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Promoting Social and Emotional Wellbeing-Transcript

Presenters: Krista Thomas, Facilitator; Lisa Conradi, Clinical Psychologist, Chadwick Center for Children and Families; Heather Ringeisen, Director Children and Families Program, RTI International Survey Research Division.

Krista Thomas: [00:00:01:80] Welcome to today's webinar on Promoting Social and Emotional Wellbeing, Uses and Limitation of Screening and Assessment Instruments. My name is Krista Thomas and I am a Child Welfare Specialist with the Children's Bureau and it is my great pleasure to welcome you all here today. A version of this presentation was first shared at the 2013 meeting of the Title IV-E Waiver demonstration states and feedback was so positive about the content and our presenters that we wanted to make the information more broadly available. So many thanks to everyone for joining us this afternoon and thanks to Drs. Lisa Conradi and Heather Ringeisen for being willing to share their expertise again. There's been an increased emphasis on social and emotional wellbeing in recent years and child welfare leaders and advocates at all levels have called our attention to the impact of trauma on the children and families we serve as well as the need for quality screening and assessment tools within child welfare, followed by the provision of appropriate evidence-based and evidence-informed treatments and services to meet the identified needs of children and families. The field has begun taking a much more robust look at wellbeing outcomes and we all have great interest in learning whether the programs and services we're implementing are resulting in the desired improvements in wellbeing outcomes. The purpose of today's webinar is twofold. The first is to help us understand the difference between screening and assessments as well as get a handle on the array of screening and assessment tools that are currently available and what we know about their intended uses as well as their reliability and validity. Dr. Conradi will be leading that part of the presentation. Secondly, it's important to understand that while certain screening and assessment tools may be perfectly appropriate in a clinical setting, it does not always mean that they're the most appropriate tools for evaluation and measuring change in wellbeing over time in the area that's of great interest to many of the states and the grantees that we work with and Dr. Ringeisen is with us today to help us learn more about measuring wellbeing and important things to consider when doing this work. So without further ado, it's my great pleasure to introduce our

two speakers, Lisa Conradi and Heather Ringeisen. Our first speaker is Lisa Conradi, a clinical psychologist at the Chadwick Center for Children and Families at Rady Children's Hospital in San Diego. Currently, Lisa is serving as the project co-director for both the SAMHSA-funded Chadwick Trauma Informed Systems Dissemination and Implementation Project and she's also co-directing the ACYF-funded California Screening Assessment and Treatment Initiative. Both of these projects are focused on helping child welfare systems become more trauma informed in their daily practice and in this role she has authored and co-authored many publications on trauma screening and assessment practices creating trauma-informed systems and she's presented nationally in innovative practices designed to improve the service delivery system for children who have experienced trauma. Welcome, Lisa, and thank you so much for joining us.

Dr. Lisa Conradi: [00:02:41:10] Thank you, Krista, and thank you, Bethany, and to the Child Welfare Information Gateway for the opportunity to present this material to all of you today. As a…yes?

Krista Thomas: [00:02:54:50] And I was also going to introduce Heather.

Dr. Lisa Conradi: [00:02:54:60] Oh, I'm sorry. You're right. Okay.

Krista Thomas: [00:02:57:30] And after Lisa's presentation, we'll transition to Heather Ringeisen who is the director of the Children and Families Program in RTI International's Survey Research Division. Dr. Ringeisen is a clinical child psychologist and mental health services researcher and her research specialties include identifying and treating children with emotional and behavior problems, particularly those that are served by the child welfare system. She currently serves as co-investigator of the HHS OPRE-funded National Survey of Child and Adolescent Wellbeing, better known as NSCAW. And she is also working as part of the University of North Carolina Evaluation Team studying the wellbeing impact of the Illinois Title IV-E Waiver. So welcome, Heather, as well and with that I will turn it over to the two of you for today's really exciting presentation. Thank you.

Dr. Lisa Conradi: [00:03:44:70] Thanks, Krista, again. This is Lisa Conradi and today I'm going to be talking about screening for trauma and behavioral health concerns in child welfare settings and as Krista mentioned, this has been a topic, I think, of great interest both to professionals who work within child welfare, those who work within mental health, and to, I

think, across the country as we think about what does it really mean to address the wellbeing concerns of kids who are in the child welfare system and so I just want to note that this work has really been informed by our two projects. The first is the California Screening and Assessment and Treatment Initiative which is funded by the Administration for Children, Youth, and Families and as well as for our SAMHSA-funded Chadwick Trauma Informed Systems Dissemination and Implementation Project. So today what I'm hoping to accomplish is really first, start with some definitional issues related to screening and assessment. Second, to talk more specifically about tools that exist that can help child welfare jurisdictions as they are thinking about what screening they would like to implement within their population and finally, to be able to identify strategies that child welfare agencies can use to improve their screening practices.

So the first topic that has come up pretty much in every conversation that we have related to screening and assessment is that these terms are often used quite interchangeably. Folks will talk about screening when they are talking about mental health assessment practices and use the word assessment when they're talking about screening within child welfare systems. So the first thing that I wanted to do, really, was put out a definition of each of those. I'm going to make a note here though that as jurisdictions are very different and sometimes tools are very different and can kind of go between both screening and assessment, that this is certainly open for some confusion and you may define these terms very differently in your jurisdiction or in the work that you're doing every day. But I wanted to provide definitions that we've come up with so that you understand kind of where we're coming from and that we have kind of a playing field where when we say screening, we all mean the same thing.

So let's start with screening. As you'll see on this slide, screening really is kind of that big bucket. It's designed to be administered to everybody in a particular group. It's brief. It's easy to complete. Often it's yes or no information and it's focused on a specific topic. So when we think about screening across, for example, healthcare settings, a great example of a screener might be a TB test. You know, I work at a hospital here in San Diego and every spring, we're required to get that TB test, you know, kind of put in our arm and then we come back two days later to see if it's positive or negative. All that does is suggest whether or not we need to get a more comprehensive assessment, which would be in this case a chest x-ray. So that thinking is

very similar to what we're talking about when we're talking about screening within the child welfare population. Again, it's something that should be brief, easy, can be administered pretty quickly and give you some helpful information to determine if a more comprehensive assessment is necessary.

When I talk about assessment, and I do recognize that the term assessment is used under risk and safety within child welfare, but when I'm talking about assessment within this presentation, I am talking about a more comprehensive assessment that is conducted by a mental health provider that is in-depth and is completed in order to really do some treatment planning and to decide which practice would be the most appropriate for that child or that family in terms of therapy. An assessment is administered to folks who have been identified as needing more comprehensive assessment. It requires some pretty specific training on what are measures, how do you interpret scores from measures, how do you take the information from measures and integrate that into other kinds of data that you would gather such as behavioral observations or clinical interview data, and an assessment also takes a couple of visits usually. It's not often done within kind of a, you know, one-hour period. It's usually done over a couple of different visits with the mental health provider. We're not going to spend time talking about psychological evaluation today except to say that when I talk about a psych eval, it really is often much more in-depth. It's designed to answer a specific question and is usually completed by psychologists. We know that there are some jurisdictions across the country that, for example, will refer all their kids to psych evaluations but, again, that really is designed to dive much more in-depth into a specific problem.

So let's talk about trauma-related needs for screening. So Gene Griffin did a presentation about, I think it was August of last year, where he really talked about the three E's related to screening. So the first E is the event. So screening measures, specifically those that are focused on trauma, include what trauma the child has experienced. So for example, domestic violence, neglect, physical abuse, sexual abuse, community and school violence, and traumatic grief. Now if we stopped here as we were thinking about screening, most every child that we see within the child welfare system would screen positive. So if we just do a screener that says have they experienced trauma, every single child would be referred for a more comprehensive assessment and, indeed, one of the most common questions that we get when we present this material at

various places across the country is that why do we even bother with a screening when we know that all children in child welfare have experienced trauma? That's what in many ways is the doorway of entry into the child welfare system is these experiences of trauma. However, what we would argue is that the second and third E's, experience and effect, are really the key domains to think about when we're screening for trauma and whether or not a child should be referred for a more comprehensive assessment.

So experience. When we're screening for experience, we're really talking about reactions that are specific responses to trauma, you know, avoidance of triggers, intrusive thoughts, nightmares about the event. So what I invite you to do right now is to think about a family that perhaps you've worked with, some kids that you've worked with either in your current role or in a past role before this one, and to think about how often in families two kids may have very similar experiences. They might have both been exposed to domestic violence. Both live in communities where there is violence. Both have had traumatic events in their history, but I bet that if you think about these two kids, their experience of that trauma could be very, very different. So their reactions that they exhibit when they think about the event, some kids, you know, when we think about exposure to domestic violence for example, some kids get very fearful, distracted, may, you know, if they're, you know, in school they might be displaying some issues and other kids really aren't affected in the same way. And so we really want to acknowledge that kids experience trauma in different ways. So not every child that has experienced trauma necessarily needs to be referred for that more comprehensive assessment.

The final E is effect. So that is really the longer term symptoms that could be related to trauma. They may not necessarily and they may develop over time. So when we think about these symptoms, we're thinking about things like your generalized anxiety, behavior problems, depression. So, again, as we are thinking about those two kids who come from the same family and have had the same events that have occurred in their lives, they may have different experiences of those events and as a result, they may have even different effects of how those events have affected their lives.

So, again, no two children are the same and I would argue that one of the key reasons why we think about screening is that it helps us to determine who do we need to prioritize an assessment for? The other thing I wanted to note here, and depending on the jurisdictions within which you

work this may or not be an issue, but for example, I work at a center here in San Diego where we usually have long wait lists and one of our number one referral sources is child welfare and they get, you know, very frustrated when they hear that, you know, it's a 3-, 4-, 5-month wait list to get children in for services. So if we think about needs and making sure that the kids that are in the system get the best services to meet their needs, I want to just put forth that if we send all kids in child welfare to a mental health assessment, there's not always the capacity within a system to do that and it can be really frustrating. So screening really offers an opportunity for the kids that need it the most to get access to those services more quickly.

So where does screening fit into the overall process? This is a very gross figure. It's usually much more complex than this but I just wanted to show this to you to say that screening usually occurs right at the front end. Right when kids come into the service. We often get questions, you know, when should screening occur because we don't know when effects are going to start showing up. So we usually say that screening should generally occur somewhere between 72 hours and 30 days within entry to the system. That has been kind of a good rule of thumb. We don't want to do it right at removal and 72 hours in many cases might be too short but no more than 30 days because we really would like to identify those kids as soon as possible.

Assessment then is the next step in that process for those kids who are screened as needing a more comprehensive assessment and then what I'd like to highlight regarding assessment is that assessment ideally directs treatment planning. So what I mean to say here is that, for example at our center, we often get referred kids and it's shared that they, you know, they're referred to trauma-focused cognitive behavioral therapy. So within the referral, it says this child needs trauma-focused cognitive behavioral therapy, which I'm assuming many of you are familiar with, is a highly researched treatment for treating trauma symptoms in kids. But not every kid benefits from that specific treatment modality. So what I want to highlight here is that one of the key purposes of this comprehensive assessment is to direct which treatment would be the most appropriate for that child. So, you know, we often at our center will push back a little bit and go, you know, you've referred them for an assessment and then we'll determine based on the results of that assessment which treatment would be the best to meet their individualized needs.

So why screen? And, again, this question comes up quite a bit. You know, if all our kids have had trauma, why don't we just refer them directly into that assessment process? So the first thing

is screening provides information on broad symptoms that the child may be experiencing but warrant a more comprehensive assessment. So what I like to say here is that it tells us just a little bit more about what that child is experiencing. We don't always get the full story when we, you know, meet with a child or when we kind of see a family for the first time. A screener can provide kind of a general idea of what that child is experiencing in a pretty quick period of time. Also in many cases, workers are already gathering this information but they don't necessarily have a process to make sense of the information that they're gathering. So some pushback that you may or may not have heard across the country regarding screening is, you know, is this really mental health's domain because we're asking about specific experiences and effects? And I would argue that I believe that the work of child welfare is understanding this at least on a gross level and that they're already doing it. Child welfare is already gathering quite a bit of information and making recommendations for a family and so I think they already have this expertise and it's just really harnessing that and providing some training on how to use it.

The other thing I like to say is that screening can assist caseworkers in identifying specific types of events or situations that can be trigger symptoms for the child. So for example, let's imagine that through a screening process or through kind of the overall intake process, a worker finds that the child…through a general intake process you might just hear that the child's been exposed to domestic violence for many years but maybe through the screening process you find that they were exposed to that domestic violence and it happened usually in the evening around dinnertime. I think that that would be helpful information that you could potentially pass onto a foster parent and it may not be specific, because I know there are issues of confidentiality that certainly vary across jurisdiction, but to say that, you know, dinnertime might be a scary place and might be a time where the child needs additional support, I think, would be really fair to share with that foster parent and certainly that could come from mental health later in the process after they've done an assessment, but I think it also could certainly be helpful coming from a child welfare worker who is working with these foster parents all the time.

And finally I would like to argue that screening plays a critical role in case planning and referral, again, to mental health services but also to other kinds of services that are available out there such as mentorship, coaching, more alternative kinds of services that support the children. I like to, you know, as much as I'm a mental health provider and believe in mental health services, I

also believe there's kind of no wrong doorway of entry and so as we're thinking about improving the wellbeing of our kids that have entered the system, whatever we can do that's going to provide that support, whether it is mental health services or other kinds of services, can certainly help develop their relational capacity and help improve wellbeing efforts.

Now I think hopefully you all agree that it's important to do screening but I think that maybe the biggest challenge is, okay, now we know we should screen, how do we select tools? What are the critical pieces of information that we need to consider as we're selecting tools? And what kinds of tools actually exist? I am betting you've all heard of a number of different tools out there and it can be hard to make sense of what exists and what would be best within a given jurisdiction. What I'll say right up front here is that this is an ever-evolving field. You know, as Krista said, this was presented in April and I can tell you that we have thought through this and learned both internally as a team and with our partners across the country to fine tune and update this information so it really is ever-evolving. But what I wanted to do is just put out some questions that potentially administrators can think about as they're considering what types of tools or which tools they would implement within their process. So here is more the systemic decision-making process that we've thought through and I'm sure you could also think of additional questions.

The first one is what is the purpose of the tool? Are we using it to facilitate case decision-making, informed clinical practice, or evaluate outcomes and this is going to tag a little bit into what Heather's going to talk about later in thinking about evaluation but we know that there are some tools that are quick, easy to complete, but they would not be the kinds of tools that you would use to evaluate intervention outcomes; however, they might be great in determining whether a child should be referred for a more comprehensive assessment. So there really is are we using the tool to track our data and there are some tools that exist for that or are we using the tool to refer as a referral strategy? And often those tools are not going to be the same.

The next question is what type of research has been conducted on the tool? Does it have established reliability and validity and sensitivity and specificity? So when I say those terms, what I'm saying is does it screen in the right kids who need treatment or an assessment for treatment and does it screen out the kids who don't? And I'll be honest right up front that there are some tools that exist for that but this is a need that has been identified. We need to do some

more research on tools that exist and whether they are reliable, valid, and probably more importantly, sensitive and specific.

The third question which many of you might have thought should be the first question is what is our budget and what is the cost of the tool? Fortunately there are a lot of tools out there. Many are free. Unfortunately, when we talk about whether or not research has been conducted on a tool, we find that the tools that have sensitivity, specificity, reliability, and validity, those are the tools that tend to have a cost associated with them whereas many of the other tools that folks are developing within their jurisdictions may not have that level of research. So that becomes a key decision-making is, you know, we've certainly heard from places that they can't afford to purchase tools. Whereas other places do have that and are able to invest in research tools.

The next is what staff do we have available to complete the screening? What is their level of education and experience in mental health and trauma? So every jurisdiction, we find it across the country, is quite diverse in the level of training and experience that their staff has. Some places, they only have master's degree child welfare workers and they have had quite a bit of training and experience on the tools, psychometrics, and they feel pretty confident with that. In other places, the workforce may not have that same level of training and experience. So as we're thinking about the kinds of tools that exist, some don't necessarily need a high level of training. You can do an hour and a half, walk through the tool, and folks can complete that. Other tools that tend to have more research support for them usually have a little bit more rigor involved in the types of requirements, what folks' types of degrees or training or experience that folks need to have in order to complete them. So that's clearly an area that needs to be considered.

And finally, what happens if the child does not meet the identified threshold? Is there a process to re-screen at regular intervals? So this question often comes up. If you remember I was talking about screen early, you know, anywhere from 72 hours to 30 days, that would certainly vary depending on the system, but what happens if they don't hit that threshold, if they don't need to go to assessment right away? The first thing I'd say is that if the worker feels very strongly that they do need that assessment, we certainly suggest kind of putting in an override mechanism that, you know, maybe there's a feeling that the tool wasn't an accurate reflection of the behaviors or the concerns. So we certainly suggest putting in an override mechanism, but we also suggest re-screening at regular intervals and to make it easier, those intervals would really

tie into other kinds of events that are happening within the life of the case. So court dates or appearances or reports are other kinds of things that are happening. If a screener can then be embedded in that process, it would certainly make it easier.

So let's think about some client-level decision-making for selecting and implementing screening tools. And I'm going to talk about it in a moment, but there's a lot of different kinds of tools that exist. There's child tools, there's caregiver-completed tools, there's kind of provider-completed tools, and so as we're thinking about tool selection on an individual case level, the first question we want to ask is how old is the child? Are they old enough to answer questions about their own history? A 2 year old, probably not able to answer questions about their own history. A 13 year old, probably able to do that. So thinking about that. The second consideration, is the caregiver a reliable informant? Some caregivers, as we know, come in and they can be honest and some for many reasons that I think are pretty valid, aren't ready to share all the experiences and effects that their child may be having related to things like trauma or behavioral health symptoms so making sure that the caregiver is a reliable informant. A third consideration is do the case files provide enough information? Maybe we can do a provider-completed tool where we don't need to interview the child or the caregiver. With whom will the information be shared? One of the things that I really want to highlight as we're talking about screening is that we've seen over and over and over again that folks do a really wonderful job in some jurisdictions of screening kids. They complete the tool. It's done but then it goes in the case file and nothing is actually done with it. So as folks are thinking about implementing a screening process, thinking about how that information would automatically then be shared with who it needs to be shared with. And finally, will the results inform case or treatment planning?

So the first thing I'd just like to put out there prior to embedding a screening process, is that we really recommend that folks get some basic broad training on mental and behavioral health issues that kids experience and child traumatic stress. I say this for a couple of reasons. One, if you've ever looked at any of the available screening tools, you'll notice that there is some terminology. There are certain behaviors or indicators that one really needs to have some training and experience in order to understand what those really mean and to complete those tools, but also in the administration of those tools. We've certainly heard some concerns raised that child welfare doesn't necessarily feel comfortable administering a trauma screening tool, thinking that the

questions are maybe too…there's kind of fears that the child will get activated. That they're opening Pandora's box asking questions related to a child's history and to their effects and so really having some training on how to ask these sorts of questions, how to administer the tool, understanding what these sorts of questions mean, I think can be incredibly helpful.

And while we're talking about this, I did want to share that we've certainly heard that concern about trauma and trauma screeners and what it might mean to ask those questions but I think that and I believe that the research would support me in this is that that fear that asking questions about trauma is going to open Pandora's box and is going to, you know, decompensate a child or family, we've really heard that doesn't necessarily happen and Heather might have more experience in that but from many of the jurisdictions that we've worked with, that's been one of the things that we've really worked through with them and I haven't heard of one story of a child being asked about their trauma history and them decompensating or a parent being asked and them freaking out about it. If anything, it actually helps engage them in the process and folks often share that they've never been asked these questions before and it actually helps them start thinking about, for example, their own trauma history. So I just wanted to put that out there as well.

Some other recommendations is to establish a relationship with your mental health partner and to work with them to build capacity to provide the treatment that's appropriate. So what we don't want to do is put in place a screening process that would identify kids who need a mental health assessment and then have nowhere to refer them for that assessment. That can be frustrating on multiple levels as I'm sure you can imagine. So really helping to establish some of that infrastructure beforehand. And finally, have a mechanism in place to adjust secondary trauma with it, child welfare workers and supervisors. I say this because as part of a project we were involved in a couple years ago where counties and agencies across the country were looking at embedding a screening process into their systems, we did kind of small test a change where workers would administer these tools and kind of get feedback on them and see if they worked, how they liked them, and more than once we heard that workers shared that asking those questions meant that they got answers that they weren't necessarily prepared for and it opened a door for kids to talk a little bit more about their experiences and it can be incredibly hard to hear some of these difficult stories every day and so our, you know, as we're thinking about, in

particular, trauma screening but trauma and behavioral health, thinking about putting in place screening processes, I just want to acknowledge that I think it's really important to put in place other sort of mechanisms for folks to share what that experience is like for them and to really address secondary trauma.

So let's move our discussion to talking about types of screening tools. There's basically three big buckets of tools that I'm going to talk about today. The first are child-completed tools. These are really the tools that you can give to a child, or read to a child depending on the tool, and they complete it. So as a rule of thumb, kids usually 8 and above kind of hit that threshold although we know that that varies significantly across children depending on developmental capacity. That's usually the age where kids can answer some questions about their own experiences and in many ways this can be ideal because then we can hear, you know, essentially from the horse's mouth what the experiences and the events and the effects were for that particular child. However, as you might imagine, there's a number of strengths and challenges associated with a child-completed tool. The strength or benefit to this strategy is that kids can tell…it gives them an opportunity to verbalize their responses aloud and we've certainly heard that a lot of workers have asked these questions and kids have been very willing to share their experiences and it did help with that engagement process and throughout the life of the case. So that certainly can be a benefit. But of course and as I mentioned before, it can, you know, workers should take great care in asking highly personal questions and be aware that this child may be sharing their experiences for the first time or be hesitant to share them at all and we've certainly heard stories where kids deny everything so they may not always be the most accurate respondent. It may be difficult for the child to share their experiences and for the caseworker to hear and so I just want to emphasize again that training and support on asking these questions in a time-sensitive manner is critical.

The second kind of bucket of tools that exist out there are those that are designed for caregivers to complete. So as we're thinking about young children, for example that 2 year old that I mentioned earlier, you can't really sit down and interview and ask them questions or ask them to complete a paper and pencil measure. So what would be the best way to get some information on what they've experienced or their mental health symptoms or anything like that and that would be when a caregiver-completed tool could be helpful. So as you might imagine, again,

there are strengths and challenges for caregiver-completed tools. It's, of course, very helpful in detecting exposure for young children who cannot verbalize this information themselves but as we know, birth parents may be cautious in sharing detailed information about their child's trauma experiences given that the impact decisions about placement, visitation, and reunification and foster parents, let's say we administered the tool to foster parents, may not know the child's trauma history and may over or under report symptoms based on their experiences fostering other children in their care and I noted trauma here but, again, as we're talking about all behavioral health symptoms parents may be less or more likely to or maybe over or under report symptoms.

Finally, there is a bucket that is really those provider-completed tools. So we think about…these are tools where basically a caseworker would review existing information and integrate that into kind of a report which would then be used to inform the next step. So they would not be doing an interview or giving a tool to a family to complete. For those who are familiar with the CANS, that's probably the best example of a provider-completed tool. So, again, there are strengths and challenges associated with a provider-completed tool. This strategy can be helpful in allowing a caseworker to make sense of all the information that is presented to them and certainly can help provide information that is more geared towards young children and toddlers but if they haven't had the opportunity to sit down with the child or caregiver and ask specific questions, they may not have the complete picture of the child's unique experiences and effects.

So I'm just going to highlight in the last minute or two that I have a couple of tools that screen for mental and behavioral health and my hunch is that you guys have heard of most of these tools. The first one is the Child Behavior Checklist. I snicker a little bit because this is in many ways not a screener because it doesn't meet all the criteria that we have talked about in terms of screeners are often short. They are often very easy to complete and would direct towards an assessment. However, we do know that there are folks across the country who are using the CBCL because it provides quite a bit of information and it has a lot of good research to support its use. So, again, as we're talking about the decision-making process and what kinds of screeners you might embed within a particular agency or jurisdiction, there are pros and cons to all of them and sometimes they might be a little longer but they have that research that you're looking for so the CBCL would be an example of that. It has a number of different versions for

the parent or caretaker to complete. There's a teacher version. For older kids, there's actually a youth version and it provides pretty in-depth information on child behavioral and emotional problems and competencies. But, again, this tool is probably more often used within that mental health assessment but we certainly have learned that folks have been using it within a more upfront child welfare setting, but again this is a tool that folks would need to have a minimal level of training and experience to administer as well.

A much shorter tool that actually has been compared to the Child Behavior Checklist is the Pediatric Symptom Checklist. So this is a screen designed to facilitate the recognition of cognitive, emotional, behavioral problems designed for children 4 to 18 years. There's 17 items and it really is usually completed by the caregiver and it correlates highly with the Child Behavior Checklist. The perk of this particular tool is that it's free and you can download it and use it.

Another tool that's often used is the Strengths and Difficulties Questionnaire. This is a brief behavioral screening for 3 to 16 year olds and has good reliability and validity and has 5 scales, over 25 items, and it again can be downloaded for free. What I want to highlight here is a lot of folks like this tool in particular because it really does have that domain focused on strengths. I also have been hearing rumblings or bits and pieces that there is a charge to the tool if you enter the information electronically versus folks answering the questions on a piece of paper. So folks who are interested in using that, I would recommend that you connect with the developers who you can access through sdqinfo to get that specific information because I think there are some changes happening related to that.

Finally is the Child and Adolescent Needs and Strengths, the Trauma version. So many of you, I believe, are probably familiar with the longer version of the CANS. There is a shorter version of the CANS that can be a screener to gather basic information on trauma and if that child is experiencing problems with adjustment to trauma then it can indicate for a need for a more detailed assessment. Another potential tool is the Brief Assessment Checklist. It's a 20-item caregiver-report psychiatric rating scale. It looks for mental health difficulties experienced by children and adolescents in different types of care and there's two versions. One for 4 to 11 year olds and one for 12 to 17 year olds.

And then I'll just highlight a couple of trauma screening tools. The first one is the Trauma Symptom Checklist for Children developed by John Briere. It's 54 items. There is boys and girls 8 to 12 and 13 to 16 years. It's completed by the child, has a number of validity scales and clinical scales. I do want to note that there is a fee associated with the TSCC and that there are specific requirements regarding training on psychometrics that folks who are completing it need to have obtained. However, it certainly provides a lot of helpful information and is often used within a mental health assessment so like the CBCL, this is one of those where folks go is this often used as a screener, and it can be but more often than not it is used within that more comprehensive mental health assessment.

Another scale is the Child PTSD Symptom Scale. It's designed for children ages 8 to 18. It's self-report and the first 17 items look at PTSD symptoms and yield a total symptom score and then there's some additional items that look at daily functioning and functional impairment. The CPSS is available for free. And many of you are familiar with the UCLA PTSD Reaction Index. This is another one of those that can be used as either a screener or is often used within a more comprehensive assessment. It's 48 items, semi-structured interview. Includes 19 items to assess symptoms of PTSD and it may be used as a screening tool on its own or, as I said, part of a larger assessment and I believe they have just started charging for the UCLA.

And then the TESI, a 24-item, parent-administered interview assesses a child's experience of a variety of potential traumatic events and there are additional questions looking more at the exposure and about the specifics of the events. The TESI looks more specifically at exposure questions. What events has the child experienced? It does not go into as much detail about what are the effects of those experiences. And finally is the Child Welfare Trauma Referral Tool, was developed by our team working with the folks at the National Center for Child Traumatic Stress and it is an information integration tool where it's really designed for caseworkers to review the reports and all the information that is available to them regarding the case and then it takes them through an algorithm to determine if a child needs to be referred for trauma-specific treatment, for general mental health treatment, for immediate stabilization, or no mental health referral is needed at this time. This is currently being updated and shortened so it's not available right now but it will be, hopefully, in the next couple of months.

So I'm just going to end with some strategies on how to integrate screening into practice. Generally, research the available measures and identify a couple that meet their needs. So as we're thinking about agencies, systems, jurisdictions that are looking at embedding screening into their projects, their daily practice, I would say take a look at the measures I've reported on here. There's also a number of other measures that are out there. Identify a couple that you like. Ask staff to pilot test those. I'd really bring staff in early and often into this process to get their buy-in and then additionally consider embedding trauma screening into already existing system. One of the things that we're working on as part of our California Screening Assessment and Treatment Initiative is we're working with the developers, the structured decision-making, to see if maybe there are some questions or measures that we can embed within that process so it doesn't feel like more work for the worker and have multiple strategies available based on the age of the child and education level of the workforce. Often we find there's not a one size fits all that works across all the kids and all the workers in the system. So there's a couple of resources I've just highlighted here. Measures Review Database from the National Child Traumatic Stress Network has a number of tools listed on there and there is information on assessment measures on the California Evidence-Based Clearinghouse for Child Welfare. So at this point, thank you so much for giving me the opportunity to present. I am going to go ahead and pass this over to Heather for her presentation.

Dr. Heather Ringeisen: [00:47:46:30] Thank you so much, Lisa. Okay, so in my presentation, I'm going to be talking about the more broad concept of child and adolescent wellbeing which includes issues such as trauma and emotional/behavioral health but also many different domains of wellbeing. I'm also going to be honing in more specifically about how to conduct that measurement in the context of child welfare evaluations and I'm going to be grounding my presentation specifically in perspectives that are drawn from the National Survey of Child and Adolescent Wellbeing. So I want to talk at the beginning of this presentation briefly about the relationship between child wellbeing, safety, and permanency. I want to describe the National Survey of Child and Adolescent Wellbeing to you and the domains of wellbeing of the NSCAW, as we call that survey, assesses as well as really delve into some of these issues that I think should be considered when a group is selecting wellbeing measures in the context of an evaluation.

So just to set the stage a little bit, we talk in child welfare about the intersections between safety, permanency, and wellbeing, and how interconnected these constructs are. So why might child wellbeing specifically matter in the context of child welfare? Historically, as all of you know, child welfare systems have put the largest emphasis on the measurements of safety and permanency. And as Krista mentioned in her introduction, we're now increasingly recognizing the importance of this other component and the degree to which there's a connection between those outcomes of interest. And asking questions about changes in out-of-home placements impact child wellbeing or does a child's behavioral, emotional problems then impact their safety and permanency? We have some research about this.

So I want to talk with you about one study published by Gregory Aarons and his colleagues in 2010 that looked at a group of children 2 to 15 years of age who had been out of home consistently for 36 months. He looked at the connection between emotional and behavioral health problems and subsequent placement changes and one of the things they found was that levels of emotional and behavioral health problems discovered at the point of that maltreatment investigation later predicted placement changes at 18 months, and then the measurement and recognition of emotional/behavioral health problems at 18 months predicted subsequent placement changes at the 36-month mark as well. They didn't see a relationship between changes from 1 to 18 months at behavior problems at 18 months, but they did find that connection that placement changes between 18 and 36 months also impacted emotional/behavioral health problems. So again this relationship is complex and a chicken and egg sort of phenomenon but clearly placement changes and emotional/behavioral health issues are intertwined with each other.

These relationships are not exclusive to emotional or behavioral health. We can talk about a second study that looks at daily living skills or a child's ability to take care of his or her daily living personal needs. This study looks at kids 0 to 14, who remained at home shortly after the maltreatment investigation but who later were removed from their homes, and looked at what types of things predicted that later removal and they did see that levels of moderate or severe problems with daily living skills at the time of that maltreatment report, having those levels of daily health problems, daily living skills problems, made it much more likely to be placed out of home at the 36-month follow-up point.

So what do these two studies have in common? Not only were they attempts to make connections between those dots of safety, permanency, and wellbeing, they were also both rooted in data gathered by the National Survey of Child and Adolescent Wellbeing or NSCAW. So there are two cohorts of NSCAW, which we creatively refer to as NSCAW1 and NSCAW2. So NSCAW1 included 6,200 children between 0 and 14 years. At the time of the sampling, this study started in 1999. They are both longitudinal studies which means they follow a certain group of children. Here that group of children reported for maltreated over a period of time, the same group of children, and NSCAW1 included 5 ways of data collection from 1999 to 2007. NSCAW was really the first national study of children involved in the child welfare system that importantly collected data directly from the children themselves or from their family members. When that study concluded, the Administration for Children and Families opted to collect information on a second cohort of children and this cohort included 5,800 who were investigated during a 14-month period in 2008 through 2009. These children were slightly older at the point of the maltreatment investigation and we have followed those children through 3 waves of data collection or for approximately 3 years.

As I mentioned, NSCAW was sponsored by the Office of Planning Research and Evaluation within ACF, was conducted by RTI International along with several of our partners, and the study asks a series of questions such as who are the children that come in contact with the child welfare system? The study purposely included not just children placed out of home or placed into foster care but also children who remained home after their maltreatment investigation, both children whose maltreatment investigations were substantiated or not substantiated. What were the pathways and services that children and families experience during their contact with the system and then most importantly for our conversation here, what were the shorter and longer term wellbeing outcomes? I'm not going to talk a lot in this presentation explicitly about findings from NSCAW but I do have in the presentation here a link to the OPRE website where you could find everything from a research brief that describes in about 4 pages key findings from the first NSCAW cohorts along with a series of research briefs, reports, and 1-page child wellbeing spotlights that cover such issues as psychotropic medication use among children in foster care; placement instability among infants; characteristics of kin caregivers and service needs; as well as wellbeing, safety, and permanency issues. So I would encourage you to go to that website if you'd like to see more information about the outcomes.

So why is NSCAW relevant? What has it contributed to date to the field? Most importantly for you all, NSCAW provides nationally representative data about children reported to Child Protective Services. This study purposely placed an emphasis on child wellbeing and development and it did this through the use of objective standardized assessments and also included not just measures of risk but also measures of strengths and resilience. This study allowed the examination of different types of children involved with the CWS and was longitudinal which allowed the lens to watch children during critical periods of child development like from infancy to the start of school or from middle childhood through adolescence or looking at the transition from adolescence to young adulthood.

So I want to talk a little bit about domains of wellbeing and how they're measured in NSCAW and you might recognize some of these measures because some of them were described just a few moments ago by Lisa. So NSCAW measures the 4 core domains of child wellbeing that those of you in the Children's Bureau know well and are advocated by ACYF, cognitive functioning, physical health and development, emotional and behavioral functioning, as well as social functioning. And NSCAW includes a variety of measures of these wellbeing characteristics and as I mentioned, one of the cornerstones of the study is its reliance on standardized measures and tools and so you see some of these tools listed on this slide categorized by their wellbeing domain. For instance, NSCAW to measure emotional and behavioral health functioning includes both some sub-scales from the Trauma Symptoms Checklist along with some of the Achenbach scales, the Child Behavior Checklist, that Lisa mentioned earlier.

I just want to give you a snapshot of some NSCAW findings. So these bar graphs describe developmental problems that children in the first NSCAW cohort experienced 3 years after their involvement with the child welfare system. So one of the things that you see is even 3 years after their maltreatment investigation, many, many children to continue to experience issues related to wellbeing. The very last bar on the right shows cumulatively that about 43% had experienced any of these problems and problems here are represented by having 1-1/2 to 2 standard deviations above what would be considered a norm on any tool related to these domains of functioning like cognitive problems, problems with early language development, adaptive behavior, social skills, more academic achievement domains like math or reading.

So that's my quick snapshot of the types of things that NSCAW uses. What I really want to focus the discussion on today, however, are things that should really be considered when selecting specific measures of child wellbeing and because I'm going to be using NSCAW really as a platform for that discussion, I wanted you to understand a little bit about what's in the study, what concluded, and how it can be used. So here's an overview of the issues that I'm going to summarize in more detail for you today. First, a consideration of child age and development and within that, continuity. Second, issues of subjectivity and the reporter's lens in the assessment of wellbeing. Third the mode of administration for the particular tool that you may be considering. Fourth, the choice of a standardized measure that may or may not have national norms or the ability to look at clinical significance and then finally, whether or not that tool allows access to population-specific comparison data. So the rest of my presentation is going to go through each of these issues one by one in more detail.

So first, one of the most obvious things that have to be considered in the context of a child welfare evaluation is the age target population. So for this evaluation, who will be served and how old are those children? That's really critical to the assessments of wellbeing because different domains of wellbeing are more and less important at different ages. So for instance, this slide shows some wellbeing characteristics of adolescents in the second NSCAW cohort. So in adolescence, issues like grade repetition or substance use disorder or the prevalence of running away or having become pregnant become really important along with some issues that are universally important in child wellbeing like emotional/behavioral health problems and social skills. Meanwhile, if we're talking explicitly about an evaluation focused around infants and toddlers, you may have very different child wellbeing domains of focus. So some things would be the same like how important it is to look at social or emotional problems but you'd also have some issues like the development of early language skills or neurological development or cognitive development may be particularly important to assess as you identify the presence or not presence of developmental disabilities in early childhood.

So you have to think about the child's age both in the selection of the domain of interest for wellbeing and also in the measure that's appropriate to study that domain within your age group of choice. Children by virtue of children change and develop over time and very often a child welfare evaluation will assess or look at children at a couple of different points in time. Usually

that occurs before a particular intervention begins and at some point after that intervention or after that systems reform has taken place. Well, you know what's happening during that time? A child is aging and developing and changing, maybe regardless of whatever intervention has been put in place. So consequently it's very important to choose measures that can look at that phenomenon in a continuous, consistent way regardless of the child's age.

So in this slide, you see some outcomes related to emotional and behavioral health that are assessed in NSCAW1 at these various points in time. So baseline being the point of that maltreatment investigation, Wave 3 being 3 years later and Wave 4 being 4 years later, and what I want you to realize is that those bars are directly comparable to each other whether it's the purple bar about depression or the yellowish bar about posttraumatic stress because a measure was selected for a very broad age range of children that was used consistently at each of those data points. That means that no matter how old that child was at Wave 4 and at baseline, we can directly compare those outcomes.

The other thing that I want to highlight about this slide, particularly in light of an evaluation context, is that NSCAW isn't a study of a particular evaluation. It's a natural study that is watching children's behaviors over time and if you'll notice those bars are slightly going down at every wave. That's that naturalistic change that I was just talking about. Caseworkers will tell you that they are not surprised that at the point of a maltreatment investigation is a very stressful time for children and families and may not be surprising that rates that behavior problems or depression are posttraumatic stress are especially high and what we see is that those things go down over time. If you had not included a control group as one of the groups being assessed in a particular evaluation design, an evaluator might falsely conclude that those changes from baseline to 4 years later or 3 years later were as a result of their intervention because they saw the bars go down but one of the things NSCAW told us is that that pattern could happen even if the system had made no efforts of reform. So the choice of a measure that can assess things over time but they can also be sensitive enough to assess things in a comparison group to document that a change has actually occurred ideally as a result of something that a system or an agency has specifically attempted to do is important.

So the second issue that I want to talk with you about is subjectivity. So wellbeing is often assessed in a very subjective fashion. So some aspects of wellbeing are objective like a child's

performance on a measure of academic achievement, that they know X percent of math constructs that one would expect for a child of his or her age. Many, many other domains of wellbeing are subjective. So they are asking about a reporter's perspective on a particular phenomenon. So take for example behavior problems. I wanted to show you here parent versus caregiver report and youth versus teacher report on internalizing behavior problems and externalizing behavior problems. So internalizing issues are issues like anxiety or depression. Externalizing issues are like attention difficulties or conduct problems.

The thing I want to highlight about this slide is the different heights of those bars. You see that depending upon the reporter, the parent and the youth and the teacher are seeing these things very differently. It's that subjectivity that can be especially interesting and helpful in the context of an evaluation. So for instance, here for internalizing behavior problems, it may be that kids in NSCAW, youth in NSCAW, aren't as adequately recognizing their internal states, their anxiety symptoms or their depressive symptoms, but caregivers are knowing more what to look for, or teachers are recognizing those issues more. If you had only assessed those youth's perceptions of depression or anxiety at a baseline point in an evaluation and then assessed again after an intervention like cognitive behavioral therapy, this potential issue of youths underreporting could become a big deal in your evaluation and particularly if your intervention is really focused on introspection and recognizing internal states and developing coping mechanisms. So 12 months later or 18 months later, I'd use my_____ [audio interference] how to recognize and identify those issues and consequently rate those behaviors higher and you could falsely conclude that your intervention wasn't successful but if you also had gotten the perspective of parents or teachers and youths, you would have a much more comprehensive picture about what's going on with that child's emotional or behavioral health problem.

Reporters don't disagree only about wellbeing just in case you were wondering. They even disagree on issues pretty central to safety. So this is looking at caregiver and youth reports of caregiver aggression in the past year. Parent-reported blue and youth report is red and as you go through the bars further to the right, you see the discrepancy between those blue and those red bars increases for the more severe types of physical abuse. And so one of the things I want to show is this gathering of different perspectives can be helpful on a variety of fronts, not just in

the measurements of wellbeing. Youth, for instance, may be more accurate reporters of some of the caregiver expressions of aggression that they are experiencing _____ [audio interference].

We also know from data and NSCAW that caseworkers unfortunately often underreport or don't detect many wellbeing issues for the children and families that they serve. This could be for a whole host of reasons, that they're not clinicians themselves, families may not want to disclose some of the issues that are going on, but unfortunately many times systems rely exclusively on caseworkers' reported issues and that may not accurately represent what's really going on. So in this slide, I wanted to demonstrate that using NSCAW data but looking at reports of domestic violence. So the blue bars look at self-report versus caseworker-report of active domestic violence and the green lines are looking at histories of domestic violence and in each case, you see that the self-report is much higher than what a caseworker is describing. So I just want to reiterate that getting multiple perspectives and multiple reporters can give a more accurate picture of wellbeing and help facilitate correct assumptions about the impact of evaluation.

Another thing that will have to be considered in the context of setting up child welfare evaluations and measures are the actual administrative mode of that instrument. There's a lot of different options that are available to evaluators that create situations of high objectivity versus subjectivity, degrees of privacy, degrees of possible high or low response rates, and as Lisa mentioned, budget concerns and what resources are available to do that. So the most objective type of measure is a direct assessment of children. So for instance in this picture, you see a child being administered the Preschool Language Scale but sometimes you want more subjective measures like interviews of parents. And evaluators with their partners will need to sit down and discuss these issues and weigh these different things as they're going through the selection of instruments. I couldn't say what is best under each of these bullets for any given evaluation. I just want to highlight some issues that I hope would come up when thinking about the administration mode and choices that are available to evaluators and their child welfare partners.

Another issue that needs to be considered in that measurement selection is the issue of standardization. So NSCAW wasn't originally designed with a comparison group in mind so NSCAW does not include a group of children who were not reported to the child welfare system. So you cannot compare the NSCAW cadre of measures within the study to another group of children who had never been exposed to maltreatment. And so for that reason it was particularly

important that NSCAW include measures that had standardized norms that had a way that we could know how you might expect a typical US child of that age to perform. And so by doing so even though the actual NSCAW sample didn't include a comparison group we could almost imply the comparison group was there by looking at the normative performance for children of that age on the instrument.

So in this slide you see some examples of the standardized measures included in NSCAW. So for instance taking the Battelle, which is an assessment of cognition for very young children 47 months of age and younger. We see that in NSCAW2 a little over 18, almost 19%, of babies scored in the clinical range indicating that they were so far above what would be considered the norm that they merited clinical attention or further assistance. Compared to what we would expect based on the norms for the Battelle, there would only be about 2.3% of US infants scoring in that range. So we're able to see in this way across every row on this table for all the different measures that the large needs of children in the child welfare system that are well beyond what you would expect for other children of a comparable age. The second slide just demonstrates again those measures and the ability to compare by norms.

Another thing that's helpful about standardized instruments is the way in which they provide the evaluator with continuous scores. So a lot of times when we are studying the impact of an intervention or a systems reform effort on children and families, children don't go from before the intervention started, yes, they have a problem, to after the intervention is done, no, they clearly don't have a problem or no longer have a particular clinical need, but it's much more realistic is that generally you see gradual changes in the severity of that problem or the degree of that problem. Slight changes in functioning over time. The advantage of a standardized scale in the context of that evaluation is that you can capture that much more gradual, incremental changes in functioning or severity. Unfortunately, many of the tools that are used in needs assessments by caseworker report are in that yes/no fashion. So asking a caseworker, does a child have currently an emotional or behavioral health need, yes/no? If that needs assessment tool is used as the leading measure in an evaluation, the evaluator and that evaluation is set up not to be very sensitive to changes over time because that yes/no response pattern isn't showing the potential to demonstrate much variety and variation in change. So the types of standardized

scales listed here have a much higher potential to show benefits of an intervention or a systems reform effort over time.

The last point and last issue that I want to talk about is the availability of population-based comparison data. So because an instrument includes standardized tools, we can compare to the US population generally as I showed you in the previous table. But a lot of times in child welfare, we're not just interested in demonstrating whether children in the child welfare system are different than all other children nationally. Very often we know that they are and that's definitely supported by the NSCAW data. What we may be much more interested in is how children in our state or our jurisdiction are faring or doing in comparison to other jurisdictions or other states and compared to what they are doing in their child welfare system.

So NSCAW really offers us an opportunity to do just that and I want to provide an example of how that could be done. So this time let's take a health indicator, body mass index, for children with substantiated cases of maltreatment. Here we're going to compare outcomes for children in Illinois who are involved with the Illinois child welfare system versus NSCAW versus other typical US children. So let's look at the obesity bars, those that are on the far right. The blue represents those Illinois cases of children involved in the child welfare system, the red is NSCAW data, and the green are US obesity statistics. So based on this slide, Illinois could conclude that the children in their child welfare system are still much more obese than what you would expect for children of that age nationally. However, because they measured the body mass index in the way that is exactly consistent with the way that NSCAW measured BMI, which by the way replicates the way that it is measured nationally, so folks in Illinois can see that while their children are more obese than children nationally, they are less obese than what we would expect for other children involved in the US child welfare system. Illinois can do this because the state of Illinois funded separately a study that they call ILSCAW, the Illinois Survey of Child and Adolescent Wellbeing, where they collected the same information on child wellbeing outcomes that allows them to make these comparisons whether it's body mass index or emotional/behavioral health functioning or social functioning. But they can then use NSCAW as a national comparison group to their kids in their system.

So as a review, here are some key characteristics of NSCAW wellbeing measures that may be important to child welfare evaluations. Having age specific measures that are sensitive to

continuity over time using standardized instruments that allow clinical cut points or platforms for comparison to national norms, having multiple reporter types within the same wellbeing domain, and then having a mix of instrument administration types, those that assessed children directly as well as those subjectively ask the opinions of people in that child's environment.

So when we are measuring wellbeing within an outcomes evaluation, you have to consider several different questions. What wellbeing outcomes would you expect to change anyway? What outcomes have demonstrated change in other research before or other evaluations and are you selecting measures of wellbeing that would be sensitive to those changes over time? Is the wellbeing of interest that the evaluation is considering, is it targeting an outcome that would be a proximal outcome, meaning that we even expect that it would change in a short period of time or a distal outcome of interest, meaning that realistically we would expect it to take a long time for that wellbeing indicator to improve and that should affect the timing of those measurements. And how will you know that the intervention impacted wellbeing in a way that's different than what it might have typically happened to that child if they had experienced nothing different in the system?

NSCAW is relevant because it establishes national wellbeing norms for kids involved in the child welfare system. So do outcomes in your particular state look better or worse? Maybe your state's already invested heavily in effective services like a huge emphasis on early identification and early intervention services. If that's true, even if your state did pick a control group or a comparison group in your state, it might be hard to show a change if you were trying to do improvements over something that was already being reported. So if you had an NSCAW comparable measure, would you also be able to show how kids in your state got this extra service were maybe better than or slightly different than those who were already served by your system but then were they better than children in other states or children nationally?

There are several design or analytic opportunities that the NSCAW data set could offer to child welfare evaluators. NSCAW could be used as a type of experimental or control group where direct NSCAW-like data collection could happen in both the intervention and control group conditions. And we'll talk about an example of that in a minute. Or if the design, the evaluation design, didn't have a control group or didn't have a randomized control group design, an evaluator could still select measures that were used in NSCAW as a platform for national

outcome comparison but this time make those comparisons statistically, using things like propensity score matching.

So let me just illustrate two examples before we finish up today. For the first, I want to talk about a publication by Kimberly McCombs and Michael Foster in 2012. Dr. McCombs was evaluating the 0 to 3 Court Team Model. She wanted to compare permanency outcomes among children who participated in these Court Teams, specifically targeting infants and toddlers, to similar groups of cases from NSCAW who of course hadn't gotten that Court Team model. They wanted to see if kids who participated in the Court Team exited the foster care system faster. Did they exit the same way as those who did not participate in the Court Teams? In order to do this, they used a propensity score matching approach and they looked at the permanency outcomes. They measured those permanency outcomes in the same way using the same questions that were embedded in the NSCAW survey and what they found, again by matching NSCAW cases to the cases that were touched by the 0 to 3 Model, they found that the Court Team cases experienced different patterns exiting from foster care. Reunification was a more common exit for Court Teams while adoption was the most common for the NSCAW comparison cases. Children from the Court Teams also appeared to exit the system faster than children from the NSCAW comparison group and that was regardless of the type of exit. So looking at the McCombs and Foster publication is one example of how you could use NSCAW to compensate for a design that did not include a comparison group.

As a second example, I wanted to highlight the Illinois Birth through Three or IB3 Waiver Demonstration Evaluation. So the purpose of this evaluation is to provide therapeutic and psychoeducational services to the parents and foster care givers of over 1,000 infants and toddlers who are newly placed in the foster care in Cook County, Illinois. The Illinois folks are using child-parent psychotherapy in the Nurturing Parents Program and they are asking if children 0 to 3 experience reduced trauma symptoms, increased permanence, reduced re-entry into foster care, and improved social and emotional wellbeing as a result of these specialize waiver services when compared to services as usual. So this evaluation does have random assignments of treatment or care as usual conditions. So the evaluator for this evaluation is Dr. Mark Testa at University of North Carolina and we at RTI are partnering with Dr. Testa and his team to collect primary data. We're going into the children's homes, using the NSCAW

instruments for both the developmental wellbeing outcomes, and we're measuring those outcomes in both the cases that are assigned to the CPP or Nurturing Parents Program but also those cases who were not the control cases and we're assessing those outcomes at baseline and 18 months later. This is similar to the Illinois supplemental sample that I described when we were talking about body mass index and I really think demonstrates that collecting objective standardized child wellbeing data with national comparability is feasible as a part of a waiver demonstration or other types of child welfare evaluations.

So at this point, I just want to wrap up and talk about other types of opportunities. So I think NSCAW offers one way in which we can understand how the system is performing as it currently operates without doing anything differently. NSCAW by virtue of the large investment in study in so many thousands of children points to potential wellbeing outcomes of interest that could vary depending upon a particular intervention's target outcome. NSCAW shows a cadre of potential measures that you might choose or not choose dependent on the child's age, the reporter, the mode of administration, whether or not you feel that you need data that lends itself to national comparisons or how heavily you need to be able to measure those changes over time. NSCAW also demonstrates mechanisms to control for different kinds of reporter biases by including some direct objective assessments of child functioning or by getting subjective information in really private ways like through computer-assisted self-administered instruments. So thank you so much for your time today and I hope that we'll have some time to delve into the information that Lisa and I both presented in more detail later. We really appreciate your time. Thank you so much.

Krista Thomas: [01:30:54:30] Alright, thank you, Heather and Lisa, for your presentation today and I think that will be concluding this afternoon's recording.

[End webinar.]