an outcome measure helps ensure the intervention being offered is achieving its intended outcome of on-target development and improved well-being and functioning of the child.

Aggregating the data from the outcome measure to monitor progress at various levels can be useful. At the supervisory level, the data can be used to monitor the progress of individual children. The data also may identify multiple children with complex conditions that require extra strength treatment. For example, children who are at risk of hospitalization or placement in residential treatment may be monitored more closely by the caseworker, clinician, and supervisors in an effort to avoid these more restrictive placements. Information at the supervisory level also may help determine which worker is achieving better outcomes with children with specific needs. A supervisor who can identify which therapist or intervention is resulting in the improved outcomes can share this information with others. Others may wish to determine if that intervention or worker can reach similar outcomes with other similar children. A supervisor also can use the information to offer a worker praise when they achieve positive outcomes for children.

Using aggregated information to monitor progress at the program and organizational levels helps identify exemplary programs serving similar types of children. For example, children with problems at home, in school, and the community who are showing signs of depression and self-harm may require more intensive services. This information can be used to determine which programs to scale up and which programs not yielding the desired results should be scaled back. These data also can identify youth who simply need more support than others and can aid in determining which programs provide the needed intensity of services.

Using outcome information at the community or county level may help systems objectively identify the programs achieving better outcomes. These programs can be studied to help determine what contributes to their success. Service purchasing and contracting decisions can be made using specific data about what is working and what is not. Administrators also may choose to implement a specific EBI that has achieved positive outcomes for certain types of children in a given organization or community. For example, if County X has data showing poor outcomes for children who are involved with juvenile justice, they may decide to select certain clinicians to be trained in Multi-Systemic Therapy (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009) or Multidimensional Treatment Foster Care (Chamberlain & Reid, 1991). After clinicians are trained in a treatment approach, the outcomes can be monitored to see if the training achieved its intended goal of improving the well-being of children.

Finally, aggregating data at the state level helps an administrator determine which programs are successful. This information is used to identify training needs or changes in the type of provided services. In some instances, this may require the introduction of a more intensive array of services. In others, it may require the introduction of an EBI for a specific population. For example, children known to child welfare likely will need individual EBIs to address trauma related needs.

Clinicians trained in helping parents with behavioral interventions also are important. The use of the aggregated data at the state level to manage the system and determine training needs models the importance of using data for counties, programs, supervisors and clinicians. The use of data is central to the overall management of the system.

In summary, measuring outcomes and monitoring progress embeds the use of the information at all levels in organizations and is the first step to ensuring that mental health services are achieving their intended outcomes. Successful implementation of an outcome measure and monitoring performance requires using the information at all levels for different purposes. This may entail a therapist and a case manager monitoring the effectiveness of treatment with the child and family they are serving, or a supervisor discussing what is working or not working. In other instances, it will require adjusting the treatment approach, or adding some additional services to meet a particular need. The information also is useful at the organizational and system level for monitoring performance of certain organizations and to help them identify treatment approaches that are achieving their intended outcomes.

Component Three: Selecting and Implementing Evidence-Based Interventions

Selection and implementation of one or more EBIs at the system level is informed by the aggregation of standardized individual level information. This information assists the system in understanding the needs of the entire class of clients/children being screened, assessed, and monitored, as described in Component Two. Once EBIs are adopted and embedded into the service array, they are available for use by staff for individual clients/children and for use by program management to monitor the quality of implementation of each EBI.

An appropriate EBI or set of interventions must also be selected to address an individual child's service needs determined by screening, clinical, and functional assessments. The discussion in Component Two above indicates that adjustments can be made in the treatment process in response to progress monitoring.

In the following discussion, we identify five issues to consider in making informed decisions about the selection and implementation of interventions at the child or service system levels. While not an exhaustive list, the selected issues are informed both by the lessons learned from implementation initiatives, such as the case example in paper three in this series, and also by findings from the emerging field of implementation science (Proctor et al., 2009). These five considerations provide a beginning roadmap for determining how to start discussions of EBI selection.

First, the EBI must be appropriate for both the age of the child and the symptoms or conditions identified in the screening, clinical, and functional assessment processes. This information can be used to characterize individual children, as well as target populations and classes of children. There are broad categories of symptoms, such as internalizing and externalizing problems, and more specific diagnostic conditions within these categories, such as anxiety or depression. Because of the rapid developmental changes taking place as children grow to maturity, EBIs have been developed for specific ages of children. For example, parent training interventions, such as the Incredible Years or Parent-Child Interaction Therapy, have been developed for young children who present externalizing behavior problems (Reid & Webster-Stratton, 2001; Eyberg, 2005).

There are convenient resources for selecting appropriate EBIs, such as evidence-based registries of interventions. These websites arrange interventions into categories with characteristics, such as age and presenting symptoms and conditions likely to be revealed in good assessment protocols. The third paper provides an excellent example of how specific registries were useful in selecting the EBI implemented for a target population in the Kansas Intensive Permanency Project. The paper also presents considerable detail about how data sources from their community service systems informed the selection of the target population.

Second, the service delivery platform must be appropriate for delivery of the EBI. For example, most mental health and trauma specific interventions, especially those addressing internalizing problems, require the professional clinical expertise of mental health staff rather than child welfare staff. Likewise, many parent training interventions to address externalizing problems (or diagnostic categories such as oppositional–defiant disorder or conduct disorder) are best delivered by clinical staff. The third paper in this series discusses this approach in the Parent Management Training Oregon Model (PMTO) (Forgatch, Bullock, & Patterson, 2004). In Oregon, the system successfully reduced child welfare caseload size as part of its adaptation of PMTO. Other parent training interventions were developed specifically for implementation on child welfare service platforms, or have been adapted for those platforms. An example is Project KEEP (Chamberlain et al., 2008) developed in Oregon for foster and kinship parents. Project Keep has been tested for effectiveness in the foster care system in San Diego County, California, and has been scaled up in other U.S. child welfare systems and across the United Kingdom.

Third, it is critical to consider the level of research evidence demonstrated for an EBI in rigorous scientific studies (i.e., randomized clinical trials (RCT)) and benefits of the outcomes for which the EBI was designed. Registry websites such as the California Evidence-Based Clearinghouse for Child Welfare (CEBC) at <http://www.cebc4cw.org> and Blueprints for Healthy Youth Development at <http://www.blueprintsprograms.com> have included a minimum set of selection criteria. The criteria for a program model include or suggest: an available written manual; training materials or consultations that allow replication of the model in service delivery settings; and information about target populations used in the RCT studies. For example, the CEBC describes for each intervention whether the “program was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services,” and provides a rating of high, medium, or low for what is called on the website “child welfare relevance levels.”

Fourth, there are multiple opportunities and challenges in implementing and sustaining the intervention in real world service delivery settings. Managers of service systems need to determine the track record of an EBI in implementation initiatives or research studies. For example, there is considerable implementation experience and a number of rigorous research studies related to implementation for Multi-Systemic Therapy (Henggeler et al., 2009) and Multidimensional Treatment Foster Care (Chamberlain & Reid, 1991). In the case example described in the third paper of the series, Kansas stakeholders were impressed with the weight of evidence for PMTO from multiple randomized clinical trials, as well as with the robust set of experiences implementing and sustaining PMTO in service settings. The settings included the state mental health service system in Michigan. Some registry websites are including both materials on the implementation process as well as practical tools that can

be useful in planning to implement EBIs in service systems. For example, the CEBC has an Implementation Resources Section and the website of the National Implementation Research Network (NIRN) at <http://nirn.fpg.unc.edu/> has a Resource Library that offers planning tools and activities to assist in the implementation process.

An additional critical issue is determining what will be required to maintain the fidelity of the intervention. Maintaining the fidelity of the EBI can help achieve outcomes similar to those obtained in the efficacy research studies, but in a real world system. While implementing and sustaining EBIs in real world settings may be more difficult than in the original development and testing of the interventions, robust attention to maintaining fidelity is crucial to obtaining good outcomes. (Schoenwald et al., 2011; Bond et al., 2009) Implementation researchers remain focused on developing more effective and efficient methods for addressing fidelity challenges in service systems.

Fifth and finally, there are cost considerations involved in bringing an EBI into the community service array, especially if the implementation moves beyond a pilot project to becoming available for all children who need the intervention. Although the current literature on costs is rudimentary at best, there is an emphasis on distinguishing between the training costs paid to a purveyor of the EBI and the system costs to implement and sustain the EBI. These costs may include fees for each service delivery through insurance/Medicaid (Raghavan, 2012). One resource for cost information and funding strategies is Blueprints for Healthy Youth Development at www.blueprintsprograms.com.

This paper suggests a set of considerations for the successful selection and implementation of EBIs and screening, assessment, and outcomes monitoring processes. The processes that can help children to get back on track developmentally and improve their well-being are described in the first paper of this series. The third paper provides a real world example of these considerations.

References

- Achenbach, T.M., & Rescorla, L.A. (2001). *Manual for the ASEBA school-age forms & profiles: An integrated system of multi-informant assessment*. Burlington, VT: University of Vermont Research Center for Children, Youth, & Families.
- Briere, J. (1996). *Trauma symptom checklist for children: Professional manual*. Odessa, FL: Psychological Assessment Resources, Inc.
- Bond, G.R., Drake, R.E., McHugo, G.J., Rapp, C.A. and Whitley, R. (2009) Strategies for improving fidelity in the national evidence-based practices project. *Research on Social Work Practice*. (19) 569-581.
- Brownson, R.C., Colditz, G.A., Proctor, E.K. (Eds). (2012). *Dissemination and implementation research in health: Translating science to practice*. New York, NY: Oxford University Press.
- Casaneuva, C., Ringeisen, H., Wilson, E., Smith, K., & Dolan, M. (2011). *NSCAW II baseline report: Child well-being*. (OPRE Report #2011-27b). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation.
- Chamberlain, P., Price, J., Leve, L. D., Laurent, H., Landsverk, J. A., & Reid, J. B. (2008). Prevention of behavior problems for children in foster care: Outcomes and mediation effects. *Prevention Science*, 9, 17-27.
- Chamberlain, P., & Reid, J. B. (1991). Using a specialized foster care treatment model for children and adolescents leaving the state mental hospital. *Journal of Community Psychology*, 19, 266-276.
- Child and Family Services Improvement and Innovation Act of 2011, Pub. L. No. 112-34, 42 U.S.C., Title IV-B of the Social Security Act, 125 Stat. 369 .
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., ... van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390-398.
- Eyberg, S. M. (2005). Tailoring and adapting parent-child interaction therapy for new populations. *Education and Treatment of Children*, 28, 197-201.
- Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, 30(3), 376-384.
- Forgatch, M. S., Bullock, B. M., & Patterson, G. R. (2004). From theory to practice: Increasing effective parenting through role-play. The Oregon Model of Parent Management Training (PMTO). In H. Steiner, K. Chang, J. Lock, & J. Wilson (Eds.), *Handbook of mental health interventions in children and adolescents: An integrated development approach* (pp. 782-813). San Francisco: Jossey-Bass.
- Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38(5), 581-586.

- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic therapy for antisocial behavior in children and adolescents (2nd ed.)*. New York: Guilford Press.
- Jellinek, M.S., Murphy, J.M., Robinson, J., Feins, A., Lamb, S., Fenton, T. (1988), Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *The Journal of Pediatrics*, 112 (2), 201-209.
- Lou, C., Anthony, E. K., Stone, S., Vu, C. M., & Austin, M. J. (2008). Assessing child and youth well-being. *Journal of Evidence-Based Social Work*, 5(1-2), 91-133.
- Proctor, E.K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health Services Research*, 36(1), 24-34.
- Raghavan, R. (2012). The role of economic evaluation in dissemination and implementation. In Brownson, R.C., Colditz, G.A., Proctor, E.K. (Eds). *Dissemination and implementation research in health: Translating science to practice*(pp. 94-113). New York: Oxford University Press,
- Reid, M. J., & Webster-Stratton, C. (2001). The Incredible Years parent, teacher, and child intervention: Targeting multiple areas of risk for a young child with pervasive conduct problems using a flexible, manualized, treatment program. *Journal of Cognitive and Behavior Practice*, 8, 377-386.
- Schoenwald, S. K., Garland, A. F., Chapman, J. E., Frazier, S. L., Sheidow, A. J., & Southam-Gerow, M. A. (2011). Toward the effective and efficient measurement of implementation fidelity. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 32-43.
- Sheldon, G. H., Tavenner, M., & Hyde, P.S. (2013, July 11). [Letter from United States Department of Health and Human Services to each State Director]. Retrieved from <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf>
- Stein, B.D., Zima, B.T., Elliott, M.N., Burnam, M.A., Shahinfar, A., Fox, N.A., Leavitt, L.A. (2001). Violence exposure among school-age children in foster care: Relationship to distress symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(5), 455-594.
- Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports*, 6, 96–100.
- Taylor, N., Steinberg, A., & Wilson, C. (2006). *The child welfare trauma referral tool*. San Diego: Chadwick Center for Children and Families, Rady Children’s Hospital – San Diego.
- Teich, J.L., Buck, J.A., Graver, L., Schroeder, D, and Zheng, D. (2003). Utilization of public mental health services by children with serious emotional disturbances. *Administration and Policy in Mental Health*, 30(6), 523-534.
- U.S. Department of Health and Human Services (DHHS), Administration for Children Families, Administration on Children, Youth and Families, Children’s Bureau. (2012). *Information memorandum* (Log No: ACYF-CB-IM-12-03). Retrieved from http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1203.pdf.

Selected Additional Reading

Conradi, L., Wherry, J., & Kisiel, C. (2011). Linking child welfare and mental health using trauma-informed screening and assessment practices. *Child Welfare, 90*(6), 129-148.

Hurlburt, M.S., Leslie, L.K., Landsverk, J.A., Barth, R., Burns, B.J., Gibbons, R.D., Slymen, D.J., Zhang, J. (2004). Contextual predictors of mental health service use among a cohort of children open to child welfare. *Archives of General Psychiatry, 61*(1), 1217-1224.

Kisiel, C. L., Fehrenbach, T., Small, L., & Lyons, J. (2009). Assessment of complex trauma exposure, responses and service needs among children and adolescents in child welfare. *Journal of Child and Adolescent Trauma, 2*, 143-160.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., ... Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice, 39*, 396-404.

Strand, V. C., Sarmiento, T. L., & Pasquale, L. E. (2005). Assessment and screening tools for trauma in children and adolescents: A review. *Trauma, Violence, & Abuse, 6*(1), 55-78.

INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

February 2014



A CASE EXAMPLE

of the ACYF's Well-Being Framework: KIPP



Preface

This series of papers, *Integrating Safety, Permanency and Well-Being in Child Welfare*, describes how a more fully integrated and developmentally specific approach in child welfare could improve both child and system level outcomes. The papers were developed to further the national dialogue on how to more effectively integrate an emphasis on well-being into the goal of achieving safety, permanency and well-being for every child.

The overview, *Integrating Safety, Permanency and Well-Being: A View from the Field* (Wilson), provides a look at the evolution of the child welfare system from the 1970s forward to include the more recent emphasis on integrating well-being more robustly into the work of child welfare.

The first paper, *A Comprehensive Framework for Nurturing the Well-Being of Children and Adolescents* (Biglan), provides a framework for considering the domains and indicators of well-being. It identifies the normal developmental trajectory for children and adolescents and provides examples of evidence-based interventions to use when a child's healthy development has been impacted by maltreatment.

The second paper, *Screening, Assessing, Monitoring Outcomes and Using Evidence-based Practices to Improve the Well-Being of Children in Foster Care* (Conradi, Landsverk and Wotring), describes a process for delivering trauma screening, functional and clinical assessment, evidence-based interventions and the use of progress monitoring in order to better achieve well-being outcomes.

The third paper, *A Case Example of the Administration on Children, Youth and Families' Well-Being Framework: KIPP* (Akin, Bryson, McDonald, and Wilson), presents a case study of the Kansas Intensive Permanency Project and describes how it has implemented many of the core aspects of a well-being framework.

These papers are an invitation for further thinking, discussion and action regarding the integration of well-being into the work of child welfare. Rather than being a prescriptive end point, the papers build developmentally on the Administration on Children, Youth and Families' 2012 information memorandum *Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services* and encourage new and innovative next steps on the journey to support healthy development and well-being.

Acknowledgments

This publication was produced by Paltech, Inc. under the Technical Support and Product Development for the Children's Bureau and its Grantees, contract number HHSP23320095648WC with the U.S. Department of Health and Human Services (HHS). The authors of this publication were Becci A. Akin, Ph.D., MSW and Thomas P. McDonald, Ph.D., of the University of Kansas School of Social Welfare; Stephanie A. Bryson, Ph.D., MSW of the University of British Columbia School of Social Work; and Charles Wilson, MSSW of the Chadwick Center for Children & Families, Rady's Children's Hospital—San Diego.

Disclaimer

The views, opinions, and content expressed herein are those of the authors and do not necessarily reflect the views, opinions, or policies of HHS or Paltech. No official support of or endorsement by HHS or Paltech for these opinions or for particular interventions, programs, practices, tools, instruments, software, or resources is intended or should be inferred.

Introduction

This is the third in a series of three papers informed by the by the well-being framework developed by the Administration on Children, Youth and Families (U.S. Department of Health and Human Services), to further dialogue regarding the more robust integration of well-being with the safety and permanency pillars of child welfare services.

This final paper presents a case example of how one jurisdiction selected an evidence-based intervention to promote the social and emotional well-being of children. This effort provides a beginning roadmap for other jurisdictions to consider as they work to identify and implement the right service at the right time to improve outcomes.

In the past several years, the Administration on Children, Youth, and Families and its Children's Bureau has led the charge to elevate the well-being of children served by child welfare (U.S. Department of Health and Human Services (USDHHS), 2012) to the same status as the long-standing child welfare priorities of safety and timely permanence. Given this new emphasis on better integrating well-being, the question for child welfare leaders is: How can a state or county child welfare system, with limited resources, realign their service delivery system to better achieve all three Congressionally mandated goals of safety, permanence, and well-being? (Adoption and Safe Families Act of 1997).

The empirical evidence of effectiveness is an important tool to drive child welfare program planning and casework decisions. Over the last decade, the acceptance of evidence-based practice has expanded dramatically from a few early adopters and researchers to the common everyday world of child welfare management and practice (Wilson & Alexandra, 2005; Wilson & Walsh, 2012). As the notion of evidence-based practice has grown in popularity, some feared it would be just another short-lived fad in a field all too familiar with the “flavor of the month” approach to innovation and change. With the acceptance of evidence-based interventions (EBIs) there was a temptation to adopt popular models that have shown empirical promise in settings other than child welfare without carefully contemplating a number of key considerations. For example, what practice is the best fit for the particular community? What problem does the EBI address? For which segment of the population is the EBI most appropriate?

The challenge of successful implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) is not merely to add individual models to the services array, but to select the strategies that will have the greatest and most meaningful impact on the goals of the local or state system. Such decisions should not be undertaken lightly or without careful analysis and planning.

It is important for child welfare administrators contemplating enhancements to their systems and introducing evidence-based practices to explore the core issues they wish to address (Aarons, Hurlburt, & Horwitz, 2011). This exploration of core issues requires that they “mine” existing data sources to gain a more complete understanding of the challenges faced by the children and families they serve. The goal is to identify underlying issues most amenable to influence by the right service delivery model(s).

Once core issues are understood, the next step is to consider service models that are not only supported by empirical research but that also are a good fit with the families to be served, the workforce that will deliver the services, and the community and funding framework in which the services will be delivered (California Evidence-Based Clearinghouse for Child Welfare, 2013).

Leaders must plan carefully and must not only train and support those who will implement the new intervention but also those who will screen, assess, and refer families to the new services.

Attending to screening, assessment, and case planning processes and procedures ensures that the children and families best suited to the new resource will be referred to it in a timely way (Wilson, 2012). Once the intervention is in place, child welfare leaders must act to guarantee that the new intervention is being implemented as designed and that it is delivered with fidelity over time until it becomes the new ‘normal,’ ensconced in the very culture of the system.

These are challenging tasks and those aspiring to produce real improvements need exemplars that have thoughtfully adopted a strategic approach to change and carried it out with impact. The Kansas Intensive Permanency Project is one such exemplar.

Case Study

This paper demonstrates how one grantee of the Children’s Bureau’s Permanency Innovations Initiative (PII)—the Kansas Intensive Permanency Project (KIPP)—has used components consistent with of ACYF’s well-being framework (USDHHS, 2012) to improve children’s social and emotional functioning while concurrently working towards the permanency goals of reunification, guardianship, and adoption. While KIPP was initiated prior to the dissemination of the ACYF’s framework, the project illustrates how jurisdictions can integrate the well-being framework into their work.

KIPP is a statewide public-private partnership between the University of Kansas School of Social Welfare (KU), the Kansas Department for Children and Families (DCF), and Kansas’ private providers of foster care. At the time of the exploration work described below, four private providers made up Kansas’ foster care network.¹ One of six PII grantees, KIPP is a five-year demonstration project that is testing the effectiveness of an evidence-based parenting intervention on the safety, permanency, and well-being outcomes of a subpopulation of children at risk of long-term foster care: children with serious emotional disturbance (SED).

Especially relevant in the following description of KIPP are the practices intended to address social and emotional well-being of children: 1) delivery of an evidence-based intervention shown to increase parenting capacity and children’s social and emotional functioning; 2) regular use of valid, reliable functional assessment tools with children and families; and 3) continuous use of outcome measurement to determine whether services are improving social and emotional functioning and moving children back on track developmentally. In addition to providing a case study of how one site developed several project components that are consistent with the well-being framework, this paper provides other jurisdictions with a realistic example of the process of identifying data-informed target populations; selecting and tailoring an EBI to respond to the needs of the target population; and ongoing progress monitoring and continuous quality improvement to advance child and system level outcomes in child welfare.

Exploration and Adoption of an Evidence Based Parenting Intervention

This section of the paper explains how KIPP came to deliver an evidence-based parenting intervention, one of the key strategies of the ACYF’s well-being framework. Importantly, this process was informed and guided by implementation science principles and technical assistance from the

¹ Private agencies included KVC Behavioral Healthcare, St. Francis Community Services, TFI Family Services, and Youthville.

National Implementation Research Network (NIRN). The goal of the first stage of implementation – exploration and adoption – is to assess the match between community needs, evidence-based practice, and community resources (Fixsen et al., 2005). (A more detailed discussion of KIPP’s use of implementation stages can be found in (Akin et al., 2013).) Following is a description of the major activities undertaken by KIPP during its exploration and adoption stage. As described below, this stage comprised four major activities: 1) identifying the target population and its barriers to permanency; 2) examining available empirical evidence to select an evidence-based intervention; 3) selecting an evidence-based intervention; and 4) tailoring the intervention to address the specific needs of the target population and local context.

Identifying a Target Population

In their earliest planning, KIPP partners quickly agreed that children with a serious emotional disturbance face the most serious barriers to permanency. SED is defined by federal regulations as a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM that results in functional impairment that substantially interferes with family, school, or community activities. A focus on child mental health was based on local practice experience but also substantiated by national data. Children in foster care experience social, emotional, and behavioral problems at rates considerably higher than the general population. Using data from the National Survey of Child and Adolescent Well-Being, researchers found that nearly half (47.9%) of the children involved with the child welfare system had clinically significant emotional or behavioral problems (Burns et al., 2004). In contrast, the general child population experiences diagnosable mental disorders in approximately 13-20 percent of youths (Perou et al., 2013) and SED in 5-9 percent of youths (Federal Interagency Forum on Child and Family Statistics, 2012; Li, Green, Kessler, & Zaslavsky, 2010). Despite the significant prevalence of serious mental health problems among the child welfare population, considerable evidence indicates that most children do not receive the clinical treatments they need. A large disparity exists between those identified as needing mental health services and those that receive them (Bai, Wells, & Hillemeier, 2009; Burns et al., 2004; and McCue Horwitz et al., 2012).

KIPP’s university and state-level child welfare leaders had long been grappling with issues related to mental health care access and service gaps for children in foster care. They had worked on multi-system state-level committees and had conducted numerous studies on the state’s child welfare and Medicaid populations (Akin, 2011; Akin et al., 2010; Akin, Bryson, & Moore, 2009; Bryson, Levy, & Moore, 2007; Moore & Akin, 2008). Local studies revealed a troubling pattern: Children with serious social and emotional problems quickly became identified as “the client,” often to the exclusion of any meaningful family intervention, yet they rarely received evidence-based interventions in either the child welfare or children’s mental health systems.

In child welfare, child-focused interventions often were not informed by the use of valid and reliable screening and assessment tools as described in the previous paper (Conradi, 2013). In fact, the absence of universal screening and assessment with valid and reliable tools likely contributed to under-identification of SED and/or referrals that were not accurately or appropriately matched to the needs of children and families. Conversely, in the children’s mental health system, children in care had multiple assessments but did not receive appropriately targeted, effective, or sufficient services; sometimes because they moved so frequently that they could not attend scheduled appointments. Moreover, parent-directed services, including family-based interventions, were rare. The complexity of families’ and children’s needs, the difficulties of children’s behaviors, the lack of family-based

interventions, and geographic instability combined to imperil the continuity of mental health care and to forestall permanency. In some cases, the result was even greater placement instability, including repeat psychiatric hospitalizations, which further exacerbated difficulties reunifying the family. Over time, the gap between children and parents grew— affectively and geographically. In case after case, it became clear that the longer children were separated from parents, the smaller were the chances that permanency would be achieved.

KIPP's initial problem statement thus described children with SED as experiencing long stays in care and parents of these children as encountering significant and wide gaps in services. To test this initial hypothesis and fully explore the needs of the target population, KIPP partners first sought to verify the relevance of children's mental health status as a key risk factor of long term foster care (LTFC). Second, partners also sought to understand critical barriers encountered by parents of children with serious mental health problems. Finally, partners set out to identify system barriers that hinder permanency.

Key Risk Factors of Long-Term Foster Care. Multiple data mining techniques were used, including review of existing administrative and program data, to identify factors that place certain groups of children at risk of long-term foster care. In an extensive quantitative analysis that tested the association between permanency and eleven child and case characteristics, child mental health problems emerged as most predictive of long term foster care. Children with SED were 3.6 times more likely to experience long-term foster care than children without an SED, when statistically controlling for ten other potentially confounding variables (Akin, Bryson, McDonald, & Walker, 2012).

Critical Barriers Encountered by Parents. After verifying that children's serious mental health problems were a major risk factor of LTFC, KIPP partners turned to uncovering the barriers encountered by parents of children with SED. Data on family characteristics are largely unavailable in Kansas databases. Therefore, data mining included collecting information from 30 randomly selected case records. The case record sample was randomly selected to avoid selection bias but purposely kept small due to limited time and staff resources required for intensive reviews. Data from case record reviews and caseworker interviews were coded both to measure the prevalence of selected risk factors and to identify those risk factors that posed the biggest obstacle to successful reunification. At the family level, the main obstacles that were both highly prevalent and most critical to inhibiting permanency were extreme poverty (90%); historical trauma, familial inter-generational trauma, and ongoing domestic violence (80%); parental mental health (90%) and substance abuse problems (83%); and, a pervasive lack of parenting skills with which to parent children with challenging behaviors (97%) (Akin et al., 2012).

System Barriers to Permanency. Finally, system level barriers were explored by administering an electronic survey to child welfare staff, administrators, and advocates across the state (n=232). Survey questions were organized into four broad categories: child welfare service system issues, ancillary/specialized services, organizational issues, and macro-level issues. Respondents included public and private caseworkers or clinicians (49%), supervisors (17%), administrators (8%), and individuals that did not disclose their organizational position (26%). The top five system barriers identified by child welfare stakeholders as impeding permanency for children with SED were: 1) a lack of dedicated parent services (84%); 2) high caseloads (79%); 3) high caseworker turnover (77%); 4) parents' lack of transportation (76%); and, 5) court system issues (70%) (Akin et al., 2012).

Examining the Evidence Base

The next step of the exploration and adoption process was to gather evidence for selecting an evidenced-based intervention (Bryson, Akin, Blase, McDonald, & Walker, in press). Once the target population was defined as parents of children with serious emotional disturbance aged 3-16, the KIPP partners began to locate information on evidence-based interventions with significant empirical evidence for this population. They consulted the California Evidence-Based Clearinghouse for Child Welfare (California Evidence-Based Clearinghouse for Child Welfare, 2013) and the Substance Abuse Mental Health Administration (SAMHSA)'s National Registry of Evidence Based Programs and Practices (NREPP) and conducted a search of empirical literature based on initial citations found on these websites. Additionally, they used search engines like PsychInfo, PubMed, and Google Scholar to identify other journal articles describing parent-focused interventions for children with social and emotional difficulties. A table matrix was compiled with relevant information on all major interventions by important factors (e.g., age of children, intervention format, intended audience, expected and demonstrated proximal outcomes, level of research, diagnostic profiles, family characteristics, etc.). The parameters of the target population and information from case reviews and the system barrier survey were used to select the most relevant programs or practices.

After identifying a list of possible interventions, phone interviews were held with several national child welfare opinion leaders to share preliminary ideas for an intervention. KIPP initially proposed to implement a modified Intensive Family Reunification Services (IFRS) model that emphasized early intervention and parental engagement. The national permanency experts and opinion leaders unanimously supported the idea of working with parents early in the life of a foster care case. Additionally, they suggested supplementing the structural elements of IFRS (e.g., low caseload, in-home services) with a behavioral parenting intervention that had been tested in a rigorous evaluation. Based on this input, the project team identified a list of parenting models and assessed their relevance to the selected target population. Table 1 lists key questions asked of each model.

Table 1. Key Questions Asked of Each Evidence-Based Parenting Intervention

1. Has the model demonstrated, through rigorous evaluation, its efficacy with the identified target population: children with an SED in foster care?
2. Does the model address parents' needs as identified in the target population analysis (e.g., parenting competency, poverty, trauma, mental health, etc.)
3. Has the model been tested in a foster care context?
4. Is the model replicable within the Kansas practice context?
5. Is the model replicable on a statewide level (e.g., within an urban-rural-frontier geographic continuum)?
6. Have purveyors developed sufficient training, coaching, certification, and fidelity supports?
7. How long is the certification period?
8. Is there support and enthusiasm for the model among project partners?
9. What is the cost?
10. Is the model sustainable with regard to long-term infrastructure and with regard to future training cohorts?

Selecting an Evidence-Based Intervention

The next step required reducing the list of models and programs by using the criteria defined above. Ultimately, by answering the questions outlined in Table 1, on page 5, the list was honed to two programs deemed most appropriate in Kansas for parents of children in foster care, particularly parents of children 3-16 with social, emotional, and behavioral problems. To make the final selection, the project partners thoroughly reviewed each program's empirical outcomes and conducted numerous phone interviews with each model's purveyors and implementers. The final selection process included multiple considerations based on implementation best practices (Fixsen et al., 2005). Ultimately, KIPP selected the Parent Management Training Oregon Model (PMTO), which was designated as an EBI by the NREPP, listed as a "near top tier" program by the Coalition for Evidence-based Policy, and received the highest scientific rating (1 out of 5) on the California Clearinghouse of EBP for Child Welfare (and a 'Medium' rating for relevance to child welfare). In analyzing the empirical literature, three factors distinguished PMTO: 1) efficacy with our target population demonstrated through randomized controlled trials (McCue Horwitz, Chamberlain, Landsverk, & Mullican, 2010); 2) proven effectiveness in remediating parental factors associated with poor permanency outcomes (Forgatch & DeGarmo, 2007; Forgatch, Patterson, DeGarmo, & Beldavs, 2009); and, 3) sustainability. While both final contenders had exemplary outcomes and significant research support, PMTO is a progenitor model. After one generation has achieved PMTO certification, this first generation of locally-based practitioners can go on to train and coach successive cohorts of PMTO practitioners. In addition to the research base, PMTO was determined to offer the best chance for sustainability beyond the five-year grant period.

Designing and Tailoring an Intervention for the Target Population

After exploring the needs of the target population and selecting an EBI, our next step was to ensure that KIPP's intervention adequately addressed family and system level obstacles to permanency and well-being. The identification of barriers performed during the target population analysis indicated that families experience multiple and complex problems that can constrain well-being improvement and inhibit permanency. Moreover, system level barriers further complicate successful innovation. Following the "less is more" guidance of child welfare opinion leaders and a growing body of literature (Barth, 2009; Chaffin et al., 2006), the KIPP team opted to test a single EBI rather than layering or combining several EBIs. They posited that the most effective and efficient approach would be parsimony. Based on PMTO's empirical record—which demonstrated positive effects well beyond the intervention's focus on parenting, such as gains in maternal depression and substance abuse (Patterson, Forgatch, & DeGarmo, 2010)—the project sought to design a service model that would be focused, behavioral, and goal-directed.

Table 2 on page 6 shows how the KIPP service model was developed to target children with SED and to address the key family and systems barriers that were identified in the target population analysis. The table displays each family and system barrier to permanency; KIPP's strategic response, including how PMTO would be tailored to address the barrier; and, the corresponding core component of the KIPP service model. For example, the target population analysis demonstrated that parental trauma may interfere with successful permanency. To maximize trauma responsiveness, PMTO purveyors collaborated with an accomplished implementer who has tailored the intervention for use with a military population, homeless parents, and parents who experienced partner violence (Gewirtz, DeGarmo, & Medhanie, 2011; Gewirtz, Erbes, Polusny, Forgatch, & DeGarmo, 2011). Thus, trainings and curricula were augmented with trauma content for the KIPP intervention. (Further discussion of the selection and tailoring an EBI is available by Bryson et al., (in press).)

Table 2. Designing and Tailoring the Intervention for the Target Population

	Barrier to Permanency	KIPP’s Response & Tailoring PMTO	KIPP Core Component
Family Level Barriers	Parenting competency	PMTO is listed by SAMHSA’s NREPP, identified as a near-top tier program by the Coalition for Evidence-based Policy, and has the highest level of evidence in the California Evidence-Based Clearinghouse for Child Welfare for its effectiveness improving parenting capacities and reducing problematic child behavior—both in children with difficult conduct problems and in children with internalizing symptoms. PMTO is intended for use by parents of children with SED, 3-16, KIPP’s target population.	EBI = PMTO
	Parent mental health problems	By helping mothers to reduce their children’s externalizing symptoms, PMTO has been shown to reduce maternal depression and other mental health problems. In addition to anticipated reductions in parental mental health problems, KIPP workers facilitate “robust” referrals to specialty mental health services and monitor case coordination.	Comprehensive assessment Robust referrals Service coordination
	Poverty related issues	PMTO has shown to speed recovery from poverty among women and to increase standard of living (i.e., income, occupation, education, and financial stress). In addition to anticipated reductions in income-to-need ratio, KIPP workers connect families with concrete supports and services.	
	Parent alcohol and other drug (AOD) problems	PMTO has been shown to reduce use of tobacco, alcohol, and illicit drugs. In addition to anticipated reductions in parental AOD problems, KIPP workers will facilitate “robust” referrals to AOD services and ensuing case coordination.	
	Parent trauma	PMTO emphasizes emotion regulation and KIPP workers make referrals to domestic violence counseling, etc., as needed.	Trauma-informed PMTO
System Level Barriers	Lack of dedicated parent services	KIPP infuses child welfare practice-as-usual with dedicated parent resources for parents of children with SED.	KIPP/PMTO Intensive services
	High caseloads	KIPP practitioners carry a caseload of 4-6 cases.	Low caseloads
	High worker turnover	KIPP provides high quality supervision, a major factor in worker retention. In addition, KIPP provides clear job expectations, training, coaching, monitoring, and rewards for desired behavior.	Clinical & team supervision
	Parent access to transportation	To mitigate significant transportation barriers, KIPP is delivered in-home.	In-home services
	Courts/legal system	KIPP leaders engage in networking and an education process with the court system.	Systems education and advocacy

Following is KIPP’s theory of change, which flowed directly from the target population analysis and intervention selection process described above. As stated by Bryson et al. (in press):

Parents of children with SED face multiple problems that are complex in nature and not alleviated easily by current child welfare practice or within current child welfare timeframes. To bring about change of sufficient magnitude, resources must be dedicated to improve ineffective parenting practices and to connect parents with community resources and social supports, such as mental health and substance abuse

treatment. When parenting and community connections are strengthened, a more adequate and pro-social environment for children is created. Moreover, when the family's interpersonal and social environment is bolstered, child functioning increases and behavior problems decrease. These changes combine to create readiness for family reunification, which leads to more timely and stable reunifications.

Screening and Assessment

Screening and assessment strategies are central to the ACYF's well-being framework. Use of valid and reliable functional assessment instruments at regular intervals provides valuable information on all domains of well-being identified in the ACYF framework for *Promoting Social and Emotional Well-being for Children and Youth Receiving Child Welfare Services*, including cognitive functioning, physical health and development, emotional/behavioral functioning, and social functioning (USDHHS, 2012) and similarly described in the first article in this series (Biglan, 2013). Accordingly, screening and assessment strategies also are integral to the KIPP project. KIPP partners sought to address several objectives by using screening and assessment including identifying children with serious social and emotional problems, assessing child well-being and family functioning at regular intervals, measuring both competencies and problems, and using assessment information to understand project-level effectiveness. Following is a description of each of KIPP's objectives for screening and assessment.

Identifying Children with SED. KIPP changed child welfare practice across Kansas by instituting the use of a functional assessment, the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 2004), for all children, 3-16, entering foster care. The CAFAS provides valid and reliable data for determining at baseline whether a child meets the criteria for SED and thereby qualifies to participate in KIPP. Moreover, screening and assessment of children's social and emotional functioning is a requisite for determining their mental health and trauma needs and for making appropriate referrals for services.

Assessing Well-Being at Regular Intervals. For KIPP, use of the CAFAS initially and at regular intervals through the life of the case allows comparison to baseline measures across critical domains of well-being, including cognitive functioning, social and emotional competence, and psychological and behavioral development. Indeed, the desirability of functional assessments over point-in-time diagnostic impressions is that functional assessment provides a "holistic evaluation of children's well-being and also can be used to measure improvement in skill and competencies that contribute to well-being" (USDHHS, 2012, p. 9). Scales like the CAFAS also account for trauma and mental health issues commonly experienced by children with abuse and neglect histories. In addition to using the CAFAS to assess child well-being, KIPP assessments include a second measure of child well-being, the Social Skills Improvement System Rating Scales (SSIS), described below, and four measures of parenting capacity and family functioning: the Caregiver Wish List, the North Carolina Family Assessment Scale, the Parent-Child Checklist, and the Family Interaction Task.

Measuring Competencies and Problem Behavior. KIPP's decision to use a second measure of child well-being demonstrates another aspect of the ACYF's well-being framework, which emphasizes the importance of measuring skills and capacities as well as difficulties. Two primary rationales prompted KIPP partners to select the SSIS (Gresham & Elliott, 1990). First, the SSIS complements the information acquired from a professional assessment (i.e., the CAFAS) by adding caregivers' perceptions of children's behaviors. Second, the SSIS incorporates strengths and competencies rather than problem behaviors exclusively.

Gauging Project Progress. Beyond identifying individuals' needs and tracking their progress toward improved well-being, KIPP also uses its battery of assessments to gauge the project's progress on child well-being and family functioning. Aggregate scores on different measures are tracked over time. With an adequate sample size, assessment data help the project understand in which areas it is affecting positive change. For example, separate subscales of the CAFAS indicate whether child well-being has improved at home, in school, and in behavior toward others. Similarly, the SSIS provides scores for externalizing and internalizing behaviors. The use of these data informs the KIPP project about specific aspects of well-being in which services are effective versus those that deserve further attention and improvement.

Progress Monitoring and Continuous Quality Improvement

The final example of how KIPP has embedded a focus on social and emotional well-being is the project's commitment to ongoing progress monitoring and continuous quality improvement (CQI). Three administrative components of KIPP demonstrate these efforts including initiating the project with usability testing and Plan-Do-Study-Act (PDSA) cycles; monitoring implementation integrity; and monitoring project outputs, proximal outcomes, and distal outcomes. Following is a brief description of each of these monitoring and CQI components.

Usability Testing and PDSA Cycles. Guided by technical assistance from the National Implementation Research Network, KIPP's initial implementation was carefully examined by a process called usability testing (Akin et al., 2013). Usability testing establishes a systematic Plan-Do-Study-Act (PDSA) process to assess the functionality of an innovation's critical components during its initial implementation, providing the opportunity to make necessary adjustments prior to full implementation and evaluation (Akin et al., 2013). KIPP's usability testing comprised nine metrics that address three important constructs: 1) intervening early; 2) obtaining consent; and 3) engaging parents. The results were used to detect implementation obstacles and challenges during initial implementation. Usability testing allowed for an important window of "trial and learning" and set up an ongoing feedback loop between frontline staff and project leadership that provides critical information on the day-to-day world of the project.

Monitoring Implementation Integrity. Implementation integrity refers to the degree to which an intervention was implemented as planned (Dane & Schneider, 1998). Key dimensions of implementation integrity include reach (i.e., participation rates), exposure (i.e., dosage), adherence (i.e., fidelity), differentiation (i.e., program uniqueness), quality, and responsiveness (Berkel, Mauricio, Schoenfelder, & Sandler, 2011). Particularly important to KIPP's tracking of implementation integrity is a direct link to the core components of the KIPP service model (listed in Table 2). KIPP partners established a system for collecting data and monitoring progress by identifying a metric for nearly every core component of the model. For example, early intervention was tracked by calculating the number of days between children's entry into foster care and a referral to KIPP; in-home's metric was defined as the percent of sessions held in the family's home or community setting (not office-based); and, delivery of PMTO was examined via behavioral observations of video-recorded sessions and quantitative ratings on a structured scale that measures fidelity to the PMTO model (Knutson, Forgatch, Rains, & Sigmarsdottir, 2009). Data on each of the core components is aggregated and reviewed regularly by the implementation team. This practice-to-policy feedback loop permits KIPP leaders to identify areas of underperformance and address them with a deliberate and coordinated plan.

Monitoring Outputs, Proximal Outcomes, and Distal Outcomes. KIPP is guided by its theory of change. The theory of change, as stated previously, posits that improvements in permanency outcomes will be achieved by targeting families of children with SED and, through parent training, will create a more positive, nurturing environment for children's development and well-being. While KIPP will ultimately be evaluated in terms of achieving timely permanency for targeted children, this distal outcome will require considerable waiting time to collect adequate data. Project outputs and proximal outcomes are monitored in a more timely fashion to judge whether the intervention appears to be working as expected to achieve intermediate outcomes that are hypothesized to move families toward reunification and children toward permanency. As noted previously, assessment tools like the CAFAS and the SSIS are re-administered at six and twelve months to measure child well-being, a proximal outcome. The most direct measure of the impact of PMTO is parenting behavior. KIPP includes intensive monitoring of this using a purveyor-developed observational measure used in prior evaluations.

Conclusion

Today, child welfare leaders have tools to support children and families that, for the most part, did not exist twenty years ago. Not only do we have a wide range of evidence-based service delivery options, but resources now exist to identify promising and effective programs without independently scouring the literature. These resources include the National Registry of Evidence-Based Programs and Practices (NREPP) at <http://www.nrepp.samhsa.gov>; the California Evidence-Based Clearinghouse for Child Welfare (CEBC) at <http://www.cebc4cw.org>; the Coalition for Evidence-Based Policy (CEBP) at toptierevidence.org; Blueprints for Healthy Youth Development at <http://www.blueprintsprograms.com>; the National Child Traumatic Stress Network at <http://www.nctsn.org>; OJJDP Model Programs Guide at <http://www.ojjdp.gov/mpg>; Office of Justice Programs at <http://www.crimesolutions.gov>; the Campbell Collaboration at <http://www.campbellcollaboration.org>; and others. Most jurisdictions have computer-based data systems that can answer important questions about the clients they serve. Today's child welfare leaders can take advantage of these developments and realize the true potential of the new science-informed alternatives that lay before them.

We also can choose to guide implementation of chosen interventions using principles drawn from the growing, interdisciplinary field of implementation science, which is an emerging area focused on how to effectively adopt, implement, and sustain practices across systems. KIPP used the structure of implementation science to guide the state's efforts to address an important policy issue in a meaningful way that could produce tangible improvements in actual client outcomes. What emerged is a practical framework for other child welfare leaders at state and county levels to draw from as they use their own experience and administrative and assessment data to define and understand their important problems, match those problems to an appropriate evidence-based solution, draw on implementation science to guide the adoption and implementation process, and then use ongoing progress monitoring and continuous quality improvement to determine effectiveness and make mid-course corrections. In reality, the problems to be addressed and the underlying forces that drive those problems will vary dramatically from community to community and from one child welfare agency to the next. Each agency, however, can use its available data to identify and define the most pressing problem; understand what is behind the problem that may respond to an intervention; select the evidence-based solution that is the best fit for the problem, the families, and the community; and then implement it with fidelity applying the principles identified in the KIPP case study.

References

Aarons, G. A., Hurlburt, M. S., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health, 38*, 4-23.

Adoption and Safe Families Act of 1997, 42 USC 1305, Pub. L. No. 105-89, 111 Stat.

Akin, B. A. (2011). Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review, 33*(6), 999-1011. doi: 10.1016/j.childyouth.2011.01.008

Akin, B. A., Bryson, S., Gomi, S., Moore, T., Parkinson-Arnold, E., & Tullis, L. (2010). Inpatient psychiatric care for children and youth: Precipitants and predictors of admissions and readmissions. Lawrence, KS: University of Kansas School of Social Welfare Office of Child Welfare and Children's Mental Health.

Akin, B. A., Bryson, S., & Moore, T. (2009). Medicaid children's focused study: Prescribing patterns of psychotropic drugs among child Medicaid beneficiaries in the state of Kansas. Lawrence, KS: University of Kansas School of Social Welfare Office of Child Welfare and Children's Mental Health.

Akin, B. A., Bryson, S., Testa, M. F., Blase, K. A., McDonald, T., & Melz, H. (2013). Usability testing, initial implementation and formative evaluation of an evidence-based intervention: Lessons from a demonstration project to reduce long-term foster care. *Evaluation and Program Planning, 41*, 19-30.

Akin, B. A., Bryson, S. A., McDonald, T., & Walker, S. (2012). Defining a target population at high-risk of long-term foster care: Barriers to permanency for families of children with serious emotional disturbances. *Child Welfare, 91*(6).

Bai, Y., Wells, R., & Hillemeier, M. M. (2009). Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. *Child Abuse & Neglect, 33*(6), 372-381.

Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *Future of Children, 19*(2), 95-118.

Berkel, C., Mauricio, A. M., Schoenfelder, E., & Sandler, I. N. (2011). Putting the pieces together: An integrated model of program implementation. *Prevention Science, 12*(1), 23-33.

Biglan, A. (2013) *A comprehensive framework for nurturing the well-being of children and adolescents*. U.S. Department of Health and Human Services.

Bryson, S., Akin, B. A., Blase, K. A., McDonald, T., & Walker, S. (in press). Selecting an EBP to reduce long-term foster care: Lessons from a university-child welfare agency partnership. *Journal of Evidence-Based Social Work*.

Bryson, S., Levy, M., & Moore, T. (2007). Mental health and substance abuse services to parents of children in foster care. Lawrence, KS: University of Kansas School of Social Welfare, Office of Child Welfare and Children's Mental Health.

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 960.

California Evidence-Based Clearinghouse for Child Welfare. (2013). Selection guide for EBPs in child welfare. Retrieved from <http://www.cebc4cw.org/implementation-resources/tools/selection-guide-for-ebps-in-child-welfare/>.

Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., . . . Miller-Perrin, C. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment*, 11(1), 76-89. doi: 10.1177/1077559505283699

Conradi, L., Landsverk, J., and Wotring, J. (2013) *Screening, assessment, monitoring outcomes and using evidence-based interventions to improve the well-being of children in child welfare*. U.S. Department of Health and Human Services.

Dane, A. V., & Schneider, B. H. (1998). Program integrity in primary and early secondary prevention: Are implementation effects out of control? *Clinical Psychology Review*, 18(1), 23-45.

Federal Interagency Forum on Child and Family Statistics. (2012). *America's children in brief: Key national indicators of well-being, 2012*. Washington DC: U.S. Government Printing Office.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Forgatch, M. S., & DeGarmo, D. S. (2007). Accelerating recovery from poverty: Prevention effects for recently separated mothers. *Journal of Early and Intensive Behavior Intervention*, 4(4), 681-702.

Forgatch, M. S., Patterson, G. R., DeGarmo, D. S., & Beldavs, Z. G. (2009). Testing the Oregon delinquency model with nine-year follow-up of the Oregon Divorce Study. *Development and Psychopathology*, 21(2), 637-660.

Gewirtz, A. H., DeGarmo, D. S., & Medhanie, A. (2011). Effects of mother's parenting practices on child internalizing trajectories following partner violence. *Journal of family psychology: JFP: journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, 25(1), 29.

Gewirtz, A. H., Erbes, C. R., Polusny, M. A., Forgatch, M. S., & DeGarmo, D. S. (2011). Helping military families through the deployment process: Strategies to support parenting. *Professional Psychology, Research and Practice*, 42(1), 56.

Gresham, F. M., & Elliott, S. N. (1990). *Social skills rating system: Preschool, elementary level*. American Guidance Service.

Hodges, K. (2004). The Child and Adolescent Functional Assessment Scale (CAFAS). *The use of psychological testing for treatment planning and outcomes assessment: Instruments for children and adolescents* (Vol. 2, pp. 405-441). New Jersey: Taylor & Francis.

Horwitz, S. M., Chamberlain, P., Landsverk, J., & Mullican, C. (2010). Improving the mental health of children in child welfare through the implementation of evidence-based parenting interventions. *Administration and Policy in Mental Health, 37*, 27-39.

Horwitz, S. M., Hurlburt, M. S., Heneghan, A., Zhang, J., Rolls-Reutz, J., Fisher, E., . . . Stein, R. E. (2012). Mental health problems in young children investigated by US child welfare agencies. *Journal of the American Academy of Child & Adolescent Psychiatry, 51*(6), 572-581.

Knutson, N. M., Forgatch, M. S., Rains, L. A., & Sigmarsdottir, M. (2009). *Fidelity of implementation Rating System (FIMP): The manual for PMTO*. Eugene, OR: Implementation Sciences International, Inc.

Li, F., Green, J. G., Kessler, R. C., & Zaslavsky, A. M. (2010). Estimating prevalence of serious emotional disturbance in schools using a brief screening scale. *International Journal of Methods in Psychiatric Research, 19*(S1), 88-98.

Moore, T., & Akin, B. A. (2008). Focused study on mental health services for children in foster care under the PAHP. Lawrence, KS: University of Kansas School of Social Welfare, Office of Child Welfare and Children's Mental Health.

Patterson, G. R., Forgatch, M. S., & DeGarmo, D. S. (2010). Cascading effects following intervention. *Development and Psychopathology, 22*(04), 949-970.

Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., . . . Schieve, L. A. (2013). Mental health surveillance among children—United States, 2005–2011. *MMWR: Surveillance Summaries, 62*(2), 1-35.

U.S. Department of Health and Human Services (USDHHS); Administration on Children Youth and Families. (2012). Promoting social and emotional well-being for children and youth receiving child welfare services. Washington, DC: Author. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/im1204>.

Wilson, C. A. (2012). Special issue of child maltreatment on implementation: Some key developments in evidence-based models for the treatment of child maltreatment. *Child Maltreatment, 17*(1), 102-106.

Wilson, C. A., & Alexandra, L. (2005). *Guide for child welfare administrators on evidence based practice*. Washington, DC: National Association of Public Child Welfare Administrators. Retrieved from <http://www.aphsa.org/Home/doc/Guide-for-Evidence-Based-Practice.pdf>.

Wilson, C. A., & Walsh, C. R. (2012). *Guide for child welfare administrators on evidence based practice*. Washington, DC: National Association of Public Child Welfare Administrators.