EXECUTIVE SUMMARY

Improving Service Delivery for Children Affected by Trauma

An Implementation Study of Children's Institute, Inc.

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BUILDING KNOWLEDGE
TO IMPROVE SOCIAL POLICY

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Overview

The Children's Institute, Inc. (CII), is a multiservice organization in Los Angeles, California, that combines clinical mental health and other supportive services to meet the needs of children and their families who have been affected by trauma, such as physical or sexual abuse, domestic violence, or violence in the community. Through its Integrated Service Model, CII provides holistic and coordinated support to children and families by potentially engaging them in multiple services: clinical services to address children's mental health needs, programs for parents and guardians to help them better support their children, and youth activities to develop protective factors. The comprehensive nature of this model sets it apart from the often fragmented and uncoordinated child welfare system. A central aspect of CII's model is using evidence-based practices — highly specified treatment models that research has shown to be effective in treating a targeted population — in its clinical services.

The CII evaluation had two main components: an implementation study of CII's service model and a study of CII's delivery of evidence-based practices, including an in-depth fidelity study of its Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) services.

Key Findings

- CII is achieving its goal of engaging clients in multiple services to holistically meet their needs. A majority of clients receiving clinical services from CII also participated in another service at the organization.
- Analysis of management information system data indicates that nearly a third of the children engaged in clinical services received an evidence-based practice. While little is known about national norms for the use of evidence-based practices, the study's findings suggest that CII is a leader in providing them.
- Analysis also indicates that the dosage levels of Functional Family Therapy and TF-CBT — two prominent evidence-based practices at CII — were both in line with model expectations.
- The in-depth fidelity study of TF-CBT indicated that CII's implementation of the treatment model was aligned with that of other community-based organizations in similar fidelity studies. The average client had at least a 50 percent chance of receiving half of the model's core components.

A Technical Resource for this report presents the complete set of findings from the in-depth fidelity study of CII's delivery of TF-CBT and is available on the MDRC website.

CII is also involved in MDRC's Building Bridges and Bonds study of fatherhood programs, funded by the U.S. Department of Health and Human Services.

Preface

There is overwhelming evidence that traumatic experiences in childhood — such as physical or sexual assault, gang violence, domestic violence, or sudden loss of a loved one — can lead to poor outcomes in adulthood. While the child welfare field is extensive and works to improve the life prospects of trauma-affected children and families, the available services are nevertheless often fragmented and uncoordinated. Research has identified evidence-based practices that improve outcomes for these children and families, and there has been a push at the federal level in recent years to increase the use of such practices in children's mental health care. However, many of the current services available lack evidence of their effectiveness.

In this context, the Los Angeles-based Children's Institute, Inc. (CII), operates its wide range of programs and services, including clinical mental health services, early child care and Head Start programs, programs for parents and guardians, and youth development activities. Integrating and coordinating these services to address the holistic needs of children and families is a critical component of CII's service model, as is the use of evidence-based practices in mental health treatment when appropriate.

This report describes how in implementing its Integrated Service Model CII sought to overcome the barriers associated with the fragmented and uncoordinated child welfare system through an approach that attempts to identify clients' full range of needs and ensure they receive all the support required to address those needs. It offers lessons in how multiservice organizations such as CII can structure services to meet the holistic needs of clients. Integrating services as CII has done, however, is not without its challenges. Tailoring services to the varied needs of each client requires navigating the complex funding system on which multiservice organizations rely, and which includes public agencies, private foundations, and health insurance providers.

The report also adds to the understanding of the challenges of implementing evidence-based practices in community-based settings, where the highly specified protocols of these practices meet the realities of providing services in high-needs and under-resourced communities. The in-depth fidelity study of CII's delivery of Trauma-Focused Cognitive Behavioral Therapy services highlighted some of the difficulties therapists encounter when delivering a structured treatment to high-needs clients. The study found that therapists at CII did not provide all of the model's required treatment components, which is consistent with findings from other, similar studies of community-based providers. This finding suggests the need for robust and low-cost tools to help providers deliver evidence-based treatments with fidelity.

Gordon L. Berlin
President, MDRC

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This report is based upon work supported by the Social Innovation Fund (SIF), a major White House initiative and program of the Corporation for National and Community Service (CNCS). The SIF combines public and private resources with the goal of increasing the impact of innovative, community-based solutions that have compelling evidence of improving the lives of people in low-income communities throughout the United States.

The Edna McConnell Clark Foundation and the SIF include support from CNCS and 15 private co-investors: The Edna McConnell Clark Foundation, The Annie E. Casey Foundation, The Duke Endowment, The William and Flora Hewlett Foundation, The JPB Foundation, George Kaiser Family Foundation, The Kresge Foundation, Open Society Foundations, The Penzance Foundation, The Samberg Family Foundation, The Charles and Lynn Schusterman Family Foundation, The Starr Foundation, Tipping Point Community, The Wallace Foundation, and the Weingart Foundation. The Wallace Foundation provided additional support separate from its involvement with the SIF. This report would not have been possible without the support of these funders.

The assistance and support of many staff at Children's Institute, Inc. (CII), were critical to the success of this study throughout all phases of the project. We especially want to thank current CII leadership, in particular Mary Emmons, Nina Revoyr, Jacqueline Atkins, Marion Dave, and Manuel Rivera. We also thank Steve Ambrose, Todd Sosna, and Cynthia Thompson-Randle, all of whom have since moved on from CII but who were critical to the success of this evaluation. Thanks also goes to Bruce Baker for his insight. Our data analysis would not have been possible without the assistance of Joshua Shaw, Jade Wong, Bill Monro, and Patrick Foy. A special thanks goes to all the CII staff we interviewed during our site visits. We would also like to thank CII's funders and partners who participated in interviews, including representatives from Los Angeles County Departments of Mental Health and Children and Family Services.

The fidelity study of Trauma-Focused Cognitive Behavioral Therapy benefited from the efforts of many individuals. Patricia Chamberlain provided advice during the planning process. Our colleagues at the Medical University of South Carolina conducted the fidelity study: Rochelle Hanson, Jason Chapman, Sonja Schoenwald, Michael de Arellano, Carrie Jackson. CII's clinical supervisors obtained informed consent from the clients. Many thanks go to the therapists who agreed to participate in the fidelity study. We also thank Matthew Dutcher who entered all the data from the Brief Practice Checklists for the fidelity study. We would be remiss if we also did not extend our deepest thanks to the clients and their families who agreed to participate in the fidelity study as well.

The research team received useful feedback and encouragement throughout the project and comments on drafts of this report from Gabriel Rhoads, Jehan Velji, and Teresa Power at The Edna McConnell Clark Foundation.

At MDRC, John Martinez, Dan Bloom, David Butler, Rekha Balu, Kate Gualtieri, Robert Ivry, and Michael Johns provided thoughtful comments on several drafts of this report. We are grateful to Sally Dai for all the work she did to analyze the data. Melina Davis, Janae Bonsu, and Mifta Chowdhury assisted in qualitative data collection, and Mifta Chowdhury coordinated the production of the report. Christopher Boland edited the report, and Carolyn Thomas prepared it for publication.

The Authors

Executive Summary

Child abuse and neglect are significant problems in the United States, touching millions of lives each year. The U.S. Department of Health and Human Services reported that in fiscal year 2012, 3.2 million children nationwide were the subject of a report to child protective services. The majority of youth in the child welfare system exhibit behavioral or social issues that are severe enough to warrant mental health treatment, a rate up to five times greater than mental health needs among their peers in the community who are not involved in the child welfare system.[1]

Recent trends in the children's mental health care field have indicated that these behavioral and emotional issues can be largely attributed to trauma experienced earlier in life, which leads to "toxic stress responses" that can have a wide variety of adverse psychological and physiological consequences, some of which continue into adulthood.[2] Trauma can result from many experiences and events, including physical or sexual assault, gang violence, domestic violence, serious accidents, sudden or violent loss of a loved one, and natural disasters.[3] Children do not have to be the direct victims of violence to be affected by it; researchers have shown that exposure to community violence, such as hearing gun fire, has traumatic effects on children.[4] Child welfare organizations throughout the country combat trauma in all its forms through a combination of prevention programs, direct services to affected families, and advocacy. While the lifelong impact of childhood mental illness and trauma is well documented, many children and youth do not receive the mental health treatment they need. Even when they do receive treatment, services may be inadequate or ineffective, and are often fragmented and uncoordinated.

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[1]This estimate is based on studies across child welfare systems in several states, as well as recent results of the National Survey for Child and Adolescent Well-Being. John A. Landsverk, Barbara J. Burns, Leyla F. Stambaugh, and Jennifer A. Rolls Reutz, *Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature* (Seattle, WA: Casey Family Programs, 2006).

[2]Wendy K. Silverman, Claudio D. Ortiz, Chockalingham Viswesvaran, Barbara J. Burns, David J. Kolko, Frank W. Putnam, and Lisa Amaya-Jackson, "Evidence-Based Psychosocial Treatments for Children and Adolescents Exposed to Traumatic Events," *Journal of Clinical Child and Adolescent Psychology* 37, 1 (2008): 156-183; Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine* 14, 4 (1998): 245-258.

[3]Child Welfare Committee, National Child Traumatic Stress Network, *Child Welfare Trauma Training Tool Kit: Comprehensive Guide (2nd ed.)* (Los Angeles and Durham, NC: National Center for Child Traumatic Stress, 2008).

[4]Joy D. Osofsky (ed.), *Children in a Violent Society* (New York: Guilford Press, 1998).

This report presents findings from a study of the Children's Institute, Inc. (CII). A multiservice organization in Los Angeles, CII combines a broad range of clinical and nonclinical services to meet the needs of children and families who have been affected by trauma. Each year, CII serves more than 20,000 children and family members. CII's range of activities, which it calls its Integrated Service Model, serve the "whole child, entire family." Through its service model, CII provides a broad range of supports that the child and family may need to overcome a history of abuse or trauma, including clinical services to address mental health needs, programs for parents and guardians to help them better support their children, and nonclinical youth development activities to help children and youth acquire protective factors.[5] CII also operates child care and Head Start programs for young children. CII's treatment approach is trauma informed, and its services are designed to directly address the impact of trauma on children's lives. An important aspect of CII's Integrated Service Model is its focus on using evidence-based practices in clinical services. Evidence-based practices are highly specified treatment models that research has shown to be effective in treating specific symptoms in target populations.

The report's findings are based on work supported by the Social Innovation Fund (SIF), a program of the Corporation for National and Community Service.[6] The SIF combines public and private resources to increase the impact of innovative, community-based solutions with compelling evidence of improving the lives of people in low-income communities. As part of the Edna McConnell Clark Foundation SIF project, which focuses on children and youth ages 9 to 24 years, CII sought to expand its youth services, including the youth development activities offered in the Central and South Los Angeles neighborhoods.

Child Trauma and Treatment

While the lifelong impact of childhood mental illness and trauma is well documented, many children and youth do not receive the mental health treatment they need. Research has shown that many young people in need of such care either do not receive services, or, when they do, receive services that are inadequate or ineffective and often unsupported by evidence.[7] This report uses the term "usual care" to describe mental health care that is not based on evidence.[8]

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[5]Protective factors are characteristics of individuals, families, or communities that mitigate risks to health and well-being. Examples include positive social connections, parenting skills and knowledge of child development, and effective communication practices.

[6]CII is one of 12 evidence-based programs selected in 2011 to be part of the SIF program. EMCF matched $30 million from the SIF program with $30 million from its own endowment. The True North Fund, developed by EMCF in 2011, helped the 12 SIF grantees secure the $60 million they were required by statute to raise to match this funding.

[7]Barbara J. Burns, E. Jane Costello, Adrian Angold, Dan Tweed, Dalene Stangl, Elizabeth M. Z. Farmer, and Al Erkanli, "Children's Mental Health Service Use across Service Sectors," *Health Affairs* 14, 3 (1995): 147-159; Sheryl H. Kataoka, Lily Zhang, and Kenneth B. Wells, "Unmet Need for Mental Health Care among (continued)

At the federal level, there has been a significant push to incorporate evidence-based practices into mental health care for children and youth. Unlike many other types of mental health care, the treatment models for evidence-based practices are well defined. Each model or treatment practice typically specifies the target population for which the treatment has been shown to be effective, as well as the treatment's outcomes, content, dosage, and duration. While the current trend in the child welfare field is to increase the use of evidence-based practices, not every client may be appropriate to receive one of these treatments since they target highly specified symptoms or age groups.

Providing empirically supported treatment in community-based settings presents a host of challenges. Community-based settings are often quite different from the university research settings where the practices are usually first developed and tested. Community-based providers typically serve more diverse and higher-risk populations and have larger caseloads. Whether or not an evidence-based treatment offered in a community-based setting is effective depends on how the provider implements it. In order to transfer efficacy from research to practice, providers must implement the treatment with fidelity to the model that was originally tested, which can be particularly challenging in community-based settings. Fidelity encompasses a number of areas: staff training practices, targeting the appropriate population, administering the correct dosage and frequency of treatment, and adherence to the prescribed model.

Another challenge to effectively treating children and youth with mental health needs is that services are often fragmented and uncoordinated. Available services are often spread across different agencies, and funding streams support only specific types of care or treatment. This fragmentation limits the ability of providers to meet the full range of needs of children and families, which may include clinical mental health care, services to help the parents or guardians better support their children, and child and youth development activities to help the children and youth acquire protective factors and succeed in school.

Overview of CII

CII operates in three of Los Angeles County's eight Service Planning Areas: Downtown Los Angeles, Watts-South Central, and Torrance-Long Beach. Each of these areas is "high need," which means that a significant proportion of adult residents are low income, have not completed high school, have poor physical and mental health, and have experienced or reported abuse or community violence. In these areas, CII strives to implement a neighborhood approach, where-

US Children: Variation by Ethnicity and Insurance Status," *American Journal of Psychiatry* 159, 9 (2002): 1548-1555.

[8]The term "usual care" refers to treatments that are not empirically supported. Usual care is a term commonly used in the medical field to refer to the treatment received by patients in the control group of a randomized controlled trial.

by CII builds relationships with residents and institutions, such as schools, churches, and other child welfare agencies.

CII's services are roughly divided into four programmatic categories: clinical mental health services, family support, child and youth development, and early childhood care and education.

- **Clinical mental health** services include diagnosis and assessments of mental health needs, individual and group therapy, and family therapy. Licensed therapists or psychologists typically deliver these services, which may include evidence-based or evidence-informed practices.[9]

- **Family support** includes programs offered to parents or guardians. These programs address parent education, child development, and family economic success and stability through case management, parenting classes, support groups for fathers and grandparents, financial literacy workshops, and job-readiness supports.

- **Youth development** includes nonclinical activities, such as programs for young people of different ages that address life skills, social skills, literacy and education, creative arts, and health and wellness.

- **Early childhood care and education** services are for infants and children from birth to 5 years of age. They include Head Start and child care programs. Though early childhood programming encompasses more than one-fifth of CII's overall budget, these services were not the focus of this SIF initiative, which targeted youth ages 9 to 24 years.

As an operating philosophy, CII coordinates the services it provides to meet the holistic needs of children and their families. This approach stands in contrast to the fragmented services that often characterize the child welfare system. CII conceptualized this philosophy around three components: recovery, resiliency, and readiness.

- **Recovery** from adverse childhood experiences involves reducing the effects of trauma and high-risk behaviors. Recovery is the primary focus of CII's clinical services.

- **Resiliency** is the capacity of young people and their families to persevere and prevent the effects of trauma, and it is developed by enhancing protective

[9]Evidence-informed practices are treatments that share characteristics with evidence-based practices but fall short of the required threshold of evidence.

factors and reducing risks. It is the primary focus of early childhood, family support, and youth development programming.

- **Readiness** for success in school, work, and life involves positive and healthy personal behaviors and social relationships, engagement with education or occupational training, and the ability to connect to supports or resources. CII's combined services support readiness.

Through its Integrated Service Model, CII knits these components together to address the complex needs of the families it serves. Depending on their needs, clients may receive multiple types of services throughout their involvement with CII. The Integrated Service Model aims not to simply offer multiple services but to eliminate operating silos among its various services and create a system that accurately identifies clients' full range of needs and ensures they receive all the support required to address those needs. This report in large part assesses CII's implementation of the Integrated Service Model.

The CII Evaluation

Building evidence is a core component of the SIF, and each SIF grantee is required to undergo an evaluation of its service model. The evaluation of CII consisted of two main components: an implementation study of CII's service model and a study of CII's delivery of evidence-based practices, including an in-depth fidelity study of its delivery of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Both components focused on understanding how the agency implements services to address issues of childhood trauma. Overall, this evaluation provided CII staff with an independent review of its services, delivery model, and data system. Furthermore, it serves as a case study for other program operators or policymakers in how to structure services to meet the holistic needs of clients and how to overcome the barriers to effectively serving children associated with a fragmented child welfare system.

The study attempted to answer three main questions:

- How do CII's services and delivery model meet the needs of the diverse population it serves, particularly services provided to children and youth 9 to 24 years old?
- How does CII's Integrated Service Model combine and coordinate its clinical and nonclinical services to address the holistic needs of children and families?
- How does CII integrate evidence-based practices, particularly Functional Family Therapy (FFT) and TF-CBT, into its array of clinical services?

To answer these questions, the MDRC research team analyzed a mix of quantitative and qualitative data. The quantitative data included clients' demographic data and service participation records for services received during 2012 and 2013; the research team collected these data from CII's management information system. The MDRC research team also gathered qualitative data about program operations through interviews with CII staff and representatives from some of its partners, primarily during three site visits in 2013. The team also asked CII clinicians and their supervisors to complete a web-based survey in 2013. In partnership with MDRC, a team from the Medical University of South Carolina conducted a fidelity study of CII's delivery of TF-CBT services using an observational method.

Implementation of CII Services

Analyses of these data point to the following findings:

- **CII's Integrated Service Model is innovative and highly ambitious.**

CII's Integrated Service Model seeks to overcome the shortcomings of the child welfare system, but CII staff still had to work within that fragmented system to fund its services. CII staff confronted numerous external funding constraints to providing services in the holistic way envisioned by the Integrated Service Model. CII funds its programs and services through a combination of service fees and contracts. However, each of these funding streams comes with a host of requirements and stipulations. As a result, the set of services that a client may need does not always fit neatly into one of the available funding streams. To tailor services to each client's needs, CII staff must therefore find flexible funding streams or creatively combine contractual or other funding streams.

- **Preliminary analysis shows that CII's implementation of the Integrated Service Model appears to be strong with respect to clients receiving clinical services.**

CII strives to provide multiple services to clients to address their many needs and high-risk factors. The overwhelming majority of clients receiving CII's clinical services also participated in another service at CII, and nearly half of clients in clinical services participated in all three types of services. It was not possible to fully assess CII's progress in implementing the Integrated Service Model because the research team did not have access to data about clients' risk factors, which are integral to determining whether clients had unmet needs.

- **CII is a leader in adopting and implementing evidence-based practices; nearly a third of clients receiving clinical services engaged in an evidence-based practice.[10]**

CII also provides a number of evidence-informed therapies; more than 20 percent of clients in the analysis received one of these treatments.[11] CII is viewed as a leader in implementing and providing evidence-based practices. As an early adopter, CII first began incorporating evidence-based practices into its clinical model in 1999. Little is known about national norms for usage of evidence-based practices; according to one estimate of youth receiving care through California's county mental health plans, only 2 percent of youth received an evidence-based practice.[12] Importantly, evidence-based practices are neither appropriate for every client nor are they available for every age group. While the proportion of CII's clients receiving evidence-based practices exceeds the California estimate many times over, it is difficult to know whether this concentration of clients receiving these practices was appropriate without knowing more about each client's circumstances. This study, however, was not designed for such an analysis, and the research team did not have the detailed data about each client to conduct one.

- **The dosage levels of both FFT and TF-CBT aligned with model expectations.**

Analysis of data from CII's management information system indicated that, on average, clients receiving FFT attended 15 sessions over the course of five months. Similarly, clients receiving TF-CBT on average attended 19 sessions over five months. The dosage of both therapies fell within the bounds set by their respective treatment models, although both fell on the higher end of the models' acceptable ranges.[13] Data were not available on factors that may have contributed to the relatively high number of sessions; however, CII staff indicated in interviews that the complex nature of the clients' history of trauma and tumultuous lives often resulted in frequent family crises during treatment.

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[10]Evidence-based practices include the following treatments and programs: Cognitive Behavioral Intervention for Trauma in Schools, Child Parent Psychotherapy, FFT, Incredible Years, Managing and Adapting Practice, Multidimensional Treatment Foster Care, Parent-Child Interactive Therapy, Reflective Parenting Program, TF-CBT, and Trauma Systems Therapy-Substance Abuse.

[11]Evidence-informed practices include the following treatments and programs: Domestic Violence Treatment Groups, Project Fatherhood, Wraparound services, Youth with Sexual Behavior Problems, and social skills and parent support groups. These practices are informed by some evidence but not as much as evidence-based practices have accumulated.

[12]Technical Assistance Collaborative and Human Services Research Institute, *California Mental Health and Substance Use System Needs Assessment Appendices* (California Department of Health Care Services, 2012). Website: www.dhcs.ca.gov/provgovpart/Documents/Data%20Appendices%203%201%2012.pdf.

[13]The acceptable range for FFT is 8 to 12 sessions; the acceptable range for TF-CBT is 12 to 20 sessions.

- **CII's fidelity to the TF-CBT model was in line with previous fidelity studies of TF-CBT in community-based settings. Clients on average were more than 50 percent likely to receive half of the treatment's core components.**

A rigorous examination of the adherence of therapists at CII to the TF-CBT model using an observational method found that the average client had at least a 50 percent chance of receiving half of the core components of the model.[14] The finding that clients did not receive all components of TF-CBT is consistent with other research on the implementation of TF-CBT in community-based settings. Clients were most likely to receive the cognitive coping, relaxation, affective expression and modulation, psychoeducation, and trauma narrative components of TF-CBT. The study found therapists delivered the parent component at low rates, which is also consistent with prior research.[15] The study found that fidelity varied at the client level rather than the therapist level, indicating that clients seen by the same therapist could have had varying experiences with TF-CBT.

The fidelity study also found that a therapist self-report tool, the Brief Practice Checklist, led to similar conclusions about the usage of TF-CBT components as did an observational method. This finding indicates that the Brief Practice Checklist may be a promising low-cost tool to monitor fidelity. Observational methods of monitoring fidelity, such as the one used in this study, are time and resource intensive and not practical on a large scale for many community-based organizations. Therapists and supervisors could use the Brief Practice Checklist to monitor whether or not therapists are delivering the TF-CBT components, and supervisors could use the information in the checklist to advise therapists on cases and on how to eliminate any roadblocks to providing the treatment as intended. Organizations could also use data from the checklists to compare differing outcomes among cases and identify and assess any patterns. However, there are some limitations to using the checklist on its own to evaluate fidelity. Therapists in this study had the tendency to over-report their use of components, relative to the observational data. Additionally, observational methods can measure the extent to which therapists implement each component, whereas the Brief Practice Checklist can only measure whether or not therapists implement the components. However, organizations could use the Brief Practice Checklist in combination with others tools, such as periodic direct or audio-recorded observations, to monitor fidelity more comprehensively. The use of the Brief Practice Checklist as a fidelity tool merits further study.

[14]A Technical Resource for this report presents the full study and is available on the MDRC website at www.mdrc.org.

[15]TF-CBT requires that the therapist meet separately with the child and the parent or guardian with similar frequency, and meet conjointly with both at particular points during treatment.

Conclusion

As policymakers, practitioners, and researchers in the child welfare field work to improve services available through the child welfare system, CII and its experience developing and implementing its Integrated Service Model as well as delivering evidence-based practices offer important lessons. These lessons could be useful not only to similar multiservice organizations but to all those in the child welfare field looking for the best ways to serve children through an often fragmented child welfare system. Those interested in evidence-based practices may find the findings from the fidelity study of TF-CBT useful. These findings suggest that one area for further research could be investigating how to cost-effectively combine self-reporting tools and observational methods to support fidelity.

About MDRC

MDRC is a nonprofit, nonpartisan social and education policy research organization dedicated to learning what works to improve the well-being of low-income people. Through its research and the active communication of its findings, MDRC seeks to enhance the effectiveness of social and education policies and programs.

Founded in 1974 and located in New York City and Oakland, California, MDRC is best known for mounting rigorous, large-scale, real-world tests of new and existing policies and programs. Its projects are a mix of demonstrations (field tests of promising new program approaches) and evaluations of ongoing government and community initiatives. MDRC's staff bring an unusual combination of research and organizational experience to their work, providing expertise on the latest in qualitative and quantitative methods and on program design, development, implementation, and management. MDRC seeks to learn not just whether a program is effective but also how and why the program's effects occur. In addition, it tries to place each project's findings in the broader context of related research — in order to build knowledge about what works across the social and education policy fields. MDRC's findings, lessons, and best practices are proactively shared with a broad audience in the policy and practitioner community as well as with the general public and the media.

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