MEMO

DATE: September 7, 2012

TO: Special Committee on Permanency for Young Children in the Child Welfare System

FROM: Kids Matter Inc.

SUBJECT: Strategic Recommendations to Support and Promote Permanency for Young Children

Infants and toddlers comprise almost 1 out of every 3 children entering foster care nationally (USDHHS, 2009). Children this age are extremely vulnerable. Trauma that occurs during such critical developmental periods sets the stage for maladaptive responses to subsequent trauma, leading to dramatic increases in the use of correctional, social and mental health services. A report from the National Scientific Council on the Developing Child titled Excessive Stress Disrupts the Architecture of the Developing Brain (National Scientific Council on the Developing Child: Working Paper No. 3,) explains how significant adversity early in life can alter a child's capacity to learn and to adapt to stressful situations. Children who have experienced chronic maltreatment resulting in complex trauma are at a significant risk of developing other behavioral, neuropsychological, cognitive, emotional, and interpersonal disorders (Chu & Lieberman, 2010).

This memo proposes and briefly outlines three modifications to current policy that would promote permanency and well-being for infants and young children placed in out of home care:

1. Develop and implement a ZERO TO THREE Court Team pilot program in selected counties to improve well-being of young children and reduce the length of time it takes to achieve permanency.

2. Require that a concurrent permanency plan be developed for all children under the age of five who have been the subject of a CHIPS order for six months or longer.

3. Accurately define the problem by collecting, maintaining, and analyzing data related to the population and current practice.

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**** Develop and implement a ZERO TO THREE Court Team pilot program in selected counties to improve well-being of young children and reduce the length of time it takes to achieve permanency.***

ZERO TO THREE Court Teams for Maltreated Infants and Toddlers (Gersh, 2009) uses a multidisciplinary, family centered system of care to ensure the needs of the most vulnerable are being met and reduce time to permanency. ZERO TO THREE (ZTT) Court Teams are currently operating in 12 jurisdictions around the country. ZTT Court Teams share an intersystem partnership between the court, clinical, early intervention, mental health, health, child welfare, child care, and education services.

Collaboration amongst professionals who recognize the importance of evidence based treatment, timely intervention and permanency is a critical aspect of the model. This model allows for more frequent hearings on the cases, more effective sharing of information across the different child-serving systems, clearer discussions about how to proceed with each case and the resources that are available, and greater cross disciplinary awareness of issues that affect young children in the child welfare system.

One of the long-term goals of the initiative is to reduce time to permanency. Recent evaluations have shown that the initiative has a significant effect on how quickly children exit the foster care system. ZTT cases exit foster care one year earlier on average than a nationally representative group of children from the NSCAW longitudinal survey. When controlled for group differences, studies have shown that ZTT children leave foster care nearly three times as fast as the comparison group.

ZERO TO THREE Court Teams have undergone two evaluations. The first was completed by James Bell Associates, and examined evidence of system change, knowledge among Court Teams stakeholders regarding the impact of maltreatment on early development, and short-term outcomes for infants and toddlers monitored by the Safe Babies Court Teams. The study found that 99.05% of the 186 infant and toddler cases examined were protected from further maltreatment while under court supervision, and 97% of the 186 children received needed services (JBA, 2009).

The second evaluation was completed by Kimberly McCombs-Thornton, PhD of The University of North Carolina at Chapel Hill. This evaluation looked at the effect of Safe Babies Court

Teams on time to permanency and how children exit the foster care system. It also examined how program components or client characteristics affected time to permanency. Using a matched sample pulled from the National Survey of Child and Adolescent Well-Being (n=511), Dr. McCombs examined questions about time to permanency for 298 children served by the Court Teams in Des Moines, Iowa; Hattiesburg, Mississippi; New Orleans, Louisiana; and Fort Bend County, Texas. She found that the children served by the Court Teams reached permanency two to three times faster. This differential was true when the two samples were compared by types of exit (e.g. reunification, adoption). Children served by the Court Teams also exited the foster care system approximately one year earlier than children in the comparison group (McCombs-Thornton, 2011).

Young children typically exit foster care in one of four ways: reunification, adoption, relative guardianship, or non-relative guardianship. Research shows that reunification typically requires much less time in foster care than adoption. The study considered the effect of the initiative on types of exits from foster care to learn how the ZTT program accelerates time to permanence (McCombs-Thornton, 2011).

The effect of the program on time to permanency is explained to some degree by differences in types of exits. Reunification was the most common type of exit for ZTT children while adoption was the most typical for NSCAW. However, the analysis also found that ZTT children spent much less time in foster care regardless of the type of exit. Children who were reunified exited foster care 8 months faster on average. Among those who were adopted, ZTT children left foster care 10 months sooner on average. Of children who reached permanency with a relative guardian, ZTT cases exited foster care 3 to 4 months faster on average. And lastly, among children exiting to a non-relative guardian, ZTT children left foster care an average of 10 to 13 months quicker (McCombs-Thornton, 2011).

Background/Structure

When a Court Team is organized, an important first step involves educating all of the different individuals and agencies involved with the case plan about the effects of trauma on young children and expectable developmental responses at different ages. The training also includes information about the effects of trauma on brain development, principles used in applying the

science of early childhood development in court settings, and evidence based practice (Osofsky, Many, & Dickson, 2010).

Each team has a court team coordinator whose responsibility it is to bring the different systems together and integrate their activities on behalf of the young child and caregivers. The clinical team is lead by a psychologist, who provides psychoeducation, evidence-based treatment, and intensive case management (Ososfsky & Lieberman, 2010). The clinical team focuses on the relationship between the child and the parent or primary caregiver. The intervention is designed to interrupt the intergenerational cycle of abuse and neglect and to help maltreated young children achieve safety and permanency in placement. The court is updated on the progress of the therapeutic work to help the judge make developmentally informed decisions. The treatment plan may also include referrals for other mental health and rehabilitative services to address issues such as substance abuse, domestic violence, and parent and/or child cognitive deficits that could interfere with the parent's ability to adequately care for the child. The information from the different systems is integrated by the team and used to guide ongoing services and treatment planning.

**** Require that a concurrent permanency plan be developed for all children under the age of three who have been the subject of a CHIPS order for six months or longer***

Time moves quickly for infants and toddlers. Growth and development occur at a pace significantly exceeding that of any other period of life. These children need stable and nurturing caregivers as soon as possible. Typically, child welfare practice works towards reunification over the course of several months or years. An alternative form of permanency is sought only after extensive efforts to reunify the infant with their parent(s) have failed. Pursuing concurrent plans earlier in the process for this population will help to reduce the emotional damage experienced by the child and expedite permanency. It will also require child welfare to ensure that a potentially permanent placement for the child is identified early on, and encourage communication with the caregiver about permanency sooner.

**** Accurately define the problem by collecting and analyzing data related to the population and current practice.***

It is necessary to have an accurate and thorough understanding about the strengths and challenges present in our current system. Effective and targeted interventions cannot be developed or implemented without this critical information. For example, disaggregating data by

age, geography, race, ethnicity, reason for entry and previous child welfare involvement of parents can help provide a clearer picture of system strengths and gaps while also focusing attention on disparities and disproportionalities, with the goal of reducing and ultimately eliminating them.

Collecting data on failed/disrupted adoptions within the child welfare system may help identify commonalities present among the children or adoptive parents which could ultimately help to better inform future decision making surrounding licensing, placement, and permanency.

It may also be helpful to gather specific data to better understand why children placed with relatives in the child welfare system achieve permanency at a slower rate than their peers placed in non-relative foster care. This information may help determine what factors, contributed to some in this population achieving permanency, or being on the path towards permanency, within the given timeframe and to determine which, if any, impact child-well being and stability

Sources of data may include Wisconsin statewide automated child welfare information system (WISACWIS), Part C data and Medicaid data, administrative records reviews, focus group questions and stakeholder interviews.

Assessing for safety has historically been the primary focus within child welfare. However, physical health, mental health, socio-emotional and developmental needs are critical markers of well-being. Regularly monitoring and assessing such well-being indicators can help identify issues that may jeopardize a child's ability to access necessary services and ultimately impact long-term stability. This information can be extremely beneficial when making decisions related to permanency. Examples include the number/percentage of children who have a pediatric medical home; when, how, and by whom children are screened for health and developmental problems; if and how important information regarding the child's needs is communicated to the child's placement; number/percentage of children referred to specialists for follow-up care in response to screening results; number/percentage of children referred who receive the recommended services, and the average length of time between when the recommendation or referral is made and when services begin; and the availability of different services by community or zip code.

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ACF Administration for Children and Families	U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Administration on Children, Youth and Families	
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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 maltreatment[1] 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 level[3] 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-12-03, 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 relatives 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

Additional dollars may be necessary initially to support installation of evidence-based practices. However, de-scaling programs that are not working and reallocating resources ensures that effective services can be sustained without requiring new, ongoing funding.

Transforming child welfare services by de-scaling and/or converting interventions that are not working while scaling up evidence-based treatments is unquestionably complex and difficult work. Other systems have grappled with this challenge; for example, as mental health services are increasingly provided in community-based settings, the role of residential treatment facilities has been widely reexamined. As new research emerges and the population receiving services changes, it is necessary to reevaluate the way those services are delivered. To start, States can conduct an inventory of the services they are currently providing to children with child welfare involvement and gather information about how effective these services are in improving children's functioning. This information can help drive decision-making about the steps that are necessary to align State, county, and local resources to improve outcomes.

Child welfare agencies that coordinate efforts within and across departments to innovatively re-tool the complement of services available to youth and families in the child welfare system are more likely to achieve sustainable change. Service coordination at the State and local level can benefit from the growing effort across Federal agencies, including the Substance Abuse and Mental Health Services Administration, National Institutes of Mental Health, National Institute on Drug Abuse, Department of Justice, Department of Education, and others, to promote improved well-being outcomes and the use of effective practices.

X. Strategies for Shifting the System to Promote Social and Emotional Well-Being

There are many ways that child welfare systems can begin to embed a focus on social and emotional well-being in their work. A few specific examples are listed below.

Services. This IM has shown that children who have experienced abuse or neglect have significant behavioral, social, and emotional challenges; it has also shown that there are evidence-based practices and interventions that can improve outcomes for children and their families. Delivering effective services is the most critical component of a focus on promoting social and emotional well-being.

- **Screening and Functional Assessment:** Conduct high quality and regular trauma screenings and functional assessments of children, youth, and families to determine exposure to and impacts of maltreatment and other forms of complex interpersonal trauma. The American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America have developed guidelines for screening and assessment to help inform child welfare systems (AACAP & CWLA, 2002). Valid and reliable mental and behavioral health and developmental screening and assessment tools should be used to understand the impact of maltreatment on vulnerable children and youth. Screens and assessments should be sensitive enough to distinguish symptoms of trauma reactions and mental health disorders. The use of such tools is important in fulfilling child welfare agencies' responsibility for ensuring the well-being of children and youth who have been exposed to complex interpersonal trauma (Levitt, 2009). Conducting assessments as early as possible when children become involved with the child welfare system and regularly thereafter allows

caseworkers to know how children are doing initially and whether or not they are getting better with the services provided.

- **Evidence-Based Interventions:** Deliver evidence-based and evidence-informed interventions for the treatment of trauma and mental health disorders. When evidence-based screening and assessment indicates that children are suffering from trauma and/or mental health symptoms, it is necessary to provide treatments that effectively improve functioning. Child welfare systems will need to collaborate with mental health and Medicaid systems to build an array of evidence-based or evidence-informed interventions to improve trauma and mental health-related outcomes for children who have experienced maltreatment.

  In recent years, public and private sector organizations have produced extensive, publically available lists and databases of evidence-based and evidence-informed interventions for improving well-being outcomes for vulnerable children (See "Resources," below). These include, among others, SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) and the U.S. Department of Justice's CrimeSolutions.gov. The Agency for Healthcare Research and Quality is currently conducting an evidence review of "Interventions Addressing Child Exposure to Trauma: Child Maltreatment and Family Violence," which will be available later in the year. Additionally, many institutions, including SAMHSA and organizations funded by HHS, including the National Child Traumatic Stress Network (NCTSN) and the National Early Childhood Technical Assistance Center (NECTAC), have published publically-accessible reviews of valid and reliable instruments for screening and assessing various aspects of social-emotional well-being with different populations and age groups. As such, it is now more feasible than ever to identify and implement evidence-based and evidence-informed interventions.

- **Services within Child Welfare:** Consider restructuring services that are the sole responsibility of child welfare. Some services fall completely within the purview of the child welfare system. For example, services provided by Independent Living and Transitional Living Programs are often dictated by the child welfare agency. Others include investigations, case management, and foster parent training. Without requiring the coordination or collaboration of other systems, it may be possible to change the way these services are delivered. Child welfare agencies could redesign programs and modify contracts to require that Independent Living and Transitional Living Programs deliver services that are trauma-informed and evidence based.

Workforce. It is essential to develop a workforce strategy that supports an emphasis on promoting social and emotional well-being. Administrators and staff of child welfare and other systems that affect children receiving child welfare services, including Medicaid, mental health, and the courts must understand the rationale for the focus and have the capacity to implement changes.

- **Capacity around Evidence-Based Practices:** Build the capacity of child welfare and mental health systems' staff to understand, install, implement, and sustain evidence-based practices. This includes: using research to identify effective interventions that improve outcomes for the population; developing an awareness of principles of evidence-based practice among staff at all levels; and reorganizing infrastructure to support implementation

fidelity. While child welfare staff may not be responsible for delivering these interventions, they should be able to appropriately assess and refer children and families to evidence-based treatment providers and determine whether or not the interventions being delivered are having positive effects on child and family functioning. Child welfare workers should also have regular access to learning tools and communities to remain up-to-date on the latest developments in relevant evidence-based practices.

- **Training on Specific Populations:** Train staff to more effectively serve specific populations of children and youth and specific populations of prospective foster and adoptive families served by the child welfare system. While the social and emotional issues of each child differ, certain populations will share common challenges. Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are often overrepresented in the child welfare system, and they have a set of unique challenges to overcome (ACYF, 2011). In an earlier IM, States were encouraged to "claim available title IV-E reimbursement for costs associated with training staff to increase their capacity to serve young people who identify as LGBTQ and to consider how the title IV-E agency can best serve young people and keep them safe" (ACYF, 2011, p.2). Additionally, LGBT families can be an untapped resource for placement, and agencies are often working to improve their skills and competencies in serving these families. States may use IV-E training dollars at an enhanced reimbursement rate (75 percent) to improve workers' competency in serving both LGBTQ youth in care and prospective LGBT foster and adoptive families.

- **Training for Professionals Outside of Child Welfare:** Provide training on the impact of maltreatment, trauma, and the social and emotional well-being of children who have been abused or neglected. Under the *Fostering Connections to Success and Increasing Adoptions Act* of 2008, States may use title IV-E training dollars at an enhanced reimbursement rate (75 percent) for training staff of personnel outside of the public child welfare system. Eligible personnel include: staff of private agencies contracted to perform services for the child welfare agency, court personnel, attorneys, guardians ad litem, court appointed special advocates, and prospective relative guardians, as well as foster and adoptive parents.

- **Engaging the Judiciary and the Courts:** The Courts play a critical role in promoting the social and emotional well-being of children known to child welfare. The oversight role of the Courts could be enhanced by providing training on the core components of social and emotional well-being and trauma and effective screening, assessment and intervention approaches that can improve functioning. Judges are well situated to ask questions, ensure effective services are delivered, and track well-being outcomes for their individual cases and at the system level.

System. Promoting social and emotional well-being requires a careful analysis of the way the child welfare system is currently structured and the systemic changes that are necessary.

- **Program Inventory:** Examine current spending to understand where resources can be shifted to support evidence-based programs and practices. Many states are currently purchasing services that are not reliably yielding the desired results, such as generic counseling, parenting classes, and life skills training for emancipating youth. By identifying resources that are being used to support these types of services, child welfare systems can

begin planning to de-scale them and repurpose funds for evidence-based interventions. Ideally, administrators will combine this work with an analysis of data describing the needs of the population of children receiving child welfare services in order to identify areas in which de-scaling and installation of new practices can improve child and family outcomes.

- **Measure Outcomes, Not Services:** It is common for child welfare systems to gauge their success based on whether or not services are being delivered. One way to focus attention on well-being is to measure how young people are doing behaviorally, socially, and emotionally and track whether or not they are improving in these areas as they receive services. At the system level, data from trauma screenings and functional assessments can help administrators understand how successful their child welfare systems are in achieving positive outcomes for children and youth. This understanding can inform decisions about the array of services that is currently available and the procurement of services going forward.

Building a child welfare system that responds effectively to the traumatic impact of maltreatment and promotes social and emotional well-being is complex work. Multiple, complementary strategies must be employed in order to create systematic changes that improve outcomes for children. The progress that the child welfare system has made in recent years has been the result of ongoing and evolving collaborations across multiple child-serving systems, including mental health, Medicaid, education, early childhood, and more. Together, these systems integrated knowledge about the importance of permanency and family connections and structured themselves to deliver services that keep young people safer; keep children with their families more often; and ensure reunification, adoption, and guardianship for more of the children who come into foster care.

As child welfare systems continue to improve and refine their work to promote safety and permanency for children, a strengthened focus on the social and emotional well-being of children who have experienced maltreatment is the logical next step in reforming the child welfare system. Children who have been abused or neglected have significant social-emotional, behavioral, and mental health challenges requiring attention, and treating them with a trauma-focused and evidence-based approach can improve outcomes throughout child welfare. This approach can result in increased placement stability; greater rates of permanency through reunification, adoption, and guardianship; and greater readiness for successful adulthood among all children who exit foster care, especially those youth who leave foster care without a permanent home. Most importantly, it will enable children who have experienced maltreatment to look forward to bright, healthy futures.

XI. Resources

Additional information on the importance of promoting social and emotional well-being and responding to trauma can be found through a number of Federally-funded sources. For example, the National Child Traumatic Stress Network (NCTSN) is a collaboration of academic and community-based centers whose mission is to raise the standard of care and increase access to services for children and their families across the country. NCTSN develops and disseminates evidence-based interventions, trauma-informed services, and educational resources. Additional information on the work of NCTSN can be found on their website: http://www.nctsn.org/.

References

Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services (ACYF). (2011). Information Memorandum: Lesbian, gay, bisexual, transgender and question youth in foster care (ACYF-CB-IM-11-03). Washington, DC: Author.

American Academy of Child and Adolescent Psychiatry (AACAP) & Child Welfare League of America (CWLA). (2002). AACAP/CWLA policy statement on mental health and substance abuse screening and assessment of children in foster care. Retrieved on February 29, 2012 from http://www.cwla.org.

Bracken, B. A., Keith, L. K., & Walker, K. C. (1998). Assessment of Preschool Behavior and Social-Emotional Functioning: A Review of Thirteen Third-Party Instruments. *Journal of Psychoeducational Assessment, 16*(2), 153-169.

Bloom, SL. (1999). Trauma Theory Abbreviated. In "Final Action Plan: A Coordinated Community Response to Family Violence." Commonwealth of Pennsylvania: Office of the Attorney General.

Bretherton, I. (2000). Emotional availability: An attachment perspective. *Attachment & Human Development* 2(2):233.

Casaneuva, C; Ringeisen, H; Wilson, E; Smith, K; & Dolan, M. (2011a). NSCAW II Baseline Report: Child Well-Being, OPRE Report #2011-27b, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Casaneuva, C; Ringeisen, H; Wilson, E; Smith, K; & Dolan, M. (2011b). NSCAW II Baseline Report: Children's Services, OPRE Report #2011-27b, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Child Welfare Information Gateway. (2007). Addressing the needs of young children in child welfare: Part C ' Early intervention services. Washington, DC: U.S. Department of Health and Human Services.

Cook, A; Blaustein, M; Spinazzola, J; & van der Kolk, B, eds. (2003). Complex Trauma in Children and Adolescents: White Paper from the National Child Traumatic Stress Network, Complex Trauma Task Force. Los Angeles, CA and Durham, NC: National Child Traumatic Stress Network.

Griffin, E; Kisiel, C; McClelland, G; Stolback, B; & Holzberg, M. (2012). Diagnosing trauma before mental illness in child welfare. *Child Welfare*. Leslie, LK; Hurlburt, MS; James, S; Landsverk, J; Slymen, DJ; & Zhang, MS. (2005). Relationship between entry into child welfare and mental health service use. *Psychiatric Services*. 56:981.Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics (MMDLN/Rutgers CERTs). (2010). Antipsychotic Medication Use

in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study: MMDLN/Rutgers CERTs Publication #1. Accessed on February 29, 2012, at: http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.

Humphrey, N., et al. (2011). Measures of Social and Emotional Skills for Children and Young People. *Educational and Psychological Measurement, 71*(4), 617-637.

Koball, H; et al. (2011). Synthesis of Research and Resources to Support At-Risk Youth, OPRE Report # OPRE 2011-22, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Levitt, JM. (2009). Identification of mental health services need among youth in child welfare. *Child Welfare*. 88(1):27.

McCrae, JS; Guo, S & Barth, RP. (2010). Changes in maltreated children's emotional-behavioral problems following typically provided mental health services. *American Journal of Orthopsychiatry*. 80(3):350.

McMillan, CJ.; et al. (2005). The prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*. 44:88.

Mikulincer, M & Shaver, PR. (2007). *Attachment in Adulthood: Structure, Dynamics and Change*. New York, NY: The Guilford Press.

National Research Council and Institute of Medicine. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commissioner on Behavioral Sciences and Education. Washington, D.C.: National Academy Press.

National Scientific Council on the Developing Child. (2005). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper #3. Accessed on February 29, 2012, at: http://www.developingchild.net

O'Brien, M. (2011). Measuring the Effectiveness of Routine Child Protection Services: The Results from an Evidence Based Strategy. *Child & Youth Services*.32;303-316.

Perry, BD. (1995). Childhood trauma, the neurobiology of adaptation, and the "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal*. 16(4):271.

Perry, BD. (2005). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind*. 3:79.

Rees, CA. (2010). All they need is love? Helping children to recover from neglect and abuse. *Archives of Diseases in Childhood*. 96:969.Roeser, R. W., Strobel, K. R., & Quihuis, G.

(2002). Studying Early Adolescents' Academic Motivation, Social-Emotional Functioning, and Engagement in Learning: Variable- and Person-Centered Approaches. *Anxiety, Stress & Coping, 15*(4), 345-368.

Sorce, JF & Emde, RN. (1981). Mother's presence is not enough: Effect of emotional availability on infant exploration. *Developmental Psychology*. 17(6):737.

Terr, LC. (1991). Acute responses to external events and Posttraumatic stress disorders. In Lewis, M (Ed.). *Child and adolescent psychiatry: a comprehensive textbook* New Haven, CT: Williams & Wilkins.

U.S. Department of Health and Human Services (USDHHS); Administration for Children and Families (ACF); Administration on Children, Youth and Families. (2002-2011) Adoption and Foster Care Analysis and Reporting System (AFCARS) Reports Nos. 10-18. Washington, DC: Author. Accessed on February 29, 2012, at http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#afcars

Vandivere, S., Allen, T., Malm, K. McKindon, A., and Zinn, A. (2011) *Technical Report #2: Wendy's Wonderful Kids Program Impacts,* Child Trends, Washington, D.C. Retrieved from:http://www.davethomasfoundation.org/about-foster-care-adoption/research/read-the-research/technical-report-2/

White, CR; Havalchack, A; Jackson, L; O'Brien, K; & Pecora, P. (2007). Mental Health, Ethnicity, Sexuality, and Spirituality among Youth in Foster Care: Findings from the Casey Field Office Mental Health Study. Seattle, WA: Casey Family Programs.

Wotring, J., Hodges, K. and Xue, Y. (2005). Critical Ingredients for Improving Mental Health Services: Use of Outcome Data, Stakeholder Involvement, and Evidence-Based Practice. *The Behavior Therapist*. 28(7):150-157.

Appendix 1: ACYF Well-Being Framework

	Intermediate Outcome Domains		Well-Being Outcome Domains			
	Environmental Supports	Personal Characteristics	Cognitive Functioning	Physical Health and Development	Emotional/Behavioral Functioning	Social Functioning
Infancy (0-2)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-12)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (13-18)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior
					Social and Emotional Well-Being Domains	