INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

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SCREENING, ASSESSING, MONITORING OUTCOMES

and Using Evidence-Based Interventions to Improve the Well-Being of Children in Child Welfare

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Children's Bureau

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.

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Disclaimer

Introduction

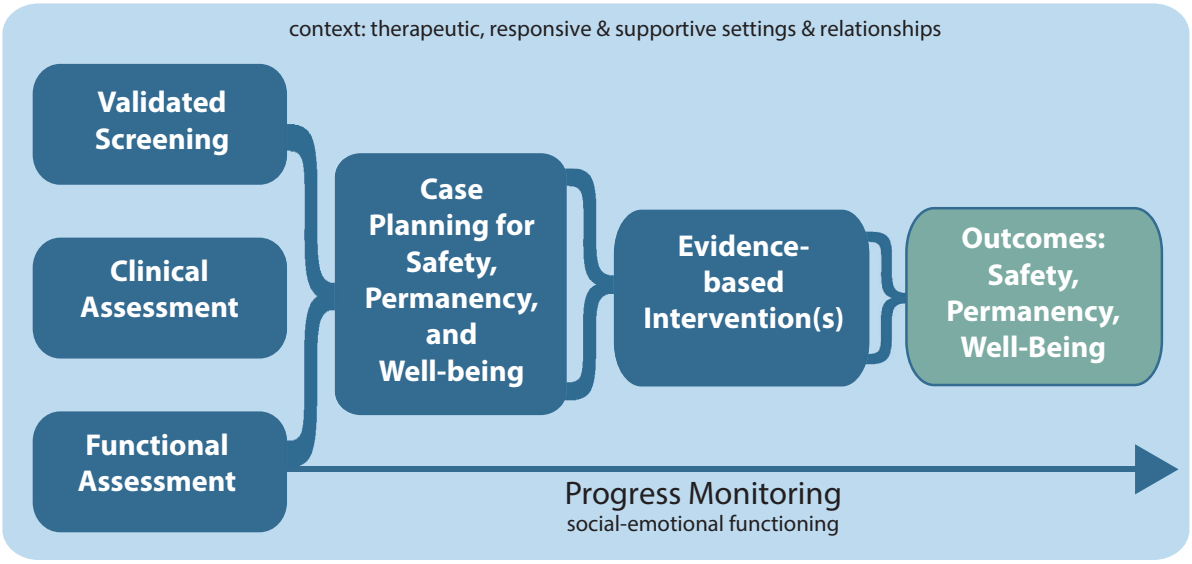
This is the second in a series of three papers informed by the well-being framework developed by the Administration on Children, Youth and Families (U.S. Department of Health and Human Services, 2012). It addresses three critical components of a well-functioning response to the social, emotional and 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 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 stake-holders 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.

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