

Site Visit Report: Kansas Intensive Permanency Project

<https://www.childwelfare.gov/topics/management/funding/funding-sources/federal-funding/cb-funding/cbreports/PII>

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Cluster: Permanency Innovations Initiative

Grantee: University of Kansas, School of Social Welfare, Center for Children & Families

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PROJECT DESCRIPTION

The Permanency Innovations Initiative (PII), a presidential initiative, is a 5-year multisite demonstration project designed to improve permanency outcomes for children in foster care who have the most serious barriers to permanency. In 2010, the Children's Bureau, within the Administration for Children and Families of the U.S. Department of Health and Human Services, released a funding opportunity announcement (FOA) titled "Initiative to Reduce Long-Term Foster Care."¹ The purpose of the FOA was to fund demonstration projects that support the implementation and test the effectiveness of innovative intervention strategies to improve permanency outcomes for subgroups of children who have experienced the most serious barriers to permanency.

The following are the intended purposes of the projects funded through this FOA:

- Implement innovative intervention strategies that are informed by the relevant literature in order to reduce long-term foster care (LTFC) stays and improve child outcomes
- Use an implementation science framework enhanced by child welfare expertise to guide technical assistance activities
- Evaluate rigorously the validity of research-informed innovations and adapted evidence-based interventions in reducing LTFC
- Develop an evidence base and disseminate findings to build knowledge in the child welfare field

The projects were to address site-specific issues in order to help children leave foster care in fewer than 3 years. The projects were to identify local barriers to permanent placement and implement innovative intervention strategies that mitigated or eliminated those barriers throughout the continuum of services.

The Children's Bureau entered into cooperative agreements with six grantees from across the country, including the University of Kansas (KU). KU's PII project, the Kansas Intensive Permanency Project (KIPP), is a public-private-university statewide partnership between KU, the Kansas Department for Children and Families (DCF), and the State's private contract providers of foster care services—KVC Kansas and Saint Francis Community Services. The project is led by the KU School of Social Welfare Center for Children & Families, a research organization with expertise in child welfare and mental health service delivery.

Recognizing that in order to increase the likelihood of successful reintegration or other family-based permanency for the target population, parents (or caregivers) needed to learn how to manage their children's behavior in their homes, KIPP selected the Parent Management Training-Oregon Model (PMTO) as the intervention for the project.² Detailed information about PMTO is included in the intervention section of this report.

¹ The FOA is available at <https://ami.grantsolutions.gov/view/HHS-2010-ACF-ACYF-CT-0022>.

² Kansas uses the terminology "reintegrate" to describe when children reunify with their parents or other family members from whom they were removed.

For more information about the PII approach and the other PII grantees, visit the [PII Project Resources](#) page on the Children's Bureau's website.

Need for Service

Before submitting the grant proposal, KU organized a project design team to determine who would be best served by a grant. The team made the decision to explore the two groups of children they believed to be the most likely to experience LTFC—children with serious emotional disturbances (SED)³ and children with developmental disabilities (DD).

The project team elected to focus on children and youth with SED, which was the larger of the two groups, but the project would also serve some youth with DD due to the overlap of the two populations. Research to support the selection of SED conducted by the grantee indicated that children and youth 3 to 18 years of age with an SED were 3.6 times more likely to remain in LTFC than children/youth without an SED. (More information about how the decision about the target population was finalized is in the target population section of this report.)

KIPP's research and data suggested that children/youth with an SED benefit most from increasing parental ability to manage problematic child behavior. KIPP reviewed several interventions and determined that there were two that could possibly meet their needs and best serve the target population and their families: Parent Management Training—Oregon Model (PMTO) and Triple P.

The KIPP steering committee determined the need for this project based on a large number of children with a SED in Kansas who remained in foster care for extended periods of time. Children with an SED in Kansas foster care make up approximately half the State's foster care population. They also have more placements, remain in foster care longer, have fewer exits to permanency, and are more likely to age out of foster care than children/youth without an SED. They make up nearly two-thirds (63 percent) of children who are in out-of-home care for 3 years or more. Case reviews of Kansas children and youth in foster care for longer than 3 years, which was completed as part of the target population vetting process, revealed that the following factors contributed greatly to the lack of permanency for children in the target population:

- Gaps in parenting skills
- Poverty
- Untreated parental trauma
- Untreated or undertreated parent mental health and/or substance abuse problems

Project Goals

Although all PII grantees have the overarching goal of improving permanency outcomes among children in foster care who have the most serious barriers to permanency, each grant can have its own specific goals. KIPP was also focused on the following goals:

- Provide intensive services to support families with children in foster care
- Help children with an SED successfully reintegrate earlier
- Increase families' capacity to provide for their children's needs

³ In KS, SED is a specific designation established by a qualified mental health professional at a community mental health center.

- Work with the family and community on addressing barriers to reintegration
- Connect families to community services and supports

The following are the key components of KIPP:

- Early identification of SED
- Contact with parents at foster care entry
- Strong parental engagement
- In-home, intensive services
- Trauma informed services
- Emphasis on consistent parent/child visits
- Low caseloads
- Clinical and team supervision
- Well-integrated service coordination

Theory of Change

Each PII grantee, with the assistance of the PII training and technical assistance team, developed a theory of change. KIPP's theory of change is comprised of six sequential, interrelated assumptions:

1. Parents of children with a SED face multiple problems that are complex and not easily alleviated by current child welfare practices or within federally mandated timeframes.
2. To bring about change of a sufficient magnitude, resources must be dedicated to improve ineffective parenting practices and to connect parents with community resources and social supports.
3. When parenting and community connections are strengthened, a more adequate and prosocial environment for children is created.
4. When the family's interpersonal and social environment is bolstered, child functioning improves and behavior problems decrease.
5. These changes combine to create readiness for family reunification.
6. These changes lead to more timely and stable reunifications.

Target Population

In order to support the selection of the target population for KIPP and recognizing that data does not tell the entire story, the project team reviewed not only data related to the children and youth who remained in foster care for long periods of time, but also conducted case reviews and interviews. The team randomly selected cases from children and youth across the State who were in foster care 3 to 5 years and used a standardized data collection tool to review the cases.

In order to determine and describe the target population, the project team sought to answer three research questions:

- Is a child's mental health status an important risk factor of long-term foster care?
- If so, what barriers to permanency are experienced by parents of children with serious mental health problems?
- What systems issues are barriers to permanency for this subpopulation of children and families?

To answer the first question, KIPP examined statewide data from foster care and mental health databases on over 7,000 children and youth who entered and remained in foster care for at least 8 days in State fiscal years 2006 and 2007 and reviewed 3 to 5 years of data on these children and youth. The child and placement characteristics that were reviewed and/or collected included, but were not limited to, gender, age at entry into foster care, primary reason for removal from the home, disability status, mental health status, initial type of placement, stability of placement, and runaway history. This information was gathered and analyzed to determine if mental health problems were a predictor of LTFC. The findings indicated that the presence of an SED had the strongest relationship with LTFC among all the variables analyzed. Children and youth with an SED remained in foster care 3 years longer and were 3.6 times more likely to experience LTFC than children without an SED.

Through the second research question, the project wanted to determine the experiences of parents whose children were identified as having an SED and experienced LTFC. In order to gather the most accurate information about this, case record reviews and caseworker interviews were conducted statewide. A random sample of cases of children and youth with an SED who were in LTFC were selected for review. Four categories of parent and family characteristics case level data were collected, including poverty and social supports, clinical needs (e.g., substance abuse issues), parenting, and home and environmental stressors (e.g., domestic violence). KIPP's research determined that parental and family characteristics that had the most effect on families not achieving permanency (particularly reintegration) were poverty, untreated parental trauma, domestic violence, untreated mental health and substance abuse, and gaps in parenting competencies.

In order to collect information to answer the final research question—"What systems issues are barriers to permanency for this subpopulation of children and families?"—an electronic survey was developed by KIPP and was completed by 232 child welfare staff and stakeholders. The 36 questions included in the survey addressed service system issues, ancillary/specialized services, organizational issues, and macro-level issues. The following system level issues were identified by respondents:

- High caseloads
- Staff turnover
- Transportation
- Limited services for parents
- Court issues

Grant Partners

KIPP is a public-private-university partnership between KU, the Kansas DCF, and the State's private foster care contractors, KVC Kansas and Saint Francis Community Services. These project partners form the KIPP steering committee. When the grant was awarded in 2011, Kansas had four contract foster care providers: KVC Kansas, Saint Francis Community Services, TFI Family Services, and Youthville. However, in 2012 the State issued a request for proposals for foster care providers and consequently awarded the contract, which took effect in July 2013, to KVC Kansas and Saint Francis Community Services. This ended the involvement of TFI Family Services and Youthville in the KIPP partnership.

Implementation

All grantees in this cluster have followed the PII approach when implementing their interventions. The PII approach consists of four implementation stages:

- **Exploration:** This stage includes activities that help grantees define their target population, identify factors that put the target population at risk of LTFC, coordinate teaming structures, select and promote interventions, and plan for implementation and evaluation.
- **Installation:** During this stage, grantees ensure that the structural and functional changes to support implementation are in place, including, but not limited to, staff selection protocols, staff training and coaching, and data systems to monitor the fidelity of program processes.
- **Initial implementation:** During this stage, all implementation supports are at least partially in place, and children and families begin to participate in the intervention. Grantees test key processes and data collection activities. Additionally, grantees modify components as needed to improve intervention processes, ensure the implementation supports focus on the right processes, and ensure that formative evaluation can begin. Once project staff have the requisite skills for the intervention processes and have institutionalized the necessary organizational and systems changes, the grantees move into the full implementation stage.
- **Full implementation:** In this stage, grantees review and refine implementation teams. They also monitor and assess implementation supports and intervention fidelity.

When grantees determine that the intervention is stable and that the formative evaluation shows the program outputs and short-term outcomes are trending in the proper direction, the grantees move to the summative evaluation.⁴ (More information about the evaluation process is included in the evaluation section of this report.)

For more information about the PII implementation process, refer to [The PII Approach: Building Implementation and Evaluation Capacity in Child Welfare](#) on the Children's Bureau website.

⁴ Permanency Innovations Initiative Training and Technical Assistance Project, & Permanency Innovations Initiative Evaluation Team. (2013). *The PII approach: Building implementation and evaluation capacity in child welfare* (Rev. ed.). Retrieved from <http://www.acf.hhs.gov/programs/opre/resource/pii-approach-building-implementation-and-evaluation-capacity-in-child-welfare>

Intervention

Since children/youth with an SED were identified as the target population, the project partners realized that to improve outcomes and the likelihood of successful reintegration, the project intervention needed to focus on services for the parents of these children/youth. According to KIPP partners, the greatest obstacle to serving children/youth with an SED is the general lack of in-home, intensive mental health services and substantial, ongoing supports to parents. Based on the information provided by the KIPP partners, parents generally do not learn how to manage the behavior of children with an SED because services and resources—particularly when children are in foster care—focus on the children. Whereas, parents have a long list of tasks, most of them court ordered, that may not promote parent and child interaction, actual hands on parenting learning opportunities, or emotional connections.

KIPP partners spent 223 hours researching interventions before narrowing the selection to two parent training models, which they believed to be the most appropriate for children and youth 3 to 18 years of age with an SED: Triple P and PMTO. In order to select the model best suited for KIPP, the partners conducted interviews with purveyors, implementers, and evaluators of both models. After considerable consideration, PMTO was selected and implemented.⁵ KIPP selected this model because it fit the needs of the target population and their parents and had the capacity to be sustained over time. In addition, the purveyor allowed the State to have its own PMTO trainers, coaches, and fidelity raters at the end of the project.

PMTO, an evidence-based practice, has proven to be effective in treating behavioral problems. The premise behind PMTO is that parents are their children's most important teachers. This belief aligns with KIPP's acknowledgement that to improve the likelihood of establishing permanency for children/youth with an SED through reintegration with family (or other permanent caregivers), the key is to provide independent skill building by teaching parents and caregivers to work with their children in a way that addresses behaviors through positive interactions. KIPP specifically did not add interventions for the children and youth into PMTO, but chose to focus solely on coaching parents to manage the children's behavior.⁶ The goal was to empower parents and address the parents' own trauma, as well as to determine whether the family could experience and sustain reintegration, if they were offered interventions focusing primarily on the parents and not working to "change" the child. According to KIPP steering committee members, children lose their connections to their parents while in foster care, which hinders their chance for reintegration or other permanency options. KIPP, through PMTO, was able to coach parents on how to manage their children's behavior in an environment that was safe for the children and instructive and empowering to the parents.

Although the purveyor had never before used PMTO with families while their children were placed out of the home, KIPP partners quickly realized that to achieve the best outcomes for and the highest level of cooperation from the families, the PMTO intervention needed to begin as soon as the child entered foster care. To determine eligibility, children and youth were administered the Child and Adolescent Functional Assessment Scale (CAFAS).⁷ To be eligible for KIPP, children 6 years of age and older had to score 60 or above on the CAFAS, while children 5 years of age and younger had to score 50 or above. In addition to the CAFAS scores, the family had to meet other criteria to be considered for KIPP, including having a permanency goal of reintegration and a parent or caregiver available to participate in the program (e.g., not

⁵Additional information about PMTO is available on the [California Evidence-Based Clearinghouse for Child Welfare](https://www.californiaevidencebasedclearinghouse.org/) website.

⁶ KIPP staff reported that some pre-teen and teenagers did ask for therapeutic interventions for themselves.

⁷ The CAFAS assesses the degree of impairment in children and youth with emotional, behavioral, psychiatric, or substance use problems.

incarcerated long-term). Once it was determined that these criteria were met, the children and families were placed into a database that allowed staff to randomly select families who would be offered the opportunity to participate in KIPP. Of the families offered the services, 82 percent said yes.⁸

PMTO integrated parent/child visits with the therapeutic coaching process. KIPP maintained lower caseloads for the therapist, which allowed the therapist to visit in the home and have more contact with the families than a traditional child welfare approach would have allowed.⁹ The therapists had contact with the parents in their homes three times a week. The first contact of the week involved face-to-face coaching of the parent on various parenting, problem solving, and behavior management techniques. PMTO begins with easier parenting tasks and skills and then moves into more difficult and complex parenting skills. The following topics were covered:

- Skill encouragement
- Positive involvement
- Effective discipline
- Problem-solving
- Monitoring/supervision

The second and third contact of the week varied. In some instances, the second contact of the week was either in person or via telephone and reviewed the topic, skills covered, or practices from the first session. It would also be an additional preparation session for the parents before the third session of the week, which would include the children/youth. In other instances, the second contact included the parent, the children/youth, and the therapist. Contact with all three parties allowed the parent to practice the skills learned and reviewed in the earlier session(s), while the therapist observed and possibly provided discreet or "whisper" coaching. The therapists went to great lengths not to provide overt coaching to the parents in the presence of the children/youth, unless there were safety concerns. In the instances when the second contact included the children, the therapist would follow up with the parents in person or via telephone for the third weekly contact. This contact would include a recap of the session with the children/youth and occurred at the convenience of the family, including nights and weekends.

In some cases, therapists would have additional contact with parents to help them be successful with specific parenting competencies. According to KIPP staff, 74 percent of families completed the PMTO curriculum within 6 months of agreeing to participate in KIPP.

Staffing

In order to implement PMTO and provide services to the families, KIPP hired 30 master-level therapists, six supervisors (who were also therapists and carried a small caseload), and four full-time administrative staff. To be fully trained on PMTO, the staff attended 18 days of training, which comprised of five different workshops over an 8-month period. The PMTO purveyor completed the training for the first cohort of KIPP therapists. The next cohort of KIPP therapists was co-trained by KIPP staff and the purveyor. The contacts between KIPP therapists and the parents were recorded and uploaded to a secure portal. These recordings were reviewed by KIPP coaches and PMTO fidelity monitors. KIPP therapists received coaching from a certified coach at least once per month and were rated quarterly for fidelity to the PMTO model.

⁸ At the time of the site visit in March 2015, the participation rate was 82 percent.

⁹ Therapists carried caseloads of four to six families each.

Dissemination

Based on information provided by KIPP, as well as information included in reports to the Children's Bureau, KIPP conducted a number of presentations to stakeholders across Kansas, as well to other Children's Bureau's discretionary grantees. In addition, KIPP project partners wrote articles that were published in various publications and presented on KIPP at national and international conferences, including the following:

- Akin, B. A., Bryson, S. A., McDonald, T., & Walker, S. (2012). Defining a target population at high risk of long-term foster care: Barriers to permanency for families of children with serious emotional disturbances. *Child Welfare*, 91(6), 79–101.
- [Measuring the Implementation of Social Work Interventions](#)
Society for Social Work Research Conference, January 2013
- *Scaling Up an Evidence Based Intervention: An Implementation Discussion*¹⁰ webinar
National Resource Center for Organizational Improvement, October 2013
- *Formative Evaluation of an Evidence-Based Intervention to Reduce Long-Term Foster Care: Assessing Readiness for Rigorous Impact Evaluation* presentation
Society for Social Work Research Conference, January 2014
- *Implementing an Evidence-Based Intervention to Reduce Long-Term Foster Care: Practitioner Perceptions of Key Challenges and Supports* presentation
Society for Social Work Research Conference, January 2014
- *A Multidimensional Approach to the Implementation of an Evidence-based Intervention to Reduce Long-term Foster Care: Practitioner, Administrator, and Researcher Perceptions of Key Facilitators and Challenges* presentation
Third International Conference on Practice Research, June 2014
- Akin, B. A., Mariscal, S. E., Bass, L., McArthur, V. B., Bhattarai, J., & Bruns, K. (2014). Implementation of an evidence-based intervention to reduce long-term foster care: Practitioner perceptions of key challenges and supports. *Children and Youth Services Review*, 46, 285–293.

The 2015 National Foster Care Month website included an article, ["Strengthening Families Through Crisis."](#) about a family who received services through KIPP and successfully reintegrated.

Sustainability

KIPP is working on long-term sustainability for the project. Through an agreement with the purveyor, KIPP owns their version of PMTO, which allows them to continue to use and train the intervention. However, obtaining funding to sustain the project beyond the grant funding period has proven to be a more difficult task. KIPP partners and staff met with and conducted presentations for leaders from the Kansas DCF and the Kansas Department for Aging and Disability Services, as well as managed care organizations, judges, and other stakeholders to discuss planning for KIPP beyond the project funding period. However, since KIPP cannot yet

¹⁰ To view the PowerPoint used for this webinar visit <http://muskie.usm.maine.edu/helpkids/telefiles/102913tele/NRCOI%20KIPP%20Oct%2029%202013%20-%2010-24-13.pdf>

share outcome data (per the grant award agreement), stakeholders are hesitant to support continuation of the project without knowing whether data suggest that the intervention works.

The uncertainty of having a long-term plan KIPP meant being unable to hire or train new therapists, which had an impact on hiring for positions left vacant through staff resignations. KIPP partners indicated this would become even more problematic during the last year of the project and would affect service delivery to families.

SITE VISIT DETAILS

The site visit occurred on March 3, 2015, at the University of Kansas-Edwards Campus in Overland Park, KS. During the site visit, a panel interview was conducted with members of the KIPP steering committee, including the following individuals:

- Becci Akin, KIPP co-principal investigator, KU School of Social Welfare
- Tom McDonald, KIPP co-principal investigator, KU School of Social Welfare
- Kim Bruns, KIPP project manager, KU School of Social Welfare
- Linda Bass, KVC Kansas
- Vickie McArthur, Saint Francis Community Services
- Cheryl Rathbun, Saint Francis Community Services
- Patricia Long, Kansas DCF

The panel interview focused on the target population and the intervention selected by KIPP to reduce LTFC for youth in the State. Additional information for the site visit report was obtained from various documents submitted to the Children's Bureau by KIPP.

LESSONS LEARNED

Successful Strategies

The KIPP steering committee reported that the following strategies have contributed to the success of the project:

- Involvement of all the partners in proposal preparation and selection of the target group and intervention
- Inclusion of leaders from the agency partners with decision-making authority on the KIPP steering committee
- Involvement of all the agency partners in project decision-making
- Administration of the project by the neutral, third-party university
- Existing data-sharing and cooperative agreements that allowed for data collection

In addition, the KIPP steering committee reported that the ongoing partnership/working relationship between KU, the State, and private providers was critical to the success of the project. The KIPP steering committee also reported that a representative from each partner agency was able to attend the PII grantee meetings in the District of Columbia, which was acknowledged as informative and beneficial to the collaborative and the overall project.

Challenges

The KIPP steering committee reported several challenges during the project period. The committee reported that it was more difficult to hire qualified staff in the more rural regions of the State, and that in these regions KIPP staff generally would have to drive farther to meet with their families than their KIPP counterparts in more urban regions. Another challenge reported by the KIPP steering committee was a change in dynamics during the recompetes contract year for the State foster care private providers. Instead of being able to interact openly and discuss all aspects of the providers' work, the conversations were limited to only discussions about the KIPP project.

Finally, the KIPP steering committee reported two other challenges, which were also lessons learned, to inform those involved in future project implementation. First, the committee reported that the KIPP therapist supervisors were trained with the first cohort of KIPP therapists. This did not provide the KIPP supervisors the credibility or knowledge needed to guide the new staff. The KIPP steering committee reported they would, if involved in future projects, have the supervisors trained first and not with the staff they would eventually supervise. Lastly, the committee reported that in exploring evidence-based practices of parental management (to work with families whose children were currently placed out of the home), it would have been advantageous to have selected an intervention that had evidence to support its use with children placed out of the home, which PMTO did not, although it did meet the other project requirements.

EVALUATION

The evaluation for the PII cluster uses two processes to examine the implementation and effectiveness of the initiative: site-specific evaluations and a cross-site evaluation. The site-specific evaluations consists of two phases: a formative evaluation and a subsequent summative evaluation. The formative evaluation monitors relationships between program outputs and short-term outcomes, specifically if the interventions selected by the grantees result in the expected outcomes. When the formative evaluation shows that program outputs and short-term outcomes are trending in the right direction, the grantees proceed to the summative evaluation. The summative evaluation is a rigorous evaluation of the long-term effects of the interventions and determines whether long-term outcomes are achieved and the extent to which these outcomes can be attributed to the intervention.

The cross-site evaluation uses a mixed-method approach that includes an administrative data study, an implementation study, and a cost study. The administrative data study looks at information from the Adoption and Foster Care Analysis and Reporting System (AFCARS), the National Child Abuse and Neglect Data System (NCANDS), and State data systems. The implementation study examines key implementation activities, and the cost study examines the costs of implementing the PII interventions. Additionally, the cross-site evaluation will examine key implementation activities and the context in which the programs operate. Westat is leading the PII evaluation team in partnership with James Bell Associates, the University of North Carolina School of Social Work, CLH Strategies & Solutions, Andy Barclay, and Ronna Cook Associates.

To learn more about the PII evaluation process, visit the [PII - Evaluation Team \(PII-ET\)](#) page on the Children's Bureau website.

To learn more about KIPP's evaluation process, refer to [KIPP Evaluation Overview](#) page on the Children's Bureau website. Evaluation findings will be published on the PII page as they become available.



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