July 20, 2018

Naomi Goldstein
Deputy Assistant Secretary for Planning, Research, and Evaluation
U.S. Department of Health and Human Services
Administration for Children and Families
330 C Street SW
Washington, DC 20024

**RE: Decisions Related to the Development of a Clearinghouse of Evidence-Based Practices in Accordance with the Family First Prevention Services Act of 2018**

**Submitted via email to ffclearinghouse@acf.hhs.gov.**

Dear Dr. Goldstein,

Child Trends is a highly respected, nonpartisan research organization focused on improving the lives and prospects of children, youth, and their families. For nearly 40 years, decision makers have relied on our rigorous research, unbiased analyses, and clear communications to improve public policies and interventions that serve children and families.

Children and families involved in the child welfare system have a complex set of needs. For example, many children have been victims of abuse and neglect, witnessed violence in their homes and communities, lived in resource-deficient and dangerous neighborhoods, and/or experienced housing instability. The detrimental impact of adverse experiences on children's development is often compounded by the additional trauma they experience when removed from their homes, as well as the placement instability they experience while in foster care. Given these issues, it is paramount that these children and their families receive comprehensive evidence-based services that help families remain intact and provide children with the resources they need to develop into healthy adults.

As an institution dedicated to promoting research-based, data-driven solutions to the challenges facing children, we are grateful for this opportunity to weigh in on the development of a clearinghouse of evidence-based practices, in accordance with the Family First Prevention Services Act of 2018. We noted the questions raised in the request for comments and have organized our recommendations accordingly.

## 2.2.1 Types of Programs and Services

**HHS should include interventions with demonstrated impact on known risk and protective factors associated with child maltreatment.** A large body of research indicates that there is no single cause of child maltreatment;[1, 2, 3] rather, constellations of various risk and protective factors can increase (or reduce) risk for child maltreatment. These risk and protective factors are found across multiple developmental contexts or "ecologies," such as within the community (e.g., access to mental health and substance abuse services, community violence, high unemployment rates, poor neighborhood support and cohesion), within the family (e.g., parent-child relationships, economic stress, social isolation, domestic violence, parent substance use, parent mental health, prior Child Protective Services referrals), and at the individual level (e.g., child/adolescent mental and behavioral health). Although there is a deep body of research on the etiology of child maltreatment, there are, comparatively, far fewer studies that have examined the impact of interventions to prevent children's entry into the child welfare system. As such, we recommend that HHS include in the clearinghouse a comprehensive array of interventions with demonstrated impact on the known risk and protective factors associated with child maltreatment, rather than maintain an exclusive focus on preventing entry into the child welfare system.

**HHS should expand the definition of "mental health and substance use prevention and treatment services" to include parent-based interventions that improve children's mental and behavioral health.** There is a body of research indicating that parent-based interventions are effective in treating child/youth mental health, problem behavior, and substance use, as well as reducing abusive parenting. For example, research has demonstrated that cognitive behavioral therapies paired with parent training interventions are more effective at reducing mental health problems in youth than cognitive behavioral therapy alone. Similarly, a recent meta-analysis investigating the effectiveness of child maltreatment prevention programs found that programs focused on improving parenting skills were more effective (had larger effect sizes) at preventing child maltreatment than programs without a focus on parenting skills. Finally, the efficacy of parent training interventions has been found to generalize across white, Hispanic, and black racial/ethnic groups.

## 2.2.2 and 2.4.2 Target Populations/Samples of Interest

**Given the diversity of children and families involved in the child welfare system, HHS should have a broad definition of children and families "similar" to definitions used in the child welfare system, focusing on populations with risk factors known to be associated with entry into the child welfare system.** As described under our response to 2.2.1, there is no single cause of child maltreatment. Families become involved in the child welfare system for a variety of reasons (e.g.,

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[1] English, D.J., Thompson, R., & White, C.R. (2015). Predicting risk of entry into foster care from early childhood experiences: A survival analysis using LONGSCAN data. *Child Abuse and Neglect, 45*, 57–67.
[2] Wilkins, N., Tsao, B., Hertz, M., Davis, R., & Klevens, J. (2014). *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; and Oakland, CA: Prevention Institute.
[3] Moore, K.A., Stratford, B., Caal, S., Hanson, C., Hickman et al. (2015). *Preventing Violence: Understanding and Addressing Determinants of Violence in the United States.* Bethesda, MD: Child Trends.

substance use, mental health, parent-child conflict, housing, abuse and neglect, parent incarceration). Thus, to capture the diversity of children and families involved in the child welfare system, we recommend that HHS define "similar" children and families broadly, prioritizing studies with samples of participants who experience multiple risk factors associated with child maltreatment/entry into the child welfare system (e.g., mental health problems, substance abuse issues, behavioral health or conduct problems, trauma/violence exposure, poverty, housing instability).

**Given the high prevalence of dual-system-involved (child welfare and juvenile justice systems) youth, HHS should also prioritize studies with, and programs and services used to target, children and families involved in the juvenile justice system.** Depending on how broadly dual-system involvement is defined, estimates of the proportion of dual-system youth in the juvenile justice system hover around 50 percent, suggesting significant overlap between the populations served by the juvenile justice and child welfare systems.[4] Moreover, youth in the juvenile justice system present many of the same needs as older youth in the child welfare system. For example, over half of youth who are incarcerated have mental health problems, more than two-thirds have substance abuse problems, and around half were enrolled in a grade level below the modal grade level for their age.[5] Furthermore, research has found that up to 90 percent of juvenile justice system-involved youth are exposed to at least one traumatic event[6] and, for most justice-involved youth, the age of onset of trauma exposure was within the first five years of life.[7]

**HHS should prioritize studies with, and programs and services used to target, populations of children and families that are overrepresented in the child welfare system (e.g., American Indian/Alaska Native, black, and Hispanic youth; and LGBTQ youth).** Research has demonstrated that youth of color[8] and LGBTQ youth[9] are overrepresented in the child welfare system. Understanding culture is crucial to any intervention that would prevent children's entry into foster care.[10] Unfortunately, however, children and families of color and LGBTQ youth have often been overlooked in evidence-based program development.[11] Thus, HHS should prioritize studies that include these populations of children, youth, and families in their samples.

The California Evidence-Based Clearinghouse for Child Welfare has a child welfare system relevance level, which might be useful to inform HHS' inclusion of studies based on samples of

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[4] Thomas, D. (Ed.). (2015). *When Systems Collaborate: How Three Jurisdictions Improved Their Handling of Dual-Status Cases.* Pittsburgh, PA: National Center for Juvenile Justice.
[5] Sedlak, A.J. & McPherson, K. (2010). *Survey of Youth in Residential Placement: Youth's Needs and Services*. SYRP Report. Rockville, MD: Westat
[6] Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., et al. (2004) Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry*, *61*, 403–410.
[7] Dierkhising, C.B., Jo, S.J., Woods-Jaeger, B., Briggs, E.C., Lee, R., et al. (2013). Trauma histories among justice-involved youth: Findings from the National Traumatic Stress Network. *European Journal of Psychotraumatology*, *4*, 1–12.
[8] Child Welfare Information Gateway. (2016). Racial disproportionality and disparity in child welfare. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
[9] Child Welfare Information Gateway. (2013). *Supporting your LGBTQ youth: A guide for foster parents.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
[10] Nadan, Y., Spilsbury, J. C., & Korbin, J. E. (2015). Culture and context in understanding child maltreatment: Contributions of intersectionality and neighborhood-based research. *Child abuse & neglect, 41*, 40–48.
[11] Annie E. Casey Foundation. (2017). *Considering Culture: Building the Best Evidence-Based Practices for Children of Color*. Baltimore, MD: The Annie E. Casey Foundation.

children and families not currently involved in the child welfare system.

## 2.2.3 and 2.3.2 Target Outcomes

**Child permanency and placement stability should be considered as target outcomes.** Given the strong evidence base highlighting the detrimental impact of placement instability (should children be placed in foster care) and re-entry into foster care, placement stability, permanency (i.e., reunification, adoption, and permanent guardianship), and re-entry into the child welfare system should be considered for inclusion as a target outcome.

**Child/youth safety should be considered as a target outcome.** Both child abuse and neglect should be included as outcomes of interest. Studies that include multiple indicators and multiple sources for measuring child maltreatment or similar parenting behaviors (using parent report, child report, and official records) should be prioritized for review because there is often low agreement between different reporters. Furthermore, child safety should be measured by new referrals to Child Protective Services (CPS) regardless of case determination, as CPS referrals (regardless of substantiation) have been linked to negative outcomes (risk of future maltreatment, poor academic performance, juvenile delinquency, risky sexual behavior, substance use, and other risky behavior).

**Child well-being should be broadly defined and considered as a target outcome**. HHS should build on progress made to ensure that safety, permanency, and well-being remain key goals for our child welfare system. When defining child well-being, HHS should take a "whole-child" approach, focusing on each domain of well-being known to impact long-term outcomes (i.e., cognitive/academic development, social development, emotional/psychological development), as well as the protective and risk factors that influence development in these domains. For example, positive relationships between youth and their parents, peers, and other pro-social adults in the community have consistently been linked to positive developmental outcomes for youth.

**Reduction of risky/delinquent behavior should be considered as a target outcome.** Youth behavior (e.g., delinquency, substance use) is a significant predictor of older youths' entrance into the child welfare system. Additionally, given the high potential for relapse among individuals with substance use/abuse problems, studies that assess substance use for one year or longer after the end of services should be prioritized for review.

**Parent well-being should be considered as a target outcome**. Parental mental health, substance abuse, stress, and social isolation have all been linked to child maltreatment. Furthermore, housing stability and parents' educational attainment and employment status also aid their ability to care for their children, and should be considered for inclusion.

**Parenting skills, parent-child interactions, and/or parent-child relationships should be considered as target outcomes.** A broad body of research highlights the importance of parenting practices. Parent-child relationships are linked not only to child maltreatment, but also to children's cognitive development, educational outcomes, and behavioral health, including youth substance use and delinquency. Given the importance of parenting skills and parent-child relationships in predicting maltreatment and child outcomes, it is imperative to consider these outcomes as proxies for child safety and well-being.

**Access to and use of support systems should be considered as a target outcome.** Access to mental health and substance abuse services, access to housing, and coordination of resources and services among community agencies are protective factors for preventing child

maltreatment/children's entry into the child welfare system.[12, 13] Furthermore, research from the juvenile justice field indicates that matching youth to services that address their needs results in substantial reductions in youth recidivism.[14]

For the many children and youth placed with relatives, Kinship Navigator programs connect their relative caregivers to the services these relatives and children need to prevent children's entry into foster care. Improving access to services is aligned with Kinship Navigator programs' logic models and theories of change, and is therefore an appropriate and reasonable outcome for determining the impacts of Kinship Navigator programs. **As such, HHS should include access to services as a key metric of impact for Kinship Navigator programs.**

## 2.2.7. Trauma-Informed

**Given that the evidence base on trauma-informed care is still emerging, it will be difficult to prioritize trauma-informed programs in this review. As such, we recommend highlighting trauma-informed programs in the clearinghouse, rather than prioritizing trauma-informed studies for review.** Over the past two decades, we have witnessed a proliferation of programs and services that target children and youth who have experienced traumatic events. Evaluations of trauma-informed programs for children involved in the child welfare system have yielded promising results.[15, 16, 17] However, the evidence base in this field is still developing and the field has yet to reach consensus on the definition of trauma-informed care.[18] Furthermore, given that this field is still new, it is likely that some programs developed before the term "trauma-informed care" became popular are nevertheless responding effectively to children's trauma without labeling their approach in such a way.

## 2.2.8 Delivery Setting for In-Home Parent Skills-Based Programs and Services

**HHS should be inclusive of interventions delivered in community settings, as well as in-home services.** Given the diverse needs of children and families and the multiple risk and protective factors associated with the risk of child maltreatment/entry into care, comprehensive service delivery must include community-based prevention programs, beyond individualistic approaches. It would be ill-advised for HHS to limit the pool of programs and services to in-home settings at

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[12] Wilkins, N., Tsao, B., Hertz, M., Davis, R., & Klevens, J. (2014). *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; and Oakland, CA: Prevention Institute.

[13] Cunningham, M., Pergamit, M., Baum, A., & Lina, J. (2015). *Helping Families Involved in the Child Welfare System Achieve Housing Stability: Implementation of the Family Unification Program in Eight States*. Washington, DC: Urban Institute.

[14] Baglivio, M., Wolff, K., Howell, C., Jackowski, K., & Greenwald, Mark. (2018). The search for the holy grail: Criminogenic needs matching, intervention dosage, and subsequent recidivism among serious juvenile offenders in residential placement. *Journal of Criminal Justice*, 55(3), 46–57.

[15] Barto, B., Bartlett, J. D., Bodian, R., Noroña, C. R., Spinazzola, J., et al. (2018). The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. *Child Abuse & Neglect*, 81, 149–160.

[16] Bartlett, J. D. & Rushovich, B. (2018). Findings on the Implementation of Trauma Systems Therapy Foster Care (TST-FC) in Child Welfare. *Children and Youth Services Review*, 91, 30–38.

[17] Murphy, K., Moore, K. A., Redd, Z., & Malm, K. (2017). Trauma-informed child welfare Systems and children's well-being: A longitudinal evaluation of KVC's Bridging the Way Home Initiative. *Children and Youth Services Review*, 75, 23–34.

[18] Hanson, R. F. & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment*, *21*(2), 95–100.

the expense of community programs delivered by trained and qualified staff.

## 2.3.1 Impact Study

**In addition to studies that appear in peer-reviewed journals and those funded by federal agencies, HHS should conduct a thorough review of "gray literature" and rate studies based on their scientific merit, rather than on their publisher.** HHS should consider studies conducted by universities, research organizations, and policy centers, as well as those funded by foundations. In addition, **HHS should broadly define government studies to include all levels of government, including state, county, and tribal.**

## 2.3.3 Eligibility of Studies Conducted with Samples Outside U.S., U.K., Canada, New Zealand, and Australia

**Given that much of the research on medically assisted substance abuse treatment is occurring in European countries such as Germany,[19, 20] HHS' restriction to samples in the U.S., Canada, U.K., New Zealand, and Australia is unnecessarily restrictive.**

## 2.4.1 Implementation Period

**Programs with implementation periods of longer than 12 months should be considered for review.** Early childhood home visiting program models often have implementation periods longer than 12 months; however, on average, 45 percent of families leave programming within the first 12 months of enrollment.[21] Home visiting programs have been found to reduce the prevalence of child maltreatment, increase family self-sufficiency (e.g., increased parental employment, reduced public assistance), reduce adolescent involvement in the juvenile justice system, improve child well-being, and improve maternal health.[22] Similarly, community-based services designed to reduce substance use may be implemented for extended durations. Furthermore, given that these services are currently funded through multiple funding streams, children and families may be able to remain in these services once the 12-month cap has passed.

## 2.5.1 Favorable Effects

**When determining the magnitude of favorable effects, HHS should consider statistical significance, effect sizes, and confidence intervals.** Although p-values below .05 are often considered the standard for determining a significant effect, the American Statistical Association has issued a statement outlining concerns with the misuse of p-values to determine effects.[23]

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[19] Reimer, J., Verthein, U., Karow, A., Schäfer, I, Naber, D., et al. (2011). Physical and mental health in severe opioid-dependent patients within a randomized controlled maintenance treatment trail. *Addiction*, *106*(9), 1647–55.
[20] Verthein, U., Bonorden-Kleij, K., Degwitz, P., Dilg, C., & Köhler, W.K., et al. (2008). Long-term effects of heroin-assisted treatment in Germany. *Addiction*, *103*(6): 960–68.
[21] Maternal, Infant, and Early Childhood Home Visiting Training Assistance Coordinating Center (2015). *MIECHV Issue Brief on Family Enrollment and Engagement.* Washington, DC. HRSA.
[22] Michalopoulos, C., Faucetta, K., Warren, A., & Mitchell, R. (2017). *Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE).* OPRE Report 2017-73. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
[23] Wasserstein, R.L. & Lazar, N.A. (2016). The ASA's Statement on p-Values: Context, Process, and Purpose. *The American Statistician*, *70*(2), 129–133.

Thus, in addition to consideration of statistical significance, HHS should consider confidence intervals and effect sizes. HHS should work to determine the size of effects considered "practically significant." Notably, the What Works Clearinghouse uses an effect size of .25 or larger to determine whether effects should be considered substantively important.

## 2.5.2 Unfavorable Effects

**Interpretation of null or unfavorable effects should depend on the quality of the study methodology and quality/fidelity of program implementation.** The appropriateness of the study design and analyses must be considered when interpreting null and/or unfavorable effects.

Null effects may arise due to Type II errors (failing to find an effect that truly exists), which is impacted by factors such as the use of improper statistical techniques (e.g., technique does not match the research question, data violate statistical assumptions, failure to account for nested structure of the data), measurement error (unreliable or invalid measures), or inadequate sample sizes (under powered studies). **Null effects that arise due to inappropriate or inaccurate methods should not be considered.**

Null effects may also arise due to Type III errors, which occur when null effects are erroneously attributed to program theory failure when they actually result from poor program implementation. Similarly, programs that are well-implemented have been found to have impacts up to three times as large as those with weak implementation.[24] **Null effects that arise due to poor program implementation quality should not be considered. Similarly, studies that monitored fidelity throughout the course of an entire study should be prioritized for review.**

**Interpretation of null effects should be dependent upon the outcome of interest.** Null effects should be of greatest concern when examining hypothesized effects on confirmatory outcomes. In the presence of significant impacts on confirmatory outcomes, null effects on exploratory outcomes or hypothesized moderating or mediating variables do not indicate ineffectiveness of programs. For example, if a program's goal is to reduce adolescent substance use, and additional exploratory outcomes such as parenting efficacy are included in the evaluation—and if the evaluation finds that adolescent substance abuse is significantly impacted and parenting efficacy is not—then the program should still be considered for inclusion in the clearinghouse.

**The composition of the study sample should be considered when interpreting null or unfavorable effects.** A program determined to be effective in one group (e.g., black families living in an urban community) may not be generalizable to another group (e.g., American Indian/Alaska Native families living in Indian Country). Thus, study sample characteristics must be considered in interpretation, and multiple studies across different samples will aid in interpretation. HHS may wish to highlight when programs have been found effective/ineffective with different populations, particularly given the diversity of families involved in the child welfare system.

**HHS should consider the "weight of the evidence" when interpreting null or unfavorable effects.** Null or unfavorable effects can arise purely due to chance, particularly if multiple outcome variables are included in a study. As such, HHS should not discredit a body of research due to one

[24] Durlak, J. A. & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*(3-4), 327–350.

null or unfavorable finding. If, however, systematic patterns with null or unfavorable effects are found (e.g., there are more studies with null or unfavorable findings than favorable findings), the null or unfavorable effects should be interpreted more strongly.

## 2.5.2 Risk of Harm

**Programs and interventions found to detrimentally impact the physical and psychological safety of children should be considered as "constituting a risk of harm"; as such, they should not be rated as "promising, supported, and well-supported practices."** Some findings may be ambiguous regardless of whether they are truly unfavorable (e.g., an increase in emergency room visits may be caused by a parent's greater awareness of the child's health, or because the child is experiencing more injuries due to neglect). However, other outcomes are clearly unfavorable when they negatively affect the physical and psychological safety of children. In the latter case, HHS should exclude those programs from the clearinghouse, or institute a rating on the clearinghouse that indicates that the program has clear evidence of harm.

## 2.5.4 Rigorous Study Design

**Common threats to internal validity (program quality/fidelity, measurement error, inappropriate methods) are described in 2.5.2.** Outside of the threats described above, **we recommend that HHS leverage existing standards of research design and execution utilized in other similar systematic reviews** (e.g., home visiting, teen pregnancy prevention, and education). If standards do not exist for specific designs common in studies identified for review, HHS should follow the procedures of the What Works Clearinghouse and utilize a committee of statistical experts to determine appropriate quality standards and make those standards available for public comment prior to finalization.

## Conclusion

Thank you for your time and commitment to the safety and well-being of children, youth, and families. We appreciate this opportunity to weigh in on the development of a clearinghouse of evidence-based practices in accordance with the Family First Prevention Services Act of 2018. As HHS continues its work to establish the clearinghouse, Child Trends would be happy to provide additional substantive expertise related to mental health, substance use, and child maltreatment prevention and intervention; trauma-informed care; parent-child relationships; child and parent well-being; evidence-based interventions; LGBTQ youth; and youth and families of color (Hispanic, American Indian/Alaska Native, and black).

For any questions regarding these comments, please contact Elizabeth Jordan at Child Trends (ejordan@childtrends.org; 240-223-9316).

Sincerely,

/s/

Carol Emig
President