Review of Grantmaking in Out-of-Home Care
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Introduction

The Duke Endowment – History & Evolution

Established in 1924 by James B. Duke, The Duke Endowment (the Endowment) is a private foundation dedicated to supporting the physical, mental, and spiritual health and well-being of citizens in North Carolina and South Carolina through four program areas: Higher Education, Health Care, Child Care, and Rural Church (The Duke Endowment Indenture of Trust, 1924). Firmly governed by the instructions detailed in *The Indenture of Trust*, the Endowment invests annually in each of these program areas, awarding over $3 billion in grants since 1925 (The Duke Endowment, 2017). Ten percent of the Endowment’s annual grant-making expenditures are dedicated to the Child Care program area, designed to support non-profit organizations operating in support of orphaned children.1 Aligned with national advances in child welfare and the decline in the number of children designated as “orphans” (Lindsey, 2004), the Endowment’s Child Care investments throughout the 20th century mainly funded private child welfare agencies and institutions providing residential services to children unable to safely remain with their parents. At present, the Child Care program area has two components: 1) Prevention and early intervention for at-risk children, and 2) Out-of-home care. This evaluation report focuses on the Endowment’s grant-making activities directed toward out-of-home care from 2006-2015, a set of investments totaling $49.6 million in 164 grants to 80 different organizations.

Until the end of the 20th Century, the Endowment employed a relatively straightforward grant-making strategy in the Child Care program area. For the most part, all eligible institutions that applied received a certain amount of grant funds annually to help support and sustain their organizations. Following a

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1 The Indenture specifically mentions “orphans and half-orphans”, which was meant to include children of single parents who required alternate placement and care.
leadership change within the Child Care portfolio in the late 1990s, the Endowment took its first steps away from this rather unrestricted grant-making strategy toward an enhanced focus on promoting the quality of service providers. Specifically, rather than invest in any and all eligible organizations providing primarily residential services to children and youth in out-of-home care, the Endowment instituted a preference for agencies that achieved or were working towards formal accreditation. To further this effort, grants were provided to select organizations to cover or defray the cost of the accreditation process.

In the beginning of the 21st century, the Endowment’s strategy evolved further to include not only private actors, but also public actors at the state and county levels within North Carolina and South Carolina, as leadership recognized that an element of system-level involvement was necessary to increase the impact of grant-making efforts. Around the same time, Child Care priorities expanded to include a prevention strategy in order to intervene with families earlier and hopefully avoid the need for out-of-home care; thus, the secondary funding component was initiated. Since then, the Endowment’s investments in prevention have exceeded those in out-of-home care, with $12.9 million in new grants directed towards prevention in 2015 compared to $7.0 million in out-of-home care (The Duke Endowment, 2017).

Within the out-of-home care portfolio, the strategy became further refined over the next few years as the Endowment’s decision-makers began to acknowledge that residential care held an important, but limited role in the continuum of child welfare services (Mabry, 2010). Specifically, there was a recognition that an alternate set of services, placement resources and casework practice approaches were needed to achieve positive outcomes for child welfare-involved children and their families. An organizational focus on child well-being emerged and began informing investment strategies throughout the time period covered in this evaluation.

From this organizational shift in priorities evolved the Endowment’s theory of change for its out-of-home care investments, formally articulated in 2013 and further refined in 2016 (The Duke Endowment, 2016). With the ultimate goal of promoting child welfare system accountability for the achievement of positive child well-being outcomes, the Endowment’s theory of change currently encompasses four core strategies: 1) Identify effective assessment tools, evidence-based programs and sustainable business models that can bring an array of services to scale; 2) Implement evidence-based child welfare models and test new approaches; 3) Advocate on behalf of and encourage redirection of public and private funds to quality providers that use evidence-based programs and measure outcomes; and 4) Build capacity of providers to adopt, broaden, and maintain effective services. These strategies are designed to increase the

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2 North Carolina is a state-supervised, county-administered state with 100 county-level social services departments. South Carolina is a state-administered state, with 46 counties that also maintain local-level social services departments.
use of a universal assessment of children entering care, create a provider network that meets the highest standard of quality, and increase the number of providers offering evidence-based interventions or well-articulated models of care. Building upon these short- and mid-term outcomes, the Endowment aims to promote a child welfare environment where children are comprehensively assessed and placed with high quality providers who are able to meet their developmental and clinical needs with best practice approaches. The theory of change also includes added emphasis on the expansion of post-permanency services to preserve placements and reduce the likelihood of re-entry. As the theory of change has gained traction within the Endowment, an increasing number of funded grants within the out-of-home-care portfolio have begun to reflect its priorities and core strategies.

Review of Grant-making – Goals and Approach

In the fall of 2016, the Duke Endowment released a Request for Proposals soliciting proposals for a retrospective evaluation of the Endowment’s out-of-home care grant-making for 2006-2015. The Endowment sought a mixed-methods study that would reflect the portfolio of projects funded during the review period, with a particular focus on the evolution of the Endowment’s strategic direction as well as changes in the child welfare system context. The review of projects was to incorporate lessons illuminating barriers and facilitators of implementation success, as well as to identify the impact of funded projects in key areas of focus.

In response, Chapin Hall proposed to leverage deep research, evaluation, and policy expertise to assist the Endowment by identifying and recommending opportunities to strengthen grant-making strategies within the context of current and future child welfare policy developments. To evaluate a decade’s worth of investments in child care initiatives, and to gain historical perspective on how the Endowment’s investments align with overarching goals and needs of children in out-of-home care, Chapin Hall proposed to assess funded projects through a collection of interviews, document reviews, data analyses, and literature review. The resulting report provides a historical depiction of the Endowment’s investment strategy, a summary of findings, and a discussion that situates these findings within the larger socioeconomic and political context. With the understanding that a retrospective study of this nature will not be able to definitively attribute impact to funded projects alone, the review attempts to answer the following key questions:

- What was the political, legal, and social environment of child welfare out-of-home services during the years 2006-2015, and how did this influence the Endowment’s grant-making and grantee efforts?
- What is the nature of grants awarded 2006-2015 in relation to the type of organization, purposes, intended outcomes, and results?
To what extent were outcome objectives achieved by the different grants and projects? What factors contributed to success and what are lessons learned?

To what extent did the out-of-home care grant portfolio achieve desired outcomes, how were outcomes achieved, and what accounts for results?

Each of these identified questions was approached using a combination of qualitative and quantitative methods, as outlined in the work plan overview:

Table 1. Work Plan Overview: Components & Deliverables

<table>
<thead>
<tr>
<th>Component</th>
<th>Approach</th>
<th>Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1: Context</td>
<td>Literature review, policy analysis, data analysis, stakeholder interviews</td>
<td>Written summary; timeline of key milestones, graphics depicting trends in out-of-home care</td>
</tr>
<tr>
<td>Question 2: Summary of grant-funded projects</td>
<td>Document Review, stakeholder interviews</td>
<td>Written summary; visuals to depict projects by focus area, strategic lever, and provider agency; framework within which to understand success of future grant-funded projects</td>
</tr>
<tr>
<td>Question 3: Implementation success &amp; lessons learned</td>
<td>Document Review, stakeholder interviews</td>
<td>Written summary of identified barriers and strategies for overcoming them; matrix of intended and achieved outcomes</td>
</tr>
<tr>
<td>Question 4: Impact</td>
<td>Document Review, stakeholder interviews</td>
<td>Written summary results and recommendations for approach to future strategy and impact analysis</td>
</tr>
</tbody>
</table>

To this end, the Chapin Hall team collaborated with Endowment leadership and staff to develop a plan to compile the necessary information; the team then embarked on an effort to collect, analyze, synthesize, and report on the materials, conversations, and data obtained through this process.
Methods

Document Review

Chapin Hall assembled a team to conduct a thorough review of documents pertaining to grant-funded projects in out-of-home care. The Duke Endowment provided over 740 documents which were posted to a Dropbox site. These documents included agency placement data; child care committee books; child care grant codes; dashboards, logic models, and strategy documents; grant-related documents; TDE’s request for proposals; and the TDE organization chart. The Chapin Hall team approached the review of the grant-related project documentation by first reviewing proposals, then final reports, and then any intermediate documents that could shed light on implementation problems or project shifts.

In all, 429 documents were reviewed concerning 222 funded projects implemented by 80 provider agencies, associations, or county and state government bodies. Reviewed documents were organized by strategic lever, and then evaluated for goals, fidelity, engagement, and impact. Implementation barriers and facilitators were noted, as well as idiosyncrasies in submitted documents. While the volume of documents provided was tremendous, the team worked to synthesize content to distill overall impressions of impact. The resulting report was reviewed by an Advisory Group consisting of subject matter experts, who weighed in on the content and presentation of findings and recommendations.

Literature Review

To review the literature concerning best practice in out-of-home care, Chapin Hall employed an Information Specialist who developed a search strategy that retrieved 491 articles, book chapters, and presentations from the peer reviewed literature. Ultimately this set of records was culled in consultation with co-investigators and other subject matter experts to identify 40 relevant resources that were reviewed for inclusion in this report. The resulting articles represent hallmark reviews of best practice in out-of-
home care, congregate care, and evidence-based approaches to mental health care for children and adolescents. The literature review also accessed the “grey literature”; from this, Chapin Hall compiled a compendium of available online resources and non-indexed literature that public and private child welfare agencies can use to inform decision making and evaluation of programs to improve one or more outcomes for children in or at risk of out-of-home placement. This curated list of resources (Appendix B) provides current, high quality, relevant information and materials, such as white papers and reports that synthesize evidence-based practice models that emerged or were empirically validated between 2006 and 2016. The search was non-systematic and not exhaustive, but was conducted by an Information Specialist trained in the retrieval and appraisal of high quality evidence sources, in consultation with subject experts.

### Interviews

The opportunity to speak with Duke Endowment leadership and staff, service providers, advocates, and county and state officials was invaluable to developing an understanding of the Endowment’s impact and strategic shifts over the period under review. Chapin Hall worked collaboratively with the Endowment to identify a group of interviewees that represent a cross-section of funded projects as well as roles within the child welfare service system. Approval for qualitative data collection was obtained from the Institutional Review Board at the University of Chicago, School of Social Service Administration (Protocol IRB17-0094).

Chapin Hall conducted an initial set of interviews with Endowment staff shortly after the initiation of the project period to gain foundational knowledge and information about the history of grant-making in out-of-home care as well as the conceptual and philosophical shifts underlying the evolution of funding strategies. Over the course of two subsequent visits, co-investigators met with a set of system partners in North and South Carolina (n=11; selected by the Endowment for diversity of service delivery, volume and breadth of funded projects, and role) who provided detailed impressions of the shift in funding priorities from the grantee perspective, as well as the impact of the Endowment’s support on their own and the larger system’s ability to deliver services effectively to children and families.

Interview data were transcribed and summarized, and key themes were extracted for inclusion and integration in this report.

### Quantitative Data

For the purpose of analyzing child welfare trend data in North and South Carolina, the Chapin Hall team obtained a license from the National Data Archive on Child Abuse and Neglect (NDACAN; License #808). The files obtained from NDACAN allowed us to conduct basic trend analyses to establish the rate
of child welfare entries and exits over the period from 2006 – 2015. Slides depicting the results can be found in Appendix C.
The evolution of the Endowment’s strategic direction regarding its out-of-home care investments was accompanied by and aligned with a similar evolution in the national child welfare dialogue and policy context. Several substantive federal legislative reforms and policy issuances emerged between 2006 and 2016, with a notable increase in national attention around assessing and addressing needs related to child social and emotional well-being. The Child and Family Services Improvement Act of 2006 introduced an increased focus on improving the quantity and quality of caseworker visits with children and authorized regional partnership grants focused on addressing the permanency and well-being needs of children affected by substance abuse (Children’s Bureau, 2006). The Fostering Connections to Success and Increasing Adoptions Act of 2008 extended federal financial support for youth in foster care from age 18 to 21, and also authorized federal support for subsidized guardianship as a permanency option (Children’s Bureau, 2008).

The Child and Family Services Improvement and Innovation Act was passed in 2011, at about the same time the Endowment began crafting its initial theory of change. This law dovetails considerably with the Endowment’s emerging foci. First, the legislation required states for the first time to begin describing their plan for monitoring and addressing the emotional trauma of children and youth associated with their removal from home (Children’s Bureau, 2011). Second, the law reauthorized the federal Department of Health and Human Services to grant “waivers”, that would allow approved states to use federal funding more flexibly to implement and test innovative approaches within child welfare. In addition to the flexible
funding, waivers also allow states to keep and reinvest within their child welfare system any savings they achieve through the demonstration³.

The waiver opportunity is particularly relevant to the Endowment’s strategic shift, as the federal government’s guidance to states communicated an explicit focus on child well-being, instituting a priority for applications designed to “produce positive well-being outcomes for children, youth, and their families with particular attention to addressing the trauma experienced by children who have been abused and/or neglected” (Children’s Bureau, 2012a, p. 3). The waiver guidance was paralleled and further supported by a separate, but seminal federal memorandum that outlined the importance of promoting social and emotional well-being among children and families served by the child welfare system (Children’s Bureau, 2012b). The well-being memorandum acknowledged and reinforced the field’s longstanding commitment to safety and permanency, but stressed that improving these outcomes alone was insufficient for achieving the well-being of child welfare-involved children and youth given the demonstrated adverse effects of child maltreatment on social, emotional, and behavioral functioning. In both federal memoranda, the focus on well-being emphasized the importance of appropriate screening, assessment, and evidence-informed interventions designed to measure and treat children and youth’s well-being needs and improve their social and emotional functioning.

From 2012-2014, the federal government approved 27 new waiver demonstration projects, many of which focused on trauma, functional screening and assessment tools, and the implementation and scale-up of evidence-based interventions (James Bell Associates, 2015). Federal leadership recognized the powerful strategic lever made available to states through the waiver opportunity to implement, test, and scale-up strategies for outcomes while contributing to the growing evidence base regarding interventions, practices, and policy levers that could be employed effectively with a child welfare population. This evidence may in turn inform legislative changes that restructure federal child welfare funding strategies, which still disproportionately finance foster care services over prevention, family preservation and treatment services (Child Trends, 2016).

Although states are still in the process of implementing and testing a wide array of waiver interventions, the national dialogue on legislative reform continues in anticipation of the waiver sunset date of September 30, 2019. In 2016, national and state child welfare advocates across the country worked closely, (albeit unsuccessfully) with legislators in an effort to pass the Families First Prevention Services Act (FFPSA). As proposed, the FFPSA introduced substantial flexibility in how states could use their

³ The Child and Family Services Improvement and Innovation Act allowed for up to ten new child welfare waivers to be approved in each of federal fiscal years 2012-2014, with a requirement for all existing waivers to terminate by September 30, 2019.
federal title IV-E dollars, the primary child welfare funding source for states, traditionally only available to support children once they have been placed in foster care (Alliance for Strong Families and Communities, 2016). On the prevention side, FFPSA provisions included the ability for states to use title IV-E funds for promising, supported, and well-supported interventions geared toward mental health or substance abuse prevention and treatment as well as in-home, skill-based programs for parents. Had it passed, the federal investment in family preservation services via the title IV-E program would have represented a profound shift in federal child welfare financing toward prevention.

At the other end of the child welfare continuum, the FFPSA proposed significant changes in the ways federal funding could be used to support children and youth placed in congregate care settings (e.g. group homes and residential treatment facilities). Responding to the growing recognition that residential placements are best utilized as time-limited treatment resources for children and youth whose clinical needs require a higher level care before a family-based setting can be facilitated and stably maintained (Blau et al., 2010; Chadwick Center and Chapin Hall, 2016; Children’s Bureau, 2015), FFPSA advocated for limits on placement settings that were not family-based foster homes (Alliance for Strong Families and Communities, 2016). Specifically, FFPSA prohibited the use of federal dollars to support congregate placements for children and youth beyond a two-week period unless the placement resource was determined to be a Qualified Residential Treatment Program (QRTP) that met certain requirements. For example, requirements included that the institution was licensed and accredited and utilized a trauma-informed treatment model. These provisions, put in place in an effort to reduce an over-reliance on long-term congregate care placements, contributed to the bill’s failure to pass. The dissenting voices of a small group of stakeholders, including some powerful voices within the North Carolina provider community, were highly critical of the legislation and prevented it from moving forward (Child Welfare League of America, 2017). Foster care finance reform efforts are anticipated to continue in the coming years as child welfare stakeholders and advocates look ahead to the end of the waiver period in 2019 and the reinstatement of traditional financing models, should a new set of legislative reforms fail to emerge before then.

Local context

While the legislative changes and policy issuances at the national level over the last decade created new opportunities for states to improve and expand their child welfare programs, the economic recession that impacted vulnerable families and states’ capacity to provide the services needed to stabilize and support them had substantial adverse effects in North and South Carolina (North Carolina Action for Children, 2011; South Carolina Department of Social Services, 2010). For example, the recession was cited as a significant contributing factor to North Carolina’s failure to conform to the federal standard for Service
Array (systemic factor) during its 2007 Child and Family Services Review (Children’s Bureau, 2007). Key stakeholders noted that the financial crisis contributed to reductions in the array of services the provider community was able to offer, resulting in a lack of access to critical services for the child welfare population.

Further, two of the fiscal levers authorized by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (subsidized guardianship as a permanency option and the extension of foster care until age 21) have not been utilized by North and South Carolina. North Carolina has recently begun to move forward with both of these options; in 2016 legislation extended the availability of foster care up to age 21 for youth in North Carolina (Scott, 2016), with the final policy issuance published in December of the same year (North Carolina Division of Social Services, 2016). Additionally, the statewide implementation of guardianship is planned as a strategy under North Carolina’s Program Improvement Plan (PIP) developed in response to the findings of its 2015 Child and Family Services review, with a goal date of 2018 for full implementation (North Carolina Division of Social Services, 2017). The South Carolina Department of Social Services has not yet moved to implement either of these options.

Neither North Carolina nor South Carolina applied for a child welfare waiver under the renewed authority following the Child and Family Services Improvement and Innovations Act of 2011. 4 However, the North Carolina Child and Family Services Plan for 2015-2019 does include an explicit focus on trauma and a system-wide effort to become a more trauma-informed child welfare system. South Carolina, on the other hand, settled a class action lawsuit in 2016, Michelle H., et al. v. Haley and Alford ("Michelle H., et al. v. Haley and Alford," 2016), filed on behalf of all children involuntarily placed in foster care within the State. While the settlement agreement is far-reaching in the breadth and depth of child welfare system improvements required of South Carolina, of particular importance are the provisions and specified target goals related to improving South Carolina’s use of family-based placements, and reducing the number of children and youth residing in congregate care placements, particularly children age six and under.

Reducing reliance on residential and group care placements is a specific child welfare practice area needing improvement in South Carolina. Similarly, the misalignment between the views of select members of the North Carolina provider community with some of the provisions of the failed FFPSA will be further examined below; it will be helpful to understand the priorities and perspectives of these key stakeholders as state and national level legislative reform efforts continue to evolve.

4 North Carolina did pursue a title IV-E waiver under previous waiver authority with the intention of testing the impact of added flexibility in child welfare funding on child and family outcomes. The waiver terminated early in 2008.
Key milestones in the federal and local child welfare policy context are illustrated in the timeline in Appendix A.

## Trends in Out-of-Home Care

Across the country, the rate of substitute care entry decreased over the first third of the review period (2006-2009) and subsequently levelled off or increased slightly. Trends in North Carolina parallel this national trend, with a slightly steeper increase than the national average from 2012-2014. Since then, North Carolina rates have levelled off in parallel with the national rate.

**Figure 1. US vs. NC vs. SC Entry Rate per 1,000 Children**

In South Carolina, the trend does not mirror the national rate of entry. In fact, after an increase in first third of the period, South Carolina rates decreased dramatically from 2009 – 2012 and subsequently began to climb. Both states remove fewer children than the national average.

Appendix C contains a set of graphics illustrating additional child welfare trends in North and South Carolina, summarized here. An examination of the rate of entries and exits during this period can deepen our understanding of these trends. In North Carolina it appears that reductions in the number of children in out-of-home care overall were accomplished by a lower rate of removal, and that the number levelled off when fewer children were discharged to permanency. While the rate of children exiting out-of-home care has increased in the past two years, it has not been able to keep pace with the rising entry rate, resulting in an overall increase in the number of children in care. In South Carolina, the reductions in overall number of children in care is paralleled by reductions in removals, and might have continued were
it not for a sharp decline in the rate of children exiting care between 2012 and 2013; the exit rate has not been able to catch up to the South Carolina entry rate since then, resulting in rising numbers of children in out-of-home care. It is important to note that the entry/exit graphs display the total number of children in care, whereas the comparison to national trends displays the rate per thousand in the population.

In both states, the rate of entry into substitute care is highest among the youngest children; for much of the review period, the rate is lowest among adolescents. In recent years the rate of entry among school age (6-11 year old) children has become as high or higher than the rate of entry of adolescents.

An examination of the racial composition of the general population of children alongside that of children in foster care allows observation of disproportionate representation in foster care where it is present. It appears that while disproportionality has decreased in both states, in North Carolina there is still a fair amount of disproportionate representation of African American youth in the foster care system (39.2% vs. 23.5% in the general population). In South Carolina 39.2% of children in foster care are African American compared to 31.3% of the general population of children, a considerably smaller discrepancy.

Patterns of exit to permanency differ between the two states, particularly in the use of guardianship as a permanency option. About 15 percent of North Carolina’s exits to permanency over the study period are to a guardianship placement, whereas South Carolina uses that option only minimally (2.8%). In comparison, nationally around 9% of exits to permanency were to a guardianship placement in 2015 (Children’s Bureau, 2016). Further, in South Carolina rates of youth exiting without a permanent home (e.g. emancipation) have remained relatively steady, whereas in North Carolina the rates of older youth exiting to emancipation has been on the rise while the rate of older youth who reunify has dropped. When placement types (among youth who enter care under age 12) are considered, North Carolina’s rate of congregate care placement (around 4.5% in 2013) is much lower than the national average (16%), while South Carolina’s rate (22%) is higher.
Clinical & Best Practice Context

As the child welfare field converges around a set of principles or “best practices” for serving children in out-of-home care, the Endowment’s work to incorporate and build the evidence base continues. The Endowment’s shift toward encouraging specific strategies and approaches, as well as the priority placed on the use of Evidence Based Practices, is justified by the documented prevalence of mental health need among youth involved in the foster care system (Landsverk, Burns, Stambaugh, & Reutz, 2009). This report highlights three themes from a review of child welfare best practice literature relevant to the Endowment’s work: (1) utilizing and evaluating programs with evidence of effectiveness, (2) refining the service array to meet the needs of children with a full continuum of services and (3) incorporating an understanding of trauma into child welfare practice.

Utilization of programs with evidence of effectiveness

One of the most notable trends over the review period has been the proliferation of Evidence Based Practice (EBP) among child welfare interventions. Despite research findings suggesting that the implementation and expansion of EBP within mental health systems may have levelled off in the mid 2000’s (Bruns et al., 2016), trends and systematic reviews suggest far more frequent use of manualized treatments, fidelity checks, and developmentally-specific Evidence-Based Treatments (EBTs). Results of multiple reviews of best/evidence-based practices identified in both the California Clearinghouse for Evidence-Based Practice in Child Welfare (CEBC) and the National Child Traumatic Stress Network (NCTSN) for use among youth in substitute care converge on a set of well-supported practices that seek to (1) address youth mental health and trauma problems and (2) enhance caregiver effectiveness for providing stable, sensitive parenting to youth exposed to trauma (Kinsey & Schlosser, 2013). Within these two general areas, there is increasing awareness that the complexity of the child welfare environment necessitates an approach that bridges multiple systems and system actors to bring about positive outcomes for youth. To this end, the use of multidisciplinary teams, wraparound approaches, and in-vivo parent training and coaching have met with more success than other approaches reviewed (Kinsey & Schlosser, 2013; Palinkas et al., 2014). Multidimensional Treatment Foster Care (MTFC), Multi-Systemic Therapy (MST), and Project KEEP are examples of these approaches that employ these strategies to improve parent-child interactions and, in turn, permanency outcomes.

The noted shifts among The Duke Endowment’s funding strategies and the Child Welfare field at large are paralleled in the broader mental health arena, as evidenced by the proliferation of EBP use in Mental Health, and particularly among State Mental Health Authorities (SMHAs). However, after an initial burst of adoption and expansion in the early 2000s, EBP implementation and the activities that support it appear to have levelled off (Bruns et al., 2016). While some of the infrastructure supports remain
prevalent in the mental health field, implementation and communication supports appear to lag behind. In a study of the use of research, data, and evidence-based treatment from 2001-2012, Bruns (et al.) note increases in the percentages of states that report funding an external research center, promoting the adoption of evidence-based treatments through provider contracts, and providing financial incentives for EBTs (Bruns et al., 2016). However, the same study documented a decrease in consensus-building approaches to raise stakeholder awareness of EBTs, as well as fidelity monitoring, since the rates of these activities peaked in 2009. Generally speaking, the promotion of EBTs for children and adolescents has lagged behind that for adults, with rates of MST (39%), therapeutic foster care (54%) and Functional Family Therapy (27%) increasing at a slower rate among states reporting on availability (Bruns et al., 2016). More concerning, the median numbers of clients served annually by child-focused EBTs from 2007 – 2012 was 250-400, reaching only 1-3% of youth with serious emotional disturbance (Bruns et al., 2016).

Evaluations of EBTs implemented in the child welfare context target an array of short-term and long-term outcomes. While many of the long-term outcomes cannot be observed for several years after treatment completion, the short-term outcomes may be so varied as to challenge comparisons across outcome evaluations to identify the best models. In alignment with these challenges, it seems clear that some forms of intervention have accumulated little evidence over the review period – individual treatments, group parent trainings, and training unaccompanied by coaching and practice all have relatively little support in the literature (Kinsey & Schlosser, 2013). While some of these approaches may have effects on short-term target outcomes (specific symptoms or knowledge), they are unlikely to bring about the stability and connectedness that are the building blocks of better child welfare system outcomes, reflected in permanency and well-being measures.

Refinement of the service array to provide treatment in the appropriate context and at the right level of care

Much of the discussion in the literature has focused on the appropriate contexts in which to serve youth in substitute care. While the literature has documented the deleterious effects of long-stays in congregate care settings, (in some cases attributed to contagion effects for disordered behavior as well as the overall impact on permanency and overall length of stay of congregate care stays), the field still struggles with implementing a shift away from congregate care settings (James, 2011).

Although it is hard to parse the impact of residential treatment because of the distinctive baseline characteristics of the youth likely to be placed in these settings, researchers have tried to document outcomes among comparable groups of youth receiving intensive services in congregate vs. family based environments (Chadwick Center and Chapin Hall, 2016). These studies show little evidence that serving
youth in high-end congregate care settings is more effective than providing comparable youth therapeutic services in the community while placed in family homes; in fact, a 2016 policy brief developed by Chapin Hall in collaboration with the Chadwick Center reported that many youth currently placed in congregate care settings have clinical characteristics similar to youth placed stably in specialized foster care settings, suggesting that these youth may be served more effectively (and cost-effectively) in well-prepared home environments (Chadwick Center and Chapin Hall, 2016).

Despite this overall trend, specific models of group care have been evaluated to be effective for achieving specific short-term outcomes. In a review initiated by the California Evidence Based Clearinghouse for Child Welfare, four such models (Positive Peer Culture, Teaching Family Model, Stop-Gap, and Sanctuary) were deemed promising or supported by the evidence (James, 2011). Of these, only the Sanctuary model incorporates an explicit focus on addressing trauma that may underlie much of the disordered behavior among foster youth placed in congregate care settings.

While some studies are working to build the evidence base for care models delivered in congregate settings, several reviews have noted that (because of both disparate outcomes and the absence of longitudinal designs) there is little research evidence for the overall effectiveness on long-term functioning of even smaller group home models, with the possible exception of several quasi-experimental studies documenting positive effects for the Teaching Family Model (TFM) of small group care. For youth placed in congregate care, sustained contact with family members seems to be one of the only predictors of positive outcomes, although this may be because those youth with engaged families may have greater likelihoods of positive outcomes regardless of placement type (Barth, Greeson, Zlotnik, & Chintapalli, 2011).

In response to the high rate of needs along with the recognition that institution-based care may have deleterious effects for some youth, the child welfare field has moved away from long-term group care models and focused on the provision of in-home and community-based services (Landsverk et al., 2009). Consequently, the last ten years have seen a proliferation of interventions designed to prepare foster parents to provide stable, consistent, and trauma-informed responses to the behavioral and emotional needs of youth in their care, with mixed results. Effective models include Parent Child Interaction Therapy (PCIT), Project KEEP, MTFC, and Trauma Affect Regulation Guide for Education and Training (TARGET), among other approaches (Kinsey & Schlosser, 2013).

**Acknowledging the impact of trauma**

According to the National Survey of Child and Adolescent Well-Being (NSCAW), one-half to three-quarters of children entering foster care exhibit behavior or social competency problems requiring clinical attention (Burns et al., 2004; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). The most prevalent
conditions include post-traumatic stress disorder, abuse-related trauma, disruptive behavior disorders, depression, and substance abuse (Landsverk et al., 2009). The National Child Traumatic Stress Network (NCTSN) estimates that nearly 80% of children referred for screening and evaluation reported experiencing at least one type of traumatic event; of the 11,104 children and adolescents who reported trauma exposure, 77% had experienced more than one type of trauma, 27% had experienced 3 to 4 types of trauma, and 31% had experienced five or more types (Greeson et al., 2011; "National Child Traumatic Stress Network,"). Along with the growing awareness of the prevalence of trauma has come a generation of evidence-based models that draw upon effective elements from other therapeutic modalities to address the affect dysregulation, hypervigilance, anxiety, and depression that can result from trauma exposure (Weiner, Schneider, & Lyons, 2009). These treatments may be targeted to specific developmental/age groups, so that skills and strategies are appropriate to the cognitive and emotional abilities of participants. Of these trauma-focused treatments, several have risen to the level of empirical support in the CEBC. They include Trauma-focused Cognitive Behavioral Therapy (TF-CBT), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), and TARGET (Ford, Steinberg, Hawke, Levine, & Zhang, 2012; Weiner et al., 2009).

Taken together, these research findings suggest a number of principles for advancing effective, responsive interventions for youth in out-of-home care:

- Evidence-based services should be delivered in the least restrictive environment
- Treatment should incorporate an understanding of the impact of trauma; treatment for trauma-related problems should be relatively brief and involve parents and/or caregivers
- Continuum of care should include multi-system case management, treatment foster care, and post-permanency support services to families
- Multidisciplinary teams are needed for the effective delivery of services and care coordination in complex systems
Summary of Projects

From 2006 to 2015, the Endowment funded an impressive array of projects. While these were generally categorized by the Endowment as aiming to “Strengthen Organizations”, “Replicate Success” or “Advance Innovation” – a closer look suggests that the distribution of projects reflects an emerging set of priorities. These priorities were initially articulated in the 2010 white paper (Mabry, 2010) and later in a series of logic models formalized in 2013 and 2016. Both focused on the explicit goal of “driving child welfare systems toward greater accountability for child well-being”, and included a core set of strategies that were hypothesized to bring about these goals.
In turn, over time funded projects became more focused on one or more of the strategies or strategic levers named in the logic models. They are:

- Increased use of a uniform assessment protocol (“Assessment”)
- Regional or statewide providers meet highest standards of quality (“Quality”)
- Increased availability of providers offering a broad service array (“Service Array”)
- Evidence-based or well-articulated models of care (“EBP”)
- Expansion of post permanency services (“PPSS”)

Because implementation of these strategic levers would (in some cases) require personnel, technology, or other infrastructure supports, the review identified an additional lever (“Infrastructure”) to encompass these projects. Generally speaking, infrastructure supports were projects in the “strengthening organizations” category, whereas the other four levers (service array, assessment, EBP, and PPSS) were distributed across categories. This review attempted to crosswalk the two (categorization by lever), but found the most fruitful approach to be an organization of projects by strategic lever in order to examine both implementation success and impact. Figure 3 illustrates the composition of the portfolio, by number of funded projects, when strategic levers were assigned. Projects assigned to the Post Permanency Support Services included those projects aimed at preparing youth for emancipation; in this way, the category is broader than traditional notions of post-permanency supports to fortify and stabilize adoptions,
guardianships, and reunifications. Although several projects could arguably be classified in more than one category, for the sake of organizing the information projects are represented only once in the analysis.

**Figure 3. Projects by Strategic Lever**

Figure 4 illustrates the changing distribution in funding by strategic lever over time. It depicts comparable amounts spent on promoting quality and implementing evidence-based practices. It is not surprising that fewer projects within the evidence-based practice area would be more deeply funded, as the Endowment has taken care to ensure implementation occurs with fidelity and an awareness of the drivers that can ensure success. Figure 4 also illustrates that funding for infrastructure has tapered off in recent years, whereas funding for assessment projects is an emerging area.

**Figure 4. Project Funding by Strategic Lever over Time**
Figures 5 and 6 depict the distribution of committed funding across strategic levers by state, as reflected in documents that included proposed budget amounts. Figure 5 illustrates the consistent focus on Quality and EBP in North Carolina, whereas the distribution in Figure 6 reflects the work with residential providers in South Carolina to encourage and support expanded service arrays.

Figure 5. Requested Funding by Impact Area over Time, North Carolina

Figure 6. Requested Funding by Impact Area over Time, South Carolina

In addition to the dynamic shifts in funding priorities, it is important to note the evolution that has occurred within each strand or project foci. In the area of Quality, initial work focused on promoting accreditation, which was understood to be a “floor” not a “ceiling” for the quality standard. Subsequent work to promote quality has involved supporting the infrastructure and personnel required to maintain
continuous quality improvement, as well as building agency capacity to implement and sustain evidence-based practices and care models. The Service Array strand has worked to reduce reliance on congregate care placements by broadening the service offerings within providers as well as building networks among providers to ensure that community-based service options are available.

The analysis that follows summarizes the implementation of 222 projects organized within the six categories derived from the Theory of Change and illustrated in the graphics above.

Assessments
There were seven projects that focused on “assessment”, with three somewhat distinct, but complementary foci. There was a set of projects that focused on the implementation of a specific standardized assessment tool (i.e. Treatment Outcome Package [TOP]). Another set of projects contributed to the development of an assessment center that was designed to foster communication and collaboration across the myriad partners involved in serving children entering foster care, while one other project supported the development of a data-driven decision-making model to assist the participating organization in using its breadth of assessment data to make child-level and agency-level decisions based on evidence. There were varying degrees of successes and challenges among the projects funded in this area. For example, staff within the organization implementing the data-driven decision-making model experienced increased capacity to use data to inform their decision-making and communication with key partners. The assessment center resulted in improved communication between key partners serving the children and youth entering foster care and enhanced quality of conducted assessments, in addition to providing increased opportunities for caregiver engagement in appointments that occurred at the assessment center. Overall, more time will be needed to observe the impact of this work, as efforts to install and implement assessment strategies are still currently underway.

The experience of implementing the standardized functional assessment tool has been accompanied by a wide range of interrelated successes and challenges. One key theme that emerged from stakeholder conversations in Wake County was the importance of meaningfully engaging the raters in the assessment process. There were challenges with the time-consuming nature of completing the assessment tool and difficulties with interpreting the results; however, stakeholders with positive experiences with the assessment tool learned to recognize the value of incorporating multiple perspectives into the process and the richness and utility of the data generated by the inclusive approach.

Evidence-based Practices
Forty-four projects were categorized as promoting “evidence-based practices”, either by implementing an established EBP or as an effort to build the evidence base for a manualized practice. These projects were
funded mainly to implement or scale-up interventions with an established evidence-base (e.g., Multidimensional Treatment Foster Care, Multisystemic Therapy, Together Facing the Challenge), or support efforts to build evidence around a promising model or approach (e.g., Family Finding, Caring Adults ‘R’ Everywhere [CARE], ‘Success Coaches’). The documents indicated that about half of the projects achieved full implementation, while the remainder appeared to have been either partially implemented or are still underway. While the availability and depth of evaluative information included in the project documents varied considerably, approximately six of the funded projects demonstrated improved client functioning or other positive outcomes as a result of the project.

The implementation challenges reflected in the documents were oriented around some commonly identified themes. Grantees experienced difficulties with recruiting and/or referring sufficient numbers of clients to the interventions; leadership and staff turnover; maintaining sufficient financial resources; lack of transportation for program participants; and inadequate communication between key partners. Another project experienced resistance from stakeholders towards the randomized controlled trial evaluation design because of a desire to make the service available to the control group; this is a persistent challenge in efforts to build evidence in child welfare. The ability to meaningfully engage key stakeholders was often related to implementation success or lack thereof. Specifically, strong engagement of community partners and Managed Care Organizations (MCOs) were cited as facilitators of successful implementation. The importance of engaging front-line staff was also acknowledged, occurring successfully in some projects and not as well in others; in fact, one project cited the lack of early engagement of front-line staff as a fundamental contributing factor to its negative outcomes.

**Service Array Expansion and Alignment**

Thirty-seven projects were funded to expand and/or align agencies’ service arrays with the needs of their child welfare population, notably including the need for more family-based placement settings for children and youth in foster care. Projects in this category tended to focus on the hiring and training of new, often specialized, staff for newly established services; enhancing existing programs or creating new ones; and constructing new facilities where additional services are to be delivered. The documents in approximately half of the projects reviewed included evidence of positive outcomes achieved, with examples including improved child and youth functioning, step-downs to lower levels of care, and increases in the number of foster family homes recruited and/or licensed. Among projects dedicated to increasing the number of therapeutic and other family-based foster homes, the most commonly acknowledged barriers were resource family recruitment and difficulties and delays in the licensing process.
**Post-permanency Support**

Twenty-six projects were categorized as post-permanency support services. While frequently conceptualized as support to stabilize and fortify permanency placements (e.g. reunifications, guardianships, adoptions), for the purpose of this report post-permanency also includes programs that prepare youth for independent living after emancipation. A substantial proportion of these projects focused on independent and transitional living programs for youth aging out of foster care, including those pursuing post-secondary education. A smaller number of grants supported other post-permanency services, such as efforts to stabilize and preserve reunifications through a ‘Success Coach’ model that provides families with ongoing case management and support services. Any efforts related to these types of programs, such as constructing facilities or hiring staff, were included in this category.

About one-third of programs reviewed showed some evidence of positive outcomes, including higher rates of high school graduation; increased knowledge, skills and attendance at trainings or meetings among program participants; and reduced likelihood of re-entries among families receiving the post-reunification support services. The most commonly observed challenge among the independent and transitional living programs was the intensity of needs exhibited by participating youths, often exceeding the level of support anticipated by the program. Some projects experienced challenges with the level of staff preparation, as well as a need for more supervision than the programs were able to provide. A key lesson learned was the importance of establishing a connection between youth and at least one caring adult; in one project, 100% of youth not reaching identified goals did not have this type of relationship. As in other impact areas, post-permanency projects cited insufficient funding as common challenge.

**Quality**

Of the 222 total projects analyzed across grantees, 92, or 41%, were broadly categorized as projects that improved the quality of organizations in some way. Projects funded to improve quality included projects that were expected to establish new programs and/or improve various aspects of existing programs, such as increasing organizational effectiveness, hiring new staff, providing training and/or scholarships to staff, promoting collaboration, supporting program mergers, and funding activities or events to bring people with shared interests together. Projects categorized as improving the quality of organizations also included construction efforts, purchasing vehicles for program use, and efforts toward becoming accredited. While it is difficult to gauge the impact of programs targeting quality, some conclusions can be drawn from data obtained from Council on Accreditation (COA, 2017).
After initial increases between 2008 and 2012, both states have experienced a leveling off of the number of accredited providers. During this period, the Endowment also supported 15 mergers among agencies that expanded the service array and volume of service provision among existing, accredited agencies. As a result, the proportion of child-serving agencies that received accreditation steadily increased over time, as seen below in Figure 8\(^5\).

\textbf{Figure 8: Accredited Agencies as a Proportion of Child-Serving Agencies}

\(^5\) “Child-serving agencies” refers to agencies that received at least one placement in a given year. While this was used as a proxy for “all agencies”, it is imprecise because it does not include those agencies that did not receive placements during the reporting period.
Infrastructure

Sixteen projects were categorized as supporting infrastructure. This category primarily included projects funded to build or upgrade information technology systems, hire and train staff, subsidize technical assistance support, and provide assistance to purchase equipment such as computers and servers. Several grantees reported positive outcomes as a result of the Endowment’s support, including the benefits associated with having access to real-time data and enhanced capacity to make better programmatic decisions. However, these benefits are limited as providers reported that data systems still lack connectivity with state and local jurisdictions; when housed within provider agencies or associations they may still be isolated. The lesson here may be that even well-built systems may not reach full potential for impacting continuous quality improvement when they live outside of major system components.
Thorough review of documents, interview notes, and quantitative data yields a cohesive picture of a system in flux, with the Endowment as a powerful driver of change and innovation. Despite the identified shifts in strategic priorities over the period under review, the Endowment has served as a source of stability and continuity for providers who serve a system with leadership that is often in transition. In this section, observations and themes will be reviewed to inform the development of a set of strategic recommendations.

Moving from Unrestricted to Strategic Support

The first shift noted by nearly every respondent was the Endowment’s move away from unrestricted financial support of agencies (previously, orphanages) charged with caring for children who have been removed from their families. While necessitated by the enhanced strategic direction and a move toward accountability and evidence, unrestricted funding to pay for the needs of children is missed by most if not all provider agencies. Similarly, the Endowment’s move toward a more intentional, thoughtful application/proposal process has been met with some difficulty by provider agencies, particularly those who, due to their small size, lack the infrastructure to prepare funding applications. Despite this perceived burden, providers felt that being pressed to clearly articulate their goals, strategies, and plans through applications for funding has become a helpful exercise that ultimately results in more cohesive and effective implementation.

With the move away from unrestricted support has emerged an expectation that providers will plan for the sustainability of their Endowment-funded projects; it is clear that the Endowment not only expects providers to have some “skin in the game” but also to plan for the long-term viability of strategies that have been proven feasible and effective.
On a related note, while some of the strategic shifts are clear to provider agencies, others are more ambiguous; some agencies reported optimistic uncertainty about whether an initiative they hoped to propose would be met with enthusiasm by the Endowment. In this case, a clear articulation of funding priorities, even for ad-hoc requests, may help to align provider goals with the Endowment’s priorities. This will be addressed further in the Recommendations section below.

**Broadening Service Array beyond Residential Care**

Almost as uncomfortable as the move away from unrestricted funding has been the move to prioritize a full continuum of services to complement high-end congregate care placements. While the Endowment has funded evaluation of models for residential-based services (CARE; Sanctuary), generally speaking the focus has been on evaluating other alternatives, and engaging agencies that previously only offered residential services in developing, testing, and scaling other models that would broaden their array of available services. Some of these, such as the Family Care Center – which allows mothers to live with their children while acquiring skills and addressing needs to ameliorate risk – have been met with substantial success.

However, for a group of providers who (for the most part) identify as faith-based organizations charged with housing and caring for youth in out-of-home care, reducing reliance on congregate care is a source of anxiety and disagreement. Despite research and policy that support the shift away from long-term congregate care placements, many providers and advocates maintain that congregate care should retain a prominent place in the child welfare service continuum. While some of these providers argue that some housing arrangements technically licensed as group care more closely resemble alternative family arrangements, it seems unlikely that disagreement on the matter is purely semantic. Biased views about biological families and their capacity to provide safe and loving homes for kin are prevalent (e.g., “the apple doesn’t fall far from the tree”). Providers report observing tremendous placement instability among youth placed in foster homes who are “stabilized” once they reach a long-term residential placement. Even among agencies who are substantively aligned with the Endowment’s agenda, these views will need to be acknowledged and addressed lest they threaten the long-term viability of strategies to reduce reliance on congregate care placements.

Along these lines, it will be important to identify ways to leverage the tremendous sense of responsibility expressed by faith-based agencies to help them develop the types of services and networks that will benefit the system at large.
Promoting Quality

Another shift that has been transparent to the field has been the move to support organizations that are invested in delivering quality services. The Endowment has undertaken this shift in a number of ways, and strategies (as described previously) have evolved over time. The first, most basic step was to require that funded agencies obtain accreditation from an accrediting body (e.g. Council on Accreditation [COA]). This had the effect of increasing the number of agencies with COA accreditation. The Endowment not only shifted their expectations in this area, but also provided some organizations with the support and infrastructure needed to take on the effort of obtaining accreditation. Beyond accreditation, the Endowment has also supported the infrastructure necessary for smaller agencies to merge or for larger agencies to absorb smaller agencies. This strategic approach to promoting quality through mergers and acquisitions may be unique in the child welfare space; while measuring its effect on the number and size of existing agencies is straightforward, gauging the effect of the strategy on child well-being is more difficult. The strategy is based on the idea that economies of scale, both in operating expenses and in service array, will bring about efficiencies and enhance the care provided to children. It is likely that the overall effect of this process may depend on a variety of other agency factors that may or may not be considered when assessing candidacy for mergers.

The second strand of the “Promoting Quality” strategy relates to enhancing the competency of the agencies and staff who serve children and families. This may be accomplished directly by funding positions, or indirectly by funding evidence-based practice and raising awareness of the complexities of implementing evidence-informed strategies in the complex child welfare context. The self-reported experience of the agencies who have received Endowment grant funding to implement evidence-based practice suggests that the impact of this work has been tremendous. Awareness of the complexity of implementation and the strategic levers that can help or hinder successful initiatives is remarkable; providers seem to have internalized the importance of fidelity, careful planning, and ongoing outcomes monitoring. Similarly, by funding the development of data systems and activities to build competence in the use and application of data and evidence, the Endowment has raised the capacity of agencies to engage in continuous quality improvement and accountable, effective practice.

Engagement with Larger Systems

In prior decades, the Endowment interfaced primarily with private provider agencies, where fiscal support imparted substantial leverage for progress. As the Endowment has worked toward implementing more directed and sophisticated strategies for improving child welfare outcomes, engagement with system partners has been essential. Success in this area has been inconsistent, in part due to the fragmentation of the county-based child welfare system in North Carolina, and the lack of clear strategic vision at the state
level. In both states, leadership may be transient and/or lack vision or credibility with providers. To compound this problem, long-term government agency staff who do bring continuity may find it difficult to change their approach or perspective on what is best for children and families, despite substantial progress and evidence in the field. While the level of innovation and best-practice approaches advocated by the Endowment seem to be beyond the current capacity of public child welfare agencies in both states, Endowment strategies provide an invaluable complement to the guidance and support that is provided by the state agencies.

Regardless of the challenges, there are a number of areas in which the Endowment has worked to provide coordination, communication, and implementation supports within the broader context; these include promoting readiness for managed care, the adoption of assessment tools and evidence-based practices, and promoting partnerships with other entities such as foundations (e.g. Annie E Casey), evaluators (e.g. Child Trends) and university partners (e.g. University of North Carolina). What remains unclear (but will be further explored in the Recommendations section) is whether the most fruitful strategic collaborations will be with the state agencies (tasked with establishing strategic vision), the county agencies (who are in the position to implement innovation and best practice) or the provider associations (which may be better positioned to advocate and lobby than to implement). From some providers’ perspectives, the Associations have shifted in scope and function, from a more uniform focus on foster care to broader child-serving agencies (e.g. mental health).

Both states lack intra- and inter-system coordination within child-serving system components. Intersystem coordination would involve coordinating functions between mental health, child welfare, and juvenile justice. Intra-system coordination would address the currently very separate public and private system. In North Carolina specifically, it can be hard to achieve a unified voice within a strong county system; much of the decision-making happens at the county level, and the state lacks a clear vision.

While it is clear that better coordination among the state, counties, and providers is necessary to bring the work into alignment, it is not clear where this coordination might take place; the existing provider associations may not be well-suited as the home for shared governance of child welfare functions. Understanding how these functions are performed in other jurisdictions to enhance public-private partnerships may be instructive.

### Alignment of Priorities

In thinking about the opportunities for greater alignment between the Endowment, the States, the Counties, and the providers, it is helpful to consider the areas of need. This review has identified several potential areas, which will be further explored in the Recommendation section to follow.
First, access to data and information is essential in order to achieve the vision of a child welfare system that prioritizes well-being and delivers evidence-based practices to children and families. The current system lacks comprehensive linked data systems, and attempts by the Endowment to support the development of such systems have been only marginally successful. County-level workers are still unable to access data on child functioning when the youth on their caseloads are placed with private agencies; Kaleidocare, KIDS and other solutions have been insufficient to allow providers to access data that state should be able to provide. Working with the state to identify this as a priority item in strategic plans will be important.

Second, some of the most impactful work has been through enhancing competency for implementation. State leaders acknowledge that they can rarely pay for the depth and breadth of activity necessary to support a full implementation with fidelity; Catawba County’s work implementing Success Coaches is just one example of the potential that can be reached with the Endowment’s support for supplementary, but crucial, elements of implementation. Building understanding among state and county partners of the implementation drivers, promoting appropriate governance structures as well as the other infrastructure needed to support implementation will be part of this effort. Similarly, the state of North Carolina looks to the Endowment for help in developing a blueprint for future collaboration designed to enhance their own understanding of how to productively engage with partners.
Recommendations

The impression that emerges is one of several worlds evolving at different rates; while the Endowment’s evolution has closely paralleled the national dialogue in child welfare, the states, counties, and providers are somewhat behind in their understanding of best practice and the rationale for the shifts that have taken place. Nowhere is this gap more pronounced than among the faith-based organizations who see it as their mission (not the state’s) to care for vulnerable children; as the population of “orphans” has changed to become a group impacted heavily by the trauma associated with child abuse, neglect, and separation, it is essential that these providers shift not only their practice but their understanding of what children and families need to be successful. The misalignment between system components calls for not only a communication strategy that is clear and conveyed in a language understood by all system partners, but also a strategy that leverages the strengths of the system partners and builds upon these rather than working against them. The impact of this gap, or misalignment, threatens to halt progress in child welfare not only at the state but national level, as evidenced by the recent defeat of the Families First legislation. Whether due to misunderstanding about the bill’s goals, levers, and impact, or fear of consequences (intended or unintended), the effect of the misalignment can be powerful and have lasting consequences for the entire system. Working to resolve differences among philosophical approaches to achieving the best outcomes for children and families will involve a “reset” of the conversation and a re-thinking of the incentives and levers that may change provider behavior.

There was a time when financial support alone was a lever sufficient to obtain provider agreement and alignment in work, but addressing the issues identified above will require the Endowment to identify and build upon other levers. In this section, recommendations are organized around three key opportunities – engagement, communication, and outcomes.
**Engagement**

It seems clear that the road ahead requires continued engagement with states and counties as well as provider agencies. In order to bridge the gap between them the Endowment should consider:

1) **Strategies to improve access to and meaningful use of data.** This may involve funding a technological consultant or business analyst to provide consultation and oversight to the State to reformulate the structure and operationality of data systems so that they provide key linkages to counties and provider agencies. In addition, investments could be made in building capacity among system- and client-level decision makers to understand relevant data and how to use it effectively in their work. This type of support would align well with and further the Endowment’s past investments in continuous quality improvement strategies and assessment, as well as promote enhanced data and evidence use with leadership and staff throughout partnering organizations.

2) **State-specific strategies to leverage expertise and build capacity.** In South Carolina this may involve helping to interpret the consent decree and developing communication strategies to enhance providers’ understanding of the implications of the ruling. In North Carolina, this could mean working with the State to develop a state Strategic Plan for Child Welfare and create a sound implementation and sustainability plan. It could also mean working with other counties to obtain the flexibility that Catawba County is able to leverage to deliver a broader range of services as a “reinventing government” county.

3) **Strategies to promote engagement between providers and biological families.** Beliefs and perceptions about families influence provider views on the viability of relatives for placement and permanency options. Other states have approached this issue using the licensing of relative foster parents to enhance fiscal incentives as well as broaden knowledge and capacity of relatives to provide trauma-informed care to their related children, thus leveraging the tremendous potential of these families for providing stable homes to youth who cannot live with their parents. The Endowment’s efforts to promote and spread Family Finding represent a strong foundation in this area.

**Communication**

Some messages around the Endowment’s strategic shift, such as the focus on outcomes and the move away from residential care, have reached the field of provider partners. Other messages, such as the importance of discerning quality providers, relying upon evidence and engaging in ongoing data monitoring, have been less clearly understood. This suggests that communication could be enhanced to clearly impart the aims, goals, and strategies that are now prioritized by the Endowment. This may entail not only a full articulation of Endowment’s priorities, but also an ongoing dialogue about the vision and where partners fit within the larger strategic approach. For example, it seems that there are some in the
field who do not see the connection between the research and evaluation functions supported by the Endowment, the growing evidence base for best practice in child welfare, and improved child and family outcomes. Consequently, they may view this work as tangential to the Endowment’s original charter. Communication strategies could be improved in several ways:

1) To articulate the Endowment’s approach to achieving strategic goals
2) To enhance providers’ understanding of the implications of big policy shifts, such as the consent decree or move to managed care
3) To enhance providers’ competency and awareness in submitting proposals for grant funds and in planning for sustainability
4) To help counties and providers understand the state vision for child welfare
5) To help prospective foster parents learn more about the positive aspects of the experience of fostering children and youth.

Evidence Based Models/Implementation

The body of work that has evolved through the Endowment’s support over the last fifteen years holds tremendous potential for improving the lives of children involved with child welfare in North and South Carolina. Going forward, ensuring that these efforts manifest in improved outcomes will require a strategy that coordinates multiple elements, including funding for projects, legislative goals, and relationship building to work toward a more cohesive, coordinated system. Given that much of the Endowment’s success has been in the area of heightening capacity and awareness around sound implementation of evidence-based practice, it is possible that building on this work could include:

1) Implementation of a Learning Collaborative model to provide a forum for providers to talk about their own lessons learned from implementation successes and challenges. We heard many examples of new knowledge gleaned through rigorous implementation. The Endowment is well-positioned to build upon this with training and opportunities for networking among providers and possibly between the two states. Furthermore, peer-learning opportunities are often sought after and generally regarded as effective strategies for information sharing and promoting collaboration.

2) Support for the development of a statewide, integrated Continuous Quality Improvement (CQI) plan that would include providers and engage them in using data to make decisions and improve services. The creation of this plan would include engaging state leadership and key stakeholders in the identification of priority outcome indicators, developing a set of sound strategies designed to improve performance in needed areas (with clear roles and responsibilities determined for state, county and private actors), and robust mechanisms for monitoring performance and providing feedback to key stakeholders.
3) Development of a research agenda to continue to monitor and evaluate the implementation and impact of strategies. This might include: (a) analyses to help better understand the relationships between enhanced provider quality and child outcomes, (b) continued monitoring of the impact of work to implement new assessment approaches, (c) gap analyses to understand whether the current service array is appropriate and well-paced to meet the needs of children and families, or (d) a “Driver’s Assessment” survey to gauge provider readiness and capacity for implementation of evidence-based models.

**Conclusion**

The Endowment should continue to fund in out-of-home care. Broadly, the Endowment should continue to model best practices in the use of data to drive innovation, implementation and practice refinement. Pursuit of this strategy may require a transition from addressing technical challenges (which requires concrete solutions in the form of resources, technology, and tools) to addressing adaptive challenges (which requires engagement, leadership, and culture change).

Working with the public sector will require continued patience and perseverance to adopt a vision that includes assessment, quality providers, evidence-based models and long-term supports for families. A focused funding strategy that includes engagement, communication strategies and emphasizes evidence-based models and implementation support presents an opportunity to improve child well-being outcomes for at-risk children in the Carolinas.
References


Chadwick Center and Chapin Hall. (2016). Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare: San Diego, CA & Chicago, IL: Collaborating at the Intersection of Research and Policy.


Appendix A. Timeline of Child Welfare Policy Changes
Figure A-1. Timeline of Child Welfare Policy Changes

- **Fostering Connections to Success and Increasing Adoption Act**: 2008
- **Child and Family Services Improvement Act**: 2006
- **Reauthorization of Title IV-E Waivers**: 2012 - 2014
- **Child and Family Services Improvement and Innovation Act**: 2011
- **Families First Prevention Services Act (Not Passed)**: 2016
- **Title IV-E Waiver Demonstration Sunset**: 9/30/2019
- **North Carolina Full Implementation of Guardianship**: 2016
- **South Carolina settles lawsuit**: 2016
- **North Carolina Expands FC to age 21**: 2016
- **Today**

In their ongoing effort to achieve better child welfare outcomes, public and private child welfare agencies are increasingly selecting, implementing and evaluating the effectiveness of new programs and practices. Federal funding from initiatives to improve child and family outcomes has expanded the types of services and program available, but the field has not yet evolved to support a robust framework of replication, evaluation for evidence-based practice. One recent study, for example, reported that 94 percent of child welfare agencies surveyed reported starting a new program or practice in the last five years, but few of those programs – less than one third, were evidence-based. (Horwitz et al., 2014) As interest in selecting, implementing, evaluating, and disseminating best practice for improving outcomes in child welfare has grown, (Bruns et al., 2016; Goldhaber-Fiebert et al., 2014; Leve et al., 2012) research and corresponding literature coverage has expanded and documents a multitude of interventions and models.

As part of the larger review of emerging and established evidence from 2006 to 2016 for effective child welfare services, we provide a compendium of available online resources and non-indexed literature that public and private child welfare agencies can use to inform decision making and evaluation of programs to improve one or more outcomes for children in or at risk of out of home placement. We searched non-indexed sources, known as grey literature, to provide the reader with curated list of resources that provide
current, high quality, relevant information and materials, such as white papers and reports, that synthesize evidence based practice models that emerged or were empirically validated between 2006 and 2016. The search was non-systematic and not exhaustive, but was conducted by an information specialist trained in the retrieval and appraisal of high quality evidence sources, in consultation with subject experts.

In the subsequent section, we present several sources that link to or summarize current and emerging evidence-based and promising practices or programs. Key highlights include an overview of the current IV-E waiver demonstrations, a list of relevant protocols registered with Clinical trials.gov, and a crosswalk of evidence ratings from seven social welfare/service evidence clearinghouses for interventions deemed “high-quality”. We reviewed each source for content relevance and currency, and organized the materials and resources by subheadings: waiver demonstrations, evaluations and research trends, quality improvement, federal funding, and child welfare evidence clearinghouses.

Waiver Demonstrations
Profiles of the Active Child Welfare Waiver Demonstration Projects
Title IV-E waivers, first authorized in 1994, reauthorized in 1997 under the Adoption and Safe Families Act creates the opportunity for states to use funding from Title IV-B and IV-E for prevention, in-home supportive services, or kinship care. The waiver demonstrations have provide an opportunity for child welfare service agencies to develop and implement interventions to build capacity and share practices that hold promise for improved outcomes through systems level change. Demonstrations under Title IV-E waivers require extensive evaluation. Promising evaluation results prompted a new round of waivers approved by Congress in 2011. The Children’s Bureau provides summaries of child welfare waiver demonstrations by jurisdiction in a standardized format that includes target population, intervention components, evaluation methods, outcomes, and cost analyses, when available. (Profiles of Active Child Welfare Waiver Demonstration Projects, 2016)

Summary of Child Welfare Waiver Demonstrations by Jurisdiction
According to the Children’s Bureau, as of June 2016, 27 states, the District of Columbia, and one tribe were implementing 30 child welfare waiver demonstrations. Title IV-E agencies describe a range of interventions intended to improve child safety and permanency, address trauma, and strengthen child and family well-being. Evaluations of waiver demonstrations have the potential to strengthen existing services and expand evidence for effective measurement and implementation of child and family services and programs. Core interventions from the waiver demonstrations include:

- **Substance and alcohol abuse and misuse programs** (e.g., Matrix Model Intensive Outpatient Program; Sobriety Treatment and Recovery Teams (START); Enhanced Recovery Coach Program)
- **Parenting programs and models** (e.g., Triple P; SafeCare; Incredible Years; Promoting First Relations; Positive Indian Parenting; Nurturing Parenting Program; Quality Parenting Initiative; Strengthening Ties and Empowering Parents (KSTEP); Keeping Foster and Kin Parents Supported and Trained (KEEP); Attachment and Bio-Behavioral Catch-Up)

- **Trauma informed systems of care and trauma-focused treatment** (e.g., PCIT; Seeking Safety; Functional Family Therapy; Trauma Focused Cognitive Behavior Therapy; Parenting with Love and Limits; Child Parent Psychotherapy; NCTSN Child Welfare Training Curriculum)

- **Family engagement and connections** (e.g., Leveraging Intensive Family Engagement (LIFE); family group decision making; family team conferencing; comprehensive team decision making; Kinship Supports; Strengthening Families Protective Factors Framework)

- **Family-centered care, family preservation and in-home services** (e.g., family finding; expansion of in-home services; increased use of wraparound services; Strengthening Families; Healthy Families America; Homebuilders; Project Connect; Preserving Family Networks; Multisystemic Therapy for Child Abuse and Neglect; Follow Along; and Alternative Response)

- **Comprehensive programming and enhanced service delivery** (e.g., crisis response teams; Multidimensional Treatment Foster Care; Partnering for Success; Stepping Out; Continuum Services; Safety Organized Practice/Core Practice Model; Permanency Round Tables; Post-Reunification Support Program)

Title IV-E agencies plans include a variety of screening and assessment tools to measure changes in child and family development and functioning over time. Some of these include Family Assessment and Screening Tool (FAST), CANS, and trauma-focused assessments. Outcomes include prevention of maltreatment, initial and re-entry to foster care, placement permanency, youth behavioral and developmental function, caregiver function, and sibling placement. Research and evaluation designs include RCTs / Cluster RCTs, case-controlled, prospective cohorts, and longitudinal. *(Summary of Child Welfare Waiver Demonstrations by Jursidiction, 2016)*

### Evaluations and Research Trends

#### U.S. Child Welfare Agencies Adoption of Evidence-based Practice

This paper reports information about child welfare agencies’ adoption of evidence-based practices derived from a national sample of county child welfare agencies. Authors examined the extent to which agencies explore and adopt new practices and the barriers to and facilitators of exploration and adoption of these practices. Programs rated as “1”, “2”, or “3” by the California Evidence-based Clearinghouse for child welfare were considered evidence-based. Authors asked agency directors if the agency had instituted a new practice or procedure in the last 5 years, the name of the practice or procedure and how far along in
the implementation process the agency had come, the most successful implementation process, and the factors that served as facilitators or barriers. Ninety-four percent of agencies surveyed reported starting a new program or practice in the last five years and, of these, most (94.6%) were implemented but few programs mentioned were evidence-based (Horwitz et al., 2014).

**Major Research Advances Since the 1993 NRC Report Understanding Child Abuse and Neglect**

This paper, commissioned by the Institute of Medicine and National Research Council, is a nicely summarized source including a broad overview of contextual issues, trends, and research advances related to child welfare. The paper was prepared for the Workshop on Child Maltreatment Research, Policy, and Practice for the Next Generation, hosted by the IOM and NRC Board on Children, Youth, and Families held January 2012. The work is presented as an appendix to the IOM and NRC Child Maltreatment Workshop Summary. Using a literature search of databases and other sources, authors characterize the evidence from social, behavioral, and health sciences studies and highlight major research advances in prevention of and improved outcomes for child maltreatment since the publication of the 1993 NRC report. Authors did not review the literature on the effects of law enforcement or judicial interventions (Chalk, 2012).

**Evaluation of Family Preservation and Reunification Programs**

Between 1994 and 2002, the Evaluation of Family Preservation and Reunification Programs evaluated programs designed to prevent the placement of children in foster care or reunify families who had at least one child placed in foster care. (Office of the Assistant Secretary for Planning and Evaluation (ASPE)) The evaluation produced related issue papers on family preservation, fiscal reform, and cost estimation.

**Bulletin on Enhancing Permanency for Youth in Out-of-Home Care**

Enactment of Federal legislation in 2008 led to The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act) which contains provisions to promote permanency and help children and youth in foster care build and maintain meaningful relationships with adults. With this and other Federal support, states and localities were able to develop programs to help youth achieve legal permanency and positive outcomes, including involving youth in permanency planning, strengthening family preservation and reunification services, maintaining relationships with kin, recruiting foster and adoptive families, pre and postplacement services, relational permanency, and strengthening the caseworker workforce. The bulletin includes program examples for each category of permanency promoting strategies. (Child Welfare Information Gateway, 2013)
Guide for Child Welfare Administrators on Evidence Based Practice

This publication by the National Association of Public Child Welfare Administrators (2012) provides a framework for evidence based practice in child welfare and offers guidelines for implementing and assessing evidence-based practices. The publication also addresses overcoming barriers to adopting evidence-based practices. (Shapiro, Wilson, & Alexandra, 2005)

Protocols Registered with ClinicalTrials.gov

ClinicalTrials.gov offers up-to-date information for locating federally and privately supported clinical trials for a wide range of diseases and conditions. (National Institutes of Health) Using the topic keyword “foster care” limited to studies conducted in the United States retrieved 17 recruiting and completed studies that included 3707 participants evaluating the following behavioral interventions: ADAPT; Attachment and Bio-behavioral Catch-up; Child Parent Psychotherapy (CPP); Developmental Education for Families; Early Education Support Program; Early Intervention Foster Care (EIFC); Engagement focused care; Fostering Healthy Futures (FHF); Immediate CARE; KITS Program; LINKS; Middle School Success Intervention (MSS); Parent Management Training; Parent Training; Promoting First Relationships Program; Siblings in foster care curriculum; Treatment Foster Care (TFCO); and Youth Skills Training.

Trends in Child Poverty, Foster Care, and Child Maltreatment

Poverty

After reaching 23 percent in 1993, the highest since 1964, child poverty fell to 16 percent in 1999, then rose slowly through 2004, to 18 percent. Corresponding with the economic downturn in 2007, the data reflect child poverty increased to 22 percent between 2006 and 2010. The rate fell to 20 percent between 2010 and 2015, with increases to 22 percent in 2013 and 21 percent in 2014. (Child Trends Databank, 2016b)

Foster Care

The rate of children living in foster care increased from 6.2 per 1,000 children in 1990, to 8.1 per 1,000 children in 1999. The rate decreased to 5.4 per 1,000 in 2012 and by 2014 the rate increased to 5.6 per 1,000. (Child Trends Databank, 2015)

Child Maltreatment

The rate of child abuse or neglect cases (substantiated or indicated) in the U.S. was 15.2 per thousand children under age 18 in 1994. Between 1994 and 1999, child abuse and neglect cases declined to 11.8 per thousand. In 2014, there were approximately 702,000 maltreated children in the United States, a rate of 9.4 per thousand. (Child Trends Databank, 2016a)
Quality Improvement

National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG)

The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) developed the QIC-AG Intervention and Program Catalog for evidence-based, evidence-informed, and promising practices to address permanency of children in foster care. The Catalog contains over 100 programs and interventions, but is not an evidence-based review system, database, or clearinghouse. (National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG))

Child Welfare Representation

In October 2009, the U.S. Children’s Bureau named the University of Michigan Law School the National Quality Improvement Center on the Representation of Children in the Child Welfare System (QIC-ChildRep). This seven-year, multimillion dollar project was designed to develop and communicate knowledge on child representation, promote consensus on the role of the child’s legal representative, and provide empirically-based analyses of legal representation for children in welfare system. (“National Quality Improvement Center on the Representation of Children in the Child Welfare System (QIC-ChildRep),”) Chapin Hall at the University of Chicago served as the QIC-ChildRep Best Practice Model Training evaluator.

Adoption and Guardianship Support

The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) is a five-year project working with eight sites that will implement evidence-based interventions or develop and test promising practices which if proven effective can be replicated or adapted in other child welfare jurisdictions. Effective interventions are expected to achieve long-term, stable permanence in adoptive and guardianship homes for waiting children as well as children and families after adoption or guardianship has been finalized. The QIC-AG completed a literature review of existing information on adoption discontinuity to understand the risk factors that lead to discontinuity in adoption and guardianship and guide current and future interventions to improve adoption and guardianship services. (“The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG),”)

Federal Funding

The U.S. Department of Health and Human Services supports demonstration, research, training, and service delivery activities for many family and youth health and welfare issues. The Children’s Bureau, a
branch of the Administration for Children and Families, Department of Health and Human Services, is the main Federal funding source for child welfare activities. Titles IV-B and IV-E of the Social Security Act fund programs to support child welfare, foster care, and adoption. These programs are administered by the U.S. Department of Health and Human Services and include: the Child Welfare Services and Promoting Safe and Stable Families, the Foster Care Program, the Adoption Assistance Program, and the Chafee Foster Care Independence Program. Among numerous other resources and curated material, the Child Welfare Information Gateway provides a list of key funding sources and information on federal expenditures. (Administration for Children and Families) The Children’s Bureau grants library offers an online tool to search for Children’s Bureau announcements and information on funded grant projects. (Administration for Children and Families)

### Child Welfare Evidence Clearinghouses

Several repositories of evidence-based child and family programs exist. Evidence clearinghouses are organized reviews of research on interventions and outcomes to confirm the evidence base. These repositories are often sponsored by federal agencies or other research organizations. The curated information clearinghouses identify evidence-based and promising practices and programs using ratings to assess levels of evidence and strength of recommendations for effectiveness. See Appendix B of the National Academies Press publication, Parenting Matters: Supporting Parents of Children Ages 0-8, for a description of the clearinghouses and the criteria used by each to identify evidence-based practices. (National Academies of Sciences, 2016)

- Blueprints for Healthy Youth Development (Blueprints)
- California Evidence-Based Clearinghouse for Child Welfare (CEBC)
- Coalition for Evidence-Based Policy Coalition
- CrimeSolutions.gov
- National Registry of Evidence-based Programs and Practice
- Promising Practices Network
- What Works Clearinghouse
- What Works in Reentry Clearinghouse

### Blueprints for Healthy Youth Development

The Center for the Study of Prevention of Violence’s Blueprints for Healthy Youth Development is a research project within the Center for the Study and Prevention of Violence, at the University of Colorado Boulder. The Blueprints mission is to identify evidence-based prevention and intervention programs that are effective in reducing antisocial behavior and promoting a healthy course of youth development. ("Blueprints For Healthy Youth Development,"
The California Evidence-based Clearinghouse

The mission of the California Evidence-Based Clearinghouse for Child Welfare (CEBC) is to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system. ("California Evidence-Based Clearinghouse for Child Welfare (CEBC),") The CEBC’s definition of evidence-based practice was adapted from the Institute of Medicine’s definition (Institute of Medicine Committee on Quality of Health Care in America, 2001) with a slight variation to incorporate child welfare language: “Evidence-Based Practice incorporates the Best Research Evidence and the Best Clinical Experience and is consistent with Family/Client Values.” The CEBC website provides a searchable database of programs that can be utilized by professionals that serve children and families involved with the child welfare system. The CEBC typically reviews all available research and related literature for a targeted program. For models that have been extensively studied, the CEBC staff and consultants review a sample of research studies and other published articles. All reviewed articles are listed in the reference section. A separate listing of other known but not reviewed literature is provided separately.

The California Evidence-based Clearinghouse ratings of child welfare programs

- 1: efficacy of the intervention is well supported by research evidence;
- 2: efficacy of the intervention is supported by research evidence; and
- 3: the intervention is supported by promising research evidence

Child Welfare Enacted Legislation Database

National Conference of State Legislatures (NCSL) provides a database of child welfare legislation in the 50 states, the District of Columbia and Puerto Rico enacted from 2012 to 2016. In 2016, 69 bills related to child protection and 56 bills related to foster care were enacted. Other child welfare legislation topics enacted include administration, kinship care, and reporting among others. (National Conference of State Legislatures (NCSL))

Coalition for Evidence-Based Policy

The Top Tier Evidence Initiative was developed to identify social programs meeting the Congressional Top Tier evidence standard criteria. “Top Tier Standard” are defined as interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society. Interventions rated as “Near Top Tier” meet almost all elements of the Top Tier standard, and need one additional step to qualify. ("Coalition for Evidence-Based Policy.") For example, a “Near Top Tier” intervention meets all elements of the standard in a single site but requires a replication trial to confirm the initial findings and establish generalizability to other sites. The coalition ended activity on the website in 2015. Sponsorship
of the website, coalition leadership, and research activities will be transitioned from the Coalition for Evidence-Based Policy to the Laura and John Arnold Foundation (LJAF). This website will remain available and updated by LJAF’s Evidence-Based Policy initiative.

**CrimeSolutions.gov**

Part of the Office of Justice Programs Evidence Integration Initiative, CrimeSolutions.gov is a searchable, online inventory of “what works” in criminal justice, juvenile justice and victim services. It is a central, credible resource to improve the quality and quantity of evidence-based programs available to practitioners and policymakers, focused on criminal justice, juvenile justice and crime victim services. The evidence ratings among 200 currently rated programs for child protection and health are: no effects: 18 percent; promising: 60 percent; and effective: 22 percent.(National Institute of Justice)

**National Registry of Evidence-Based Programs and Practices**

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Registry of Evidence-Based Programs (NREPP) is a searchable database of interventions for the prevention and treatment of mental and substance use disorders.(Substance Abuse and Mental Health Services Administration (SAMHSA)) SAMHSA developed this resource to help people, agencies, and organizations implement evidence-based programs and practices in their communities.

**Promising Practices Network**

The Promising Practices Network began in 1997 as a partnership between four state-level organizations that help public and private organizations improve the well-being of children and families.("Promising Practices Network,")) Due to funding constraints, the PPN project was suspended in 2014, however, the website covering best practices, issue briefs, and expert perspectives remains as archived online content. The PPN evaluated programs and assigned evidence level categories according to evidence criteria including outcome(s) affected, effect size and statistical significance, type of comparison, adequate sample size, and reporting / documentation. PPN rates programs with evidence of positive effects as: a) proven; b) promising; or c) other for programs that did not undergo a full PPN review but evidence of their effectiveness has been established by one or more organizations that apply similar evidence rating.

**What Works Clearinghouse**

The What Works Clearinghouse (WWC) reviews the existing research on different programs, products, practices, and policies in education. The clearinghouse includes a searchable collection of individual studies reviewed by the WWC and WWC summaries of more than one study.("What Works Clearinghouse,")
Clearinghouse ratings across interventions and programs

Result First Clearinghouse provides an easy way to find information on the effectiveness of various interventions as rated by eight national research clearinghouses. (The Pew Charitable Trusts)
Table B-1. Child welfare interventions rated as “highest evidence” \((n = 37)\) by at least one of six clearinghouses.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Blueprints</th>
<th>CEBC</th>
<th>CEBP</th>
<th>CS.gov</th>
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Abbreviations

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<td>PPN</td>
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References


Chadwick Center and Chapin Hall. (2016). Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare: San Diego, CA & Chicago, IL: Collaborating at the Intersection of Research and Policy.


National Child Traumatic Stress Network.


Substance Abuse and Mental Health Services Administration (SAMHSA). National Registry of Evidence-Based Programs (NREPP). Retrieved from https://www.samhsa.gov/nrepp


Appendix C. North Carolina and South Carolina Data
North Carolina
Figure C-1. US vs. NC. vs. SC Entry Rate per 1,000 Children
Figure C-2. North Carolina Entries, Exits, Caseload

Figure C-3. North Carolina Entry Rate per 1,000 By Age

Calculated Using: ACS 1yr estimates
Figure C-4. North Carolina General Child Population and Foster Care Population by Race

Figure C-5. North Carolina Exit Types

Figure C-6. North Carolina Exits to Emancipation, Above and Below 12 at Time of Entry

Figure C-7. North Carolina most Recent Placement Type, Entered Under Age of 12
South Carolina
Figure C-8. South Carolina Entry, Exits, Caseload

Figure C-9. South Carolina Entry Rate per 1,000 by Age

Calculated Using: ACS 1yr estimates
Figure C-10. South Carolina General Population and Foster Care Population by Race

Figure C-11. South Carolina Exit Types

Figure C-12. South Carolina Exits to Emancipation

Figure C-13. South Carolina most Recent Placement Type, Entered Under Age of 12
