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INFORMATION MEMORANDUM

TO: State, Tribal and Territorial Agencies Administering or Supervising the Administration of Titles IV-B and IV-E of the Social Security Act, Indian Tribes and Indian Tribal Organizations

SUBJECT: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services

PURPOSE: To explain the Administration on Children, Youth and Families priority to promote social and emotional well-being for children and youth receiving child welfare services, and to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect.

LEGAL AND RELATED REFERENCES: Titles IV-B and IV-E of the Social Security Act; Child Abuse Prevention and Treatment Act; Child and Family Services Improvement and Innovation Act

INFORMATION:

I. Overview

The Administration on Children, Youth and Families (ACYF) is focused on promoting the social and emotional well-being of children and youth who have experienced maltreatment¹ and are receiving child welfare services. To focus on social and emotional well-being is to attend to children's behavioral, emotional and social functioning – those skills, capacities, and characteristics that enable young people to understand and navigate their world in healthy, positive ways. While it is important to consider the overall well-being of children who have experienced abuse and neglect, a focus on the social and emotional aspects of well-being can significantly improve outcomes for these children while they are receiving child welfare services and after their cases have closed. ACYF is organizing many of its activities around the promotion of meaningful and measurable changes in social and emotional well-being for children who have experienced maltreatment, trauma, and/or exposure to violence.

¹ The terms "abuse and neglect" and "maltreatment" are used synonymously in this Information Memorandum.

The child welfare system has made significant strides in recent years. Today, there are 27% fewer children in foster care than there were in 1998 (USDHHS, ACF, ACYF, 2002-2011). There are fewer children entering foster care and more exiting to permanency through reunification, adoption, and guardianship. The system's integration of knowledge about the importance of family connections and stable, nurturing relationships, as well as collaborative efforts among child welfare and other child-serving systems, made these advances possible.

However, there is a growing body of evidence indicating that while ensuring safety and achieving permanency are necessary to well-being, they are not sufficient. Research that has emerged in recent years has suggested that most of the adverse effects of maltreatment are concentrated in behavioral, social, and emotional domains. The problems that children develop in these areas have negative impacts that ripple across the lifespan, limiting children's chances to succeed in school, work, and relationships. Integrating these findings into policies, programs, and practices is the logical next step for child welfare systems to increase the sophistication of their approach to improving outcomes for children and their families.

There is also an emerging body of evidence for interventions that address the behavioral, social, and emotional impacts of maltreatment. By (a) anticipating the challenges that children will bring with them when they enter the child welfare system, (b) rethinking the structure of services delivered throughout the system, and (c) de-scaling practices that are not achieving desired results while concurrently scaling up evidence-based interventions, meaningful and measurable improvements in child-level and system-level outcomes are possible.

Increasing the focus on well-being is not a move away from the child welfare system's essential emphasis on safety and permanency; rather an integrated approach is needed. Policies, programs, and practices can improve children's social and emotional functioning while concurrently working towards goals of reunification, guardianship, or adoption. Addressing the social and emotional elements of functioning for children in foster care can even improve permanency outcomes. For example, a study of adoption recruitment services demonstrated that, in addition to intensive recruitment efforts, ensuring that children receive effective behavioral and mental health services is critical to facilitating a smoother transition to an adoptive home, and can decrease the chances of a disruption of an adoption (Vandivere, Allen, Malm, McKindon, & Zinn, 2011).

II. A Well-Being Framework

There are many frameworks for understanding well-being of children and youth. While these frameworks differ in minor ways, they generally identify similar domains and definitions of well-being. In an effort to understand what well-being looks like and how to support it for young people who have experienced maltreatment, ACYF has adapted a framework by Lou, Anthony, Stone, Vu, & Austin (2008). The framework identifies four basic domains of well being: (a) cognitive functioning, (b) physical health and development, (c) behavioral/emotional functioning, and (d) social functioning. Aspects of healthy functioning within each domain are expected to vary according to the age or developmental status of children or youth.² The

² Within each developmental category, refinement is possible; for example, for older youth, job readiness and independent living skills are markers of well-being during the transition to adulthood.

framework also takes into account contextual factors, both internal and external to children, that may influence well-being. These include environmental supports, such as family income and community organization, as well as personal characteristics, such as temperament, identity development, and genetic and neurobiological influences. ACYF's framework for well-being is presented in Appendix 1.

Within each domain, the characteristics of healthy functioning relate directly to how children and youth navigate their daily lives: how they engage in relationships, cope with challenges, and handle responsibilities. For example, self-esteem, emotional management and expression, motivation, and social competence are important aspects of well-being that are directly related to how young people move through the world and participate in society.

As was stated above, it is important to attend to the overall well-being of children and youth who have experienced maltreatment. By focusing on social and emotional well-being in particular, ACYF is not de-emphasizing other aspects of well-being. Rather, ACYF is prioritizing social and emotional well-being because: (a) the challenges that children face in these domains are great, (b) there are resources and policies that can be leveraged to improve child functioning in these areas, (c) effective practices and programs for promoting social and emotional well-being are available, and (d) outcomes for children and child welfare systems can significantly improve with an emphasis on social and emotional well-being.

III. Emerging Evidence on the Impact of Maltreatment

Researchers have extensively documented the impacts of abuse and neglect on the short- and long-term health and well-being of children. Emerging evidence demonstrates that these biological and psychological effects are concentrated in behavioral, social, and emotional domains. These effects can keep children from developing the skills and capacities they need to be successful in the classroom, in the workplace, in their communities, and in interpersonal relationships. As a result, this can hinder children's development into healthy, caring, and productive adults and keep them from reaching their full potential. The following points describe some of the impacts of abuse and neglect on children's behavioral, social, and emotional functioning. These findings argue that many of the children involved with child welfare have a set of complex challenges; these challenges may not be addressed by the system and services as they are currently designed. Integrating these recent findings into the design of systems and services will enhance child welfare's ability to improve outcomes for these children and their families.

- **Neurological Impact:** Early childhood is a time of rapid and foundational growth. During this time, the neurological development taking place is building the architecture for the skills and capacities that children will rely on throughout life (National Research Council and Institute of Medicine, 2000).

Neglect and abuse have distinct effects on the developing brain. During early childhood, neurons are created, organized, connected, and pruned to form the complex workings of the brain. These actions depend, in large part, on the environment in which a young child grows. Neglect (physical, emotional, social, or cognitive) hinders these neurological activities such that the brain does not develop along a normal healthy trajectory towards its full potential.

This negatively impacts a young person's capacity for optimal social and emotional functioning (Perry, 2002).

Abuse has a different, though still harmful impact on neurobiology. Experiences of mild or moderate stress in the context of a secure caregiving environment, such as being temporarily separated from a reliable caregiver or frustrated by the inability to complete a task, support children's development of adaptive coping. Chronic or extreme stress, however, such as maltreatment, has a different result. Children who experience abuse or neglect have abnormally high levels of cortisol, a hormone associated with the stress response, even after they are removed from maltreating caregivers and placed in safe circumstances. Such continuously high cortisol levels adversely affect stress responsiveness, emotion, and memory (National Scientific Council on the Developing Child, 2005). Studies have also shown that heightened stress impairs the development of the prefrontal cortex, the brain region that is critical for the emergence of abilities that are essential to "autonomous functioning and engagement in relationships" (Cook, Blaustein, Spinazzola, & van der Kolk, 2003, p.11). These "executive functions" include planning, focusing, self-regulation, and decision-making. Executive functions are necessary to successfully managing school, work, and healthy relationships.

- **Traumatic Impact:** Traumatic events can elicit mental and physical reactions in children, including hyperarousal and dissociation. If these acute "states" are not treated after children experience trauma, they can become chronic, maladaptive "traits" that characterize how children react in everyday, nonthreatening situations (Perry, 1995).

Maltreatment is distinct from other types of trauma because it is interpersonal in nature. A caregiver who is supposed to be a secure base—the source of attachment, safety, and security—is also the source of hurt and harm. This creates a confused and ineffective attachment and serves as the model for other significant attachments (Bloom, 1999). Often referred to as "chronic interpersonal trauma" or "complex trauma," maltreatment's impact spans multiple domains, and its severity is further complicated depending on a child's developmental stage. Chronic interpersonal trauma can result in difficulties regulating emotional responses, accurately interpreting the cues and communications of others, managing intense moods (particularly rage and anxiety), regulating arousal states (resulting in dissociation), and accurately forming perceptions of self and others (Terr, 1991). Among children entering foster care in one State, a comprehensive assessment revealed that one in four exhibited trauma symptoms necessitating treatment, including traumatic grief/separation, adjustment reactions, avoidance, re-experiencing, numbing, and dissociation (Griffin, Kisiel, McClelland, Stolback, & Holzberg, 2012).

- **Behavioral Impact:** Whether or not children enter foster care, the prevalence of behavior problems rising to a clinical level³ is high among children who have experienced maltreatment. The National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal study of children who were the subject of child protective services reports, provides data to demonstrate this: twenty-two percent of children who remain in their homes

³ "Rising to the clinical level" describes problems that have been assessed to be severe enough to warrant clinical behavioral health services.

after a report of abuse or neglect have clinical-level behavior problems—the same rate as children who are removed and living with kin. Rates rise to 32% for children living in foster homes and nearly 50% for children in group homes or residential care (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a).

- **Relational Competence:** Maltreatment also affects the way in which children and youth engage in social interactions and participate in relationships. NSCAW findings indicate that children who are the subject of child protective services reports are twice as likely as children in the general population to have significant challenges in the area of social competence (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a). The effects of maltreatment can influence relationships across a person's lifetime, impacting the ability to form a new attachment to a primary caregiver, make friends, and engage in romantic or marital partnerships (Mikulincer & Shaver, 2007).
- **Mental Health:** Studies have demonstrated that rates of mental illness are high among children who have experienced maltreatment and have been in foster care. Posttraumatic Stress Disorder (PTSD), Attention Deficit/Hyperactivity Disorder (ADHD), Major Depressive Disorder (MDD), and Conduct Disorder (CD)/Oppositional Defiant Disorder (ODD) are the most common mental health diagnoses among this population. As McMillan, et al. (2005) demonstrated, many children meet diagnostic criteria for these disorders *before* entering foster care, indicating that it is frequently the experience of maltreatment rather than participation in foster care that predicates mental health problems. By the time they are teenagers, 63% of children in foster care have at least one mental health diagnosis; 23% have three or more diagnoses (White, Havalchack, Jackson, O'Brien, & Pecora, 2007).⁴
- **Psychotropics:** According to a 2010 study of Medicaid-enrolled children in thirteen States, children in foster care, who represent only three percent of those covered by Medicaid, were prescribed antipsychotic medications at nearly nine times the rate of children enrolled in Medicaid who were not in foster care (**MMDLN/Rutgers CERTs, 2010**). Over three years, 22% of children in foster care will have taken a psychotropic drug at some point (Leslie, Raghavan, Zhang, & Aarons, 2010). Data from NSCAW show that rates of psychotropic medication use are comparable for children receiving in-home child welfare services (10.9%), children in kinship care (11.8%), and children in foster care (13.6%) (Casaneuva, Ringeisen, Wilson, Smith, & Dolan, 2011a). Although numerous studies have demonstrated that rates of psychotropic medication prescription are comparatively high, these rates, at least in part, reflect increased levels of emotional and behavioral distress necessitating treatment among this group. More information about the use of psychotropic medications among children in foster care can be found in a related IM issued by the Children's Bureau, ACYF-CB-IM-12-03.

These scientific findings clearly demonstrate the profound impact that maltreatment has on social and emotional well-being. As such, focusing on ensuring safety and permanency alone for children who have experienced abuse or neglect is unlikely to resolve these complex biological

⁴ It is important to note that there is significant overlap between mental health and trauma symptoms, and that symptoms of trauma are often mistaken for mental health symptoms (Griffin, Kisiel, McClelland, Stolback, & Holzberg, 2012).

and psychosocial issues. For this reason, child welfare policies, programs, and practices should give greater consideration to explicit efforts to reduce young people's impairment and improve their functioning.

IV. Requirements and Policy Opportunities

Titles IV-B and IV-E of the Social Security Act and the Child Abuse Prevention and Treatment Act (CAPTA) have historically included provisions that promote the well-being of children. Title IV-B programs are intended to enhance the safety, permanence, and well-being of children who are in foster care or are being served in their own homes. The title IV-E foster care program includes requirements to address a child's well-being, such as in the areas of health and education. CAPTA provides funding for prevention, assessment, and treatment programs to increase the well-being and safety of children who have been abused or neglected. Some policy requirements and opportunities in existing policies related to social and emotional well-being are listed below:

- **State Plan for Child Welfare Services (Section 422 of the Social Security Act)** Section 422(b)(15) requires child welfare agencies to develop, in coordination and collaboration with the State title XIX (Medicaid) agency and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services, including mental health services, for any child in a foster care placement.
 - **Mental Health Services:** These health care oversight plans must include a description of how States will provide necessary mental health services to children in foster care. Additionally, States may address the mental health of children who have experienced maltreatment according to provisions elsewhere in statute. For instance, time-limited family reunification services under *Promoting Safe and Stable Families* explicitly include mental health services (431(a)(7)(B)(iii) of the Social Security Act).
 - **Early and Periodic Diagnosis, Screening, and Assessment (EPSDT):** Many States incorporate EPSDT, a standard Medicaid benefit for children and youth, into their health care plans. EPSDT ensures that children get appropriate medical, vision, hearing, and dental check-ups to identify and treat any problems as soon as possible. EPSDT also includes mental health assessments and services. Because they are categorically eligible for Medicaid, all children in foster care who are eligible for title IV-E reimbursement are entitled to EPSDT.
 - **Trauma Screening and Treatment:** 2011's *Child and Family Services Improvement and Innovation Act* requires States to include in their health care oversight plans a description of how they will screen for and treat emotional trauma associated with maltreatment and removal for children in foster care (section 422(b)(14)(A)(ii) of the Social Security Act). Identifying the trauma-related symptoms displayed by children and youth when they enter care is critical for the development of a treatment plan. It is also important to have a complete trauma history for each child. Although children come to the attention of the child welfare system as a result of a specific allegation of maltreatment, abuse and neglect are chronic in nature. Child welfare workers should

have an understanding of the multiple types and incidences of trauma children have experienced, beyond just the event that precipitated child welfare involvement. Conducting comprehensive functional assessments according to a standardized schedule (e.g., every six months, or every time a child moves to a more restrictive placement setting) can help caseworkers and administrators gauge whether or not treatment strategies are working to decrease children's symptoms. States could consider integrating trauma screening into the regular screening activities taking place under EPSDT in order to meet the new requirement.

- **Psychotropic Medication Oversight and Monitoring:** The *Child and Family Services Improvement and Innovation Act* also requires States to submit as part of the health care oversight plans a description of the protocols in place or planned to oversee and monitor the use of psychotropic medications among children in foster care (section 422(b)(14)(A)(v) of the Social Security Act). ACYF, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS), is currently providing technical assistance to States to support the development of their plans. The recent IM, ACYF-CB-IM-12-06, describes strategies for strengthening systems of oversight and monitoring of psychotropic medications.

Because use of psychotropic medication with children has not been as extensively tested as use with adults, and because these drugs can have complicated side effects, they should be prescribed with care. When they are prescribed, their use should be justified by clinical evidence identified in EPSDT, trauma screenings, and children's treatment plans. As States develop their plans for prescription psychotropic medication management, there is also work to be done to identify effective psychosocial interventions that can improve behavioral and mental health outcomes of children receiving child welfare services.

- **Child Abuse Prevention and Treatment Act (CAPTA) State Grants:** In order to receive CAPTA funds, States are required to submit a plan that describes how they will support and enhance interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs to improve the health outcomes, including mental health outcomes, of children identified as victims of child abuse or neglect. This includes supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports.
- **Early Intervention:** States receiving CAPTA funds are required to refer children under the age of three with a substantiated case of maltreatment to early intervention services funded under Part C of the Individuals with Disabilities Education Act (§106(b)(2)(B)(xxi)). Children with substantiated cases of maltreatment are assured timely, comprehensive, and multidisciplinary screenings, and, if a developmental disability is identified, they are entitled to ongoing early intervention services. In many States, child-serving systems have worked in collaboration to support early intervention referrals, evaluations, and services for children who have experienced abuse or neglect (Child Welfare Information Gateway, 2007).

Maltreatment impacts how young people form relationships with others throughout their lives. For many maltreated children, nurturing and supportive parental behavior was inconsistent or unavailable, leaving children lacking confidence to explore new environments and relationships (Bretherton, 2000; Sorce & Emde, 1981). States should consider how these policies might best be linked and carried out to support healing and recovery and promote healthy functioning of children and youth.

Other Federal child welfare policies also address elements of well-being, including policies related to kinship care, family connections, sibling placements, monthly parent visits, placement stability, and school stability. When implemented in a purposeful way, these policies all contribute to improving social and emotional well-being, repairing ruptured relationships, and enhancing relational skills.

V. Current State and County Investments

Currently, state and county child welfare systems are investing significant funds in providing services intended to improve well-being outcomes for children and their families. Three of the most common services purchased by states and counties are counseling, parenting classes, and life skills training. However, a number of studies suggest that some of these services are not grounded in the best available evidence and may be provided to children without sufficient attention to their specific maltreatment and trauma histories.

In a study of children receiving mental health services, McCrae, Guo, and Barth (2010) found that children who got typical mental health services had more behavioral problems over time than those who received none. “The study should not be understood to indicate that all [mental health services] for children involved with [child welfare services] are ineffective; rather, it indicates that children [in child welfare] do not predictably receive services that are sufficient to help them overcome their behavioral difficulties” (p.358).

Another study examined interventions to improve caregivers’ parenting skills and found “that most of the parent focused interventions currently delivered to families in child welfare and most foster family training do not use treatment strategies with solid empirical support” (Horwitz, Chamberlain, Landsverk, Mullican, 2010, p.28).

Child welfare systems also work to provide youth who are exiting foster care to emancipation with the skills and resources they will need to function as adults. Often this takes the form of programs that teach basic life skills, budgeting and financial management, and health and nutrition. In an evaluation of outcomes for youth in foster care participating in four youth development programs around the country, researchers determined that the life skills training programs studied resulted in no statistically significant improvement on any of the key outcomes measured (Koball, et al., 2011).⁵

⁵ These outcomes included: High school completion, current employment, earnings, net worth, economic hardship, receipt of financial assistance, residential instability, homelessness, delinquency, pregnancy, possession of personal documents, any bank account, and sense of preparedness in 18 areas of adult living.

VI. Screening and Functional Assessment

Functional assessment is a central component of promoting social and emotional well-being for children who have experienced abuse or neglect. Traditionally, child welfare systems use assessment as a point-in-time diagnostic activity to determine if a child has a particular set of symptoms or requires a specific intervention. Functional assessment, however, provides a more holistic evaluation of children's well-being and can also be used to measure improvement in skill and competencies that contribute to well-being. Functional assessment—assessment of multiple aspects of a child's social-emotional functioning (Bracken, Keith, & Walker, 1998)—involves sets of measures that account for the major domains of well-being. Rather than using a “one size fits all” assessment for children and youth in foster care, systems serving children receiving child welfare services should have an array of assessment tools available. This allows systems to appropriately evaluate functioning across the domains of social-emotional well-being for children across age groups (O'Brien, 2011). They capture children's strengths, including skills and capacities, as well as potential difficulties (Humphrey, et al., 2011; Roeser, Strobel, & Quihuis, (2002) in a developmentally-appropriate manner, accounting for the trauma- and mental health-related challenges faced by children and youth who have experienced abuse or neglect. Similarly, some assessment tools can be used to measure parenting capacities and improvements over time.

Screening for symptoms related to trauma, specifically how experiences of trauma may impair healthy functioning, is an essential element of functional assessment. Trauma screening involves universal administration of a brief tool(s) to: (1) estimate the prevalence of trauma symptoms and/or traumatic experiences and (2) identify children who may require further assessment and intervention. Examples of trauma screening tools include the Child and Adolescent Needs and Strengths (CANS) Trauma Version, the Childhood Trauma Questionnaire (CTQ), and the Pediatric Emotional Distress Scale (PEDS).

Functional assessment tools can be used to inform decisions about the appropriateness of services. They can be useful tools, for example, for informing the design of outcomes-oriented case plans (Wotring, Hodges, & Xue, 2005). Functional assessments can also track progress toward social-emotional well-being outcomes. Several valid and reliable tools used to measure domains of social-emotional functioning with children and adolescents have been tested and normed with representative samples of children from the general population.⁶ Data from these assessments allow States and programs to measure a child's level of functioning and monitor how it compares with general populations of the same age group. In other words, assessment helps systems to determine not only whether a child meets the threshold for a particular concern but also how the child fares relative to the expected developmental trajectory for child functioning. This allows States and programs to better understand whether interventions are moving each child back on track developmentally within the well-being domains.

Additionally, the universal administration of these types of functional assessment tools to all children in a system at entry and at key follow-up periods can help systems track changes in children's social-emotional functioning compared to their own baseline during and after the

⁶ Examples include the Strengths and Difficulties Questionnaire (SDQ), the Child Behavior Checklist (CBCL), the Social Skills Rating Scale (SSRS), and the Emotional Quotient Inventory Youth Version (EQ-i:YV).

delivery of services. This allows systems to generate data that help them understand whether their services are making a positive difference for children and youth. Continuously monitoring progress using these functional assessment tools also helps decision-makers reassess the appropriateness of the service array over time for individual children. Broader analyses of the aggregate data from assessments can help decision-makers at the program and systems levels to identify the best and most effective practices for all children in the target population and for particular subgroups (Wotring, Hodges, & Xue, 2005).

VII. Effective Interventions

Recent research has expanded the knowledge base regarding interventions that treat the behavioral, social, and emotional problems that are common among children who have experienced maltreatment. While generic counseling is not consistently effective in reducing mental health symptoms for children in foster care, several evidence-based treatments have been successful when delivered with fidelity to the model; the same is true for parenting interventions and programs for youth. Many of these interventions have been rigorously tested and shown to reliably improve child functioning by targeting the impact of maltreatment and developing skills and competencies that help children navigate their daily lives. The emergence of promising and effective interventions at multiple levels – at the child level related to trauma and behavioral/mental health; at the older youth level related to relational health and social and emotional –well-being; and at the caregiver level related to increasing capacity to care for their children – provides an opportunity to impact the life circumstances of families as a whole.

Child welfare and mental health systems can develop the capacity to install, implement, and sustain these evidence-based and evidence-informed interventions by using research to identify effective and promising interventions that meet the needs of the specific population to be served; making needed adaptations to bring the interventions to scale within the child welfare system, developing an awareness of principles of evidence-based practices among staff at all levels; and reorganizing infrastructure to support implementation fidelity and further evaluations of these practices and interventions.

Evidence-based and evidence-informed practices have been developed to address the most common mental health diagnoses, trauma symptoms, and behavioral health needs of children and show measurable improvements or promising results.⁷ These interventions show measurable improvements or promising results in decreasing emotional/behavioral symptoms; diminishing depression, anxiety; increasing the ability to self-regulate; improving physical health; and helping traumatized children and youth form and maintain healthy attachments. There are also evidence-based and evidence informed interventions geared toward improving outcomes related to youth skill development, education, and employment. (Job Corps and Big Brothers/Big Sisters are examples.) Many of these practices are available but have not been brought to scale or targeted to the foster care population even though they have been shown to improve functioning. Others have shown promising results, and should be evaluated more broadly as they are implemented more widely.

⁷ Evidence-based and evidence-informed practices such as Trauma-focused Cognitive Behavioral Therapy, Multisystemic Therapy, and Parent-Child Interaction Therapy are examples. There are also evidence-based and evidence informed interventions geared toward improving outcomes related to youth skill development, education, and employment; Job Corps and Big Brothers/Big Sisters are examples.

It is important to note that many of the evidence-based interventions that improve child functioning require the involvement of caregivers and specifically target their behaviors for change as well. Caregivers need support in managing the behaviors of children who have experienced maltreatment and in providing a nurturing environment in which healing can occur. In such supportive contexts, children can learn “the value, purpose and safety of relationships” (Rees, 2010). In order to achieve better outcomes for children who have experienced maltreatment, it is essential to engage families, whether biological, foster, or adoptive, in the process of healing and recovery.

VIII. Maximizing Resources to Achieve Better Results

By leveraging current policies and requirements and shifting existing resources to promote social and emotional well-being, child welfare systems can begin to align policies, practices, and programs to achieve significantly better results, both for individual children and for the system as a whole.

- **Better Child and Family Outcomes:** Focusing on social and emotional well-being means attending to the specific skills, capacities, and characteristics that children and youth need to develop while they are young in order to be autonomous, healthy adults. Although the impact of maltreatment is pernicious, the experience of abuse and neglect does not guarantee that children will develop the behavioral, psychological, and social-emotional problems listed above. Neither does it mean that children with behavioral concerns, trauma symptoms, and/or mental health disorders cannot heal and recover and become happy, successful adults. By integrating evidence-based and evidence-informed services and supports to promote social and emotional well-being, child welfare systems can help children develop healthy coping mechanisms, relational skills, and the other capacities that they need to succeed in school, to participate in the workforce and their communities, to care for their own children, and to have positive relationships with others.
- **Better System Outcomes:** With services and supports to promote children’s social and emotional well-being, system-level outcomes, such as length of stay, congregate care placements, exits to permanency, and reentries, can be expected to improve as well. Children may spend less time in foster care before exiting to reunification, adoption, or guardianship, and reentries into foster care may become less common. While children and youth are certainly not to blame when they do not exit to permanency quickly or when they reenter foster care, children’s behavioral problems, when unaddressed, often contribute to placement changes, adoption disruptions, and returns to foster care.

IX. Focusing on Social and Emotional Well-Being

Focusing the work of a child welfare system on well-being, particularly social and emotional well-being, requires a concerted effort on behalf of all staff and stakeholders, from directors, to managers, to supervisors, to caseworkers, to foster parents. It entails (a) understanding the challenges that children who have experienced maltreatment bring with them when they come to the attention of the child welfare system, (b) considering how services are structured and delivered at each point along children’s trajectory through the child welfare system, and (c) de-scaling practices that are not improving outcomes while simultaneously installing and scaling up

effective approaches. ACYF recognizes that it is not simple to transform a system in this way and that these processes take time. As the logical next step in reforming the child welfare system, it requires the careful development of capacity to integrate new research and implement new practices without compromising ongoing efforts to achieve safety and permanency for children who have experienced maltreatment.

Understanding Impact of Maltreatment and Anticipating Challenges: As discussed above, maltreatment leaves a particular traumatic fingerprint on the development and functioning of children and youth. Often the behavioral, social-emotional, and mental health problems that children in foster care have are assumed to be the result of their experience with the child welfare system. McMillan, et al. (2005) and Griffin, Kisiel, McClelland, Stolback, & Holzberg (2012) have shown that children and youth frequently display these challenges before they enter foster care.⁸ An understanding of the impact maltreatment has had on children when they come to the attention of the child welfare system allows providers to be more proactive, knowing what to look for and anticipating the services that may be needed. This capacity is necessary at the caseworker-level, but also at the level of administrators who are making decisions about the array of services needed internally or through contracts.

Responding and Intervening along the Child Welfare Continuum: Focusing child welfare on improving social and emotional well-being requires careful consideration of how services are structured and delivered throughout the system. For example, a child welfare system with a focus on social and emotional well-being might be characterized by the following:

- Assessment tools used with children receiving child welfare services are reviewed to ensure that they are valid, reliable, and sensitive enough to distinguish trauma and mental health symptoms.
- Children are screened for trauma when their cases are opened.
- In-home caregivers receive services that have been demonstrated to improve parenting capacities and children's social-emotional functioning.
- Child welfare staff and foster parents receive ongoing training on issues related to trauma and mental health challenges that are common among the children and youth being served by the system.
- Assessments take place at regular or scheduled intervals to determine whether services being delivered to children and youth are improving social and emotional functioning.
- Independent living and transitional living programs implement programs to support youth's development of self-regulation and positive relational skills.

De-Scaling and Scaling Up: When child welfare systems make changes, new programs and practices are often added onto the already existing array of services. Ongoing contracts and the need to provide continuous services make it difficult to discontinue or downsize programs that are not improving outcomes for children and youth. Transforming the array of services, rather than simply augmenting it, requires "de-scaling" programs that are not reliably enhancing child functioning by divesting funds and simultaneously shifting resources to support proven practices.

⁸ This is not to say that foster care is never detrimental to the well-being of children and youth. However, the fact that children display problems before they come to the attention of the child welfare system indicates that the experience of maltreatment often predicates their difficulties.

