INTEGRATING SAFETY, PERMANENCY AND WELL-BEING SERIES

February 2014

A CASE EXAMPLE

of the ACYF's Well-Being Framework: KIPP

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.

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

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 intergenerational 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 dare: 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 ofthe American Academy pf 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 Institue, 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 mplementation 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 Ccildren—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 nased practice*. Washington, DC: National Association of Public Child Welfare Administrators.