Research to Policy: Improving outcomes for children and youth in foster care

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Presentation Overview

• Child welfare system overview
• Using data to understand system functioning
  – Placement types
  – Outcome indicators
  – Change over time and place
• Strategic approaches to improving child welfare outcomes
• Questions and discussion
Chapin Hall Mission

• Chapin Hall provides public and private decision-makers with rigorous data analysis and achievable solutions to support them in improving the lives of our most vulnerable children, youth and families.

• Chapin Hall partners with policymakers, practitioners and philanthropists to provide actionable information, practical tools, and tailored solutions by applying a unique blend of scientific research, real world experience, and policy expertise to create positive change.
Chapin Hall Services and Supports

1. Program evaluation, multiple methodologies
2. Administrative data analysis, database management, and data linkage
3. **Policy analysis** and change management
4. Use of administrative data for dashboards and reporting
5. **Readiness assessment**, including drivers and organizational capacity
6. Selection and implementation of **Evidence Based Practices**, including process evaluation
7. **Fidelity measurement**, including the identification and/or revision of measurement tools and installation of processes
8. Implementation **output monitoring**, including development of data systems for monitoring and reporting on project outputs
9. GIS support to project and monitor the **geographic distribution** of cases relative to capacity to deliver intervention
10. Identification of **proximal** and **distal outcomes**, logic model design
11. **Cost analysis** that incorporates the cost of scaling up as well as savings associated with projected and actual outcomes
Child Welfare System, Nationally

• Each year, states investigate roughly 3 million reports of child maltreatment
• Of these, just under 700,000 are substantiated
• Approximately 30% of substantiated cases are placed in out-of-home care
• 15-20% of youth in out-of-home care are placed in congregate care settings
• Treating abused and neglected children costs $29.4 billion dollars each year
The Child Welfare System in the U.S.

Prevention
In-home services to prevent maltreatment and placement

Mal-treatment Report
Investigation
Substantiated Unsubstantiated

Removal
Placement
Foster Care Kinship Care Group Home/Residential

Screening and Assessment
Services and Supports

Exit to Permanency
Reunification Guardianship Adoption Emancipation

Case Closed
Post-adoption services and subsidy Supports for youth aged out of care

Aftercare
Supportive Community Based Services to Reduce Readmissions
Traditional hierarchy of placement types...

- Traditional foster home (kin or non-relative)
- Therapeutic foster home
- Group home
- Residential treatment center
Internalizing vs. Externalizing Problems

- Depression
- Anxiety
- Eating disorders
- Aggressive behavior
- Oppositionality
- Conduct problems
Contrasting Characteristics by Placement Type

Percentage of Youth above the CBCL Clinical Cut Point by Placement Type

- No Out of Home Care
- Out of Home, no Congregate Care
- Emergency Shelter Care
- Therapeutic Foster Care
- Group or Residential Treatment

- Total Behavior Problems
- Externalizing
- Internalizing
Goals/Approach

• Understand variation in the use of congregate care among jurisdictions
• Describe the characteristics and clinical needs of youth placed in congregate care settings
• Identify evidence-based approaches to addressing the needs of youth to avert or shorten congregate care placements
Key Findings: Utilization

• While rates of congregate care utilization have dropped overall, states vary in patterns of utilization.

• These patterns suggest different strategies for reductions:
  – States with high rates (up to 43%) of congregate care as first placement may need capacity-building strategies to develop home-based placement options to reduce the dependence on institutional settings, which may include shelters.
  – States with high rates of lateral transfers (up to 50%) or long lengths of stay may need community-based approaches to meeting mental health needs in homes.
Key Findings: Child Characteristics

• Youth placed in congregate care have rates of internalizing and externalizing emotional and behavioral problems that are
  – Higher than peers in traditional foster homes
  – Comparable to peers in therapeutic foster homes
• Youth placed in congregate care are more likely to have externalizing problems (risk behaviors) than their peers in therapeutic foster care settings
Key Findings: Evidence Based Practice

• Disruptive Behavior Treatments
  – Build skills among parents and caregivers to respond effectively to disruptive behaviors
  – Improve affect regulation and mindfulness among youth
  – Encourage positive reinforcement for improvement across systems

• Placement Stabilization Programs
  – Encourage positive caregiver-child interactions
  – Enhance caregiver competence and skill
Using Evidence to Accelerate the Safe and Effective Reduction of Congregate Care for Youth Involved in Child Welfare

**KEY FINDINGS**

- The overall use of congregate care has decreased by 20% since 2009, but there is substantial variation among states even in this trend (suggesting detailed analysis is needed to understand local trends).
- Some states rely heavily on congregate care as a first placement (suggesting capacity building for foster homes is needed).
- Youth placed in congregate care and therapeutic foster homes have significantly higher levels of internalizing and externalizing behaviors than those placed in traditional foster care (suggesting that increased access to services that effectively address internalizing and externalizing behaviors are essential to safely reducing the use of congregate care).
- Compared to youth whose clinical needs are met through therapeutic foster care, youth placed in congregate care are more likely have externalizing problems (suggesting that strategies for serving these youth in home-based settings should focus on preparing those homes to respond by de-escalating difficult behaviors).
- The California Evidence Based Clearinghouse for Child Welfare (CEBC) contains tested strategies for disruptive behavior problems, however, many of them have not been tested for use with the child welfare population (suggesting that support is needed for implementation and evaluation of interventions that may stabilize foster care placements).
Moving toward a multi-dimensional model for understanding how placement & treatment can meet child needs

Restrictiveness of placement

- Group home
- Traditional foster home
- Residential treatment center
- Therapeutic foster home

Intensity of services
Research to Inform the Development of Alternatives to Residential Care

Youth In Care In Illinois 2005-2014 (N=35,790)

- 6,078 (17%) cases experience congregate care during their first child welfare spell
- Of these, 4,569 (75%) cases that ever experience congregate care do so as their first placement.
- Of these, 2,712 (59%) come from another institutional setting (e.g. detention, hospital)
Follow Up: Direct vs. Later Entry

- Two different groups requiring different strategies and approaches
- Among direct-entry youth, important to understand prior placements and possible institutional pathways
- Among later-entry group, important to identify clinical risk factors present early in the case
Clinical Characteristics based on Integrated Assessment (IA CANS): Direct vs. Later Entry to Congregate Care (FY06-FY15, n=3,780)

<table>
<thead>
<tr>
<th>IA CANS Domain with ≥2 “Actionable” Items</th>
<th>Direct Entry to Congregate Care (n=2,983)</th>
<th>Later Entry to Congregate Care (n=797)</th>
<th>Total (n=3,780)</th>
</tr>
</thead>
<tbody>
<tr>
<td>***Trauma</td>
<td>60.0%</td>
<td>66.4%</td>
<td>61.4%</td>
</tr>
<tr>
<td>***Traumatic Stress</td>
<td>23.0%</td>
<td>33.5%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Strengths (Absence)</td>
<td>65.5%</td>
<td>65.1%</td>
<td>65.5%</td>
</tr>
<tr>
<td>***Life Domain Functioning</td>
<td>50.8%</td>
<td>63.6%</td>
<td>53.5%</td>
</tr>
<tr>
<td>***Behavioral/Emotional Needs</td>
<td>46.1%</td>
<td>61.6%</td>
<td>49.4%</td>
</tr>
<tr>
<td>***Risk Behaviors</td>
<td>28.7%</td>
<td>37.8%</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

***p<.001
Predictors of Future Placement in Congregate Care

- **Older age at case opening**
  - Ages 6-11; (6.93, p<.001)
  - Over age 12; (24.36, p<.001)
- **Male**: (1.64, p<.001)
- **African-American**: (1.27, p<.01)
- **Cook County Region** (Chicago): (1.93-2.64, p<.001)
- **Case managed by private agency** (instead of state agency): private agency (.39, p<.001)
Clinical (CANS) Predictors of Future Placement

- **Life domain functioning** (e.g. family, interpersonal, etc.)
  - $>1$ actionable: (1.52, p<.01)
  - $\geq 2$ actionable: (2.25, p<.001)
- **Risk behaviors**
  - $>1$ actionable: (1.52, p<.01)
  - $\geq 2$ actionable: (2.29, p<.001)
- **Behavioral/emotional needs**
  - $>1$ actionable: (1.46, p<.01)
  - $\geq 2$ actionable: (2.06, p<.001)
- **Traumatic Stress Symptoms**
  - $\geq 2$ actionable: (1.26, p<.05)
Child Welfare System Outcomes

• Safety – investigations, removals, repeat maltreatment, re-reports, re-entries (admissions to foster care)

• Permanency – length of stay, placement instability, reunification, adoption (discharges from foster care)

• Well-being (functioning before, during and after foster care)
  – Cognitive Functioning and Growth
  – Physical Health and Development
  – Behavioral/Emotional Functioning
  – Social Functioning
Caseloads, Entries, & Exits
Tennessee Statewide 2012 to 2015

Caseload Dynamics

Total Caseload

Total Entry

Total Exit

Poly. (Total Entry)

Poly. (Total Exit)
IL Out-of-Home Care Entry Rate per 1,000:
Among the lowest in the nation

IL Out-of-Home Care Rate per 1,000, 2012

Median length of stay in out-of-home care: Illinois is the highest of any state

Data Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, [http://cwoutcomes.acf.hhs.gov/data/overview](http://cwoutcomes.acf.hhs.gov/data/overview) 2010 Data Highlights, Children in care on 9/30/10
Dynamic Systems: Understanding Change across Time and Place

Change in Intake into DCFS 2000 to 2010.

- Cook County: -46%
- Suburban Cook: -18%
- Chicago: -52%
- Downstate: 14%
- Illinois: -11%

Intake % Chg.
What is Data-Driven Decision-Making?

- Using available information on needs (epidemiology) and outcomes (program evaluation) to inform
  - The development of new programs & the continuation of existing programs
  - Choices among different strategies for addressing problems
  - The distribution of resources among communities according to local needs
Data Driven Decision-Making is an alternative to business as usual…

• In the absence of data, policy decisions can be made based on
  – Values, ideals, or philosophies
  – Relationships
  – Status quo
  – Reactions to sensational stories

• Data driven decision making requires policy makers to
  – Challenge popular notions
  – Change course as needed
  – Invest in data infrastructure and support compliance with data collection
Use Data to Inform Proactive Practice

- Use known risk factors to anticipate and prevent negative events, like runaway episodes and other Unusual Incidents
- Target at-risk groups with developmentally appropriate stabilizing, de-escalating interventions
- Use assessments to identify youth in need of residential treatment early to avoid placement instability and “failing up”
Use Data to Make System Adjustments

• Use new knowledge about the heterogeneity of the residential population to guide the development of a continuum of placement options

• Address institutional pathways to congregate care with system-level interventions

• Develop goals, metrics, and indicators to facilitate ongoing self-monitoring by providers
How can you help?

• Ask questions!
• Cultivate partnerships with applied research capacity
• Support evaluation as part of the implementation of new practices, so that we can learn from our successes and our mistakes
• Allocate time for careful planning for implementation, evaluation, and sustainability
• Be flexible, and prepared to change course if the data tell us our strategies are not effective
Evidence-Based Practice

- Evidence-Based Treatment (EBT): interventions or techniques that have produced therapeutic change in controlled trials

- Fidelity: consistency with the treatment approach/model/delivery method as it was delivered in the RCT that document its effectiveness
EBP in Mental Health

- EBP frames Mental Health as Medicine, where evidence-based approaches are built into FDA regulatory standards
- EBP can eliminate perceived subjectivity in managed care practices
- EBP can enables less highly trained individuals to receive practical guidance
- Focuses the field on practices that have empirical support
- Prioritizes empirical support above other evidence of success in treatment
- Relies upon Randomized Controlled Trials as the primary source of empirical support
How do we match interventions to at-risk populations?

• Identify the problem/negative outcome
• Use data to identify who is at greatest risk for experiencing the outcome
• Use data to understand the service or clinical needs of the population at greatest risk
• Identify EBPs that target those needs
• Interview purveyors to assess fit and applicability
• Assess capacity to deliver the EBP
Matching Populations, Screening, and Outcomes to Evidence Based Interventions

**Population**
- Children, 8-17
- Children, 13-17
- Children, 2-7

**Screening & Assessment**
- UCLA PTSD Index
- Strengths & Difficulties Questionnaire
- Child & Adolescent Needs & Strengths
- Strengths & Difficulties Questionnaire
- Child & Adolescent Needs & Strengths
- Trauma Symptoms Checklist for Young Children
- Infant Toddler Emotional Assessment
- CBCL

**EBIs**
- Trauma-Focused Cognitive Behavioral Therapy
- Multisystemic Therapy
- Parent-Child Interaction Therapy

**Outcomes**
- Behavior problems
- PTS symptoms
- Depression
- Delinquency/Drugs
- Peer problems
- Family cohesion
- Conduct disorders
- Parent distress
- Parent-child interaction
Continuum of Evidence Based Practice

- Emerging Practice
- Promising Practice
- Evidence-Informed Practice
- Evidence-Based Practice
Sources of EBP Information

- California Evidence-Based Clearinghouse (CEBC)
  - Scientific Rating Scale (SRS)
  - Evidence rated on a continuum from Well-Supported to Concerning
  - [http://www.cebc4cw.org](http://www.cebc4cw.org)
- SAMHSA
- Cochrane Database for Systematic Reviews
- National Child Traumatic Stress Network
- Child Welfare Information Gateway
Families First: Summary and Implications

• Shifts savings from residential reductions to prevention
• Restrict congregate care placements to promote family-based placements
• Re-authorize Title IV-B (evidence-based prevention programs for substance abuse, mental health, and in-home parent training)
• Expand Title IV-E to include prevention
• Support Kinship Navigator
• Support family preservation for substance-abuse affected families
• Extend educational and vocational supports to age 23
• Revise & enhance programs for inter-state placement & permanency as well as foster care licensing
Questions and Discussion
For more information, please contact:

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