

Title IV-E Prevention Plan

Section III: Title IV-E Prevention Services (Service Description and Oversight) Table Template

Last updated on 4/8/2021

The below table is designed to display the necessary information for Section III of the Title IV-E Prevention Plan. This document also provides excerpts from other states' submitted Prevention Plans that detail their approaches to section III.

Evidence-Based Practice	Manual	Target Population	Level of Evidence Assigned by the Title IV- E Prevention Services Clearinghouse	Intended Outcomes	Level of Evaluation Evaluation, evaluation waiver, and/or CQI needed	Implementation Capacity and Readiness to Scale	Trauma-Informed Framework
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-

The below pages provide excerpts of other states' submitted prevention plans that detail their approaches to section III (updates evolving quarterly as new plans are submitted, or submitted plans are revised and approved). For more information contact us at FamilyFirstChapin@Chapinhall.org.

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Arkansas

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Title IV-E Prevention Services Description and Oversight

Pre-Print Section 1

Arkansas has worked hard the past several years to build its prevention services and In-Home program prioritizing evidence-based services that meet the needs of families and help to keep kids safely in their homes. Family First offers an opportunity to continue and expand some of the existing services and expand the array of evidence-based services. Below are the programs Arkansas has identified to best meet the needs of its clients. DCFS has started this transformation with in-home parenting programs but will include Mental Health and Substance Abuse services and programs in the future as the Division expands implementation of Family First. Arkansas is working with the National Council on Crime and Delinquency (NCCD) to complete the independent systematic review of each service as necessary to claim transitional payments.

a. In-Home Parenting

SafeCare – SafeCare is a home visiting program with more than 30 years of research supporting its effectiveness at reducing child abuse and neglect and strengthening positive parenting skills. The parentskill based intervention is for parents or caretakers of children ages zero to five. SafeCare is module based and delivered over 18-22 sessions. The three modules address three risk factors that can lead to child abuse and neglect: 1) The parent-child relationship, 2) home safety, and 3) caring for the health of young children. Each module includes a baseline assessment, intervention (training sessions), and a follow-up assessment to monitor progress over the course of the program. SafeCare is trauma informed and is a clearly defined and replicable program.

DCFS has a partnership with Arkansas Children's Hospital (ACH). ACH is responsible for the provision of SafeCare in central Arkansas and through subcontracts with local providers across the state. They are supported by the National SafeCare Training and Research Center, which monitors fidelity and grants accreditation. Arkansas's SafeCare received accreditation in April 2019.

SafeCare is under the umbrella of the Arkansas Home Visiting Network; unlike other home visiting programs in the network, it is exclusively for DCFS clients. It is currently in all ten of the division's geographic areas, though they are not accepting referrals yet in three of those counties. Training for DCFS staff is planned in Jan. 2020.1 SafeCare is currently funded by Medicaid, but DCFS will provide a

15% match starting Oct. 1, 2019. DCFS will assume full responsibility for payments on Oct. 1, 2020. As such, DCFS will not be asking for reimbursement on SafeCare until FFY 2021. However, DCFS is requesting that the 15% state match spent on SafeCare in FFY 2020 count towards the 50% state expenditures on well-supported programs.

Current referral criteria for SafeCare includes a child who is the subject of a Garrett's Law investigation or a protective services case is open due to a true finding of medical neglect, failure to thrive, Munchausen by Proxy, or other neglect categories. As Safecare started prior to the passage of Family First, candidacy and/or Family First eligibility was not initially included in the eligibility criteria; however, this will be a requirement starting Oct. 1, 2019. This should not have a negative impact on referrals as a review of SafeCare clients showed that 96% of referrals met Arkansas's definition of candidacy. Once, DCFS assumes payment the PIs will be changed so that SafeCare can also be provided to parenting foster youth who do not have a true determination of maltreatment. SafeCare has not been rated by the Title IVE Prevention Services Clearinghouse at this time but is scheduled to be reviewed. DCFS believes that SafeCare meets the standards set forth in the Family First Services and Prevention Act² as a well-supported practice. Below are 4 relevant studies.

1. Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics*, 129(3), 509-515. doi: 10.1542/peds.2011-1840.
2. Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project Safecare: Teaching bonding, safety and healthcare skills to parents. *Child Maltreatment*, 7(3), 277-285.
3. Beachy-Quick, K., Lee, C., McConnell, L., Orsi, R., Timpe, Z., & Winokur, M. (2018). SafeCare Colorado program evaluation report 2014-2017. Unpublished report, Colorado State University, Fort Collins, CO.
4. Burke, J., Bigelow, K., Carta, J., Borkowski, J., Grandfield, E., McCune, L., Irvin, D., et al. (2017). Long-term impact of a cell phone-enhanced parenting intervention. *Child Maltreatment*, 22(4), 305-314.

Nurturing Parenting Program – NPP is an evidence-based, trauma-informed in-home parenting program. Nurturing the Families of Arkansas (NFA) is Arkansas's version of the Nurturing Parenting Program, a program for parents and caregivers involved in in-home cases with children between the ages of 5-18, though exceptions can be made for children 0-4. The 16-week program is administered in groups and/or individually and is designed to build and strengthen positive parenting skills. By providing parents with improved parenting techniques, NFA aims to safely reduce the number of children entering the foster care system and decrease future involvement with DCFS.

As part of Arkansas's IV-E waiver initiative, NFA was Arkansas's first evidence-based prevention program. The evaluation of the program concluded that NFA had positive outcomes for children and

families in Arkansas including reducing future maltreatment and removal into foster care. Arkansas saw the best outcomes for families who had a D.R. and then subsequently had a protective services (PS) case where NFA was provided. After seeing these results, referral criteria were changed to allow for NFA to be provided through a supportive services case. This allows NFA to be provided to appropriate families from a DR/supportive services case and hopefully prevent a true finding from ever occurring. Arkansas also updated referral criteria to allow a parenting foster care youth who is placed with their child to participate in NFA. Due to this change, NFA trained their staff on NPP curriculum for the 0-4 age group in the winter of 2019. The evaluation also showed that parents who completed the program consistently had positive feedback regarding the program and the staff. Because of the positive feedback received and the measurable outcomes for families, Arkansas plans to continue this EBP. NFA is already available in all 75 counties.

NPP was developed in 1983 and based around the 6 protective factors: Nurturing and Attachment, Knowledge of Parenting and Child Development, Parental Resilience, Social Connections, Concrete Support Services for Parents, and Social and Emotional Competence of Children. The lessons provided address inappropriate parenting expectations, lack of empathy, strong belief in use of corporal punishment, inappropriate family roles, and oppressing children's power and independence. Assessments are completed pre, during, and post services to measure differences in a parent's knowledge, skills, and parenting beliefs.

NPP has 30 years of research supporting its effectiveness in the treatment and prevention of child abuse and neglect. NPP is currently being reviewed by the Title IV-E Prevention Services Clearinghouse. Despite it being on the list for review, Arkansas has decided to continue with an independent systematic review as receiving transitional payments for this service will assist DCFS in implementing Family First by Oct. 1, 2019. The following are 7 relevant studies demonstrating the effectiveness of NPP.

1. Hodnett, R.H., Faulk, K., Dellinger, A., Maher, E, Evaluation of the Statewide Implementation of a Parent Education Program in Louisiana's Child Welfare Agency, 2009
2. Maher, E. J., Marcynyszyn, L. A., Corwin, T. W., & Hodnett, R. (2011). Dosage matters: The relationship between participation in the Nurturing Parenting Program for Infants, Toddlers, and Preschoolers and subsequent child maltreatment. *Children and Youth Services Review*, 33, 1426-1434. DOI: 10.1016/j.childyouth.2011.04.014
3. Wagner, K.F., "Parenting Education and Child Welfare Recidivism: A Comparative Study of the Nurturing Parenting Program Graduates and Non-Graduates of Fresno County" Abstract, May 2001
4. Broyles, G., Easter, L., Primak, K., Shackford, L., "Nurturing Program Follow-Up Study: Boulder County Department of Social Services Nurturing Program" Research Report, 1992
5. Bavolek, S.J., Keene, R., Weikert, P., "The Florida Study: A Comparative Examination of the Effectiveness of the Nurturing Parenting Programs" Research Report, 2005

6. Cherry, K, Cooper, C, Cross-Hemmer, A, Duong, T, Furrer, C, Green, B, Rockhill, A, Rodgers, A, "Oregon's IV-E Waiver Demonstration Project: Final Evaluation Report." Relationship-Based Visitation & Parent Mentor Evaluations. Center for the Improvement of Child and Family Services Portland State University. December 2015
7. Hornby Zeller Associates, Inc., "Arkansas IV-E Waiver Demonstration Project: Final Report." June 2019.

Intensive In-Home – Arkansas implemented Intensive In-Home Services in February 2019. This is a pilot program in 37 counties.⁵ Arkansas identified a gap in its service array, for families that needed intensive services for longer than four to six weeks to help them achieve stability and maintain gains. Arkansas wanted a program that was similar to its Intensive Family Services⁶, but in addition to crisis intervention, provided longer-term support to help families achieve the necessary skills and social support network to maintain long-term stabilization. Arkansas put out an RFQ with the parameters that needed to be met including length of service and expected outcomes, but requested the providers propose the evidencebased intervention used to deliver the service. Arkansas chose three different providers that presented different intervention models. Below are the interventions (additional information on Intensive In-Home Services can also be found in Arkansas's 2020-2024 Child and Family Services Plan Goal 2, Strategy 4. For a family to be eligible for Intensive In-Home Services they must have an open in-home case where at least one child is a candidate for foster care or an open foster care case where intensive services is needed for reunification to be successful. While not the target population, any of the Intensive In-Home programs may be appropriate for a parenting foster youth, if their needs cannot be met by NFA or SafeCare once available.

YVIIntercept™

YVIIntercept™ is the model used by Youth Villages. It is an integrated approach to in-home parenting skill development that offers a variety of evidence-based practices to meet the individualized needs of a family and young person. Specifically, it employs the following evidencebased practices, as clinically indicated: Adolescent Community Reinforcement Approach (ACRA), Community Advocacy Project (CAP), Collaborative Problem Solving (CPS), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Motivational Interviewing. This program is a trauma informed in-home services program providing family-centered treatment with strength-based interventions. This comprehensive intervention takes a therapeutic approach to parenting skills education, educational interventions, development of positive peer groups, and extensive help for families and children in accessing community resources and long-term, ongoing support.

Family intervention specialists work with both the child and the caregivers to address issues that are impacting the stability of the family, meeting with children and caregivers a minimum of twothree times weekly depending on family need and providing families with access to 24-hour oncall support. Services are tailored to meet each family's needs, ongoing assessments and reviews measure progress throughout the intervention.

The goals of the program are to reduce subsequent maltreatment, prevent foster care placement, and reduce time in state custody by successfully reuniting children with their families in a timelier manner. Diversion services generally last four to six months, while reunification services generally last six to nine months.

YVIIntercept™ is currently available in Alabama, Arkansas, Florida, Georgia, Indiana, Massachusetts, New Hampshire, North Carolina, Oklahoma, Ohio, Oregon, and Tennessee. YVIIntercept™ is currently the subject of a rigorous evaluation by an independent third party that examines whether YVIIntercept™ (1) reduces the risk of placement into foster care among children who are at risk of placement having never been in out of home care previously, and (2) affects the rate of permanency, time to permanency, and re-entry into care for children referred to the program while in foster care. At this time, YVIIntercept™ has two quasi-experimental studies underway that should be completed fall of 2019. Youth Villages is confident that it will meet the standard for a promising practice as defined by Family First.⁷ Arkansas is contracting with NCCD to complete an independent systematic review in order to receive transitional payments for this service.

Family Centered Treatment

Family Centered Treatment (FCT) is a strength-based, trauma-informed, and evidence-based family preservation model that provides services to families directly in their homes. FCT is designed to find simple, practical, and common-sense solutions for families faced with disruption or dissolution of their family.

This program follows a four-stage process of Joining and Assessment, Restructuring, Valuing Changes, and Generalization. The length of treatment is determined by the family's needs and progress, but the average length of treatment is six months. The foundations of FCT are grounded in Eco-Structural Family Therapy and Emotionally Focused Therapy. FCT is clearly defined and replicable. The Family Centered Treatment Foundation has a best practice implementation process that allows prospective and current licensed FCT providers to identify and plan for sustainable implementation. FCT has not been evaluated by the Title IV-E Clearinghouse; however, Arkansas contracted with NCCD to complete an independent systematic review in order to receive transitional payments for this service. NCCD determined a rating of Well-Supported for FCT.

St. Francis Ministries has implemented FCT in 15 counties in the Northern and Eastern parts of Arkansas.

Youth Advocate Programs (YAP) has implemented a different model to provide Intensive InHome Services; however, after the results of the Independent Systematic Review, YAP is currently working on

switching their model to FCT. YAP is servicing an additional 13 counties in the Northern and Southern parts of Arkansas.

Once YAP is trained and implementing FCT, roughly a third of the state will have access to this well-supported practice.

There is only one version of FCT. The manuals used for implementation are The Wheels of Change: The Family Centered specialist's handbook and training manual©- William E. Painter Jr. and Mario Smith and Family Centered Treatment® Design and Implementation Guide- Tim Wood.

The following are relevant studies which demonstrate the effectiveness of FCT.

1. Bright, C. L., Betsinger, S., Farrell, J., et all. (2015). Youth Outcomes Following Family Centered Treatment® in Maryland. Baltimore, MD: University of Maryland School of Social Work.
2. Bright, C. L., Farrell, J., Winters, A. M., Betsinger, S., & Lee, B. R. (2018). Family Centered Treatment, juvenile justice, and the grand challenge of smart decarceration. Research on Social Work Practice, 28(5), 638-645.
3. The Indiana University Evaluation Team & The Department of Child Services. (2018) Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project Final Report. Indianapolis, IN: Indiana University School of Social Work and Indiana Department of Child Services.
4. Sullivan, J. P. (2006). Family Centered Treatment: A unique alternative. Corrections Today, 68(3)

Intensive Family Services – Arkansas currently provides Intensive Family Services (IFS) in 23 counties. IFS is a four to six-week intensive in-home service to improve parenting skills, parent-child relationships, and prevent children from coming into foster care. IFS is delivered by six different providers across the state. Current IFS providers are not required to be accredited by or to otherwise utilize an evidence-based model. As the current contract for IFS ends June 30, 2019, Arkansas has researched evidence-based models and selected Homebuilders® as the required evidence-based model for the RFP. Homebuilders is extremely similar to the current model allowing for an easy transition for DCFS staff and providers. Homebuilders® has a rigorous amount of research supporting its effectiveness and systems in place for the implementation of and maintaining fidelity to the model.

As the current IFS is not a specified model, Arkansas will not claim reimbursement for IFS until July 2020, and HomeBuilders® is rated on the Title IV-E Prevention Services Clearinghouse. However, IFS will already be an option in the family's prevention plan. As the population IFS serves will remain the same, this will help DCFS plan for cost and refining candidacy and referral criteria.

Homebuilders®

Homebuilders® is a home and community-based intensive family preservation service designed to avoid unnecessary placement of children in foster care, group care, psychiatric hospitals, or juvenile justice facilities. When working with families involved in child welfare due to neglect, activities focus on improving the physical condition of the home, improving supervision, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. This program is typically delivered in a four to six-week time frame and serves families with children ages 0-17. Homebuilders® is clearly defined, replicable, and formal support is available for implementation. Homebuilders® is set to be reviewed by the Title IV-E clearinghouse, and Arkansas believes that Homebuilders® will meet the criteria for a well-supported practice. DCFS did not include this service to be in its independent systematic review because it should be rated by the Title IV-E Clearinghouse prior to the implementation of the service. The following are relevant studies that demonstrate the effectiveness of Homebuilders®.

1. Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. *Children and Youth Services Review*, 18(4/5), 335-361.
2. Fraser, M. W., Pecora, P.J., and Haapala, D.A. (Eds.) (1991), *Families in Crisis: The Impact of Intensive Family Preservation Services*. New York: Aldine de Gruyter.
3. Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton, W., (1996), An Experiment in Family Reunification Services: Correlates of Outcomes at One Year Follow Up. *Children and Youth Services Review*, Vol. 18, Nos. 4/5 pp. 335-361.
4. Kirk, R.S. & Griffith, D.P., (2004), Intensive family preservation services: Demonstrating placement prevention using event history analysis. *Social Work Research*, Vol. 28, No. 1, pp. 5-15.
5. Blythe, B. & Jayaratne, S., (2002), Michigan Families First Effectiveness Study.

Teaching Family Model (TFM)

While Arkansas is not currently procuring a contract for the Teaching Family Model, it will be considered in the future for expansion of Family First. TFM is a unique approach to human services that uses "teaching parents" to model positive healthy parenting, living, and interpersonal interaction skills. This program is designed to be provided in any residential setting. When implementing TFM as a home-based diversion program, the model calls for 10-15 sessions a week for 6-10 weeks. TFM is trauma informed, clearly defined, and replicable with formal support for implementation. There are providers in Arkansas who currently provide TFM in residential settings and are interested in providing TFM as a diversion program in partnership with DCFS.

TFM is currently not rated by the Title IV-E Prevention Services Clearinghouse, but Arkansas believes that it meets the definition of a well-supported practice under Family First.⁹ The following shows relevant research demonstrating the effectiveness of TFM.

1. Lewis, R. E. (2005). The effectiveness of Families First services: An experimental study. *Children and Youth Services Review*, 27, 499-509.
2. Lee, B. R., & Thompson, R. (2008). Comparing outcomes for youth in treatment foster care and family-style group care. *Children and Youth Services Review*, 30, 746-757.
3. Hess, J.Z., Arner, W., Skyes, E., Price, A.G., & Tanana, M. (2012). Helping juvenile offenders on their own turf: Tracking the recidivism outcomes of a home-based intervention. *OJDDP Journal of Juvenile Justice*, 2(1)

Table 1 Chosen In-Home Parenting EBP's, with proximal outcomes, and selection reason¹⁰

EBP Intervention	Target Population	Expected Proximal Outcomes	Expected Distal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed ¹¹
SafeCare	Children ages 0-5 and their caregivers	<ul style="list-style-type: none"> • Increase positive parent child interaction; • Improvement in parents' care of child's health; • Enhanced home safety. 	<ul style="list-style-type: none"> • Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population. 	Evidenced based practice with successful outcomes for the population DCFS serves that filled a service gap for a vulnerable age group.	Formal Contracted Evaluation	✓
Nurturing Families of Arkansas (Nurturing Parent Program)	Children ages 5-18 and their caregivers, and parenting foster youth regardless of the child's age	<ul style="list-style-type: none"> • Measurable gains in individual self-worth of parents and children; • Increase in parental empathy in meeting their children's and their own needs in healthy ways; • Increase in utilization of dignified, non-violent disciplinary strategies and practices; • Increase in nurturing parenting beliefs, knowledge, and utilization of skills and strategies. 	<ul style="list-style-type: none"> • Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population. 	Evidence- based parenting program with results in preventing child abuse and neglect. Implemented as part of the IV-E Waiver in an effort to build up prevention services in Arkansas. As it was a successful intervention, DCFS has continued to increase access to NFA.	Formal Contracted Evaluation	✓
YYIntercept™	Children ages 0-18 and their caregivers	<ul style="list-style-type: none"> • Decrease in length of time spent in residential, psychiatric or other out-of-home placement; • Decrease in emotional and behavioral problems in youth; • Decrease in substance abuse and involvement with juvenile justice system. 	<ul style="list-style-type: none"> • Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population. 	Proven track record of helping to reduce the number of children in foster care in Tennessee and has experience providing prevention services in multiple states. Uses evidence-based interventions with a stringent supervision model. Meets a gap in the DCFS service array.	Formal Contracted Evaluation	✓
Family Centered Treatment	Children 0-18 and their caregivers	<ul style="list-style-type: none"> • Reduction in hurtful and harmful behaviors affecting family functioning; • Development of emotional and functioning balance in family so that 	<ul style="list-style-type: none"> • Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; 	St. Francis has had success in providing Family Centered Treatment in two other states. This model addresses the needs of families with a	Formal Contracted Evaluation	✓

EBP Intervention	Target Population	Expected Proximal Outcomes	Expected Distal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed ¹¹
		<p>the family system can cope effectively with individual members' intrinsic challenges;</p> <ul style="list-style-type: none"> • Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist; • Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability. 	<ul style="list-style-type: none"> • Reduction in overall foster care population. 	trauma -informed and evidence-based service. St. Francis included in their proposal an understanding of the challenges and impact of community poverty which is important as some of the counties where they provide services are some of the poorest areas in the nation.		

b. Mental Health

Arkansas recognizes that evidence-based mental health services are critical to the populations it serves. Furthermore, DCFS wants to continue to improve the quality of mental health services available to clients. Mental health treatment for adults and children involved with child welfare are mainly covered through Medicaid and private insurance. Many DCFS clients already have Medicaid and workers can

help eligible clients apply if they do not have coverage or their coverage has lapsed. DCFS does have small contracts for counseling services for those children and caregivers who do not have coverage. These contracts are for counseling agencies and/or private licensed providers.

The Division's current counseling contracts do not specify that therapists must be certified to provide specific therapies. While DCFS will not amend its contracts to require certification in the below therapeutic modalities, as that would be too limiting on providers and clients, the contract PIs will be revised to encourage providers to be trained in these approaches. DCFS is also changing the format of the providers' monthly reports. Providers will now report not only which clients they see and whether or not the payor source is Medicaid, DCFS contract, or other, but also if they are using one of the specified trauma-informed, evidence-based therapies listed in the Division's IV-E Prevention Program Five-Year Plan, and if the client is eligible under Family First. DCFS recognizes that not all of clients will be appropriate for one of these therapies, that not all mental health diagnoses have a corresponding evidence-based therapy as a best practice standard of care, and that some clients may need an evidence-based therapy that is currently not included in the plan. For these reasons, DCFS is not limiting its contracted therapists to these treatment modalities. In addition, providers may choose to add to their monthly report other evidence-based therapies they are providing which may lead to other evidencebased therapies added to Arkansas's IV-E Prevention Program Five-Year Plan.

In the past, DCFS has partnered with ARBest to help educate DCFS staff on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and increase the use of this therapy for children in foster care. ARBest is a state-funded program through the University of Arkansas Medical Sciences, Psychiatric Research Institute which aims to improve outcomes for traumatized children and families through excellence in clinical care, training, advocacy, and evaluation. In addition to the work ARBest has done in regards to TF-CBT, they also provide training for therapists in the evidence-based, trauma-informed practices of Parent Child Interaction Therapy (PCIT), Cognitive Processing Therapy (CPT) and Parent Child Psychotherapy (CPP). ARBest keeps an up-to-date register of therapists in Arkansas who are able to provide each of these therapies. Because of the respected work ARBest is already doing in the state and the strong partnership between ARBest and DCFS, the Division included these therapies in its IV-E Prevention Program Five-Year Plan. DCFS also chose Functional Family Therapy (FFT) to include in the plan. While ARBest does not provide training for this intervention, FFT is well-supported and specifically addresses the needs of older youth and their families.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) – TF-CBT is a trauma informed evidence-based mental health treatment for children and adolescents who have experienced trauma from events such as sexual or physical abuse. TF-CBT is considered the gold-standard in treatment for child trauma. TF-CBT aims to reduce trauma symptoms while strengthening the parent-child relationship. The Title IV-E Clearinghouse has rated TF-CBT as a promising practice. As such, Arkansas will not be requesting

reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Parent Child Interaction Therapy (PCIT) – PCIT is an evidence-based dyadic behavioral intervention for children ages two through seven and their parents or caregivers. The treatment focuses on decreasing externalized disruptive behavior in young children with a history of trauma. This treatment has been shown to improve parent-child attachment, reducing symptoms of trauma in children, and improvements in children's behavior. PCIT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse. DCFS has contracts across the state with multiple counseling agencies. PCIT is provided by several therapists in these various agencies. All therapists providing PCIT have been certified in PCIT with The Parent-Child Interaction Therapy Protocol- Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011. PCIT International, Inc. This is the manual used in the Title IV-E Prevention Services Clearinghouse review of PCIT. ARBest provides the training for PCIT which involves an 18-month process including a four-day in-person training, a two day follow up training, and 18 months of consultation calls held weekly and requiring the completion of two full PCIT cases. PCIT also requires agency support for therapists. Contracted therapists providing PCIT must show proof of training and fidelity to the model. The DCFS Assistant Director of Mental Health provides contract oversight and CQI of contracted mental health providers. In addition to monthly reports, quarterly meetings are held to discuss issues and address barriers and the DCFS Assistant Director of Mental Health also completes quarterly Vendor Performance Reports. Arkansas will not be requesting reimbursement for this service at this time.

Cognitive Processing Therapy (CPT) – CPT is a trauma-informed cognitive behavioral treatment for PTSD in adults. It has shown to be effective in reducing PTSD symptoms to a variety of traumatic events such as rape, abuse, and events of war. CPT is endorsed by the U.S. Departments of Veterans Affairs and Defense as a best practice for the treatment of PTSD. In order to increase the number of CPT-trained therapists in Arkansas, ARBest began providing CPT training in 2019. The Title IV-E Clearinghouse has not yet rated CPT. As such, Arkansas will not be requesting reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Child-Parent Psychotherapy (CPP) - CPP is a trauma-informed, evidence-based treatment for young children (ages zero through five) who have experienced trauma. It has been shown to be effective at reducing emotional and behavioral difficulties associated with trauma, strengthen the parent-child relationship, and enhance safe caregiving practices. The Title IV-E Clearinghouse has not yet rated CPP. As such, Arkansas will not be requesting reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Functional Family Therapy (FFT) – FFT is a trauma-informed evidence-based therapeutic intervention for at-risk families and juvenile justice involved youth. The FFT model is for families with children ages 10-18 to help develop better family relationships, learn to control anger and problem solve without fighting, improve positive communication skills, build trusting and respectful family relationships, and prevent involvement in the juvenile and legal system. FFT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse. DCFS has contracts across the state with multiple counseling agencies. Currently no therapists are trained in FFT, but several are interested in becoming FFT providers. All therapists providing FFT will be certified in FFT with Functional Family Therapy for Adolescent Behavioral Problems Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for Adolescent Behavioral Problems*. Washington, D.C.: American Psychological Association. This is the manual used in the Title IV-E Prevention Services Clearinghouse review of FFT. Contracted therapists providing FFT must show proof of training and fidelity to the model which includes three phases: clinical training, supervisor training, and maintenance phase. The maintenance phase includes ongoing training and annual renewal. In addition to the requirements set by FFT, DCFS' Assistant Director of Mental Health would provide contract oversight and CQI of providers through monthly reports and quarterly meetings to discuss issues and address barriers. Arkansas is not requesting reimbursement for this service at this time.

Table 2 Chosen Mental Health EBP's, with proximal outcomes, and selection reason

EBP Interventions	Target Population	Expected Proximal Outcomes ¹²	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed ¹³
TF-CBT	Children ages 3-18 and their caregivers	Improved PTSD, depression, and anxiety symptoms; reduced behavior problems; reduce parenting distress; improved adaptive functioning, and improved parenting skills.	TF-CBT is an evidence-based and considered the gold standard in trauma treatment for children. Arkansas has a good support and training system for TF-CBT therapists through ARBest.	Promising	No	✓
PCIT	Children ages 2-6 and their caregivers	Increased parent-child closeness; decreased anger and frustration; increased self-esteem; increased parental ability to comfort child; improved parenting skills in behavior management and communication.	PCIT is a well-supported evidence-based model that addresses many of the needs of children and families served by DCFS. ARBest also trains therapists across Arkansas in PCIT.	Well-Supported	No	✓
CPT	Adults	Decrease symptoms of PTSD and depression; help clients feel emotions about the traumatic event and reduce avoidance; develop balanced and realistic beliefs about the event,	CPT is an evidence-based treatment for adults with trauma. Many of the adults the Division serves have unaddressed	Not yet rated	No	✓

EBP Interventions	Target Population	Expected Proximal Outcomes ¹²	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed ¹³
		oneself, others and the world; decrease the emotions that result from maladaptive beliefs (guilt/shame/anger).	trauma that is a complicating factor in their lives. ARBest is currently training therapists in this modality. Arkansas expects CPT to be well-supported when it is rated by the Title IV-E Clearinghouse.			
CPP	Children 0-5 and their caregivers	Support and strengthen the caregiver-child relationship; reduce emotional and behavioral difficulties associated with trauma.	CPP is a trauma informed evidence-based model that addresses many of the needs of children and families served by DCFS. ARBest also trains therapists across Arkansas in CPP. Arkansas expects CPP to be well-supported when it is rated by the Title IV-E Clearinghouse.	Not yet rated	No	✓
FFT	Children 11-18 and their families	Eliminate behavior problems, delinquency, and substance abuse; improve prosocial behavior for the youth; and improve overall family functioning and skills.	FFT is a well-supported evidence-based model that addresses many of the needs of older youth and families served by DCFS.	Well-Supported	No	✓

EBP Interventions	Target Population	Expected Proximal Outcomes ¹²	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed ¹³
		functioning and skills.	families served by DCFS.			

At this time, DCFS is not able to provide an evaluation for each therapeutic intervention listed. Therefore, while the work will begin in terms of teaching the Division's front-line staff about these therapies, changing the PIs in the DCFS counseling contracts, and implementing the new provider monthly reports in January 2020; DCFS will not request claimability on all of these services until such time as they are on the Title IVE Prevention Services Clearinghouse as well-supported or it becomes feasible for DCFS to conduct its own evaluation.

c. Substance Abuse

DCFS is not currently requesting any substance abuse programs or treatment be a part of its Title IV-E Prevention Program Five-Year Plan. There are no approved substance abuse treatment models on the Title IV-E Prevention Services Clearinghouse that are currently being used in Arkansas, nor does Arkansas have the resources at this time to do an independent evaluation of substance abuse treatment modalities. However, DCFS is looking at the following programs/services to explore for expansion of FFPSA implementation at a later date.

Methadone Maintenance Therapy – Methadone Maintenance Therapy combines therapy with methadone medication for the treatment of opiate addiction. There are currently five Methadone Maintenance Clinics in Arkansas. The Title IV-E Prevention Services Clearinghouse has rated Methadone Maintenance Therapy as a promising practice. DCFS does not have the resources at this time to do an independent evaluation of clients in this treatment but will be exploring this as a possibility for expansion of FFPSA implementation.

Arkansas Center for Addictions Research, Education, and Services (Arkansas Cares) – Arkansas Cares is a program of Methodist Family Health. It is a 3-month residential treatment program for parenting mothers with children 12 years old and younger. It is a dual diagnosis program that treats substance abuse and mental illness simultaneously. The family centered approach used is based on the Teaching Family Model. Additional services include parent training, vocational and educational training, children's mental health services, early education services, and transitional housing. The program aims to decrease maternal substance abuse and promote healthy families. Arkansas Cares is currently rated as a promising practice on the CEBC. As the Title IV-E Prevention Services Clearinghouse has not rated the program and DCFS does not currently have the ability to do an independent evaluation, DCFS is not requesting transitional payments for this service at this time. However, DCFS will be working with Methodist Family Health to explore how to partner to expand service availability and make this an official part of Family First in Arkansas.

d. Cross Sectional

Motivational Interviewing (MI) - Motivational interviewing is a client-centered method used to help increase clients' intrinsic motivation to change. MI can be used by itself or in combination with other treatments. It is often used in pre-treatment work to help engage and motivate clients for other treatment modalities as it helps clients explore and resolve their ambivalence to change. MI is currently being reviewed by the Title IV-E Prevention Services Clearinghouse under substance abuse interventions; however, DCFS is encouraging the Children's Bureau to take a broader look at MI as a beneficial piece in multiple disciplines. Such an expansion might then warrant all front-line child welfare staff being trained in MI. DCFS is exploring the costs associated with MI training, the logistics of training and coaching staff, and the feasibility of implementing an independent evaluation.

Table 3 Chosen Substance Abuse and Cross-sectional EBP's, with proximal outcomes, and selection reason

EBP Interventions	Target Population	Expected Proximal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed ¹⁴
Methadone Maintenance	Adults with opioid addiction	Reduction in the use of other opioids; mortality; injection drug-related risk behaviors, criminal activity; improvement in physical and mental health, social functioning, quality of life; retention in treatment programs.	Methadone Maintenance Therapy is evidence-based and is available in Arkansas. Methadone Maintenance Clinics could be a vital support to parents with opioid addiction.	To be determined	✓
AR Cares	Mothers with dual diagnosis (children must be 12 and under)	Decrease maternal substance abuse; promote healthy families; reduce foster care placements.	AR Cares is a successful residential program where mothers can keep their children with them. There is a lack of services available in the state.	To be determined	✓
Motivational Interviewing	All clients as a support for other interventions	Higher rates of active participation in services including drug treatment	MI is appropriate for use with youth and adults. It is evidence-based but does not	To be determined	✓

EBP Interventions	Target Population	Expected Proximal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed ¹⁴
			<p>require a Master's level education enabling all front-line staff to be able to provide this service.</p> <p>Being trained in MI would give staff another tool and resource to help build their skills and ability to work with clients.</p>		

Table 4 Timeline of Services¹⁵

In-Home Parenting	Service	DCFS Contract	Provider	Coverage	Payment Source	Title IV-E Clearinghouse Rating (Designated (D)/Anticipated (A))	Expected FFPSA IV-E Match
	SafeCare	✓	Arkansas Children's Hospital and subcontractors	Statewide ¹⁶	Medicaid	Well-Supported (A)	TBD
	NFA	✓	MidSouth University Partners	Statewide	Waiver funded	Promising (A)	TBD
	YVInterceptTM (IIHS)	✓	Youth Villages	9 Counties	DCFS	Promising (A)	TBD
	Family Centered Treatment (IIHS)	✓	St. Francis	15 Counties	DCFS	Well-Supported (A)	Oct. 1, 2019

	Family Centered Treatment (IHS)	✓	Youth Advocate Programs	13 Counties	DCFS	Well-Supported (A)	TBD ¹⁷
	Homebuilders ® (IFS)	✓	To be determined	To be determined	DCFS and Medicaid	Well-Supported (A)	July 1, 2020
	Teaching Family Model (IFS)	✓	To be determined	To be determined	DCFS	Well-Supported (A)	TBD
Mental Health ¹⁸	TF-CBT		Multiple Providers	Statewide	Medicaid/ DCFS	Promising (D)	TBD
	Parent Child Interaction Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (D)	TBD
	Cognitive Processing Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (A)	TBD
	Child Parent Psycho-therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (A)	TBD
	Functional Family Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (D)	TBD
Substance Abuse	Methadone Maintenance Therapy		Multiple Providers	5 Counties	Medicaid/ private pay ¹⁹	Promising (A)	TBD
	Arkansas Cares		Methodist	Pulaski	Medicaid/ DCFS	Promising (A)	TBD
Cross-Sectional	Motivational Interviewing		DCFS	Statewide	DCFS	Well-Supported (D)	TBD

Oversight and CQI

Oversight is provided by DCFS Program Management Staff and DHS contract management staff. DCFS uses monthly reports and a contract provider portal for monthly data analysis along with provider meetings and feedback loops between front line staff and providers. DCFS will implement semi-annual case reviews performed by the Program Management staff to oversee contract performance and ensure quality service delivery to children and families. Contract providers using evidence-based models are required to maintain fidelity of the model.

In addition to DCFS' contracted evaluation, many of these services also have fidelity measures to which they must adhere in order to administer the program. SafeCare is a model that requires oversight and accreditation from the national SafeCare office. Intercept, and Family Centered Treatment (FCT) are the current models for Intensive In-Home in Arkansas. FCT requires licensure through the Family Centered Treatment Foundation which provides training, coaching, and certification to allow agencies to implement this model. Intercept was created by Youth Villages which has strong fidelity measures to ensure appropriate implementation. The proposed IFS service is HomeBuilders®. Homebuilders requires certification through the Institute for Family Development and has fidelity measures. Lastly, NFA is accredited through the Nurturing Parenting.

Specifically, in regard to FCT, in order for an agency to apply to provide the FCT model, they have to commit to ensure Family Centered Treatment Certification for all FCT clinicians, ensure FCT approved supervisor training for all FCT supervisors, sustainability of adherence of fidelity to the FCT model after implementation and certification, and provide a system to provide data collection to assure fidelity to the model. FCT requires licensure through the Family Centered Treatment Foundation which provides training, coaching, and certification to allow agencies to implement this model. As the providers of FCT are licensed by the Family Centered Treatment Foundation, there is already stringent monitoring of fidelity to the model. The DCFS In-Home Program Manager is in communication with the Family Centered Treatment Foundation consultant in charge of monitoring fidelity for St. Francis and will continue that for Youth Advocate Program.

DCFS is committed to providing continuous quality improvement and has included FCT into the overall activities for the State's CQI process and is amending the contract with Public Consulting Group (PCG), to include CQI of FCT. PCG currently conducts Quality Service Peer Reviews for DCFS using the federal Onsite Review Instrument (OSRI) to continually assess the ability of DCFS to improve its case practice. The CQI team will expand to assess the extent to which the FCT contracted providers are adhering to the model of the evidence-based program and that positive outcomes in the areas of Safety, Permanency, and Well-Being are being achieved for families who are served.

PCG will use a combination of case record reviews; interviews with parents/caregivers, DCFS staff, and providers; and a survey administered to program participants to inform the CQI reviews. These reviews aim to answer the following questions:

Process Questions

- To what degree were the Family Centered Evaluation tools used to adequately identify changes needed to improve family functioning?
- To what degree was sufficient structure provided to families to guide them to complete tasks to meet their goals?
- To what extent were families able to learn to recognize and value their improved behaviors?
- To what extent do families have the capacity to handle crises independently of DCFS and other external parties?
- To what extent are families satisfied with the support they received from the FCT provider?

Outcome Questions

- To what extent are children of participating families able to remain safely in their own homes?
- To what extent do children have improved behavioral and emotional functioning?
- To what extent have parenting practices improved?
- To what extent has family functioning improved?

As described above, data collection shall include case record reviews, interviews, and surveys. The collection strategy for each is described below.

Case record reviews – PCG will select a total of 50 cases annually, with 25 cases reviewed semiannually. The semi-annual reviews will provide DCFs with the opportunity to make mid-course corrections if needed. The CQI team will create a structured case record review instrument for reviewers to gather needed information to answer the research questions, minus the one which assesses client satisfaction, as that will be captured elsewhere.

St. Francis Ministries implements FCT in 15 counties, with an additional 13 counties to be served by Youth Advocate Program once trained. A stratified sample will be taken, selecting cases in proportion to those who began FCT within the last four to eight months prior to the start of the review month. This provides an opportunity to conduct a review of cases for families that have completed the program, providing the ability to assess all four phases of FCT, as well as an increased opportunity to meet with families in the interview phase of data collection, especially with those who are still active.

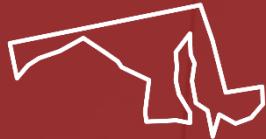
Interviews – As part of the case reviews, the CQI review team will conduct and interview with at least one parent or caregiver from each case, the case manager from the FCT provider who is or was assigned the case, and the DCFS family service worker. Attempts will be made to ask families who are no longer participating in the program to also participate in the interviews. A semi-structured interview protocol will be developed to encourage discussion with the respective parties and to learn about the successes and challenges the families, FSW, and FCT provider encountered while receiving or providing support. This data collection strategy will be most helpful in shaping recommendations to improve the FCT program and likely other in-home service models as well.

Surveys – A survey will be administered to all families as they exit the program, regardless if they completed FCT successfully or not. The survey will consist of a series of yes/no, multiple choice, and Likert scale questions, and at least one open-ended question, in order to quantify the extent to which the FCT providers adhered to the four phases of the model, from the perspective of the clients themselves. Results of the survey will also be used to gauge client satisfaction. The open-ended question(s) will allow respondents an opportunity to either explain their answer(s) or provide additional input. Based on the past experience of PCG, the providers will be asked to give the survey to families as they exit the program. The survey will include an online address which families can access to respond. Alternatively, families will be given an opportunity to return the completed survey in a postage paid return address envelope. These measures promote an increased response rate by allowing families to respond to PCG directly, promoting anonymity.

PCG will use both qualitative and quantitative analyses to inform the process and outcome components of the CQI review. As the CQI team carries out their onsite reviews of the sampled cases, the results will be posted to a secure online data collection instrument developed and hosted by PCG. Analysts will use a combination of SQL and R to measure frequencies and test for statistical significance. Comparisons will be drawn across the two providers and, where sufficient cases are sampled, across counties or at least across service areas. In future years, comparisons will also be drawn across review periods to measure practice improvement and to identify where practices or outcomes may be slipping. Quantitative data analysis will be used to inform the results of the surveys. Dependent on the rate of response, additional analysis will be done to identify the extent to which a family's characteristics have an influence on their satisfaction of the program. The CQI team will conduct qualitative analysis of the interviews conducted with families, FSWs, and the FCT providers, looking for common themes as well as differences. Qualitative analysis will also be conducted of the open-ended question(s) included within the survey to clients.

At the end of each semi-annual review, the CQI team will meet as a group to discuss emerging trends both in terms of successes and challenges for participating families as well as the two provider and DCFS. This information, gathered and assimilated qualitatively, will also be used to inform the results of the CQI reviews and provide input into promising practices and shaping recommendations for improvement.

Within a month of completing the case reviews, PCG will provide DCFS with a draft report. The draft report will provide answers to each of the research questions, drawing comparisons over time, including across the two FCT providers and Service Areas. Each report will also include a summary of the program's strengths, areas of improvement, and recommendation for change. These reports will be discussed with Area Directors and supervisors at each area's QSPR Presentation and Discussion.



Maryland

Status: Approved

Section III: Evaluation Strategy and Waiver Request

Title IV-E Prevention Services Description and Implementation Plan

Maryland has selected an array of prevention programs for this plan that meet the evidence levels required by Family First and best align with the needs of children identified as at imminent risk of entering foster care, pregnant/parenting young people and their families. These services were identified through robust analysis of data on the needs and characteristics of potential candidates for foster care, the circumstances that are associated with children's placement into foster care, and a thorough scan of existing evidence-based programs implemented across the state.

Proposed Evidence-Based Preventive Services

Table 1 represents the programs that Maryland is requesting in its Prevention Plan that align with the needs of Maryland's target population and are currently rated by the Title IV-E Prevention Services Clearinghouse (Clearinghouse) as having achieved an approvable evidence rating. For each program, Maryland plans to implement the same EBP model version as reviewed and approved by the Clearinghouse. Maryland does not plan to implement any of these models with adaptations or alterations to the model.

Table 1: Maryland proposed preventive programs with a Title IV-E Prevention Services Clearinghouse rating

Program Type	Evidenced Based Program	Clearinghouse Rating	Version in Use/Documentation
Parenting	Healthy Families America	Well-Supported	Consistent with current required model training and manuals for Healthy Families America per https://www.healthyfamiliesamerica.org/
	Nurse Family Partnership	Well-Supported	Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamilypartnership.org/
Mental Health	Functional Family Therapy	Well-Supported	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i> . Washington, D.C.: American Psychological Association
	Parent Child Interaction Therapy	Well-Supported	Eyberg, S. & Funderburk, B. (2011) <i>Parent-Child Interaction Therapy</i>

			<i>Protocol: 2011. PCIT International, Inc.</i>
	Multisystemic Therapy	Well-Supported	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). <i>Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (2nd ed.)</i> . New York: The Guilford Press.

- Healthy Families America (HFA). HFA is home visiting program with a goal of preventing abuse or neglect or intervening with families at high risk of abuse and neglect. Families are eligible to receive HFA services beginning prenatally or within three months of birth. When referred from

child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experience. HFA is currently implemented in 20 jurisdictions, many with support from the Maryland Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, an initiative funded by the Health Resources and Services Administration (HRSA), in partnership with the Administration for Children and Families (ACF). The goal under this Prevention Plan is to ensure facilitation of these services for child welfare system-involved families.

- Nurse Family Partnership (NFP) NFP is a home-visiting program where nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. It targets young, first-time low-income mothers from early pregnancy through the child's first two years. Given this program's target population, it may be most suited to pregnant and parenting youth in foster care or families with low risk who are referred to SSA due to their newborn's substance exposure. NFP is implemented in 8 jurisdictions in Maryland, many with support via MIECHV. The goal under this Prevention Plan is to ensure facilitation of these services for child welfare system-involved families.
- Functional Family Therapy (FFT). FFT a short-term, high-quality intervention program for youth demonstrating behavioral health problems. The target population is pre-teens to teens with serious concerns such as conduct disorder, violent acting-out and substance abuse. Approximately 15% of children entering foster care in Maryland have the child's behavior as a factor in the placement, indicating a significant need for programs such as FFT. FFT is currently available in 21 jurisdictions across Maryland via two providers, who both receive FFT clinical consultation from FFT, LLC. In 2007, Maryland's Children's Cabinet, DJS, and local Departments of Social Services began to work collaboratively to substantially increase the availability of FFT to youth and families in Maryland. Maryland's stakeholders selected FFT with the goals of improving outcomes for youth and families and reducing the use of out-of-home placements.
- Parent Child Interaction Therapy (PCIT). PCIT is a behavioral parent training program with coaching by a trained therapist in behavior-management and relationship skills. It targets 2-7 year olds with emotional/behavioral issues and their parents/caregivers. PCIT is currently available in at least 6 jurisdictions in Maryland. One program was established via the Title IV-E Waiver demonstration; the rest have been installed via other grant and implementation efforts, with some operating for many years. Under the Title IV-E Waiver demonstration, DHS/SSA provided funding for training and other implementation support costs. The Institute has partnered with PCIT International to coordinate the training and certification of new PCIT-trained clinicians, and had also established a contract with a PCIT Master Trainer to provide on-going implementation consultation for the jurisdiction involved with the Waiver. Maryland is fortunate to have several certified PCIT trainers in the State to assist with clinician development and expansion.
- Multisystemic Therapy (MST). MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. It targets youth, ages 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors. MST is currently available in 5 jurisdictions in Maryland through three providers and implementation is supported by The Institute. Like FFT, stakeholders from Maryland's child-serving agencies selected MST with the goals of improving outcomes for youth and families and serving youth in their homes, thereby

reducing out-of-home placements. The current providers have been implementing MST for well over 10 years.

The next set of interventions, represented in Table 2, are not rated by the Clearinghouse as of the submission of this plan. However, DHS/SSA research indicates that these programs have demonstrable evidence that will make them approvable by the Children's Bureau in the near future. Until they are determined to be allowable by the Children's Bureau, we are not claiming title IV-E reimbursement for the programs in Table 2 at this time.

Table 2: Maryland proposed preventive programs not yet rated

Program Type	Evidenced Based Program	Evidence Source and Rating
Parenting	Nurturing Parenting Program	Pending Clearinghouse review CEBC - Promising
Mental Health	Family Centered Treatment	Anticipated systematic review CEBC – Promising
Substance Use Disorder	Sobriety Treatment and Recovery Teams	Anticipated systematic review CEBC – Promising

These programs represent important elements of Maryland's service array that are already implemented and would be beneficial to continue or expand.

Nurturing Parenting Program (NPP). NPP for Parents and their Infants, Toddlers and Preschoolers is a family-centered program designed for the prevention and treatment of child abuse and neglect. Both parents and their children birth to five years participate in home-based, group-based, or combination group-based and home-based program models. Lessons are competency-based ensuring parental learning and mastery of skills. The program lessons focus on remediating five parenting patterns known to form the basis of maltreatment. The Nurturing Parenting Program for Parents and their School Age Children 5 to 12 Years is a 15-session program that is group-based and family-centered. As home visiting programs for parents of children from pregnancy to age 2 are the most prevalent type of evidence-based parenting skills programs in Maryland, the Nurturing Parenting Program represents a program that targets parents of children up to the middle years and can thus reach an essential part of our target population.

Sobriety Treatment and Recovery Teams (START). START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. The program targets families with at least one child 5 or younger in

the child welfare system and have a parent where substance use is a primary child safety risk factor. Maryland used its Waiver to invest in a needs assessment as well as fit and readiness activities prior to selecting and beginning installation of START in over half of Maryland's jurisdictions. START is uniquely situated to address the needs of families with young children affected by substance use disorders, which is a significant group within our target population. Data shows that there were 2,568 substance exposed newborn notifications to local departments in SFY2018, 1,534 of them receiving in-home services. As mentioned early, approximately one quarter of entries into foster care are associated with parental substance use – many of whom have young children. Approval of START via the Prevention Plan offers Maryland the opportunity to continue and potentially expand DHS/SSA initial investment in START.

Family Centered Treatment (FCT), is a well-established and evaluated intervention available in all jurisdictions in Maryland with a focus on youth involved in the juvenile justice system. FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. It is targeted towards family members at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. Since FCT has been used particularly effectively with crossover youth, Family First provides Maryland the ability to expand its use to child welfare populations and potential crossover youth who are at imminent risk of foster care.

All of the programs in Table 2 have been rated by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare as highly relevant to child welfare and as promising interventions. One of these programs, NPP, is pending review by the Clearinghouse review as of December 2019 and Maryland anticipates that it will meet one of the required evidence levels in the near future. Maryland is considering the remaining two programs, FCT and START, for a systematic review. SSA has become aware of other states that are similarly interested in pursuing, or have already submitted to CB, a systematic review for these two programs based on the strength of evidence. SSA respectfully requests that the Children's Bureau and the Administration for Children and Families prioritize these programs for review in the Clearinghouse.

Finally, Maryland has identified additional services that would meet the needs of our families that are not included here for a variety of reasons. Maryland intends to submit additional iterations of this plan as more programs are approved by the federal government, DHS/SSA engages in additional planning around the implementation, training and evaluation of those programs, and Maryland works with the provider community to further expand effective services. Further, Maryland remains committed to using all available resources and funding sources to ensure that there is a quality array of services to strengthen families and prevent foster care.

Please see Appendix C for a summary of all proposed evidence-based interventions, including a brief description of the program and target population, evidence ratings, intended outcomes and current scope of the program across Maryland.

Trauma Informed Framework

A key criteria for selecting the evidence-based services included in this plan was that the service itself had a trauma-informed approach. DHS/SSA identified whether a service has a trauma-informed approach by several methods:

- Identification as a trauma-informed intervention on the National Child Traumatic Stress Network website;
- Listed as a trauma treatment on the California Evidence-Based Clearinghouse (CEBC); and/or;
- Otherwise described as including trauma-informed approaches via the CEBC, another federal clearinghouse such as the Home Visiting Evidence of Effectiveness (HOMVEE) review project, or the purveyor's websites or other literature.

One of Maryland's core strategies for implementing its vision is to promote safe, reliable and effective practice through a strength-based, trauma-responsive practice model for child welfare and adult services. As described in Maryland's 2020 - 2024 Child and Family Services Plan, DHS/SSA will integrate the practice model into our standard contract language for providers. This includes ensuring that providers are using a trauma-informed framework and co-creating with providers the standard reporting methods and metrics to assess their delivery of trauma informed care.

DHS/SSA anticipates at least annual monitoring of the trauma-informed framework, consistent with our contracts review and continuous quality improvement strategy. In particular, DHS/SSA currently requires placement providers to complete a Program Questionnaire to gather comprehensive information about the services offered and youth served by programs that are utilized by the Department of Juvenile Services and local departments of social services. This information is used to describe the service array, to identify gaps in services, and to improve service matching based on youth characteristics, including identified risks, needs, and strengths. Included in the Program Questionnaire is the following set of questions related to the provision of trauma informed care

- Written policies and procedures are established based on an understanding of the impact of trauma on children, youth and families.
- Staff members have regular team meetings and/or supervision where topics related to trauma and self-care are addressed.
- Every child has a written crisis-prevention plan that includes: list of triggers; list of ways child shows they are stressed/overwhelmed; specific strategies that are helpful/not helpful when a

child is feeling upset/overwhelmed; list of people the child feels safe around/can go to for support.

- Based on trauma screening and the intake assessment, children are referred for further assessment and trauma-specific services by providers with expertise in trauma.
- The program educates children, youth and families about traumatic stress and triggers.
- Staff at all levels of the program receive training and education that includes what traumatic stress is, how traumatic stress affects the body and brain, and the relationship between mental health and trauma.

Providers implementing an evidence-based program under DHS/SSA prevention plan will be required, through a contractual obligation, to answer a similar set of questions to ensure that their services are delivered within a trauma informed framework.

See Appendix D for Maryland's assurance that each service and program in this plan is delivered under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach.

Implementation Approach

Maryland selected its services for this plan with a focus on the feasibility of implementation. In particular, consistent with the National Implementation Research Network's Hexagon exploration tool (Metz and Louison, 2019), DHS/SSA explored and considered whether programs demonstrate evidence, whether there are implementation supports, and usability. Maryland's experience with Waiver also provided us with valuable lessons which influenced our selection of services and informs our approach to ongoing examination of implementation and sustainability. SSA selected programs for this plan that have been installed and have an existing provider base in at least five jurisdictions, ensuring that there is both reach and efficiencies of scale. SSA also selected programs that had some level of established fidelity and/or outcomes monitoring consistent with purveyor criteria.

As the programs have already been installed, Maryland will implement Family First initially utilizing existing DHS/SSA contracts and/or expanding contracts and memoranda of understanding with sister agencies for those programs that have been primarily supported through another public agency.

Primary responsibility for the development and implementation of the Title IV-E Prevention Plan rests with the Implementation Teams. These teams are further informed and guided by the Outcomes Improvement Steering Committee within Maryland's existing Implementation structure. These teams include representatives from the stakeholder and provider community, including families and youth,

advisory and advocacy groups, community providers, university partners, the court system, and the Families Blossom evaluation team. The Implementation Structure allows for:

- Real-time refinements and enhancements during development and implementation;
- Identification and allocation of needed resources;
- Promotion of timely policy and programmatic decisions;
- Continual tracking and monitoring of progress towards identified outcomes; and
- Managing and sustaining the desired change.

The Implementation Teams will take information synthesized through continuous quality improvement and evaluation activities to ensure that the Prevention Plan is meeting agency goals and to address and resolve any organizational or systemic challenges or barriers. Please see the continuous quality improvement strategy section below for additional information on how Maryland will engage in ongoing activities to inform and enhance successful implementation.

Appendix C: Table of Proposed Evidence-Based Programs for Maryland's Prevention Plan

Evidence-Based Program Name, Description & Requested Funding	Target Age & Clients	Targeted Outcomes/ Select Program Goals	Evidence Rating & Source	Installed Jurisdictions	
Healthy Families America (HFA) HFA is a home visiting program with a goal of preventing abuse or neglect or intervening with families at high risk of abuse and neglect. Families are eligible to receive HFA services beginning prenatally or within three months of birth. When referred from child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experience. <i>Title IV-E Prevention Services Funding Requested</i>	<input checked="" type="checkbox"/> 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<i>Child Safety, Child Well-Being, Family Well-Being</i> <ul style="list-style-type: none"> • Reduce child maltreatment • Improve parent-child interactions and children's social-emotional well-being • Increase school readiness • Promote child physical health and development • Promote positive parenting • Promote family self-sufficiency • Increase access to primary care medical services and community services • Decrease child injuries and emergency department use² 	<i>Clearinghouse –Well supported</i>	<input checked="" type="checkbox"/> Allegany <input type="checkbox"/> Anne Arundel <input checked="" type="checkbox"/> Baltimore <input checked="" type="checkbox"/> Baltimore City <input checked="" type="checkbox"/> Calvert <input checked="" type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input type="checkbox"/> Cecil <input checked="" type="checkbox"/> Charles <input checked="" type="checkbox"/> Dorchester <input checked="" type="checkbox"/> Frederick <input checked="" type="checkbox"/> Garrett <i>20 jurisdictions</i>	<input checked="" type="checkbox"/> Harford <input type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input checked="" type="checkbox"/> Montgomery <input checked="" type="checkbox"/> Prince George's <input checked="" type="checkbox"/> Queen Anne's <input checked="" type="checkbox"/> St. Mary's <input checked="" type="checkbox"/> Somerset <input checked="" type="checkbox"/> Talbot <input checked="" type="checkbox"/> Washington <input checked="" type="checkbox"/> Wicomico <input checked="" type="checkbox"/> Worcester
Nurturing Parenting Program (NPP) NPP for Parents and their Infants, Toddlers and Preschoolers is a family-centered program designed for the prevention and treatment of child abuse and neglect. Both parents and their children birth to five years participate in home-based, group-based, or combination group-based and home-based program models. Lessons are competency-based ensuring parental learning and mastery of skills. The program lessons focus on remediating five parenting patterns known to form the basis of maltreatment. The Nurturing Parenting Program for Parents and their	<input checked="" type="checkbox"/> 0-2 <input checked="" type="checkbox"/> 3-5 <input checked="" type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Group	<i>Child Safety, Child Well-Being, Family Well-Being</i> <ul style="list-style-type: none"> • Measurable gains in the individual self-worth of parents and children • Measurable gains in parental empathy and meeting their own adult needs in healthy ways. • Measurable gains in parental empathy towards meeting the needs of their children. • Utilization of dignified, non-violent disciplinary strategies and practices. • Measurable gains in empowerment of the parents and their children. • Measurable gains in nurturing parenting 	<i>CEBC –Promising Clearinghouse - Pending Review</i>	<input type="checkbox"/> Allegany <input type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input checked="" type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input checked="" type="checkbox"/> Cecil <input type="checkbox"/> Charles <input type="checkbox"/> Dorchester	<input checked="" type="checkbox"/> Harford <input type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input type="checkbox"/> Montgomery <input type="checkbox"/> Prince George's <input checked="" type="checkbox"/> Queen Anne's <input type="checkbox"/> St. Mary's <input type="checkbox"/> Somerset <input checked="" type="checkbox"/> Talbot <input type="checkbox"/> Washington

School Age Children 5 to 12 Years is a 15-session program that is group-based, and family-centered.		beliefs, knowledge and utilization of skills and strategies as measured by program assessment inventories • Reunification of parents and their children who are in foster care		<input type="checkbox"/> Frederick <input type="checkbox"/> Garrett <i>6 jurisdictions</i>	<input type="checkbox"/> Wicomico <input type="checkbox"/> Worcester
Nurse Family Partnerships (NFP) NFP is a home-visiting program where nurses provide support related to individualized goal setting, preventative health practices, parenting skills and educational and career planning, based on the needs/requests of the parent. NFP targets young, first time low income mothers from early pregnancy through the child's first two years. <i>Title IV-E Prevention Services Funding Requested</i>	<input checked="" type="checkbox"/> 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18 <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<i>Child Well-Being, Family Well-Being</i> • To improve pregnancy outcomes by promoting health-related behaviors • To improve child health, development and safety by promoting competent care-giving • To enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment ³	<i>Clearinghouse - Well Supported</i>	<input type="checkbox"/> Allegany <input type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input checked="" type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input checked="" type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input checked="" type="checkbox"/> Cecil <input type="checkbox"/> Charles <input type="checkbox"/> Dorchester <input type="checkbox"/> Frederick <input checked="" type="checkbox"/> Garrett <i>8 jurisdictions</i>	<input checked="" type="checkbox"/> Harford <input type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input type="checkbox"/> Montgomery <input type="checkbox"/> Prince George's <input checked="" type="checkbox"/> Queen Anne's <input type="checkbox"/> St. Mary's <input type="checkbox"/> Somerset <input checked="" type="checkbox"/> Talbot <input type="checkbox"/> Washington <input type="checkbox"/> Wicomico <input type="checkbox"/> Worcester
Family Centered Treatment (FCT) FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. FCT is targeted towards family members at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities.	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input checked="" type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<i>Child Permanency, Child Well-Being, Family Well-Being</i> • Enable family stability via preservation of or development of a family placement • Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution • Reduce hurtful and harmful behaviors affecting family functioning	<i>CEBC – Promising Systemic Review</i>	<input checked="" type="checkbox"/> Allegany <input checked="" type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input checked="" type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input checked="" type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input checked="" type="checkbox"/> Cecil <i>8 jurisdictions</i>	<input checked="" type="checkbox"/> Harford <input checked="" type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input checked="" type="checkbox"/> Montgomery <input checked="" type="checkbox"/> Prince George's <input checked="" type="checkbox"/> Queen Anne's <input checked="" type="checkbox"/> St. Mary's <input checked="" type="checkbox"/> Somerset
	<input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	• Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges. ³		<input checked="" type="checkbox"/> Charles <input checked="" type="checkbox"/> Dorchester <input checked="" type="checkbox"/> Frederick <input checked="" type="checkbox"/> Garrett <i>Statewide</i>	<input checked="" type="checkbox"/> Talbot <input checked="" type="checkbox"/> Washington <input checked="" type="checkbox"/> Wicomico <input checked="" type="checkbox"/> Worcester
Functional Family Therapy (FFT) FFT a short-term, high-quality intervention program for youth demonstrating behavioral health problems. <i>Title IV-E Prevention Services Funding Requested</i>	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input checked="" type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<i>Child Well-Being, Family Well-Being</i> • Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e., school attendance) • Improve family and individual skills ³	<i>Clearinghouse - Well Supported</i>	<input type="checkbox"/> Allegany <input checked="" type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input checked="" type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input checked="" type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input checked="" type="checkbox"/> Cecil <input checked="" type="checkbox"/> Charles <input checked="" type="checkbox"/> Dorchester <input type="checkbox"/> Frederick <input type="checkbox"/> Garrett <i>21 jurisdictions</i>	<input checked="" type="checkbox"/> Harford <input checked="" type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input checked="" type="checkbox"/> Montgomery <input checked="" type="checkbox"/> Prince George's <input checked="" type="checkbox"/> Queen Anne's <input checked="" type="checkbox"/> St. Mary's <input checked="" type="checkbox"/> Somerset <input checked="" type="checkbox"/> Talbot <input checked="" type="checkbox"/> Washington <input checked="" type="checkbox"/> Wicomico <input checked="" type="checkbox"/> Worcester
Parent-Child Interaction Therapy (PCIT) PCIT is a behavioral parent training program with coaching by a trained therapist in behavior-management and relationship skills. PCIT targets 2 -7 year olds with emotional/behavioral issues and their parents/caregivers.	<input checked="" type="checkbox"/> 0-2 <input checked="" type="checkbox"/> 3-5 <input checked="" type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual	<i>Child Well-Being, Family Well-Being</i> • Build close relationships between parents and their children using positive attention strategies • Help children feel safe and calm by fostering warmth and security between parents and their children • Increase children's organizational and play skills • Decrease children's frustration and anger	<i>Clearinghouse - Well Supported</i>	<input type="checkbox"/> Allegany <input checked="" type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input type="checkbox"/> Caroline <input type="checkbox"/> Carroll <i>21 jurisdictions</i>	<input type="checkbox"/> Harford <input type="checkbox"/> Howard <input type="checkbox"/> Kent <input type="checkbox"/> Montgomery <input type="checkbox"/> Prince George's <input type="checkbox"/> Queen Anne's <input checked="" type="checkbox"/> St. Mary's

<i>Title IV-E Prevention Services Funding Requested</i>	<input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<ul style="list-style-type: none"> Educate parent about ways to teach child without frustration for parent and child Enhance children's self-esteem Improve children's social skills such as sharing and cooperation Teach parents how to communicate with young children who have limited attention spans³ 		<input type="checkbox"/> Cecil <input checked="" type="checkbox"/> Charles <input type="checkbox"/> Dorchester <input type="checkbox"/> Frederick <input type="checkbox"/> Garrett <i>6 jurisdictions</i>	<input type="checkbox"/> Somerset <input type="checkbox"/> Talbot <input type="checkbox"/> Washington <input type="checkbox"/> Wicomico <input type="checkbox"/> Worcester
Multisystemic Therapy (MST) MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. MST targets youth, ages 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors.	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input checked="" type="checkbox"/> 12-17 <input type="checkbox"/> 18+ <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	<i>Child Permanency, Child Well-Being, Family Well-Being</i> <ul style="list-style-type: none"> Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) Empower parents with the skills and resources needed to: (a) Independently address the inevitable difficulties that arise in raising children and adolescents, and (b) Empower youth to cope with family, peer, school, and neighborhood problems³ 	<i>Clearinghouse - Well Supported</i>	<input type="checkbox"/> Allegany <input type="checkbox"/> Anne Arundel <input checked="" type="checkbox"/> Baltimore <input type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert <input type="checkbox"/> Caroline <input type="checkbox"/> Carroll <input type="checkbox"/> Cecil <input type="checkbox"/> Charles <input type="checkbox"/> Dorchester <input checked="" type="checkbox"/> Frederick <input type="checkbox"/> Garrett <i>5 jurisdictions.</i>	<input type="checkbox"/> Harford <input type="checkbox"/> Howard <input type="checkbox"/> Kent <input checked="" type="checkbox"/> Montgomery <input type="checkbox"/> Prince George's <input type="checkbox"/> Queen Anne's <input type="checkbox"/> St. Mary's <input type="checkbox"/> Somerset <input type="checkbox"/> Talbot <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Wicomico <input type="checkbox"/> Worcester
<i>Title IV-E Prevention Services Funding Requested</i>	<input checked="" type="checkbox"/> 0-2 <input checked="" type="checkbox"/> 3-5 <input type="checkbox"/> 6-11 <input type="checkbox"/> 12-17 <input type="checkbox"/> 18+	<i>Child Safety, Child Permanency, Family Well-Being</i> <ul style="list-style-type: none"> Ensure child safety Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible Achieve child permanency within the ASFA timeframes, preferably with one or 	<i>CEBC – Promising Systematic Review</i>	<input type="checkbox"/> Allegany <input checked="" type="checkbox"/> Anne Arundel <input type="checkbox"/> Baltimore <input type="checkbox"/> Baltimore City <input type="checkbox"/> Calvert	<input checked="" type="checkbox"/> Harford <input type="checkbox"/> Howard <input checked="" type="checkbox"/> Kent <input checked="" type="checkbox"/> Montgomery <input type="checkbox"/> Prince George's
child welfare system and have a parent where substance use is a primary child safety risk factor.	<input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Group	both parents or, if that is not possible, with a relative <ul style="list-style-type: none"> Achieve parental sobriety in time to meet ASFA permanency timeframes Improve parental capacity to care for children and to engage in essential life tasks Reduce repeat maltreatment and re-entry into out-of-home care Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues Improve collaboration and the system of service delivery between child welfare and mental health treatment providers.³ 		<input checked="" type="checkbox"/> Caroline <input checked="" type="checkbox"/> Carroll <input checked="" type="checkbox"/> Cecil <input type="checkbox"/> Charles <input checked="" type="checkbox"/> Dorchester <input checked="" type="checkbox"/> Frederick <input type="checkbox"/> Garrett <i>13 jurisdictions.</i>	<input checked="" type="checkbox"/> Queen Anne's <input type="checkbox"/> St. Mary's <input checked="" type="checkbox"/> Somerset <input checked="" type="checkbox"/> Talbot <input type="checkbox"/> Washington <input type="checkbox"/> Wicomico <input checked="" type="checkbox"/> Worcester



Washington, DC

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Pre-print Sections 1 and 4

The Backdrop: Lessons Learned through CFSA's Waiver

Through the implementation of the Waiver, CFSA learned important lessons that have strongly influenced the development of this five year plan, and specifically, the selection of evidence-based program (EBP) services included herein. Namely, CFSA learned that:

- Narrow inclusionary/exclusionary requirements of nationally recognized EBP models led to low rates of referral acceptance in DC's local implementation. Moreover, different EBPs work well for different families, as family preferences vary regarding program intensity, format, and focus. Consequently, it is essential to maintain an array of EBPs that is as diverse as the families served to ensure that each family can be matched to EBPs that align with their needs and circumstances.
- Families often struggle to take up and sustain participation in EBPs due to a variety of barriers. Families are more likely to initiate EBP participation if actively supported by a skilled and engaged caseworker in order to overcome psychological, logistical, and other barriers.
- Successful EBP implementation and program sustainability require diligent attention to business processes and continuous quality improvements. These processes must be planned carefully and monitored through CQI and evaluation, as will be discussed in Section 4 below.

To select the EBPs outlined in this five year plan, CFSA staff and stakeholders closely assessed not only each program's level of research evidence, but also the target populations, eligibility criteria, and time-intensity of each intervention to ensure the available service array includes the best-fit services for greatest number of families within the identified target populations.

Rationale for Service Selection

CFSA drew on diverse evidence as well as a robust stakeholder engagement process to drive datadriven and locally-informed decisions around the most appropriate evidence-based services to support the District's Family First prevention-eligible children and their caregivers to reduce risk factors and increase protective factors for child abuse and neglect. Services were explored and selected by the District of Columbia Family First Prevention Work Group (Work Group), which met for over six months and comprised diverse CFSA staff and external stakeholders from key community organizations and sister agencies (see Stakeholder Engagement in Target Population and EBP Service Selection below for additional details). The Work Group prioritized three broad criteria in selecting each service: (1) Identifying a service array that aligns with the characteristics and service needs of target families, thus

ensuring that each family will be able to secure a service that meets their specific needs and circumstances, (2) Ensuring each service identified has a high level of evidence of effectiveness—not only from national evaluations, but also drawing on data and experiences with these very programs as implemented in DC, and (3) Prioritizing selecting services that currently are in place and successful within DC, building on existing capacity, model familiarity, and effectiveness. To follow is an overview of how data and evidence were used to inform selection in accordance with each of these criteria

(1) Identifying a service array that aligns with the characteristics and service needs of targeted families.

Building upon the lessons learned from the Waiver described above, CFSA selected an array of EBPs in the domains of in-home parent skill-based programs, mental health, and substance abuse prevention and treatment services selected specifically to meet the needs of Family First prevention-eligible children and their caregivers. To gain an understanding of the needs of these children and families, CFSA conducted extensive analyses, including taking into account the following data and evidence to inform a deep understanding of the range and nature of service needs of Family First prevention-eligible children and their caregivers.

- Child and family demographic data derived from FACES, including but not limited to child age, parent age, and family size, which are among the top eligibility criteria for each EBP under consideration.
- Case characteristic data derived from FACES, including removal reasons and maltreatment indices, which illustrate patterns family risks and needs.
- Child and family assessment data, including aggregate results from CFSA's comprehensive assessments: the Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and the Caregiver Strengths and Barriers Assessment (CSBA). These results paint a rich picture of child and family strengths and needs.
- Input from subject matter experts and stakeholders who work directly with or administer programs for the target population, to answer questions not addressed by data sources listed above and to make recommendations based on first-hand experience regarding necessary components of the preventive services array.
- Sister agency data analyses describing the service needs of the families they serve who also have CFSA involvement.
- Two focus groups with families who have both engaged or disengaged in evidence-based services across the District. The conversations yielded an understanding not only of family service needs broadly but also the characteristics of services that tend to work best, barriers to services, and characteristics of case managers that can support and promote service participation.
- A focus group with service providers provided insights about barriers to services and perceptions as to which EBPs have worked best for families locally.
- DC's Title IV-E Waiver preliminary evaluation, providing insights and lessons-learned about the implementation and effectiveness of Waiver-funded EBPs.
- Evaluation of CFSA's Initiative to Improve Access to Needs-Driven, Evidence-Based/Informed Mental and Behavioral Health Services in Child Welfare trauma grant, including information

about CFSA's experiences completing extensive workforce training on trauma, implementing trauma-sensitive assessment tools, and engaging in data-driven case planning and monitoring.

Taken together these data clearly illustrate the characteristics and service needs of Family First prevention-eligible children and their caregivers. Following synthesis, meaning-making, and discussion within the Work Group, these data directly informed the specific array of preventive services proposed herein. This process produced a broad proposed array of services, none of which are duplicative. Each EBP serves a different target population, operates with different format or intensity, and/or is designed to produce different outcomes, thus aligning with the diverse identified needs and characteristics of the children and families in the target population.

(2) Ensuring each service identified has a high level of evidence of effectiveness. As the Work Group explored and defined the service needs of families in DC, it became apparent that the 12 programs under initial review on the Title IV-E Prevention Services Clearinghouse were not sufficient alone to meet the needs of the families CFSA serves. Therefore, CFSA developed a proposed service array that demonstrates a high level of evidence according to the ratings of the California Evidence-Based Clearinghouse for Child Welfare (CEBC) 14 and estimated ratings based on the criteria defined in the legislation that will be used by the Title IV-E Prevention Services Clearinghouse. Ratings likely to be produced by the Title IV-E Prevention Services Clearinghouse were estimated based on a close review of research evidence associated with each program within the District's proposed service array relative to criteria for ratings clearly described in PI 18-09, Attachment C.15 Using these methods, CFSA has closely considered the evidence associated with each program and determined that the proposed service array reflects a mix of programs likely to be rated as promising, supported, and well-supported in accordance with the requirements of the legislation, including projections indicating that over 50% of claiming will be for well-supported programs.

(3) Prioritizing selecting services that currently are in place and effective within the District, building on existing capacity, model familiarity, and effectiveness. DC maintains an unusually broad array of social services available to residents through the Department of Behavioral Health (DBH), Department of Human Services (DHS), DC Health, and numerous other agency and community-based providers. The Work Group and CFSA obtained extensive information about existing services in order to assess the supply of existing services relative to the estimated demand from Family First prevention-eligible children and their caregivers, including the following:

- A prevention services survey completed by all Work Group stakeholder organizations to capture information on existing mental health, substance abuse, and in-home parenting EBPs, as well as key information about each. The survey was designed to help CFSA and stakeholders gain a holistic understanding of the breadth of existing service array and the depth of capacity already within the District.

- Collaborative and sister agency presentations to the Prevention Work Group, including key health and human services agency stakeholders and DC's Department of Employment Services to gather additional information about EBPs and other prevention activities already in place in the District.
- In-depth information and data gathering about existing EBP models, current capacity and utilization, staffing, effectiveness, and cost.

Evidence collected indicated that an impressive array of in-home parenting, mental health, and substance abuse treatment EBPs exists in DC. All selected services have existing capacity within DC. The Work Group determined leveraging existing capacity, where programs are currently meeting the needs of families within the community, will allow CFSA to realize proximal outcomes (see Theory of Change in Section 4) for families while continuing to assess program efficacy and refine the best set of programs to meet the candidate populations' needs over time. By selecting existing service interventions currently offered within the community, CFSA is ensuring the ability to effectuate this plan while minimizing time and energy to start-up new services.

Implementation Approach

As described in the sections above, CFSA has developed strong partnerships with our health and human services sister agencies and community-based service providers to offer an array of parenting, mental health, and substance use treatment services to families currently involved with CFSA and more broadly to vulnerable populations across the District. CFSA's comprehensive approach to preventing child maltreatment and strengthening families is embedded deeply in the fabric of the Agency and threaded throughout the child welfare system. The efforts undertaken to identify a comprehensive service array for prevention-eligible children and their families has produced a roadmap for possible services to be claimed under Family First as part of CFSA's five year Prevention Plan. As CFSA's Family First implementation begins in year one, CFSA will leverage existing partnerships and evidence-based program capacity to serve candidate children and their families. Of the services currently deemed allowable by the Title IV-E Prevention Services Clearinghouse, the six outlined below in CFSA's proposed service array have existing capacity in the District and are funded through other federal sources (Medicaid and the Maternal, Infant, and Early Childhood Home Visiting Program; MIECHV). Due to the existing federal funding mechanisms in place to support the existing service capacity, at the time of this submission, CFSA will be using local dollars to support adding capacity to one of the allowable evidence-based programs, the Parents As Teachers (PAT) model, outlined in the proposed service array below.

CFSA will use year one of our five year Prevention Plan to conduct State-level CQI activities to assess capacity needs across our existing prevention service array to determine if additional capacity is needed and additional slots of existing services, or new interventions, should be added to our Prevention Plan to be claimed under Family First in subsequent years. As additional services are rated by the Title IV-E Prevention Services Clearinghouse, Independent Systematic Reviews are conducted and approved, or if

additional capacity is needed to support prevention-eligible children and their families, and is not already funded by Medicaid or MIECHV, CFSA may amend our Prevention Plan to expand our service array and specify additional services to be claimed under Family First. At this time, CFSA does not plan to submit an Independent Systematic Review (ISR) of services currently not yet rated by the Title IV-E Prevention Services Clearinghouse.

Proposed Service Array

Tables 2 and 3 below provides an overview of the selected prevention services, including the service type, target population, their rating on the CEBC and Title IV-E Prevention Services Clearinghouse, whether each intervention is currently under review by the Title IV-E Prevention Services Clearinghouse, and the estimated rating that is likely to be produced by the Title IV-E Prevention Services Clearinghouse. These tables clearly show the high level of research evidence associated with the service array, as well as the distinct target populations and desired outcomes across programs, demonstrating that the District has selected a continuum of services that is as diverse as the needs and characteristics as the families we serve. This builds on the waiver lesson learned that a diverse array of EBPs is necessary to ensure that each family can be matched to an EBP that aligns with their needs and circumstances. The service array is well-calibrated to effectively and comprehensively meet the needs of Family First prevention-eligible children and their caregivers and will effectively utilize the opportunity created by Family First to claim Title IV-E dollars for allowable EBP service capacity not already supported by other federal sources. Table 2 highlights the specific evidencebased prevention service, Parents As Teachers (PAT), that the District will claim for under Family First as part of the District's comprehensive prevention service array, fully outlined in Table 3.

Table 2. Family First Prevention Service (Claiming)

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes ¹⁷	Average Length of Service	Currently Rated on Clearinghouse "Allowable" ¹⁸	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating ¹⁹	Funding Source (Family First, Other Federal, or Local)
In-home Parenting	Parents as Teachers (PAT)	Parents of children 0-5	Increased knowledge of child development, improved parenting practices, detection of developmental delays, school readiness	60 months	✓ Allowable	Well Supported	N/A	Family First

Table 3 Comprehensive Overview of Selected Evidence-Based Prevention Services

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes ²⁰	Average Length of Service	Currently Rated on Clearinghouse "Allowable" ²¹	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating ²²	Funding Source (Family First, Other Federal, or Local)
In-home Parenting	Parents as Teachers (PAT)	Parents of children 0-5	Increased knowledge of child development, improved parenting practices, detection of developmental delays, school readiness	60 months	✓ Allowable	Well Supported	N/A	MIECHV
	Nurturing Parent Program (NPP)	Parents of children 5-12	Increased self-worth for parents and children, increased parental empathy, use of non-violent discipline strategies, increased nurturing parenting knowledge and skills	4.5 months	✗	Not Yet Rated	Promising	Local
	Healthy Families America (HFA)	Parents of children 0-5	Increased nurturing parent-child relationships, healthy child development, enhanced family functioning, increased protective factors, reduced risk	60 months	✓ Allowable	Well Supported	N/A	MIECHV
	Chicago Parenting Program (CPP)	Parents of children 2-5	Improved parent-child relationships, reduced reliance on harsh discipline methods, increased parent confidence & competence, reduced child behavior problems	4 months	✗	Not Yet Rated	Well Supported	Local
	Effective Black Parenting Program (EBPP)	Parents of children 0-17	Reduce parental stress, promote cultural pride, improve child school performance & behavior, strengthen family cohesion, increased coping with racism and prejudice	15 weeks	✗	Not Yet Rated	Promising	Local
	YVLifeset	Pregnant or Parenting Youth 17-22	Increased engagement in education and vocational pursuits, improved interpersonal and social skills, decreased interference from substance abuse and mental health issues, increased independent living.	7-9 months	✗	Not Yet Rated	Promising ²³	Local
	Transition to	Pregnant or	Increased engagement in education and vocational	18	✗	Not Yet	Promising	Local

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes ²⁰	Average Length of Service	Currently Rated on Clearinghouse "Allowable" ²¹	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating ²²	Funding Source (Family First, Other Federal, or Local)
	Independence (TIP)	Parenting Youth 14-29	pursuits, improved interpersonal and social skills, decreased interference from substance abuse and mental health issues, increased independent living.	months		Rated		
Substance Abuse	Project Connect	Parents of children 0-17	Decreased problematic substance use, improved parenting skills, linkages to community resources	16 months	✗	Not Yet Rated	Promising	Local
	Recovery Coaches ²⁴ - Connecticut Center for Addiction and Recovery (CCAR) certification	Caregivers (all ages)	Caregiver: Support with addiction and recovery: improved relationships with providers and social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, and increased retention in treatment.	Specific to program	✗	Not Yet Rated	Promising	Local
	Adolescent Community Reinforcement Approach (A-CRA)	Children 12-25	Child: Abstinence, increased positive social activity, improved family and peer relationships. Caregiver: Support for child abstinence, increased parenting knowledge and skills.	3-6 months	✗	Not Yet Rated	Well Supported	Medicaid
	Multi-Systemic Therapy (MST)	Children 11-17	Youth: Reduce behavior problems. Caregiver: increased ability to address parenting difficulties and empower youth.	4-6 months	✓ Allowable	Well Supported	N/A	Medicaid
Mental Health	Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	Improved PTSD, depression, anxiety symptoms, reduced behavior problems, improved adaptive functioning improved parent skills, reduced parent distress.	3-6 months	✓ Allowable	Promising	N/A	Medicaid
	Functional Family Therapy	Children 11-18	Youth: Eliminate behavior problems, delinquency, and substance abuse; improve prosocial behavior. Family: Improve functioning and skills.	7 months	✓ Allowable	Well Supported	N/A	Medicaid
	Parent Child Interaction Therapy (PCIT)	Children 2-6	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem. Parent: Increased ability to comfort child, improved behavior management and communication with child.	6 months	✓ Allowable	Well Supported	N/A	Medicaid

	EBP Interventions	Target Population (in years)	Selected Proximal Outcomes ²⁰	Average Length of Service	Currently Rated on Clearinghouse "Allowable" ²¹	Title IV-E Clearinghouse Rating	Estimated Title IV-E Clearinghouse Rating ²²	Funding Source (Family First, Other Federal, or Local)
	Parents Anonymous ²⁵	All families	Caregiver: Develop strengths-based personal goals, learn to monitor personal progress and advocate for effective services, learn modeled effective coping techniques and self-help strategies, help with resolving issues, help navigating the behavioral health system, build community supports	12 – 18 months	X	Not Yet Rated	Promising	Local
Cross-Cutting	Motivational Interviewing (MI)	Parents (all ages)	Enhance internal motivation to change, reinforce that motivation, develop a plan to achieve change.	2-3 sessions, as needed	X ²⁶	Not Yet Rated	Well Supported	Local

Table 4 Overview of Other District Prevention Service Interventions – CFSA's Additional Suite of Prevention Services and Partnerships

	Service Interventions	Target Population (in years)	Selected Proximal Outcomes ²⁷	Average Length of Service	Estimated Title IV-E Clearinghouse Rating ²⁸
Family Stabilization Services	Mobile Stabilization Services (MSS)	All families	De-escalate family crises, stabilize children in the home.	<1 month	Insufficient evidence
Mental Health and Substance Abuse Treatment Services	Certified Peer Specialists	Caregivers (all ages)	Caregiver: Develop strengths-based personal goals, learn to monitor personal progress and advocate for effective services, learn modeled effective coping techniques and self-help strategies, help with resolving issues, help navigating the behavioral health system, build community supports	Specific to program	Unknown
	Family Peer Coaches - Strengthening Family Coping Resources (SFCR) ²⁹	Caregivers (all ages)	Child: Reduce symptoms of traumatic stress and other trauma-related disorders in any family member Family: Increase coping resources in children, caregivers, and in the family system to help families a) boost their sense of safety, b) function with stability, c) regulate their stress reactions, emotions, and behaviors, d) and make use of supports	2-4 months	Unknown
Post-Permanency Supports/ Mental Health	C.A.S.E. - Center for Adoption Support and Education	Caregivers and youth (all ages)	Program designed to support CFSA staff with technical assistance including intervention planning and matching. CASE provides support to families through individual and family therapy before and after guardianship or adoptions have taken place.	9 -12 months	Unknown
	Adoptions Together	Caregivers and youth (all ages)	Program designed to provide support for grief and loss, attachment and bonding through 6-week support groups, as well as provide children/youth and caregivers with individual/family therapy to address adoption/guardianship issues and mitigate disruption or adoption dissolution. ³⁰	6-9 months	Unknown

	Service Interventions	Target Population (in years)	Selected Proximal Outcomes ²⁷	Average Length of Service	Estimated Title IV-E Clearinghouse Rating ²⁸
In Home Parenting/ Support for specific populations	The Association for Successful Parenting (TASP): Successful Parenting DC ³¹	Parents with intellectual and other learning disabilities	Increase the safety and well-being of children living with parents who have an intellectual disability and to provide appropriate supports to families to ensure all are safe. Decrease the rate of children entering the foster care system by increasing protective factors and parents' abilities to care for their children.	6 months	Unknown

Consultation and Coordination: Federal Funding for EBPs

In-home parenting and skill-based programs:

DC Health currently receives federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)³² funds to implement the Parents As Teachers (PAT) and Healthy Families America (HFA) home-visiting program models. In addition to the existing capacity supported by DC Health's grant, DC

Health also funds local program slots. CFSA will work with DC Health to determine how best to leverage existing funds and support/expand locally funded slots as needed using Family First funding. In year one, CFSA has determined to support additional slots of PAT (see Table 2) to meet the needs of the target populations identified in this plan (see Table 1). In addition to intra-district government partnerships, CFSA may also compete funds for award to private agencies to provide in-home parent skill-building evidence-based curricula. CFSA selected in-home parent skill-building programs in part due to their existing capacity, perceived effectiveness within DC, as well as the substantial number of city-wide providers with implementation expertise.

Medicaid funding and Mental Health and Substance Abuse prevention and treatment services:

DBH directly contracts with mental health and substance abuse prevention and treatment providers across DC. When selecting EBP services, DBH presented the services sub-group with an array of behavioral health services and treatment modalities that have been rigorously evaluated and implemented in DC for several years, and in alignment with this evidence, have been both rated by the CEBC as well-supported practices and have been approved in DC as Medicaid allowable services. Under the payer of last resort requirement, therefore Medicaid is the primary payer for these well-supported services.

CFSA's recommends the Children's Bureau clarify the provided program guidance in PI 18-09 Section C 33 such that the requirement around prevention spending on well-supported EBPs be 50% of all spending (inclusive of spending that is reimbursed through other programs or payers, such as MIECHV and Medicaid). Programs included in this five year prevention plan that could be reimbursable through another public or private source should be included in the calculation. As the guidance is currently written, DC and other Medicaid expansion states/states that receive other federal funds are penalized for having identified and developed other federal funding sources for existing well-supported services and cannot maximize claiming under Family First. Please see Appendix B for full analysis of the impact of Medicaid expansion and Family First requirements.

While CFSA notes the tension in the requirements related to prevention program financing and federal reimbursement, EBP recommendations were made by the services sub-group with the particular focus on selecting the program models that would be the best fit to serve DC's Family First preventioneligible children and their caregivers while ensuring optimal levels of evidence. CFSA will work with DBH to determine how best to leverage existing programs and support/expand locally funded slots as needed using Family First funding. As noted above, CFSA may also compete funds for award to private agencies to provide additional mental health and substance abuse treatments services where appropriate to meet the needs of children and families.

Case Management: A Fundamental Service

To provide Family First prevention-eligible children and their caregivers with access to this array of EBPs, CFSA recognizes the critical importance of robust case management and ongoing engagement with families. CFSA's existing practice model³⁴ employs a trauma-informed service delivery framework that threads theory to practice through casework with families (see Section 6 for more about CFSA's trauma-informed service delivery). Building on the lessons learned from the Waiver implementation around the challenges of service utilization and ongoing engagement in EBPs, CFSA is investing in training focused specifically on encouraging meaningful connections-to and engagement-in EBP services. Under Family First, CFSA will train all In-home social workers and supervisors and contracted prevention services case management providers (Collaboratives) in Motivational Interviewing (MI), which will be integrated as a core component of the practice model³⁵. As a central aspect of the practice model, MI will equip CFSA and Collaborative caseworkers with the tools needed to work with families to ensure service referrals are both (1) a good fit for both children and caregivers and (2) that each family has the dedicated support and motivation to sustain engagement in often intensive service interventions. While its roots are grounded in substance abuse treatment, MI has emerged as a prominent case management tool in the field of child welfare beyond substance abuse.

"Much like clients in the substance use field, child welfare clients may be ambivalent to change, which makes them good candidates for the use of motivational interviewing. Child welfare practice also tends to embrace some of the same tenets present in motivational interviewing, such as engaging clients in decisions and focusing on their strengths. Additionally, motivational interviewing incorporates self-determination, which is one of the tenets of trauma-informed care. Research has shown that motivational interviewing is also effective when paired with other treatment strategies, such as cognitive behavioral therapy (Substance Abuse and Mental Health Services Administration, 2017)."37 (Child welfare Information Gateway, 2017)

Research and evaluation to date has already highlighted MI as an effective service delivery strategy with both adult and youth populations, making it an ideal fit for CFSA's foster care candidates as well as pregnant or parenting youth in care.³⁸ By providing an evidence-based service at the heart of case management to improve service engagement, CFSA is leveraging continuous quality improvements garnered from the Waiver implementation to be responsive to the existing service-delivery challenges and requested service enhancements identified by families to improve EBP engagement (noted in family focus group feedback).

EBP Procurement

CFSA will select the best procurement vehicles to ensure timely delivery of the five year prevention plan services to DC residents. Upon approval of this plan, CFSA will establish Memorandums of Understanding (MOUs) with sister agency partners: DC Health, the Department of Behavioral Health (DBH), and other sister agencies as relevant, to expand or leverage their respective capacity/slots for inhome parenting, mental health, and substance use disorder services to meet the needs of CFSA's

candidate populations. By capitalizing on DC's existing providers and service infrastructure, CFSA can ensure timely start-up with minimal costs associated with standing up new providers. In using a combination of agency partnerships and competitive procurements, CFSA's array of evidence-based interventions will afford CFSA and partner organizations the ability to create a robust prevention services continuum across District agencies and private non-profit partners.

EBP Training/Referral Capacity Building

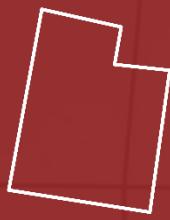
Case management and EBP provider trainings will be needed to support start-up or ramp-up for provider's new and existing staff. Please see Section 6 for CFSA's training plan and activities to ensure success of the Family First programs and services across the District. In addition to trainings needed to support the ongoing implementation of EBP models, CFSA also recognizes the opportunity to better coordinate and align referral processes from the point the social worker documents the child-specific prevention plan and service needs. As part of the Family First implementation, CFSA will leverage available technology to create a referral pipeline to available EBP services and community-based resources to quickly link parents and children with appropriate services and ensure timely connection once a referral has been made. Technology updates will also allow CFSA staff and community-based organizations to effectively track engagement in EBP service delivery and support financial claiming. CFSA has already begun initial discovery work to outline needed business requirements for technical system design and build. Once technology has been developed fully, staff will be trained by CFSA's Child Welfare Training Academy (CWTA) to effectively use these system enhancements in daily practice to support children and families.

Trauma-Informed Service Delivery

In 2012, CFSA was awarded a five year grant from the U.S. Department of Health and Human Services' Administration for Children and Families (ACF) to make trauma-informed treatment the foundation of serving children and youth in the District's child welfare system. Since that time, CFSA, through its Child Welfare Training Academy (CWTA) and Office of Well Being designed the Practice Guidance for Resilience, Adversity, and Trauma (PGRAT) and infused trauma-informed training components at the foundation of pre-service and in-service trainings for CFSA direct service staff, resource parents, foster care providers, and Collaborative contractors. CFSA focused the trauma grant on deepening child welfare practice through implementation of critical thinking and clinical case work practice through a trauma-informed lens. Specialized training was also developed for prevention services staff and nondirect services staff. The Trauma Systems Therapy (TST) model, an EBP shown to dramatically speed and improve healing in children who have experienced abuse or neglect without relying on medication, hospitalization, or prolonged counseling, was used in the initial training and development of ongoing trauma-informed practice curriculums. Please see Appendix C - Attachment III for Assurance, for each service, that each HHS approved title IV-E prevention service provided meets trauma-informed service delivery standards, per CFSA CWTA.

Improving Outcomes

By providing children and families at risk of foster care entry with an expanded array of well-implemented evidence-based preventive services, coupled with evidence-based case management using motivational interviewing techniques to support service uptake and participation, DC posits that outcomes for families will be significantly improved in accordance with the intended outcomes of each program. For example, parents enrolled in substance abuse treatment EBPs will experience reductions in problematic patterns of use; parents and children enrolled in dyadic therapy will experience improved attachment; and a teen enrolled in an EBP focused on improving mental and behavioral health will experience increased pro-social behaviors and reduced acting out. These improvements in individual and family functioning will in turn lead to reduced child maltreatment and, ultimately, reduced demand for foster care as the preventive services expand. CFSAs Theory of Change (see the Evaluation section) depicts the sequence of causal events and mechanisms by which outcomes for children, families, and communities are expected to improve due to Family First.



Utah

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Service Description and Oversight

Service Categories

The Utah Department of Human Services will provide services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregiver's needs for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. Categories of prevention services and programs include:

Mental Health and Substance Abuse Prevention and Treatment Services

Approved, evidence-based mental health and substance abuse prevention and treatment services will be provided by a qualified clinician to a child or to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

In-Home Parent Skill-Based Programs

Approved, evidence-based in-home parent skill-based programs will be provided to a child and to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

Evidence-Based Services and Programs

The evidence based services and programs selected for Utah's five-year Title IV-E Prevention Plan are listed in the tables below.

Service	<i>Functional Family Therapy (FFT)</i>
Service Description	Functional Family Therapy (FFT) is a short term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18 year old youth who have been referred for behavioral or emotional problems. The program is organized in five phases that consist of (1) developing a positive relationship between therapist/program and family, (2) increasing hope for change and decrease blame/conflict, (3) identifying specific needs and characteristics of the family, (4) supporting individual skill-building of youth and family, and (5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months. Master's level therapists provide FFT. They work as part of an FFT-supervised unit and receive ongoing support from their local unit and FFT LLC.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services

Version of Book or Manual	<p>FFT will be implemented without adaptation.</p> <p><u>Functional Family Therapy for Adolescent Behavioral Problems.</u></p> <p>Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i>. Washington, D.C.: American Psychological Association.</p>
Plan to Implement	<p>FFT is a new service being implemented in Utah. To implement, the following steps are being completed:</p> <ul style="list-style-type: none"> • Contract with FFT Certified Trainers to provide training to multiple sites, preferably representing both urban and rural areas, in order to establish a network of providers credentialed to provide FFT. • Work with FFT trainers to identify start up resources necessary to support implementation. • Have providers apply for acceptance into FFT and, when accepted, offer funding for start-up resources. • Fund and host training sessions for prospective FFT providers. • Grant funds for start-up costs to new providers, which may include training costs for each site for the first 2 years, access to Youth Outcomes Questionnaire (YOQ) assessment protocols, and technology resources unique to FFT. • Establish contracts with qualified providers, using specific FFT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on FFT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve	<p>Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, Utah expects to see the following outcomes for children and families receiving this service:</p> <p>Improved family functioning and skills, reduced family conflict, improved youth behavior, and reduced youth recidivism and alcohol and drug use.</p>
Plan to Monitor for Fidelity and to Use Outcome Data and	<p>See Section 2.C. Continuous Quality Improvement Overall Strategy.</p> <p>DHS will monitor fidelity and outcomes related to the implementation</p>

Information Learned in Monitoring to Improve Practice	<p>of FFT using program specific tools as a foundation, along with the CQI overall strategy described in Section 2.C. Fidelity and outcome measures are reported to FFT LLC on an ongoing basis in all FFT sites. DHS is engaged with FFT LLC and providers to deploy FFT to multiple sites across the state of Utah. DHS will coordinate with FFT LLC and providers for ongoing technical assistance, and will obtain fidelity and outcome measures for all sites on a regular basis.</p> <p>Implementation of FFT includes intensive procedures for monitoring quality of implementation on a continuous basis. Information is captured from multiple perspectives (family members, therapists, and clinical supervisors). The two measures that are utilized to represent therapist fidelity to the model are the Weekly Supervision Checklist and the Global Therapist Ratings, which are available through FFT LLC.</p> <ul style="list-style-type: none"> • <u>Weekly Supervision Checklist:</u> Following every clinical staffing, the clinical supervisor completes a fidelity rating for the case that was reviewed for each therapist. This fidelity rating reflects the degree of adherence and competence for that therapist's work in that case in a specific session. Thus, the weekly supervision ratings are not global, but specific to a single case presentation. Over the course of the year, a therapist may receive up to 50 ratings, which provides the supervisor with critical information about the therapist's progress in implementing FFT. • <u>Global Therapist Ratings:</u> Three times per year the clinical supervisor rates each therapist's overall adherence and competence in FFT. The Global Therapist Rating (GTR) allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each phase and general FFT counseling skills. The GTR specifically targets time period measures with the hope of displaying therapist growth. With respect to the GTR, supervisors are encouraged to utilize the comments box under each phase to target specific strengths and specific phase areas of growth.
How Selected	<ul style="list-style-type: none"> • A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey

	<p>of existing providers.</p> <ul style="list-style-type: none"> • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. • Based on input from each of these sources, DHS selected FFT as an intervention to be included in the prevention service array.
Target Population	FFT is intended for 11 to 18 year old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DHS is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2.B. below for supporting documentation that the effectiveness of the practice is compelling.

Service	<i>Parent Child Interaction Therapy (PCIT)</i>
Service Description	In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach parents and caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents and caregivers from behind a one-way mirror or with same-room coaching. Parents and caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to

	achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and their parents or caregivers.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Version of Book or Manual	PCIT will be implemented without adaptation. <u>The Parent-Child Interaction Therapy Protocol. Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011. PCIT International, Inc.</u>
Plan to Implement	PCIT is a new service to be offered through contracts by DHS in Utah. To implement, the following steps are being completed: <ul style="list-style-type: none"> • Contract with PCIT Master Level trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of providers credentialed to provide PCIT. • Work with PCIT Master Level trainers to identify start up resources necessary to support implementation. • Have providers apply for acceptance to participate in state-sponsored training for PCIT. • Fund and host training sessions for prospective PCIT providers. 23 clinicians participated in the first PCIT training session. • Explore options and capacity to grant funds for start-up costs to new providers, which may include technology resources unique to PCIT. • Establish contracts with qualified providers, using specific PCIT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PCIT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, Utah expects to see the following outcomes for children and families receiving this service:

	<p>Improved parenting knowledge, increased positive parenting practices, improved parent and child interactions, decreased child behavior and attention problems, and improved parent/caregiver emotional health.</p>
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	<p>See Section 2.C. Continuous Quality Improvement Overall Strategy.</p> <p>DHS will monitor fidelity and outcomes related to the implementation of PCIT using program specific tools as a foundation, along with the CQI overall strategy in Section 2.C. DHS is engaged with PCIT International to train and provide technical assistance to providers. The DHS quality and design specialist assigned to PCIT maintains close coordination with PCIT International staff and providers in support of implementation.</p> <p>As an assessment-driven treatment, PCIT is guided by weekly data from the Eyberg Child Behavior Inventory (ECBI) and the Dyadic Parent-Child Interaction Coding System (DPICS). These standardized instruments are supplemented by additional measures the clinician may select for careful tracking of presenting concerns of families during treatment. Providers of PCIT are required to implement fidelity monitoring and outcome measurement using these PCIT tools, which are available through PCIT International.</p> <p>Following are key assessment tools used in PCIT:</p> <ul style="list-style-type: none"> • <u>Dyadic Parent-Child Interaction Coding System Comprehensive Manual for Research and Training 4th edition (DPICS-IV)</u>. The DPICS is a behavioral coding system that measures the quality of parent-child social interactions. It is used to monitor progress in parenting skills during treatment and provides an objective, well-validated measure of changes in child compliance after treatment. • <u>Eyberg Child Behavior Inventory (ECBI)</u>. The ECBI is a 36-item parent report instrument used to assess common child behavior problems that occur with high frequency among children with disruptive behavior disorders. It is sensitive to changes with treatment and used to monitor weekly progress in PCIT. • <u>Therapy Attitude Inventory</u>. The TAI is a 10-item parent-report scale of satisfaction with the process and outcome of therapy. • <u>CDI Homework Sheet</u>. This form is a fillable PDF to track homework assigned to parents and children

How Selected	<ul style="list-style-type: none"> A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. Based on input from each of these sources, DHS selected PCIT as an intervention to be included in the prevention service array.
Target Population	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process)	DHS is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2.B. below for supporting documentation that the effectiveness of the practice is compelling.

Service	<i>Parents as Teachers (PAT)</i>
Service Description	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and

	<p>neglect, and increase school readiness and success. The PAT model includes four core components: Personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, child care centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training.</p>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	<p>PAT will be implemented without adaptation.</p> <p>PAT has a Model Implementation Library with resources available to those who receive PAT training. Depending on the ages of the families served, the PAT Foundational Curriculum is available to support families with children prenatal to age 3, and the PAT Foundational 2 Curriculum is available to support families with children ages 3 through Kindergarten. PAT website:</p> <p>https://parentsasteachers.org/resources-tools</p>
Plan to Implement	<p>Parents as Teachers programs have been used for primary prevention in a limited number of sites in Utah, but generally have not broadly served at-risk children and families involved with DCFS who will qualify as prevention candidates. To implement as a service under Utah's Title IV-E prevention program plan, the following steps are being completed:</p> <ul style="list-style-type: none"> • Starting first with PAT offered by Prevent Child Abuse Utah (PCAU), which is a Blue Ribbon Affiliate PAT Program, determine interest and contract with local health departments and other sites that are current PAT affiliates to expand their population served to include prevention candidates. • Identify local health departments or other sites that are not currently PAT providers but that are willing to become PAT providers. Assist in standing up new programs (by helping fund initial trainings, affiliation costs, etc.). • Create an expansion plan to develop PAT programming in rural

	<p>areas through the local health departments or other community providers, including expansion of the PCAU PAT program to target counties.</p> <ul style="list-style-type: none"> • Establish contracts with qualified providers, using specific PAT rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PAT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve	<p>Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PAT, Utah expects to see the following outcomes for children and families receiving this service:</p> <p>Increased child safety, improved child behavioral and emotional functioning, increased positive parenting practices, and improved parent/caregiver mental or emotional health.</p>
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	<p>See Section 2.C. Continuous Quality Improvement Overall Strategy.</p> <p>DHS will monitor fidelity and outcomes related to the implementation of PAT using program specific tools as a foundation, along with the CQI overall strategy described in Section 2.C. DHS is requiring PAT programs with department contracts to maintain PAT affiliate status and utilize developer processes to measure progress and program fidelity. Program will verify affiliation by providing PAT affiliate certification to DHS.</p> <p>To help achieve fidelity to the PAT model, the PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. In addition, affiliates are expected to participate in the affiliate quality endorsement and improvement.</p> <p>The PAT National Center provides ongoing technical assistance to any organization that is implementing the Parents as Teachers model and requests assistance. Each state is assigned a National Center technical assistance provider who provides state-wide information as well as</p>

	<p>one-on-one work with the programs. Technical assistance is provided on a variety of topics with a focus on meeting the Parents as Teachers essential requirements. These essential requirements focus on staffing and staff oversight, visit frequency, delivering home visits, using the required forms, screenings and participating in model fidelity reviews.</p> <p>In addition to these fidelity processes, providers will be required to report fidelity and outcome measures to DHS on a quarterly basis. DHS will work with the PAT National Center and with providers to further incorporate the annual data gathered for the PAT National Center into overall program development, as well as for ongoing technical assistance.</p> <p>Providers of PAT are required to implement fidelity monitoring and outcome measurement using PAT planning and reporting tools. Following are key tools used in PAT:</p> <ul style="list-style-type: none"> • <u>Guidance on Continuing Quality Improvement</u>. Provides instructions for CQI using the plan, do, study, act (PDSA) process, including how to complete the PDSA worksheet. • <u>PDSA Worksheet</u>. Tool to guide the PDSA process. • <u>PAT Quality Assurance Blueprint</u>. Outlines the tasks and activities that PAT affiliate supervisors should engage in to monitor and strengthen services, supervision and professional development, and administration. • <u>2020 Essential Requirements</u>. Describes PAT program elements and how they are measured. • <u>Performance Measures Report for Service Delivery Essential Requirements</u>. Depicts affiliate's performance on the service delivery essential requirements based on the affiliate's data, and assists in understanding level of fidelity and in planning CQI efforts.
How Selected	<ul style="list-style-type: none"> • A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. The number of children served in DCFS in the 0-5

	<p>age range supported targeting services to this age group.</p> <ul style="list-style-type: none"> • PAT was already available in the state in some capacity, including DCFS contracts funded by CBCAP. • Local health departments are available in all areas of the state, including rural and frontier areas, and have shown in some areas that this service is a good match for their structure. • Based on input from each of these sources, DHS selected PAT as an intervention to be included in the prevention service array.
Target Population	<p>PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population.</p>
Assurance for Trauma-informed Service Delivery	<p>See Attachment III, State Assurance of Trauma-Informed Service-Delivery</p>
How Evaluated (Well-Designed and Rigorous Process)	<p>DHS is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2.B. below for supporting documentation that the effectiveness of the practice is compelling.</p>



Virginia

Status: Submitted

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Service Description and Oversight

Beginning in 2019, the Prevention Services and Child Protective Services (CPS) programs will play an integral role in targeting resources and services that prevent foster care placements and help children remain safely in their homes or with relatives when appropriate. Specifically, programmatic efforts have and will continue to focus on enhancing the following:

- Developing the prevention services workflow, including prevention services planning, case management process, and practice guidance and training;
- Improving ease of access to prevention services; and
- Ensuring quality of programs and services through implementation of a quality assurance and continuous quality improvement process (CFSP Prevention Strategies 1, 2, 3).

This approach aligns with the concept that prevention services are an integral part of the continuum of all child welfare services. The Prevention Services and CPS programs will leverage collaboration with the Prevention Advisory Committee, CPS Advisory Committee, CWAC and internal Family Services programs, to develop a repertoire of prevention strategies and best practice guidelines that can be used by LDSS in their delivery of prevention services.

Health and Human Services-Approved Prevention Services VDSS plans to utilize the following evidence-based practices currently rated in the Title IV-E Prevention Services Clearinghouse which currently exist in Virginia. VDSS intends to expand the offering of evidence-based practices as the federal clearinghouse continues to approve programs.

Program	Service Category	Rating
Functional Family Therapy	Mental Health Prevention or Treatment Services	Well-Supported
Healthy Families America	In-Home Parent Skill Based Training	Well-Supported
Multisystemic Therapy**	Mental Health Prevention or Treatment Services, Substance Use Disorder Prevention or Treatment Services	Well-Supported
Parent-Child Interaction Therapy	Mental Health Prevention or Treatment Services	Well-Supported
Nurse-Family Partnership	In-Home Parent Skill Based Training	Well-Supported
Parents as Teachers	In-Home Parent Skill Based Training	Well-Supported
Trauma-Focused Cognitive Behavioral Therapy	Mental Health Prevention or Treatment Services	Promising

****VDSS does not intend to utilize the Multisystemic Therapy for Child Abuse and Neglect**

In order to inform our service selection, implementation, and evaluation process, the Evidence-Based Services workgroup designed a stakeholder survey and distributed it electronically via an internet link. The survey was designed to gather stakeholder perceptions regarding evidence-based practices (EBPs), current gaps in Virginia child welfare service offerings, availability of specific EBPs across the commonwealth, and additional insights and comments regarding the implementation of evidence-based services.

A total of 657 child welfare stakeholders participated in the survey. Of these, 16.6% of respondents were clinicians (n = 109), 34.6% were brokers (n = 227) (those who refer for services), and 48.9% were senior leaders (n = 321). Most participants had their master's (60.9%) or bachelor's (29.4%) degrees. Employment settings included public child welfare (28.4%), child/family mental health (12.7%), educational settings (8.9%), juvenile justice (6.4%), and others. Respondents reported an average of 15.5 years in child welfare (range: 1-27 years). Across Virginia, 22.5% (n=139) of respondents were located in the northern region, 23.8% (n=147) in the central region, 20.4% (n=126) in the eastern region, 22.0% (n=136) in the Piedmont region, 8.6% (n=53) in the western region, and 2.6% (n=17) working statewide or across two or more regions.

All stakeholders (clinicians, brokers, and senior leaders) were asked to respond to a core set of questions regarding attitudes and perceptions toward EBPs, EBPs offered by their agency, perceived gaps in services in child welfare-related services in their community, and additional comments and insights regarding Family First. Each survey also had one supplemental area of inquiry: clinicians offered more detailed information about aspects of their perceptions and attitudes toward EBPs, brokers were asked to provide specific information regarding the availability and accessibility of Family First-related

services in their community, and senior leaders were asked to describe their familiarity with 30 (10 adult, 20 child/family) specific EBPs considered “well-supported” by the California Clearinghouse of EvidenceBased Practices in Child Welfare (at the time of survey design, 9/2018). For all qualitative items (gaps, additional comments), a codebook was created to collate all responses. Then responses were coded by two coders (research assistants) to create quantitative indicators for each identified code. In this report, results are provided across respondents, and a regional perspective based on VDSS’ five regions is provided when appropriate.

In regard to the services supported for reimbursement under Family First, respondents of the survey provided the following results. A total of 75 individuals described at least one parenting-related need and gaps. A total of 110 parenting-related needs and gaps were provided by respondents. Nearly a quarter—24.7%—of respondents who provided us with a response described something in the area of parenting, and 23.6% of the total gaps described involved parenting. Most described a specific need or gap within parenting, and these are detailed in the subsequent table. As can be seen, almost half of parenting-related gaps identified related to tangible supports for caregivers. Fifty-one respondents described gaps related to substance use. A total of 62 gaps were described. This represents 16.8% of respondents and 13.3% of all gaps described. Many respondents described more specifically caregiver or youth substance use service needs and gaps. Sixty-eight individuals described a gap or need related to mental or behavioral health, with a total of 83 gaps described. This represents 22.4% of respondents and 16.9% of all gaps described. Many respondents described more specific areas of mental/behavioral health.

All respondents were asked to list programs and treatments provided by their agencies that they believed were evidence-based, or that they thought were working well and were unsure whether they were considered evidence-based. Across respondents, more than 200 programs, treatments, and models were listed. Regarding the programs currently supported under Family First, the following results were obtained

EBP Name	Number of Senior Leaders	Never Heard of It	Heard of It Only	We Don't Offer It, But It's Available In Our Community	We Have Some Training In This Or Use It Rarely	This Is Regularly Used At Our Agency
Multi-systemic Therapy	96	15 (15.6%)	20 (20.8%)	31 (32.3%)	9 (9.4%)	21 (21.9%)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	96	1 (1.0%)	8 (8.3%)	13 (13.5%)	14 (14.6%)	60 (62.5%)
Healthy Families America	95	41 (4%)	20 (21.1%)	20 (21.1%)	6 (6.3%)	8 (8.4%)
Nurse-Family Partnership	95	64 (67.4%)	17 (17.9%)	10 (10.5%)	3 (3.2%)	1 (1.1%)
Parent-Child Interaction Therapy	92	31 (33.7%)	31 (33.7%)	10 (10.9%)	13 (14.1%)	7 (7.6%)

In addition to the evidence-based services previously referenced on page 12, VDSS plans to offer Kinship Navigator services throughout the Commonwealth (Prevention Strategy 1.5). VDSS received a grant from the Children's Bureau for \$379,246 for use from October 1, 2018-September 30, 2019. With the grant, VDSS developed six regionally located Kinship Navigator programs involving 40 localities (33% of the state) and partnered with 2-1-1 VIRGINIA to provide a dedicated, toll-free number specifically for kinship families to receive 24-hour information and referral services across the state. Our programs are diversified and were created to meet the needs of their particular communities; however, all of the programs provide information, referral, outreach, and advocacy. Many of our programs use creative strategies, such as strategically placed electronic kiosks, to assist families with applying for benefits. Programs engage school systems and the faith-based community to reach kinship families and form regional public-private consortiums, including kinship caregivers and youth, to assess the needs of kinship families in their communities. VDSS is providing technical assistance to each program on a quarterly basis by hosting conference calls that allow programs to communicate with one another and problem-solve, as well as talk on an ad hoc basis in between conference calls.

During the first year of Kinship Navigator funding, we served 207 youth and 188 kinship caregivers. One hundred and sixty eight (168) kinship families received information and referral services, including information about local, state, and federal benefits, mental health services, medical services, and advocacy, including face-to-face assistance in applying for benefits. The highest number of services for kinship families was the provision of outreach, training and/or supportive activities, including case management, support groups, and social support activities (229 individuals).

All local departments of social services provide benefit and support services to families. The following local departments and surrounding localities offer Kinship Navigator programs:

Arlington Department of Social Services (Partnering with Alexandria, Fairfax, Prince William, and Loudoun Departments of Social Services)

Bedford Department of Social Services (Partnering with Amherst, Appomattox, Campbell, Lynchburg, and Nelson Departments of Social Services)

Dickenson Department of Social Services (Partnering with Buchanan, Russell, Tazewell, Lee, Wise, Scott, and Norton Departments of Social Services)

James City County Department of Social Services (Partnering with Williamsburg and YorkPoquoson Department of Social Services)

Virginia Department of Human Services (partnering with Chesapeake, Portsmouth, Suffolk, and Norfolk Departments of Social Services)

Smyth Department of Social Services (partnering with Wythe, Bland, Bristol, Carroll, Galax, Giles, Grayson, Montgomery, Pulaski, Radford and Washington Departments of Social Services)

Our Kinship Navigator programs continue to strive to problem-solve challenges that arise in providing Kinship Navigator services. Challenges our programs have identified include:

Regionally located programs require a considerable amount of travel. In our rural areas, this could mean travelling several hours to visit a family.

Engaging school systems has been challenging, as many of our school systems only recognize kinship families when they have formal legal arrangements.

Lack of financial assistance and appropriate housing options are major barriers to kinship families in general.

VDSS anticipates receiving second-year funding in the same amount of the first year funding. This second year of funding will allow VDSS to continue the work with the six regionally supported programs

to align services with evidence-based Kinship Navigator programs, as defined in the Title IV-E Prevention Services Clearinghouse.

Implementation Services and Fidelity Monitoring

Virginia is a state-supervised and locally-administered child welfare system and each locality is responsible for the service provision in their community depending on various funding streams. Family First presents an opportunity to utilize federal funds to more equitably provide services across the Commonwealth rather than being dependent on each localities resources. Therefore, Virginia intends to provide the Title IV-E Prevention Services Clearinghouse for LDSS through a state contract system. VDSS will issue a Request for Proposal (RFP) in early 2020 to solicit providers of the evidence-based programs referenced on page 12. VDSS will provide a list of all service providers, to include the localities served, to LDSS through our intranet, Fusion. VDSS will manage all contractual and financial obligations with service providers to ensure that LDSS are able to focus their efforts on working with children and families.

As evidenced in the table on pages 13-14, while the programs are available in Virginia, they may not be readily available to every locality at the time of Family First implementation; however, this does not preclude an agency from utilizing the service. In preparation for implementation of Family First, through the Three Branch team, VDSS requested and ultimately received \$851,000 from the Virginia General Assembly to support providers in enhancing their evidence-based service delivery, specifically for services listed in the Title IV-E Prevention Services Clearinghouse. VDSS plans to utilize these funds to offer statewide training for providers, in order to enhance service delivery throughout the state (Prevention Strategy 2). Virginia is offering training opportunities, at no cost to providers, for Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Parent-Child Interaction Therapy (PCIT) to increase availability across the Commonwealth. Provider selection for these services will occur through an application process in collaboration with MST Services, FFT Site Certification Training Services, and The Center for Child and Family Health (CCFH) respective to their program expertise.

VDSS is partnering with MST Services to provide additional implementation, sustainability and fidelity supports to new Multisystemic Therapy programs in Virginia. MST Services will provide MST model implementation support, training and Quality Assurance oversight and support as outlined in their standard MST Program Support and Training Licensing Agreement, both to VDSS and to provider organizations. MST Services will support program development and start up services by:

Conducting a needs assessment with each provider agency to discuss the need for MST and the feasibility of building a sustainable program,

Conducting a critical issues review session to discuss the key elements of a successful MST program including Stakeholder relationships, defining target populations, developing referral processes, program finance, and program evaluation. Participants will gain information necessary to develop a comprehensive program description,

Conducting a Readiness Review meeting to provide an overview of MST to the community, and to meet with key stakeholders to refine the final implementation plan,

Providing staff recruitment assistance by providing sample advertisements, job descriptions, interview protocols and selection criteria, and

A 5-day Orientation Training for each new program start-up. The training provides the foundation for on-going implementation and program support and includes program managers, supervisors and therapists.

Once MST program operations has been initiated, MST Services will provide MST program support and training services tailored to the needs of the agency's program. MST Services will provide annual support and training services by:

Weekly MST telephone consultation for the MST Clinical Team(s). This weekly telephone consultation will average one hour per MST Clinical Team per week for up to 45 weeks during the year,

Unlimited consultation regarding the following: program quality assurance and improvement; organizational/systems consulting addressing issues related to the program's adherence to MST protocols or those that impact the quality of the MST program's outcomes; program development assistance related to program expansion,

Up to four (4) Booster Training sessions in each year of operation, and

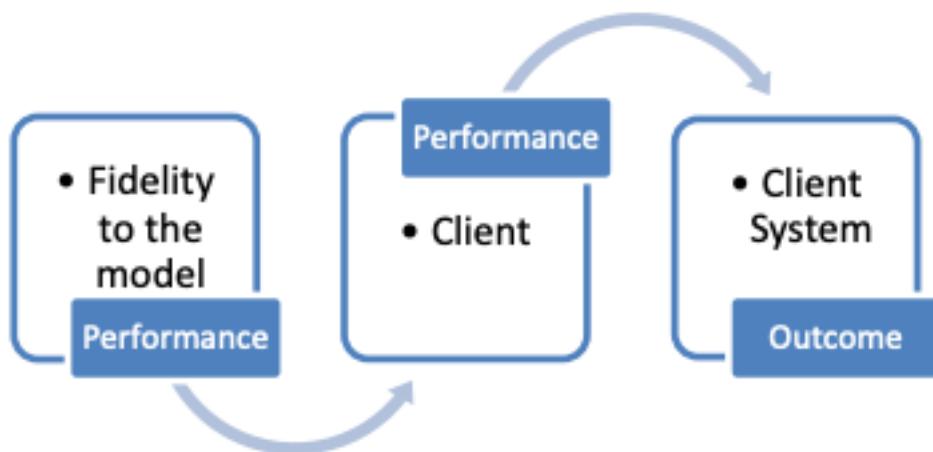
All required training materials and manuals.

VDSS is partnering with The Center for Child and Family Health (CCFH) to offer PCIT/CARE Training to support new Parent Child Interaction Therapy (PCIT) programs. CCFH will provide two in-person training sessions including all training materials, including treatment protocols, training manuals, training binders, a set of required ECBI assessments, preparation and post-cohort reporting. CCFH staff will coordinate and schedule all consultation components and provide technological supports (conference call lines, video upload services, and data collection tools) as required. CCFH will support PCIT treatment through weekly data submission, bi-weekly phone-based clinical consultation, and review of selected session video recordings. CCFH will provide updates on clinician achievement of skills mastery and case experience requirements on a monthly basis through the completion of twelve months of training, and a final report of the training course including participant evaluation of all in-person training events,

participant evaluation of the clinical consultation process, and a clinician-level report showing achievement of all national certification requirements.

VDSS will also partner with FFT Site Certification Training Services to provide implementation supports and technical assistance for new Functional Family Therapy (FFT) programs. Functional Family Therapy will provide support through a 3-phase process. During the first phase, FFT Site Certification Training Services will provide clinical training to providers. In the second phase, FFT Site Certification Training Services will provide supervision training to support greater self-sufficiency in the delivery of FFT while maintaining and enhancing site adherence and competence in the FFT model. In the third phase, FFT Site Certification Training Services, Est. will assure ongoing fidelity, support issues of staff development, interagency linking, and program expansion. FFT Site Certification Training Services will review the database for site/therapist adherence, service delivery trends, and client outcomes as well as providing a one day on-site training for continuing education in FFT.

VDSS is committed to performance monitoring and outcomes to ensure the best service delivery system for clients of the child welfare system. Ensuring positive outcomes is a process that includes monitoring the fidelity of the EBP model, achieving client goals and monitoring the outcomes of the entire client system (as illustrated in the graphic below).



VDSS will require all providers to report and adhere to their continuous quality improvement (CQI) process and fidelity monitoring process. The Family First Evaluation team will regularly monitor providers through adherence to performance measures (both established by the Family First Evaluation Team but also by each provider). The Family First Evaluation team will continuously work with the contracted providers through regular contact and monthly reporting requirements. If a concern arises, The Family First Evaluation team will work with providers to remedy the concern and if the concern cannot be remedied, the contract will be dissolved.

VDSS assures that each Health and Human Services-approved Title IV-E Prevention Service provided as outlined in this state plan meets the trauma informed service delivery as outlined in section 471(e)(4)(B) of the Act (See Attachment III) VDSS will monitor this through the state contract process.

Improving Outcomes for Children and Families

By providing Title IV-E Prevention Services and Kinship Navigator Services, VDSS expects to see the following outcomes identified in our 2020-2024 Child and Services Plan (CFSP) strategic plan (See Attachment B) and annually reported in Annual Progress and Services Report (APSR).

- Annual increase in the percentage of families served through Kinship Navigator Programs
- Annual increase in the number of KinGap cases
- Identification and annual increase of evidence-based service providers providing services in the Title IV-E Prevention Services Clearinghouse
- Annual increase in number of children and/or caregivers who receive evidence based services through Family First funding
- Annual decrease in the number of children who enter foster care



West Virginia

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

In-Home Visitation Programs – Parents as Teachers and Healthy Families America

The in-home parenting education programs, Parents as Teachers® (PAT) and Healthy Families America® (HFA), are well-supported, evidence-based programs that have demonstrated positive outcomes in preventing abuse and neglect for a population of families that West Virginia currently serves through its Bureaus for Public Health and Children and Families. These services were chosen for inclusion in this plan after the public health analysis revealed the lack of prevention services provided to West Virginia children prior to entering foster care. The analysis also showed that many mothers of West Virginia children in foster care are young and likely unprepared. In-home visitations programs' research and outcomes measures provide compelling evidence of their efficacy and since West Virginia's families meet the same demographics as those involved in established outcomes, DHHR believes that in-home visitation can help West Virginia in realizing a reduction in the rate of out-of-home placements, among other outcomes, as discussed below.

PAT® is currently available in 49 of West Virginia's 55 counties. Most of the counties have wait lists. HFA® is located in six counties along the south-eastern portion of the state. Both programs have the infrastructure to expand services with additional home visitation staff to meet increased needs. DHHR's Office of Maternal, Child and Family Health, housed within the Bureau for Public Health, has worked strategically over the past five years to develop leadership and resource/referral partners in counties to more readily add staff as needed (based upon funding availability). In addition, West Virginia now has a state-level PAT® training team, which has reduced staff training costs. Both programs have demonstrated positive outcomes for West Virginia's families and children.

Attachment C includes infographics related to the outcomes for PAT®. These in-home visitation programs can offer life-changing opportunities for the young mothers of West Virginia's foster care population. Program staff help schedule regular doctor's visits, improve diets, reduce stress levels, and provide supports to quit smoking or substance use (University of Texas at Austin 2015). These benefits could be the path to reducing poverty and increasing economic stability over the mother's lifetime.

Currently, the Maternal, Infant and Early Childhood Home Visitation funds (MIECHV) and a small amount of Community-Based Child Abuse Prevention (CBCAP) funding, and the required state match,

are the only funding streams for in-home visitation programs. This causes limited availability despite positive outcomes.

Target Population of In-Home Visitation Programs

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will implement Mountain State Healthy Families/HFA® to families with increased risk of child maltreatment or those who have already experienced abuse/neglect within the home, and

- have an active Child Protective Services case; and
- at least one parent is pregnant or has a newborn.

The service will be initiated during pre-natal or at birth, continuing for a minimum of three years. This service will also be available to pregnant foster children or a foster child who has a newborn, as their children will be eligible as foster care candidates.

Parents as Teachers® will be implemented for families expecting a new infant, have increased risk of child maltreatment or have already experienced abuse/neglect in the home with a child kindergarten age or younger and have an active child protective services case, and meet the criteria to be defined as a foster care candidate. This service will also be available to pregnant and/or parenting foster youth.

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment K.

Phased-in Implementation

A two-phased approach is planned for the utilization of IV-E funding for these in-home visitation programs.

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to DHHR's Office of Maternal, Child and Family Health (OMCFH) for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include CPS families and pregnant and/or parenting youth in foster care. The utilization process would include tailored guidelines that have the same look and feel that all other social necessary services possess.

The second phase includes efforts to expand services beyond their current localities of coverage as well as increase service capacity in areas where services are located but have waiting lists. Service

expansion will require budgetary appropriation from the West Virginia Legislature and proposals will be drafted for the 2021 legislative session.

Functional Family Therapy as a Mental Health Service in West Virginia

The Functional Family Therapy® (FFT) program was implemented in West Virginia following a 2015 legislative bill that required development of community-based mental health services for youth engaged with the juvenile justice system. Funding has been the primary issue for FFT® not being available statewide. When adopted by the Juvenile Justice Commission to meet the requirements of West Virginia Code §49-4-712, a legislative appropriation was provided in the amount of \$1,000,000 yearly. With training and administrative costs, this amount was not enough to fund expansion to more than a few providers.

FFT® is a well-established, well-supported, evidence-based intervention model utilized in 12 countries, including the United States. FFT® was chosen for inclusion within West Virginia's array of services because it has been shown, among other outcomes, to reduce recidivism as much as 50%. Research and outcomes measures provide compelling evidence of its efficacy. Since West Virginia's families meet the same demographics as those involved in established outcomes, DHHR believes FFT® can help West Virginia in realizing its outcomes for reducing the rate of children entering congregate care settings, improving youth and community safety factors, reducing recidivism rates and reducing out-of-home placements, among other outcomes, as discussed below.

FFT® has the added benefit of cost savings allowing West Virginia to reinvest dollars saved to fund additional preventative community-based programs. West Virginia currently has one FFT® team, consisting of three master's level therapists, with the ability to add five more therapists to their team. FFT® is available in six counties in the northern half of the state. FFT® is primarily utilized to prevent removal of children from the home but may also be utilized to help reunify families when youth have been living in a foster care setting.

Functional Family Therapy®, LLC, the proprietors of the FFT® model, provides internal fidelity controls for the one existing FFT® team in West Virginia. This is primarily accomplished through the required use of the Client Services System (CSS), which monitors therapist contacts with families, diagnosis, demographic information, and referral reasons. The CSS identifies primary and secondary reasons for referrals to the program. These range from youth delinquency behaviors to mental health and substance use problems. The chart below represents referral reasons for active cases in FFY18. The most common referral reason is parent/youth conflict in the home.



Families are more likely to voluntarily accept FFT® services than be required to participate through a court order. Those who are mandated to participate in FFT® do not typically see positive outcomes; the 12% of cases which were court ordered during FFY18 all experienced treatment failure.

FFT® is most often successful when utilized as a voluntary prevention strategy to keep children and families from being separated due to abuse and neglect or juvenile justice involvement. Fifty percent of families who voluntarily participated in services completed the program, and of those, none of the youth were placed outside of the home. This makes FFT® ideal for youth who are at-risk of removal but can be diverted through the utilization of a well-supported service.

The FFT® model currently available in West Virginia, which is being utilized for expansion through this Title IV-E opportunity, was built from the framework of the evidence-based model. The manual and resources supporting West Virginia's FFT® program is: *Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy® for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association.*

Target Population for Functional Family Therapy

As described on the *Title IV-E Prevention Services Clearinghouse*, West Virginia will be implementing FFT® for 11 to 18-year-old youth who experience behavioral or emotional problems that bring them into contact with the juvenile justice system and meet the criteria to be

defined as a foster care candidate. These children will be assessed for eligibility through the completion of the FAST (Family Advocacy and Support Tool).

For more information about eligibility, please review the utilization management guidelines for prevention services in Attachment K.

Phased-in Implementation for Functional Family Therapy

The first phase is to create a utilization management process for CPS and Youth Services workers to make referrals to current providers for foster care candidates and their families who meet the service population and would benefit from these programs. The target population would include children who interface with the juvenile justice system and pregnant and/or parenting youth in foster care.

Expansion of FFT® will require appropriation from the West Virginia Legislature and budget proposals will be drafted for the 2021 legislative session. Future phases will include onboarding new FFT® providers and extending geographic coverage.

Motivational Interviewing – A Complement to West Virginia’s Substance Use Disorder Strategies

As outlined, an extraordinarily high number of children are removed due to substance use disorders of their parents or guardians. State Opioid Response grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Ryan Brown Act (passed by the West Virginia Legislature in 2017) and DHHR’s Bureau for Medicaid Services have provided West Virginia with significant funding opportunities related to substance use prevention and treatment. The Ryan Brown Act allowed DHHR to provide more than \$20.8 million in funding to nine substance use disorder programs to expand residential treatment services across West Virginia. This funding is supported by the Ryan Brown Addiction Prevention and Recovery Fund as part of a comprehensive statewide plan to combat the opioid epidemic.

Motivational Interviewing will be an important complementary service due to its ability to enhance client motivation for behavior change. Motivational Interviewing will be utilized by the providers who deliver prevention services, as well as BCF staff. A more detailed plan for West Virginia’s intentions for using Motivational Interviewing will be provided in a prevention plan modification, once West Virginia develops the required infrastructure to meet the requirements of FFPSA.

Trauma-Informed Delivery of Prevention Services

The organizations providing Title IV-E evidence-based services will be required to contractually attest to their adherence to a trauma-informed organizational structure. The MCO will incorporate measures into the retrospective review process to determine the organizations' understanding and ability to recognize and respond to the effects of all types of trauma. The evidence that the MCO will require is as follows:

- Sufficient workforce development in understanding trauma and staff support in sustaining trauma-informed treatment;
- Residents and their families are part of care planning and decision-making;
- Use of data as a driving force with quality improvement; and
- Systemic reviews conducted within the organization.
-



Alaska

Status: Submitted

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Service Description and Oversight

Service Categories

Under Alaska's State Title IV-E Prevention Program, either the Office of Children's Services or Tribes and Tribal organizations with pass-through agreements will provide Prevention Plan development and Prevention Plan case management services to families whose children are identified as candidates for care. Using the Strengthening Families™ Framework, in partnership with the parents, existing and diminished parental protective factors will be assessed. Together with the family, the services needed to enhance protective factors will be explored, identified and incorporated into the Prevention Plan. OCS and Tribal Prevention Caseworkers will offer and promote the utilization of the new Home-based Family Treatment (HBFT) services developed and made available through the 1115 Waiver Project. Homebased Family Treatment is a new service array designed by the Division of Behavioral Health to reduce use of child/youth inpatient hospitalization and residential services by providing wrap-around services in the child/youth's home targeted at stabilizing the family as a unit. HBFT services are available for Medicaid eligible children/youth who are at risk for out-of-home placement, and their caregivers. There are three progressively intensive level of HBFT services See Attachment VII for diagram reflecting the DHSS Mental Health Continuum of Care for At-Risk Children and Youth and Attachment VI for a 1115 Medicaid Services and Title IV-E Services Array and Payment Source Crosswalk.

At least one well-supported evidenced based mental health, or substance abuse prevention and treatment service, or in home parent skilled based program pre-approved by the Title IV-E Clearinghouse will be included in every family's Prevention Plan. For their Tribal citizens and members, Tribal Title IV-E providers may also incorporate cultural family support services into the Prevention Plans.

Mental Health and Substance Abuse Prevention and Treatment Services

Services will be provided through existing Alaska service providers by a qualified clinician to a child or the child's parent or kin caregiver for up to 12 months for each prevention period.

In-Home Parent Skill-Based Programs

Well-supported, evidenced based in-home parent skill-based programs that have been pre-approved by the Title IV-E Clearinghouse will be provided to a child or the child's parent or kin caregiver for up to 12 months for each prevention period.

Cultural/Tribal Based Family Support Services and Programs

Alaska Tribes and Tribal Organizations with pass-through agreements will provide culturally and Tribally appropriate parenting programs or support programs.

Outcomes

Alaska's vision to "Empower Communities to Strengthen Families and Prevent Child Abuse" recognizes that to change the trajectory of the child welfare system to be less contingent on foster care and more focused on keeping families together, it will require a strong community based, collaborative approach. Based on this vision the outcomes selected for this Prevention Program are two pronged:

First, to ensure accountability of the child welfare system to enhance community partnerships and alliances. Second to build on these partnerships to enhance the five universal family strengths identified in the Strengthening Families Protective Factors Framework.

Outcomes Include:

- Improved collaboration with Tribes and community agencies to provide support and services to families.
- Improve protective factors:
 - Improved parental resilience
 - Improved positive social connections
 - Increased willingness to use concrete support in times of need
 - Improved knowledge of parenting and child development
 - Improved social and emotional competence of children
- Increase the number of children and families served in their own home and their home community.
- Reduce repeat maltreatment
- Reduce number of children entering foster care;
- Reduce the number of foster care re-entries

Evidence-Based Services and Programs

To identify the existing evidenced-based services available throughout the state, the OCS partnered with the DHSS Division of Behavioral Health and the Center for States to conduct a statewide gap analysis. Between January and May, 2019, the Office of Children's Services State Office team conducted a comprehensive needs assessment of the Alaska service array. The assessment included in-person onsite facility visits to 75 Medicaid providers across Alaska, including 20 Tribal organizations providing behavioral health services, participation in a joint DBH/OCS survey of Medicaid providers, and surveys of OCS frontline staff in 13 OCS Field Offices. The process provided the opportunity for OCS staff to learn from providers about the most effective services utilized in Alaska. The results of this analysis were

used to identify the services to be incorporated into child welfare prevention services. These services are described below.

Service	<i>Parent Child Interaction Therapy (PCIT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Mental Health Programs and Services
How Selected	<ul style="list-style-type: none">• An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit.• OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers.• Providers participated in a feedback group providing information on existing services and interest in providing new EBP services.• PCIT was already available in the state in some capacity, including OCS contract funded by CBCAP.• Based on input from each of these sources, OCS selected PCIT as an intervention to be included in the prevention services array.
Target Population	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.

Service	<i>Parent Child Interaction Therapy (PCIT)</i>
How Evaluated (Well-Designed and Rigorous Process)	OCS is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported practice, with supporting documentation.

Service	<i>Trauma Focused Cognitive Behavioral Therapy (TF-CBT)</i>
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Mental Health Programs and Services
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS surveyed its DHSS Senior and Disability Services (SDS) partner within the Early Intervention field. As a result SDS submitted a request to the Title IV-E Prevention Services Clearing House for inclusion of this service.
Target Population	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	Alaska will be using TF-CBT but will not be seeking federal reimbursement for this service until evaluated and approved by the Title IV-E Clearinghouse.

Service	<i>Multisystemic Therapy (MT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Mental Health and Substance Abuse Programs and Services
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services.

Service	<i>Multisystemic Therapy (MT)</i>
	<ul style="list-style-type: none"> Based on input from each of these sources, OCS selected MT as an intervention to be included in the prevention services array.
Target Population	This program provides services to youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.

Service	<i>Functional Family Therapy (FFT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Mental Health Programs and Services
How Selected	<ul style="list-style-type: none"> An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. Based on input from each of these sources, OCS selected FFT as an intervention to be included in the prevention services array.
Target Population	FFT is intended for 11 to 18 year old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	OCS is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported practice, with supporting documentation.

Service	<i>Motivational Interviewing (MI)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Substance Abuse Programs and Services
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • Based on input from each of these sources, OCS selected MI as an intervention to be included in the prevention services array.
Target Population	MI targets individuals who are less motivated or ready to change, and who may show more anger or opposition. MI can target a wide range of problem behaviors, such as smoking, gambling, or eating disorders. But it was originally developed to change substance abuse behaviors. MI can target substance abusers who may be ambivalent about changing their behavior.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	OCS is requesting a waiver for evaluation of MI, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported practice, with supporting documentation.

Service	<i>Methadone Maintenance Therapy (MMT)</i>
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Services Category	Substance Abuse Programs and Services
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • Based on input from each of these sources, OCS selected MMT as an intervention to be included in the prevention services array.

Service	<i>Methadone Maintenance Therapy (MMT)</i>
Target Population	This program is designed to treat individuals who have an opioid use disorder. Typically, individuals must be at least 18 years old to receive MMT. However, individuals under 18 may be eligible to receive MMT if they have already had two unsuccessful treatment attempts and they have parent/guardian consent.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	Alaska is using MMT but will not be seeking federal reimbursement for this service until evaluated and approved by the Title IV-E Clearinghouse.

Service	<i>Nurse-Family Partnership (NFP)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Services Category	In-Home Parent Skill-Based Programs and Services
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • Based on input from each of these sources, OCS selected NFP as an intervention to be included in the prevention services array.
Target Population	NFP is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	OCS is requesting a waiver for evaluation of NFP, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported practice, with supporting documentation.

Service	<i>Parents as Teachers (PAT)</i>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)

Service	<i>Parents as Teachers (PAT)</i>
Services Category	In-Home Parent Skill-Based Programs and Services
How Selected	<ul style="list-style-type: none"> An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. Based on input from each of these sources, OCS selected PAT as an intervention to be included in the prevention services array.
Target Population	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	OCS is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported practice, with supporting documentation.

Service	<i>Parenting with Love and Limits (PLL)</i>
Level of Evidence	Supported on the California Clearing House
Services Category	Parent Skill-Based Program and Services
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	The PLL evidence-based program has been implemented over the last nine years with the Department of Behavioral Health (DBH). PLL targets children between the ages of 10 and 18 with severe emotional and/or behavioral problems. The primary goal of the evaluation is to examine the effectiveness of PLL programming in comparison to similar services being provided to youth and their families in the state. The evaluation will assess second-year outputs and outcomes for youth served by PLL between May 12, 2010 and October 31, 2018. Retrospective, secondary client data provided by PLL, DBH and OCS will be examined for analysis.

Service	<i>Parenting with Love and Limits (PLL)</i>
How Selected	<ul style="list-style-type: none"> • An OCS subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • OCS conducted a survey to gather stake-holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • Based on input from each of these sources, OCS selected PLL as an intervention to be included in the prevention services array.
Target Population	PLL offers services to children and families that can reduce residential lengths of stay and can also be used to prevent residential placement for teens.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	Alaska is using PLL but will not be seeking federal reimbursement for this service until evaluated and approved by the Title IV-E Clearinghouse.

Service	<i>Circle of Security (COS)</i>
Level of Evidence	Requested for Title IV-E Prevention Clearinghouse Listed as Promising on the California Clearinghouse
Services Category	Parent Skill-Based Program
Plan to Implement, Monitor for Fidelity, and Determine and Use Outcomes to Improve Practice	Early Intervention and Infant Learning Program staff are all trained and will monitor fidelity.
How Selected	<ul style="list-style-type: none"> • An Early Intervention subject matter expert workgroup reviewed at length numerous EBP's, both available in Alaska and not available in Alaska, including consideration of fit with needs, populations, ages, evidenced base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • EI/ILP conducted a survey to gather stake holder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • COS was already available in the state in some capacity, including to OCS recommended families at several sites throughout the State • Based on input from each of these sources, OCS and EI/ILP selected COS as an intervention to be included in the prevention services array.
Target Population	Circle of Security ® Parenting ™ is a parent-reflection program offering the core components of the evidence-based and internationally acclaimed COS

Service	<i>Circle of Security (COS)</i>
	protocol. The program presents video examples of secure and problematic parent/child interaction, healthy options in care giving, and animated graphics designed to clarify principles central to COS. Circle of Security Parenting implements decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling.
Assurance for Trauma-informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	Selected as this is a model used in homevisiting by the State's Part C program. Circles of Security was submitted to the Title IV-E Clearinghouse on 10/31/2019 for consideration. Alaska will be using this service but will not be seeking federal reimbursement for this service until evaluated and approved by the Title IV-E Clearinghouse.

D. Tribal Based Services and Programs

Service	<i>Wellbriety Support Group</i>
Target Population and Service Description	The Wellbriety support group incorporates concepts and teaching from various resources which include the 12 steps of recovery from a Native perspective, the Medicine Wheel, Grief Support and Healing, and Traditional American Indian/Alaska Native rituals and practices.
Longevity of practice, community feedback and evaluation.	Tlingit & Haida has been using this program since 2008. A formal evaluation has not been completed. There is consistent participation from Tribal citizens. This is an on-going group with continuous enrollment.

Service	<i>Yéil Koow Shaawát (Raven Tail Woman)</i>
Target Population and Service Description	Phases I, II, & III. This curriculum project was selected as 1 of 6 Tribal projects from across the nation to work with the Center for Native Child and Family Resilience to formalize, pilot, test, evaluate, refine, and export her existing family-focused, culturally based counseling/treatment model to address the increasing complex issues of layered domestic violence, abuse, and child maltreatment through group work and discussions around root causes of maltreatment, and related traumas impacting Native women within SE Alaska. Each phase builds upon the other in terms of intensity and content. Native spiritual healing practices are part of the curriculum, so participants engage in sweat lodge ceremonies, purification and healing ceremonies, pipe ceremony, talking circles and teachings on Native culture as well as healthy discussions on the traditional tribal values of the Tlingit/Haida throughout each phase.
Longevity of practice, community feedback and evaluation.	Yéil Koow Shaawát, Women's group as they are commonly referred to has been running for 10 years. There are women who have returned to group after a period of time when they have re-lapsed for example and want to get back to a healthier way of living, or if they feel they need the support from the group atmosphere, or if they are struggling with post trauma issues and want to re-examine and heal parts of their life, that have gone untreated. The group is based off of an empowerment model so that if a woman attended the 36-week program for two consecutive years, she is invited to co-facilitate, this has brought women back as some are interested in

Service	<i>Yéll Koow Shaawát (Raven Tail Woman)</i>
	helping others with a deeper understand of the untreated or unresolved trauma issues.

Service	<i>Native Wellness Institute/Healthy Relationships</i>
Target Population and Service Description	The goal of the Native Wellness Institute is to continue bringing about positive changes in the lifestyles, relationships, education, and overall wellness of Native Americans. Highly skilled Native trainers and consultants come together for conferences, workshops and other projects. Healthy Relationships is a three day certification for women, men, youth, and service providers to help support their personal growth and development.
Longevity of practice, community feedback and evaluation.	Cook Inlet Tribal Council (CITC) has implemented and utilized the NWI Healthy Relationships Curriculum for approximately 7 years. This curriculum was selected because of the cultural lens of the content. The learning constructs in the curriculum are values-based and adaptable to different communities. The tools assist participants to understand how actions are connected and interdependent. It uses traditional ways of knowing to impart ideas such as storytelling and imagery. Self-report survey data is collected at the end of each session from participants using Likert scaling questions to document knowledge gain along with an open-ended questions about topic feedback. This tool was created by CITC and is not validated; however, the positive response rate on these scaling questions ranges from 80-100%. Although this is not a formal, external evaluation of effectiveness, the responses suggest knowledge gain for participants engaged in this service.

Service	<i>Linking Generations by Strengthening Relationships</i>
Target Population and Service Description	Native American Fatherhood and Families Association (NAFFA) created this training program for fathers, mothers and families including foster parents and step parents. Aimed to increase knowledge and skills to assist families by building relationships in the community.
Longevity of practice, community feedback and evaluation.	Sitka Tribe recently began using this curriculum that is based on increasing self-awareness, knowledge, and healing without judgement or shame. Can be used with individuals, couples, and groups

Service	<i>Intertribal Cultural Night</i>
Target Population and Service Description	Drumming and Craft Activities are conducted every Friday during the Cultural Night to promote spiritual awareness, awakening and connection, positive community interaction and connection, increased self-esteem, respect, confidence and identity. This is a positive social gathering of the local community Tribal people who come together. The intention of the gathering is to provide a safe, sober, comfortable and positive place for a person or family to have the opportunity to learn a new craft while connecting and interacting with other positive community members and families.

Service	<i>Intertribal Cultural Night</i>
Longevity of practice, community feedback and evaluation.	Tlingit & Haida has been implementing this program since 2015. A formal evaluation has not been completed however, the program has consistent participation from Tribal citizens. This is an on-going group with open and continuous enrollment.

Service	<i>Nurturing Parenting Program</i>
Target Population and Service Description	Tribal Family and Youth Services with Tlingit & Haida is in the process of implementing the Nurturing Parenting Program. This is an evidence based parenting curriculum. Tlingit & Haida is partnering with Tribal Temporary Assistance for Needy Families to employ one full time worker to implement this program.
Longevity of practice, community feedback and evaluation.	Tlingit & Haida implemented NPP in November of 2019. Pre and post assessments are administered. The program follows a ten-week schedule with on-going services on an "as needed" basis.

Service	<i>Fatherhood Is Sacred</i>
Target Population and Service Description	Native American Fatherhood and Families Association (NAFFA) created and designed this program for fathers using a Native American approach. The goal of the program is to strengthen families through responsible parenting. NAFFA teaches parents to connect with their heritage as they become actively involved in the lives of their families. Provides fathers with a welcome environment and fun activities that focus on the sacredness of being a father and the importance of Alaska Native/Native American heritage and how it applies to each father in the past, present and future.
Longevity of practice, community feedback and evaluation.	Sitka Tribe has been providing an average of 8 sessions per month of this curriculum for over a year. They have received positive feedback and see change in the lives of participants. Sitka Tribe believes this program assists with family reunification and building relationships within the family. Tlingit & Haida has been using the FIS program since 2012. The curriculum requires a pre-assessment. There is consistent participation from Tribal citizens, including alumni.

Service	<i>Motherhood Is Sacred</i>
Target Population and Service Description	Native American Fatherhood and Families Association (NAFFA) created and designed this program for mothers using a Native American approach. The goal of the program is to strengthen families through responsible parenting. NAFFA teaches parents to connect with their heritage as they become actively involved in the lives of their families. The sessions help mothers strengthen their families through responsible parenting, encourage participants to use critical thinking, and focus discussions on choice, wisdom, self-identity, and relationships.
Longevity of practice, community feedback and evaluation.	Sitka Tribe has been providing an average of 8 sessions per month of this curriculum since 2015. They have received positive feedback and see change in the lives of participants. Sitka Tribe believes this program assists with family reunification and building relationships within the family. Tlingit & Haida has been using the MIS program since 2015. The curriculum requires a pre-assessment. The program has consistent participation

Service	<i>Motherhood is Sacred</i>
	from Tribal citizens, including alumni. This is a 12-week program. In order to graduate from the program, participants cannot miss more than two classes.

Service	<i>Structured Decision Making</i>
Target Population and Service Description	Tlingit & Haida utilizes the evidence-based prevention Structured Decision Making (SDM) tools authored by National Council on Chemical Dependency (NCCD) to identify Alaska Native/American Indian families that are at risk of future OCS involvement. The initial assessment asks nine questions related to abuse and nine questions related to neglect in determining level of risk. Once the initial assessment is completed and parent(s) score very high or high, a referral is made to the Preserving Native Families (PNF) Program for services. PNF caseworkers provide the next level of assessment – the Family, Strengths and Needs Assessment (FSNA). The FSNA and Child Strengths and Needs Assessment identifies the strengths and needs of the individual or child. The PNF caseworker will develop a family case plan based on the assessments and provide culturally appropriate services. PNF caseworker conducts a follow-up assessments every 45 days.
Longevity of practice, community feedback and evaluation.	Tlingit & Haida has been using the evidence based SDM Prevention tools since 2012. NCCD provides Tlingit & Haida with a Management Report that provides data that assists in documenting the needs of Tribal citizens and in making resource allocation decisions.

Service	<i>Positive Indian Parenting</i>
Target Population and Service Description	Positive Indian Parenting is designed to meet the needs of both Native and non-Native parents, relatives, caregivers, foster parents, and others who strive to be more positive in their approach to parenting. It is implemented within a Tribe and/or community serving American Indian and Alaska Native people. This program offers participants a structured exploration of traditional American Indian and Alaska Native values concerning parenting and helps participants apply those values in a modern setting.
Longevity of practice, community feedback and evaluation.	Kawerak, Inc. is a non-profit Alaska Native Social Service entity in Nome, Alaska that serves both the community of Nome and many of the coastal villages in the Bering Strait region of North West Alaska. Kawerak, Inc. has been using Positive Indian Parenting model since 2001 with families involved with OCS and others who self-refer. Feedback is that this model is highly effective because it can be tailored to the local native people. Many young native parents who participate in the program have been disconnected from their culture, which can be a powerful agent for healing and change. The curriculum incorporates the inclusion of Native Elders and community members to help facilitate discussions regarding local cultural customs, strengths, and values. This helps to build a positive framework while exploring specific historical and intergenerational traumas that have been experienced by the people of that region. This knowledge is critical to understanding some of the underlying reasons for the struggle with addictions, which is often the basis for the parents' involvement with the child welfare system. Parents benefit from this holistic, culturally rich approach to learning about being a healthy adult and parent, while also

being exposed to the secondary benefit of making solid social connections with strong Elders and Community members.



Kansas

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Service Description and Oversight (Section 1 Pre-print)

The title IV-E Prevention Clearinghouse (section 476(d)(2) of the Act) ratings will be defined as such:

Promising Practice

- At least 1, independently verified, "well-designed and well-executed" study
- Used some form of control measures outcome

Supported Practice

- Same as above + used "rigorous random-controlled trial or quasi-experimental research design"
- Carried out in usual care or practice setting
- Showed sustained effect after 6 months

Well-Supported

- At least 2, independently verified, "well-designed and well-executed" studies
- Used "rigorous random-controlled trial or quasi-experimental research design"
- Carried out in usual care or practice setting
- Showed sustained effect after 12 months

Evidence-Based Table of Services

The following array of selected evidence-based programs (Figure 5, page 12) includes the service name, target age, and the Title IV-E Clearinghouse rating, the California Evidence-Based Clearinghouse (CEBC) rating and program funding sources. Kansas awarded grants for these selected services for October 1, 2019 through June 30, 2020, with intent to expand services and prevention partners in the future. Some chosen services have not been reviewed by the Title IV-E Clearinghouse, making them ineligible for Family First funds. Kansas selected these targeted services to fill a specified gap and is hopeful many will be rated or approved soon. Figure 6, located on page 13, demonstrates the distribution and availability of selected services statewide.

See Appendix 6 for DCF's signed assurance all services provided under this Prevention Plan will be administered within a trauma-informed organizational structure and treatment framework.

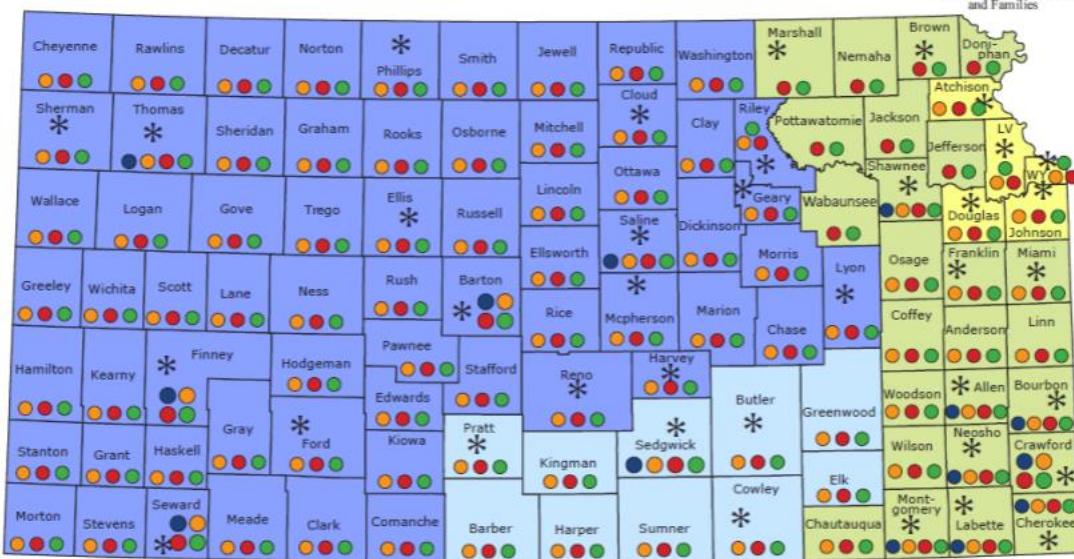
Kansas' Family First Evidence-Based Services

Figure 5

Evidence Based Service	Target Age	Title IV-E Clearinghouse Rating (X = not rated in Title IV-E Clearinghouse)	CEBC Clearinghouse Rating	Funding Source
Substance Use Disorder Services				
Adolescent Community Reinforcement Approach (A-CRA)	12 to 18 years	X	Supported	State
Parent Child Assistance Program (PCAP)	Prenatal to 1 year	X	Promising	State
Seeking Safety (SS)	0 to 3 years.; teens	Does not meet criteria	Supported	State
Mental Health Services				
Family Centered Treatment (FCT)	0 to 17 years	Well-Supported (Approved Independent Review)	Promising	Family First
Functional Family Therapy (FFT)	11 to 18 years	Well-Supported	Well-Supported	Family First
Parent Child Interaction Therapy (PCIT)	2 to 7 years	Well-Supported	Well-Supported	Family First
Multi-Systemic Therapy (MST)	12 to 17 years	Well-Supported	Well-Supported	Family First
Kinship Navigator Services				
Kinship Interdisciplinary Navigation Technologically Advanced Model (KIN-TECH)	0 to 18 years	Does not meet criteria	Supported	State
Parent Skill Building Services				
Attachment and Biobehavioral Catch-Up (ABC)	6 months to 4 years	X	Well-Supported	State
Family Mentoring Program (NPP)	0-17 years	Does not meet criteria	X	State
Fostering Prevention (NPP)	6-16 years	Does not meet criteria	X	State
Healthy Families America (HFA)–Signature Model	Prenatal to 3 years	Well-Supported	Well-Supported	Family First
Healthy Families America – Child Welfare Adaptation	Prenatal to 5	X	X	State
Parents as Teachers (PAT)	Prenatal to 3 years	Well-Supported	Well-Supported	Family First
Service Enhancement				
Motivation Interviewing (MI)	Parents & caregivers	Well-Supported	Well-Supported	Family First

Figure 6

Family First Prevention Services Act Programs



* DCF Service Center

West

Wichita

Mental Health

Substance Use Disorder

East

Kansas City

Parent Skill Building

 Kinship Navigator

Substance Use Disorder and Treatment Services

Approximately 161 at risk children and families may receive these new evidence-based services

Adolescent Community Reinforcement Approach (A-CRA)

Not rated in Title IV-E Clearinghouse

Supported in California Evidence-Based Clearinghouse

A-CRA will provide an outpatient treatment intervention for youth with substance use and co-occurring mental health disorders, and their families. The goals of the program are:

- Promote abstinence from alcohol, marijuana, and other drugs
- Promote positive social activity
- Promote positive peer relationships and improved relationships with family
- Motivate caregiver participation in the A-CRA treatment process
- Promote caregiver support of adolescent's abstinence from alcohol, marijuana, & other drugs
- Provide information to the caregiver about effective parenting practices
- Help the adolescent and caregiver(s) create a home and community environment conducive to recovery
- Teach the adolescent problem solving

Service Provider: DCCCA

Motivational Interviewing (MI) will be used with A-CRA. The A-CRA model is congruent with DCCCA's historical approach grounded in the National Institute of Drug Abuse Thirteen Principles of Effective Treatment, and incorporates Cognitive Behavioral Therapy, Motivational Interviewing, Trauma Informed Care, and engagement in community-based social support efforts such as Twelve Step. Motivational Interviewing (MI) is a goal-directed, client centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. DCCCA's use of MI is first evidenced as a strategy during the screening and assessment process by measuring stage of change – a key MI tenant – with the SOCRATES 8A/8D tool. Understanding where a youth and his or her family are on the stage of change continuum allows the DCCCA clinician to adjust his or her approach with the A-CRA components to meet the client where he or she is.

Program manual/book/information used in Implementation:

Miller, W.R. & Rollnick, S. (2012). *Motivational Interviewing, Third Edition: Helping People Change*. Guilford Press.

Available in:

East Region: Crawford, Cherokee, Labette, Neosho, Allen, Bourbon and Montgomery Counties
Approximate Number of Families to be Served: 15

Parent-Child Assistance (P-CAP)

Not rated in Title IV-E Clearinghouse

Promising on California Evidence-Based Clearinghouse

P-CAP will help parents maintain sobriety and learn skills to help them parent their child and provide an environment which teaches skills like self-regulation. The target population for this program is parents using substances with a child under the age of one, or pregnant women who may be referred if there is concern of substance use during pregnancy. Goals of the program are:

- Assist mothers in obtaining alcohol and drug treatment and to stay in recovery
- Link mothers and their families to community resources that will help them build and maintain healthy and independent family lives
- Help mothers prevent the births of future alcohol and drug-affected children

Service Provider: Kansas Children's Service League

Available in:

East Region: Shawnee County

Approximate Number of Families to be Served: 48

Seeking Safety (SS)

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse

Well-Supported on California Evidence-Based Clearinghouse

Seeking Safety is an integrated cognitive behavior-based model designed to concurrently address symptoms of post-traumatic stress disorder and substance use through a single trained person with flexibility to treat other high-risk behaviors. Gender-specific and gender-responsive treatment lead to the integration of family-centered treatment approaches to engage the whole family, helping members find their voice and feel valued. Services are provided in individual, group and/or family settings to support recovery.

The SS program targets families with children ages 0–3 and teens who are at-risk of being removed from the home as a direct or indirect result of the teen's or parent's substance use. Children ages 0–3 could be currently living with a relative due to a parent's substance use. Pregnant or parenting youth in foster care or out-of-home placement who are currently experiencing SUD are also eligible. Services typically last 6 months. Goals of the program are:

- Reduce trauma and/or substance abuse symptoms
- Increase safe coping in relationships
- Increase safe coping in thinking
- Increase safe coping in behavior
- Increase safe coping in emotions

Service Provider: Saint Francis Ministries

Available in:

West Region: Thomas, Finney, Barton, Seward, Saline

Wichita Region: Sedgwick

Approximate Number of Families to be Served: 98

Mental Health Services

Approximately 1,030 at risk children and families may receive these new evidence-based services.

Family-Centered Treatment (FCT)

Not rated on the IV-E Prevention Clearinghouse; Approved for Transitional Payments

Promising on the California Evidence-Based Clearinghouse

FCT provides intensive in-home treatment services for youth and families to prevent children being removed from the home, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's physical, mental, emotional and educational well-being through changing family value.

FCT will be offered to families with children 0-17 and crossover youth. Services last an average of 6 months. Specifically, families eligible for this service include those: impacted by trauma, conflict due to abuse and/or neglect, who have environmental stressors which have deteriorated the family's resiliency, whose prior treatment models indicate the client's progress is thwarted by non-involved family members, those with a family member who is hospitalized or in OOH placement, who need intervention due to crisis or the cumulative effect of a family member with chronic physical or mental illness, and those with serious behaviors of a family member which include substance abuse, domestic violence, youth running away or delinquent. Referrals for children who are actively suicidal, homicidal, or psychotic without medication stabilization are not appropriate. However, referrals for a child who is stabilizing/finishing treatment can be accepted. Goals of the program are:

- Enable family stability via preservation of or development of a family placement
- Enable necessary changes in the critical areas of family functioning identified as the underlying causes for the risk of family dissolution
- Bring a reduction in hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so changes are not dependent upon the therapist
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Service Provider: Saint Francis Ministries

Program manual/book/information used in Implementation:

Painter WE, Smith MM. (2004). *Wheels of Change—Family Centered Specialists Handbook and Training Manual*. Richmond, VA: Institute for Family Centered Services.

Wood TJ, (2014) *Family Centered Treatment® Design and Implementation Guide*. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.

Family Centered Treatment® is taught to staff through an intensive training and orientation curriculum entitled "Wheels of Change©." This dynamic education program includes tools and resources tailored to various learning styles and clinical backgrounds. In 2008, the Wheels of Change (WOC) training manual was digitalized as part of an interactive online learning platform. Currently, the WOC is maintained by the FCT Foundation and hosted by Mindflas.

Available in:

Wichita: All Counties

West: All Counties

Approximate Number of Families to be Served: 300

Functional Family Therapy (FFT)

Well-Supported on the Title IV-E Clearinghouse

Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors impacting the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in five phases consisting of 1) developing a positive relationship between therapist/program and family, 2) increasing hope for change and decreasing blame/conflict, 3) identifying specific needs and characteristics of the family, 4) supporting individual skillbuilding of youth and family, and 5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months. 9 Goals of the program are:

- Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use)
- Improve prosocial behaviors (i.e., school attendance)
- Improve family and individual skills

Service Provider: Cornerstones of Care

Program manual/book/information used in Implementation:

Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association.

Available in:

Kansas City Region: All counties

Approximate Number of Families to be Served: 160

Parent-Child Interaction Therapy (PCIT)

Well-supported on the Title IV-E Clearinghouse

In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two to seven-year old children and their parents or caregivers designed to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve quality of the parent-child relationship. During weekly sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families achieve mastery of program content in 12 to 20 one-hour sessions.¹¹ Goals of the program are:

- Build close relationships between parents and their children using positive attention strategies • Help children feel safe and calm by fostering warmth and security between parents and their children
- Increase children's organizational and play skills
- Decrease children's frustration and anger
- Educate parent about ways to teach child without frustration for parent and child
- Enhance children's self-esteem
- Improve children's social skills such as sharing and cooperation
- Teach parents how to communicate with young children who have limited attention spans
- Teach parent specific discipline techniques which help children to listen to instructions and follow directions
- Decrease problematic child behaviors by teaching parents to be consistent and predictable
- Help parents develop confidence in managing their children's behaviors at home and in public

Service Provider: Horizon Mental Health Center

Program manual/book/information used in Implementation:

Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011. PCIT International, Inc.

Available in:

Wichita Region: Barber, Harper, Kingman, Pratt West Region: Reno

Approximate Number of Families to be Served: 120

Service Provider: TFI Family Services, Inc. will provide Grow Nurturing Families utilizing PCIT

Program manual/book/information used in Implementation:

Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol: 2011*. PCIT International, Inc.

McNeil, C. B. and Hembree-Kigin, T. L. (2011). Parent-Child Interaction Therapy Springer.

Niec L. N (2018). Handbook of Parent-Child Interaction Therapy Springer.

Available in:

East Region: Allen, Anderson, Bourbon, Chautauqua, Cherokee, Coffey, Crawford, Franklin, Labette, Linn, Miami, Montgomery, Neosho, Osage, Shawnee, Wilson and Woodson

Wichita: Elk, Greenwood, Butler

West: Finney, Riley

Approximate Number of Families to be Served: 285

Multisystemic Therapy (MST)

Well-Supported through the Title IV-E Clearinghouse

Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program is designed to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17- year-old youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address identified drivers. The program is delivered for an average of three to five months, and services are available 24/7. Program duration and availability enables timely crisis management and allows families to choose which times will work best for them. Goals of the program are:

- Eliminate or significantly reduce frequency and severity of the youth's referral behavior
- Empower parents with the skills and resources needed to:
 - Independently address the inevitable difficulties which arise in raising children and adolescents
 - Empower youth to cope with family, peer, school, and neighborhood problems

Service Provider: Community Solutions, Inc.

Program manual/book/information used in Implementation:

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). New York: The Guilford Press.

Alternative manual/book/information used in Implementation:

Cunningham PB, Schoenwald SK, Rowland MD, Swenson CC, Henggeler SW, Randall J, Donohue B. Implementing contingency management for adolescent substance abuse in outpatient settings. Family Services Research Center, Medical University of South Carolina; Charleston, SC: 2004.

Available in:

Kansas City Region: Atchison, Leavenworth, Wyandotte;

East: Allen, Crawford, Labette, Montgomery, Neosho, Shawnee;

Wichita: Butler, Cowley, Sedgwick;

West: Barton, Ellsworth, Harvey, Reno, McPherson, Saline

Kinship Navigator Services

Approximately 400 at risk children and families may receive these new evidence-based services.

Kinship Interdisciplinary Navigation Technologically Advanced Model (KIN-TECH)

Does Not Meet Criteria in the Title IV-E Prevention Clearinghouse

Not Rated in the California Evidence-Based Clearinghouse

The target population for KIN-TECH will be children and youth at risk for out-of-home placement, and their kin caregivers. Services provided include legal advice, representation, mediation services for guardianship, adoptions family law issues and assistance with other legal issues impeding progress to permanency. Kinship caregivers who participate in KIN-TECH can access resources through multiple channels.

Service Provider: Kansas Legal Services

Available Statewide

Approximate Number of Families to be Served: 400

Parent Skill-Building Services

Approximately 836 at risk children and families may receive these new evidence-based services.

Attachment and Biobehavioral Catch up (ABC)

Not Rated on the Title IV-E Prevention Clearinghouse

Well-Supported in the California Evidence-Based Clearinghouse

Attachment and Biobehavioral Catch up (ABC) targets several key issues identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways which push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals leading them to provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced

early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable, warm environment which enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children's lead with delight. The third intervention helps caregivers decrease behaviors which could be overwhelming or frightening to a young child. Goals of the program are:

- Increase caregiver nurturance, sensitivity, and delight
- Decrease caregiver frightening behaviors
- Increase child attachment security and decrease disorganized attachment
- Increase child behavioral and biological regulation

Service Provider: University of Kansas Medical Center Research Institute, Inc. – Project Eagle

Available in:

Kansas City Region: Wyandotte, Douglas, Leavenworth

West Region: Cheyenne, Rawlins, Sherman, Thomas, Wallace, Logan, Decatur, Norton, Sheridan, Graham, Gove, Trego, Phillips, Smith, Rooks, Osbourne, Ellis, and Russel

Approximate Number of Families to be Served: 172

Family Mentoring

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse Not Rated on the California Evidence-Based Clearinghouse

The Family Mentoring program utilizes the Nurturing Parenting Program (NPP) to educate parents about healthy child development through parenting skills training and comprehensive professional support. A Family Mentor provides in-home visitation, one-one-one parent training, classroom instruction, parent/child intervention and advocacy and support to the parent. Goals of the program are:

- Measurable gains in the individual self-worth of parents and children
- Measurable gains in parental empathy and meeting their own adult needs in healthy ways
- Measurable gains in parental empathy towards meeting the needs of their children
- Utilization of dignified, non-violent disciplinary strategies and practices
- Measurable gains in empowerment of the parents and their children

- Reunification of parents and their children who are in foster care
- High rate of attendance and completion of their program
- Reduction in rates of recidivism of program graduates

Service Provider: Child Advocacy and Parenting Services (CAPS)

Available in:

West Region: Saline and Ottawa

Approximate Number of Families to be Served: 100

Fostering Prevention

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse Not Rated on the California Evidence-Based Clearinghouse

Fostering Prevention operates on the Nurturing Parenting Program (NPP) curriculum of a 15- session group-based family-centered program. Parents and their children attend separate groups which meet concurrently. Lessons in the program are based on known parenting behaviors contributing to child maltreatment: Inappropriate parental expectations, parental lack of empathy in meeting the needs of their children, strong belief in the use of corporal punishment, reversing parent-child family roles, and oppressing children's power and independence. Program outcomes as follows:

- Parents experience an increase in family cohesion
- Parents experience an increase in nurturing and safety capabilities

Service Provider: Foster Adopt Connect, Inc.

Available in:

Kansas City Region: Johnson and Wyandotte

Approximate Number of Families to be Served: 23

Healthy Families America (HFA)

Signature Model: Well-Supported on the Title IV-E Prevention Clearinghouse Child Welfare Adaptation:
Not Rated on the Title IV-E Prevention Clearinghouse

Healthy Families America (HFA) is a home visiting program model designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance use issues. Services are offered to families during pregnancy or at the time of birth of their child and can be provided long term.¹⁷ Goals of the program are:

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors

Service Provider: Great Circle

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote.

Alternative manual/book/information used in Implementation:

Great Circle will utilize the signature model of Healthy Families America and the Child Welfare Adaptation. Healthy Families signature model utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote.²⁰ There is not an alternative manual for the Child Welfare Adaptation, although HFA has created a guideline document outlining this model in a few pages, see link in footnote

Available in:

East Region: Chautauqua, Woodson, Coffey, Anderson, Linn, Franklin, Osage, Wabaunsee, Pottawatomie, Jackson, Marshall, Nemaha, Brown, and Doniphan

Kansas City Region: Atchison and Douglas Approximate

Number of Families to be Served: 232

Service Provider: Kansas Children Services League (KCSL)

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote.

Alternative manual/book/information used in Implementation:

KCSL will utilize the signature model of Healthy Families America and the Child Welfare Adaptation. Healthy Families signature model utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote. There is not an alternative manual for the Child Welfare Adaptation, although HFA has created a guideline document outlining this model in a few pages, see link in footnote.

Available in:

Wichita Region: Sedgwick

East Region: Wilson, Allen, Neosho

Approximate Number of Families to be Served: 60

Service Provider: Success by 6 Coalition of Douglas County

Program manual/book/information used in Implementation:

Healthy Families utilizes a series of Best Practice Standards which define the structure of the program model. Fidelity to the program model requires adherence to the 2018-2021 HFA Best Practice Standards, see link in footnote²⁵. This grantee is providing only the Signature Model.

Available in:

Kansas City Region: Douglas County

Approximate Number of Families to be Served: 20

Parents as Teachers (PAT)

Well-Supported on the Title IV-E Prevention Clearinghouse

Parents as Teachers (PAT) is an early childhood parent education, family support and wellbeing, and school readiness home visiting model. Parent educators work with parents to aid in assisting caregivers with strengthening protective factors and ensuring young children are healthy, safe, and ready to learn. Goals of the program are:

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Service Provider: Kansas Association for Parents as Teachers (KPATA) and local Parents as Teachers Affiliates

Program manual/book/information used in Implementation:

Program will serve families with children 0-3 years of age utilizing the Parent as Teacher Foundational 1 Curriculum, see link in footnote

Available in:

Statewide

Approximate Number of Families to be Served: 229

Service Enhancement

Service will be provided for all families receiving Family First Prevention Services.

Motivational Interviewing (MI)

Well-Supported on the Title IV-E Prevention Clearinghouse

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities. Goals of the program are:

- Enhance internal motivation to change
- Reinforce this motivation
- Develop a plan to achieve change

Service Provider: All providers have included Motivational Interviewing as part of their services delivery. However, Kansas is only seeking approval at this time for Motivational Interviewing to be utilized with Adolescent Community Reinforcement Approach (A-CRA). Please see page 14 for additional information supporting A-CRA's use of Motivational Interviewing.

Available:

Statewide all services; MI used with A-CRA available in Crawford, Cherokee, Labette, Neosho, Allen, Bourbon and Montgomery Counties

Oversight

In addition to the detailed evaluation plan (Attachment 3), the allowable services will be continuously monitored to ensure fidelity to the practice model by the provider and DCF. Please refer to the evaluation plan (see attachment 3) for details of how services will be monitored to ensure fidelity to the practice model. The Evaluation Team will rely on model-specific accreditation monitoring and provider-based fidelity assurance methods and administrative data to corroborate the quality and fidelity of the service delivery of each intervention. These findings will be included in the evaluation. In addition to the evaluation plan's fidelity monitoring approach, each provider of a well-supported or allowable service, has their own fidelity monitoring activities used to refine and improve practices, as outlined below.

Family Centered Treatment (FCT)

Family Centered Treatment will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Services are monitored through video review of specialist sessions with families, weekly staffing in team, tracking dosage and activity completion of each family based on

the wheels of change. Additionally, a monthly reporting process developed by the FCT Foundation is utilized to collect data related to dosage, monitoring of progress through the treatment phases, and fidelity to the model. FCT also collects information from families at discharge through a survey process as well as following up with families after discharge. Specialists, with family input, complete the Discharge Data Collection form, and information from this form is reported to the Foundation utilizing the Discharge Tracker report.

Information learned from monitoring Family Centered Treatment will be used to refine and improve practices. Family Centered treatment offers a consultant that will assist Program Director and Clinical Supervisor on refining and improving practices through analyzing data for dosage, oversight of training and skills completion of supervisor and specialists.

Functional Family Therapy (FFT)

Functional Family Therapy will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. This program benefits from double evaluation, feedback, and refinement processes. Cornerstones of Care, the agency contracted to provide this evidence-based service, implements outcome and efficacy monitoring processes as does the FFT Corporation. Program results are entered into a proprietary database for FFT LLC evaluation. Program staff and internal Performance Excellence Specialist regularly monitor outcome data, cultural competency measures, and other issues through the continuous quality improvement process.

Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System (CSS), FFT weekly consultations and FFT training activities. Staff will have access to appropriate technology including Electronic Health Record (HER), myAvatar, and the FFT CSS database, clinical resources and workspace sufficient to achieve the outcomes proposed. In addition, a national consultant from FFT, LLC oversees the team at a frequency determined by the phase of the team (level of experience). Three times per year, the national consultant provides a TYPE report which provides multiple measures of the adherence and fidelity of the team to FFT.

Outcomes of this program will be:

1. Families will engage timely in FFT services.
2. Children are safely maintained at home with their families.
3. Families will demonstrate improved family relationships.
4. 70% of families will complete therapeutic services successfully in the first nine months of service (80% thereafter).

Information learned from monitoring Functional Family Therapy will be used to refine and improve practices via a collaborative multi-agency approach with multiple levels of monitoring. FFT is a well-supported evidence-based practice with over thirty years of monitoring used to refine and improve practices. Many different tools are used to do so, including the format of the Electronic Health Record, regular case reviews by the manager and team, TYPE reports (3x per year reporting on FFT team data), and oversight by the FFT, LLC Consultant.

Cornerstones of Care also has its own means to improve and refine practices including supervision by managers, team meetings, Performance Excellence Department reviews, oversight by the FFT implementation manager and outpatient director. Collaboration with DCF staff for best outcomes will also occur on multiple levels to continue to learn and improve. Individual therapists and referring DCF staff are encouraged to communicate and collaborate. Managers and the implementation manager will be purposeful in regularly discussing problem areas and celebrating successes. Information from monitoring will be key to keep these discussions from being anecdotal and instead focusing on data-derived trends.

The advantage of using an evidence-based model is there is evidence it can be used to refine and improve practices. Collaborative work with DCF and FFT, LLC as well as internal efforts likely to gather increasingly positive results in this area.

Healthy Families America (HFA)

Healthy Families America will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Kansas Department for Children and Families is partnering with three agencies to provide HFA: Great Circle, Kansas Children and Service League, and Success by 6/Lawrence Douglas County Health Department.

Model fidelity is illustrated through a comprehensive accreditation process. Currently, there are over 550 affiliated HFA program sites in the United States and Internationally.

Great Circle Home Visiting will utilize important documents published by HFA as its comprehensive planning guide for expert guidance and practical tips. These documents offer guidance on model implementation and expectations related to all aspects of policy and practice. Sites implementing HFA commit to providing high quality home visiting services and demonstrate model fidelity through the Quality Assurance and Accreditation process established through national standards. In addition, Great Circle currently offers a monthly leadership meeting to include staff from around the state whereby model fidelity and implementation, peer record results, and adherence to best practices is assured. For example, the 12-critical element Standards are integral to the Quality Assurance and Accreditation

process. They serve as the site's guide to model implementation and is structured into 3 steps: completion of a thorough program self-study, a site visit, and final determination on accreditation.

Kansas Children's Service League (KCSL) has been providing Healthy Families services in Kansas since 1996, and in 2017 became an affiliated multi-site system with Healthy Families America. As a multi-site system, KCSL goes through an additional level of accreditation for central administration functions to provide training, quality assurance, technical assistance, evaluation, and administrative functions for the Healthy Families programs within the multi-site system. KCSL contracts with HFA to bring national trainers to Kansas or arranges for staff to travel to other states when necessary to complete required trainings. The central administration staff at KCSL complete an annual site visit with each program, ensure a random selection of files are reviewed twice each year, and regularly monitor program outcomes and outputs to ensure fidelity to the model. KCSL completed five site visits for re-accreditation in 2019 and expects to receive final approval for renewed accreditation in 2020.

Lawrence Douglas County Health Department (LDCHD) has maintained programming for Healthy Families program for over six years. It was within those years the program first became accredited in 2015. Healthy Families Douglas County (HFDC) completes re-accreditation every four years from Healthy Families America. The HFDC program has annual goals and benchmarks specifically related to HFA Best Practice Standards. An annual Quality Assurance plan also comprehensively reviews components of the program as related to Best Practice Standards.

Information learned from monitoring Healthy Families America will be used to refine and improve practices. Great Circle's Performance and Quality Improvement (PQI) team completes quarterly site visits and facilitation of quarterly Peer Record Review of select cases, and monitors timeliness and completion of programmatic data entry, and adherence to Healthy Families America Best Practice Standards. Quarterly, the PQI department also assesses client and shareholder satisfaction with services. PQI provides detailed information and recommendations on how to enhance client satisfaction with services. PQI has been instrumental in assisting teams to increase consistent application of assessment tools and consistent entry of data crucial to monitoring progress and outcomes.

LDCHD utilizes data gathered from HFA National program re-accreditation, outcomes of the program's annual goals/benchmarks and the annual quality assurance plan. These are monitored by the program manager/supervisor and reviewed with staff and advisory council. The reviews result in mechanisms to address areas of improvement. These areas of improvement are incorporated into the next year's annual program goals/benchmarks and/or the annual quality assurance plan.

KCSL's administration team reviews participant files twice each year. They manage the database for all programs and assist with data entry. The administration team provides reports to the programs twice each year to show their compliance with specific HFA standards. They complete an annual evaluation of outcomes and an annual site visit with each program to ensure fidelity to the model. Technical assistance is provided in any area the program may be struggling in. Annually, the central administration team meets to review reports and feedback from the previous year. This information assists in determining what improvements to policies, forms, procedures, and/or reports are needed. The process for improvement is ongoing as systems are continually reviewed and adjusted to improve effectiveness.

Motivational Interviewing – Service Enhancement to A-CRA

Motivational Interviewing (MI) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. DCCCA staff have been trained by Motivational Interviewing Network of Trainers (MINT) credentialed trainers. The focus of the training included theory, practice and skill building in the Miller/Rollnick Model of Motivational Interviewing and incorporated lecture, live demonstrations, experiential practice, and video demonstrations. The philosophy of Adolescent Community Reinforcement Approach (A-CRA), the Evidence Based substance use disorder treatment model DCCCA utilizes, coincides with that of Motivational Interviewing and uses a warm, understanding, nonjudgmental, nonconfrontational clinician approach to build strong therapeutic relationship.

A-CRA incorporates a supervision model which includes weekly supervision sessions, monitoring of certified clinicians via reviews and rating randomly selected sessions. The Clinical Coordinator utilizes this model for supervision and monitoring clinician fidelity to the A-CRA model and implementation of Motivational Interviewing practices and looks for evidence of that in documentation as well.

Information learned from monitoring Motivational Interviewing will be used to refine and improve practices. The information obtained through supervision and monitoring of clinicians is used to provide positive and constructive feedback to improve or refine technique and skills and ensure fidelity to the ACRA model and in keeping with the spirit of Motivational Interviewing.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Staff and stakeholders work together to ensure referred clients are a good fit with the program and problem solve challenging cases. The therapists and clinical supervisor meet monthly with referral sources and other key stakeholders for the purpose of case review. Pertinent staff are updated on each case and collaborate in the planning process. Case specific and systemic concerns are addressed using the MST analytical process.

MST teams use myEvolv, or a similar electronic case record management system, where therapists record the progress of each case. Client files are the permanent record of services provided and detail a client's progress in the program. Each therapist uploads weekly summaries into myEvolv within 72 hours of service. The clinical supervisor logs into the system and reviews the summaries. They add feedback and ultimately approve or request an addendum to the case note. The clinical supervisor downloads all summaries from myEvolv and scans them into the System Supervisor for further review and feedback. In addition, MST programs comply with all layers of the MST QA system. As part of MST Quality Assurance Program implementation, information is gathered from caregivers, therapists, and Clinical Supervisors. Families receiving MST will be asked to answer a few questions about treatment periodically. In addition, therapists will be asked bimonthly, to rate their clinical supervisor. Finally, clinical supervisors report on organizational practices.

In all recently developed MST programs and in most of the mature programs, ratings of therapist adherence is received from caregivers two weeks after the start of treatment and monthly thereafter. The Therapist Adherence Measure Revised (TAM-R) is completed via phone interview through the MST Institute Call Center or by completion of a written TAM-R. The TAM-R is a validated 28-item tool used to evaluate a therapist's adherence to the MST model as reported by the primary caregiver of the family. The adherence measure was originally developed as part of a clinical trial on the effectiveness of MST and has proved to have significant value in measuring an MST therapist's adherence to MST. The tool is equally significant in predicting positive outcomes for families who received MST treatment.

Therapists rate their clinical supervisors by completing the Supervisor Adherence Measure (SAM) one month after their first MST supervision session. Ongoing subsequent ratings occur at two-month intervals. The SAM is a 43-item tool designed to measure and evaluate the MST Supervisor's adherence to the MST model of supervision, as reported by MST therapists. Similar to the TAM-R, data from the SAMS are entered into a database via an internet-based system. Structure for collection and the Quality Insurance process for monthly SAMS surveys includes:

1. The System Supervisor sets the dates for the collection of SAMS.
2. The MST clinical supervisor instructs therapists after supervision and consultation to complete SAMS before leaving the office.
3. System Supervisor pulls the SAM report monthly and reviews with each supervisor during their development plan meeting.

Information learned from monitoring Multisystemic Therapy will be used to refine and improve practices. Family Feedback is used to provide feedback to the MST program about how to improve adherence and program outcomes. Performance assessments of staff are primarily based on the

employee's understanding of model principles, their ability to comply with the model, achievement of outcome measures, and compliance with agency policies.

Supervisors complete staff supervision plans on a monthly basis. These staff plans acknowledge strengths of the clinicians during the month, along with any areas of improvements. Monthly staff plans provide data for the quarterly development plans. The development plan reviews the clinician's outcome measures for the quarter based upon model criteria. The development plan includes strengths and areas for improvements. Interventions are put in place for any outcome measures not meeting model requirements. Data from the staff plans and quarterly development plans are an integral part of the annual evaluation. Strengths and weaknesses from the staff and development plan become a part of the annual evaluation. Any issues identified will be addressed through additional training, coaching, modeling, supervision, and/or disciplinary action when necessary. When the formal CAMs evaluation is administered, the employee is aware of their performance up to this point. All evaluations are performance based and tie directly to the job description as well as model adherence and outcomes.

Parents as Teachers (PAT)

Parents as Teachers (PAT) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. All Kansas State Department for Education (KSDE) Parents as Teachers Affiliates partnering with DCF through Family First Prevention Services will have completed the PAT Quality Endorsement and Improvement Process (QEIP). This process ensures the PAT program is functioning with fidelity to the model.

The degree to which an affiliate accurately implements the PAT model with an emphasis on the Essential Requirements and Quality Standards indicates fidelity to the PAT model. KSDE PAT affiliates must be designed to meet all Essential Requirements. Annually, PAT affiliates must submit data addressing the requirements to PAT National Center, KSDE, and Kansas Parents as Teachers Association.

PAT affiliates who achieve success in all 20 Essential Requirements and 75 of the 100 Quality Standards ensure fidelity is achieved through the model and high-quality services are delivered.

Information learned from monitoring Parents as Teachers will be used to refine and improve practices. Data is collected by local program affiliates, KSDE, and PAT National Center. Aggregate data capturing usage of funds, outcome compliance, and families served is collected by the Kansas Parents as Teachers Association (KPATA) in a monthly performance measure report (PMR) and in the annual performance review (APR). These reports include data related to length of visits, number of families served, and cancellations. The report informs and provides program staff targeted approaches in mitigating challenges affiliates are facing.

As a grantee with a statewide footprint, KPATA utilizes referral trend data to identify geographic areas which may benefit from expanded PAT programs in the coming years. Based on the planned funding strategy of incorporating private donors, grants, and foundations, the data provides support and justification for increased investments in communities who experience a high level of referrals.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. TFI Family Services therapists and support workers have a firm understanding of behavioral principles. They are trained in cognitive-behavior therapy, child behavior therapy, and therapy process skills. The PCIT training model requires therapists to complete forty (40) hours of intensive skills training followed by supervised service delivery with two (2) families. This must be completed prior to independent practice. Training requirements for supervisory staff remain consistent in the required 40 hours of intensive skills training. Supervisor training differs by requiring supervised service delivery to four (4) families prior to independent practice.

Clinical fidelity tools for both agencies include observation, videotaping, completing supervision, and consultation with a Master PCIT practitioner. TFI Family Services and Horizon's Mental Health Center collaborate with an established Master Training agency.

Information learned from monitoring Parent Child Interaction Therapy will be used to refine and improve practices. TFI Family Services will ensure Therapist are trained and moving toward certification. On-going supervision will occur after certification is completed. TFI will engage and collaborate with the institute related to data or information leading to needs for enhancement to the model. PCIT International is currently working on protocols for adaptions. TFI ensures they will remain aware of updates or changes to the protocols.

Horizons Mental Health Center utilizes a PDSA (Plan Do Study Act) Model for process improvement. This same structure will be applied to the monitoring and refining process for PCIT.

Rationale for Selected Services

Programs were evaluated, scored and rated by a Grant Peer Review Panel, consisting of representatives from the Kansas Department of Health and Environment (KDHE), Kansas Department of Aging and Disability Services (KDADS), the Children's Cabinet, each DCF region and DCF Administration. Team representatives had program expertise in foster care, mental health, early childhood programming, quality assurance, substance use disorder services, and prevention services. Peer reviewers evaluated

applications to ensure the information presented was reasonable, understandable, measurable and achievable, as well as consistent with program and legislative requirements. Reviewers made recommendations based on many factors such as: underserved populations, strategic priorities, geographic balance, available funding, and evidence of foster care prevention.

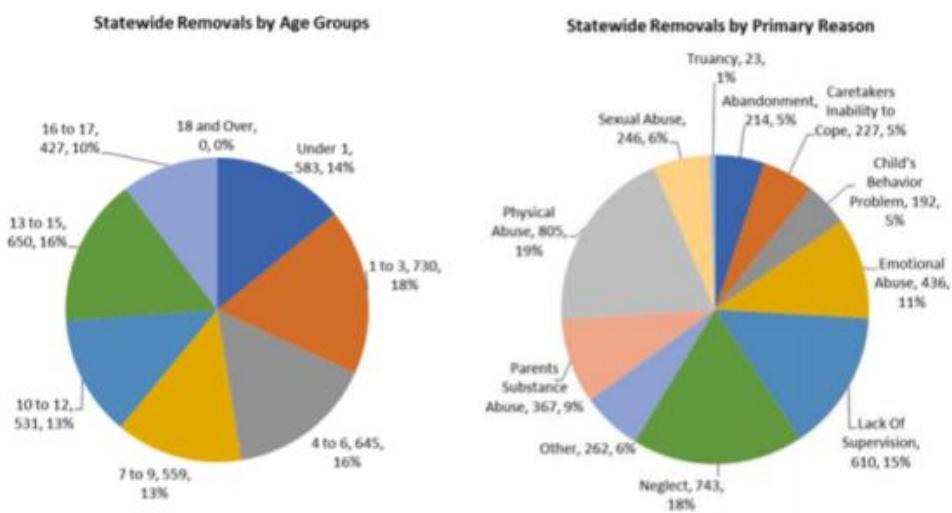
The following three factors were highly influential when selecting the chosen services:

- Kansas data showing the reasons children are placed in foster care and the ages of the children at the time of foster care referral
- Geography of services and gaps in services across Kansas
- Targeted services for crossover youth

SFY 2019 Removal Data

Of the children removed in SFY2019, 62% were age 9 or younger. When recommending removal from home, PPS practitioners indicate one primary reason for removal and may indicate up to 15 secondary reasons for removal. The most frequent abuse and/or neglect reason for removal for SFY 2019 is physical Abuse (19%) and neglect (18%). The highest non-abuse neglect removal reason is parental substance abuse (9%) (figure 7). The number of referrals with secondary reasons of parental substance abuse is drastically higher at 40%.

Figure 7



Kansas selected more than half of the evidence-based services to target children under 9 years of age. Additionally, many of the services chosen, outside of the category of substance use, have a focus on substance use disorders and will provide support and connection to services.

Geography and Service Gaps

Kansas has urban, rural, and frontier counties. Many areas in Kansas are designated medically underserved areas by the Health Resources and Services Administration.²⁸ When selecting services, the review teams considered needs based on geography and current service gaps. Page 12, Figure 5, provides a visual of the Family First Prevention Services array across the state.

Kansas has only one adolescent residential substance use disorder treatment facility, located in Johnson County, an urban area in Northeast Kansas. The Adolescent Community Reinforcement Approach (A-CRA) was proposed as an outpatient substance use disorder program in Southeast Kansas. Southeast Kansas is a more rural area where families frequently struggle finding transportation to services. Family First Prevention services will increase availability of substance use services to teenagers in rural Southeast Kansas.

The Kansas Department of Health and Environment has been collaborating with 32 hospitals across the state as part of the Neonatal Abstinence Syndrome opioid grant. Topeka and Wichita, both urban areas, have experienced high rates of substance-exposed birth. Two Family First Prevention services chosen will target these areas: Parent-Child Assistance Program in Topeka and Seeking Safety in Wichita.

When children in Kansas live with non-related kin, those extended families across the state often lack access to affordable legal services to prevent the children from being placed in foster care. The Kin-Tech program fulfills this service gap by assisting kinship families with family law issues such as paternity, consumer issues to relieve financial stress, housing concerns with landlord/tenant disputes or foreclosure. Services also may assist kinship families with direct legal assistance, training or education, support groups, referrals to other social, behavioral, or health services, advocacy, Guardianship clinics and maintaining a "Kansas Kin Care" web page. This program will be implemented statewide.

Access to mental health services is also a barrier for some rural and frontier counties. The review team selected Family Centered Treatment for 75 counties in the West and Wichita Regions. Family Centered Treatment provides in-home treatment services for youth and families to prevent children being removed from the home using psychotherapy designed to reduce maltreatment and enhance family resiliency.

Crossover Youth

In SFY 2019 DCF budget proviso outlined the legislative directive to convene a workgroup charged with gathering information about youth with offender behaviors entering or already in the child welfare

system, referred to as "crossover youth." This group met on June 13, 2019 to achieve three objectives: (1) defining characteristics or risk factors of crossover youth, (2) evaluating services offered to crossover youth, and (3) identifying additional services needed for crossover youth. The Crossover youth Services Working Report²⁹ and continued conversations with child welfare community stakeholders influenced Kansas' evidence-based service selections.

In 2016, Kansas enacted Senate Bill (SB) 367, which sought to decrease the number of youth in the juvenile justice system by creating community-based alternatives to detention centers. The law was intended to focus intensive system responses on juveniles with the highest risk to reoffend, restricted the use of out-of-home placement in detention and Kansas Department of Corrections – Juvenile Services (KDOC - JS) custody, and planned to shift significant resources toward evidence-based alternatives with supervised in-home services. Implementation of SB 367 successfully reduced the number of youth placed in the juvenile justice system. According to the Fiscal Year Flashback³⁰, in SFY 2016 the total youth in department of corrections custody was 1121, compared to 333.6 in SFY 2019, a 30% decrease.

An unintended consequence of implementation of SB 367, as amended, might be diverting youth and their families who previously were served by the juvenile justice system to access services from other state agencies, particularly the Department for Children and Families. State agencies historically have not tracked crossover youth in their data collection systems in a manner to verify crossover youth now being served by the child welfare system at higher rates. However, child welfare contractors, law enforcement representatives, child placing agencies and other partners report high rates of undertaking increasing challenges in managing behaviors and accessing effective services for crossover youth.

Due to these reported experiences and lack of resources for crossover youth, Kansas is focusing on strong evidence-based services to target this population and maintain them in their home whenever safely possible. Therefore, Kansas selected the following services: Adolescent Community Reinforcement Approach, Seeking Safety, Family Centered Treatment, Functional Family Therapy, and Multi-Systemic Therapy. Although each of these services will not be available statewide, one or more of these programs will be available in 97 of the 105 counties in SFY 2020, with hopes of future expansion.



Kentucky

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Title IV-E Prevention Services

To inform the development of this Title IV-E Prevention Plan and the selection of proposed interventions, DCBS conducted a rigorous analysis of its child welfare data to understand the reasons children were entering care, risk factors for maltreatment present in families, and their geographic representation across the State and its nine regions. DCBS analysts specifically examined the prevalence of needs that could be addressed through preventive programs contained within the three categories of allowable services under Family First: 1) In-home, skillbased parenting programs; 2) Substance abuse treatment and prevention; and 3) Mental health treatment. The prevalence of those needs was then geographically mapped across Kentucky's nine regions and discussed with the relevant Transformation workgroups who helped make meaning of those findings.

Substance abuse treatment and prevention

Substance abuse disorders, by youth or caretaker, are prevalent among Kentucky's child welfare population and represents a specific area DCBS intends to target through this prevention plan. Kentucky has existing infrastructure to address a portion of the needs of this population with the Title IV-E Waiver programs, START, and KSTEP. When considering Kentucky's potential Family First candidates, 17,471 children are involved in a case with substance abuse as an identified risk factor within the family. The more vulnerable population of Family First potential candidates under 10 years of age, with substance abuse as a case characteristic, totals 12,164 in the CY2018 cross-section. Sixty-six percent of the potential candidates are under 10 years old. When considering potential Family First candidates, under 10 years of age, with a case characteristic of substance abuse in comparison to the current population being served by in-home services, Kentucky has identified regions where a gap exists in service delivery. The need for additional substance abuse interventions is indicated for one county in the Eastern Mountain service region, four counties in the Northeastern Service Region, six counties in the Northern Bluegrass service region, four counties in the Cumberland service region, three counties in the Salt River Trail Service Region, three counties in the Southern Bluegrass Region, seven counties in the Lakes Service Region, and one county in the Two Rivers Service Region. See Appendix D, Potential Family First Candidates with Substance Abuse as a Case Characteristic map, and Appendix E, Potential Family First Candidates Under 10 with Substance Abuse as a Case Characteristic map.

Addressing family violence

The presence of family violence is another significant risk factor for entry into foster within Kentucky's child welfare population. While family violence is not one of the three service categories supported

within the Family First legislation, recent State data indicate that 12,280 families experience challenges with family violence. Therefore, addressing family violence remains a key priority area for DCBS as efforts continue to expand and align the State's service array with the needs of the families served by the agency. Some examples of current services and interventions include EBPs that embed strategies to address underlying contributing factors of violence within the family. Additionally, there are 5,369 potential Family First candidates known to DCBS with co-occurring substance abuse and family violence as case characteristics (See Appendix F). Existing programs have the ability to serve both needs.

Provider readiness assessment

Complementing this analysis of the child welfare population, DCBS engaged its provider network in a readiness assessment for Family First. DCBS conducted a comprehensive survey of providers, targeting agencies both with a current contract with DCBS as well as providers who could potentially contract with DCBS following implementation of Family First. Sister agency partners (e.g. Medicaid, Department for Behavioral Health Developmental and Intellectual Disabilities) were consulted to identify additional providers to which DCBS should outreach beyond their current network.

The provider assessment addressed both the preventive and congregate care provisions of Family First and contained a number of domains: Trauma-Informed Care, Implementation of Evidence-Based Practice, Federal Qualified Residential Treatment Program Criteria, and Continuous Quality Improvement and Data Use. With regard to evidence-based practices, the survey specifically asked which interventions provider agencies were implementing and assessed their current capacity to monitor model fidelity and impact on intended outcomes. In addition, the survey inquired about provider capacity, specifically the number of children and families that could be served within each program on an annual basis.

Leveraging the Transformation workgroups and stakeholders as key decision-making partners, DCBS examined the target population analyses alongside the provider readiness assessment findings and developed Kentucky's proposed list of interventions for the Title IV-E prevention plan. The proposed list was informed by Kentucky's waiver demonstration efforts as well as the EBPs currently reviewed and rated by the Title IV-E Prevention Services Clearinghouse.

Proposed Evidence-Based Preventive Services

The information detailed below represents the array of preventive programs that best aligns with the needs of children and families involved with Kentucky's child welfare system.

Table 1 represents the evidence-based programs that are currently rated by the Title IV-E Prevention Services Clearinghouse as having achieved a promising or well-supported rating. These services align with the needs of Kentucky's child welfare population and we submit them to the Children's Bureau for approval.

Table 1: DCBS proposed prevention programs with a Title IV-E Prevention Services Clearinghouse rating

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating
Mental health treatment	Functional Family Therapy	Well-Supported
	Multisystemic Therapy	Well-Supported
	Parent-Child Interaction Therapy	Well-Supported
	Trauma Focused-Cognitive Behavioral Therapy	Promising
Substance abuse treatment and prevention	Motivational Interviewing	Well-Supported
	Multisystemic Therapy	Well-Supported

This next set of interventions, Table 2, are not currently rated by the Title IV-E Prevention Services Clearinghouse, but they have been rated by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare and they align with the needs of Kentucky's child welfare population. Many represent important elements of Kentucky's service array that would be beneficial to expand. In particular, the Commonwealth has invested significant effort in implementing and evaluating START to the benefit of Kentucky children and families. Ideally, Kentucky seeks the Children's Bureau's approval of these preventive programs as well, and the State is exploring mechanisms for conducting independent systematic reviews per federal guidance. Given the significant level of effort and capacity such an independent review requires, Kentucky respectfully requests that the Title IV-E Prevention Services Clearinghouse review and rate these programs as soon as possible so that DCBS can meet the needs of families in a timely manner.

Table 2: DCBS proposed prevention programs rated by the CEBC

Prevention Program categories	DCBS Proposed Evidence-Based Programs	CEBC Rating
Mental health treatment	Cognitive Behavioral Therapy	Well-Supported
Substance abuse treatment and prevention	Sobriety Treatment and Recovery Team (START)	Promising
In-home, skill-based parenting programs	Homebuilders Sobriety Treatment and Recovery Team (START)	Supported Promising

Please see Appendix G for a summary of all proposed evidence-based interventions, including the evidence ratings, a brief description of the program and target population, intended outcomes, and the evaluation strategy.

Brief narrative summary of evidence-based programs

Cognitive Behavioral Therapy (CBT)

CBT for co-occurring disorders of substance use and depression, generalized anxiety, posttraumatic stress disorder (PTSD), anger management or domestic abuse, is a treatment approach that utilizes social learning theory, classical conditioning and operant conditioning to help individuals acquire healthier, prosocial behaviors to replace established maladaptive behaviors. Given the strong level of empirical support for the efficacy of CBT when applied to either substance-dependent or mood-disordered patients, investigators have recently moved toward evaluating integrated CBT approaches for populations in which these disorders cooccur. These integrated CBT approaches emphasize recognition of the associations between substance use and recurrence or worsening of affective symptoms, relapse, or noncompliance.

The California Evidenced-Based Clearinghouse (CEBC) does not provide a rating for CBT specific to co-occurring disorders. Several studies have been conducted over the years documenting the effectiveness of CBT for adults and adolescents. In these studies, CBT was shown to be somewhat superior to antidepressants in the treatment of adult depression – which is often comorbid with substance use disorders. CBT was equally effective as a behavioral therapy in the treatment of adult depression and obsessive-compulsive disorder (Butler, Chapman, Forman, & Beck, 2005). Short and long-term effectiveness is shown with cognitive-behavioral approaches for treating depressive symptoms with this population (Reinecke, Ryan, & Dubois, 1998). Kentucky will utilize the CBT manual, Cognitive behavioral

therapy: Basics and beyond (Beck, 2011). Kentucky will use the CBT adaptation for co-occurring disorders. Kentucky is requesting approval to claim transitional payments for Cognitive Behavioral Therapy for Co-occurring Disorders due to it not currently being reviewed or rated by the Title IV-E Prevention Services Clearinghouse. Public Consulting Group (PCG) completed a systematic review of Homebuilders® to support this request, proposing a supported rating. Please see Appendix M.

Functional Family Therapy

Functional Family Therapy (FFT) is a family intervention program for youth experiencing dysfunction with disruptive, externalizing problems. The target population is 11-18 year olds with serious concerns such as conduct disorder, violent acting-out and substance abuse. FFT is rated Well Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will utilize FFT manual, Family Therapy for Adolescent Behavioral Problems, and will not use any adaptations to the FFT model (Alexander, Waldron, Robbins, & Need, 2013).

Homebuilders®

Homebuilders is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at

times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. Homebuilders® is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports. Kentucky will utilize Homebuilders manual, Keeping families together: The Homebuilder® Model, and will not use any adaptations to the Homebuilders® Model (Booth, 2017). Kentucky is requesting approval to claim transitional payments for Homebuilders®, due to it not currently being reviewed or rated by the Title IV-E Prevention Services Clearinghouse. Public Consulting Group (PCG) completed a systematic review of Homebuilders® to support this request, proposing a well-supported rating. Please see Appendix N.

Motivational Interviewing

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance a person's internal motivation to change, to reinforce this motivation, and develop a plan to achieve change. The target population includes caregivers of children referred to the child welfare system and it has also been used with adolescents. MI is rated Well-Supported with Medium child welfare relevance per the CEBC. Kentucky is looking forward to the Title IV-E Prevention Services Clearinghouse's release of the rating for MI and the approval of the independent systematic review of MI completed by Public

Consulting Group (PCG), as it is an intervention deeply embedded in the agency's services array designed to address the opioid epidemic and other substance use disorders challenging families within the Commonwealth.

Several studies have been conducted to determine the efficacy of MI; leading the CEBC to give it a Well-Supported rating. Studies report that when compared to other active treatments such as 12-step and cognitive behavioral therapy (CBT), the MI interventions took over 100 fewer minutes of treatment on average yet produced equal effects. Furthermore, MI is likely to lead to client improvement when directed at increasing healthy behaviors and/or decreasing risky or unhealthy behaviors as well as increasing client engagement in the treatment process (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). A study examined the efficacy of Motivational Interviewing (MI) as an enhanced treatment initiation with substance abusers. Participants were randomly assigned to receive either standard treatment or standard treatment with MI. Measures utilized include the rates of participants who attended one or three subsequent drug abuse treatment sessions after the evaluation as well as basic demographic data and substance abuse history was also collected. Results showed that significantly more participants in the MI group went on to attend treatment sessions than in the standard group (59.3% versus 29.2%). However, this advantage did not persist beyond treatment initiation. Limitations include small sample size, lack of follow up, and generalizability of findings due to ethnicity (Carroll, Libby, Sheehan, & Hyland, 2001). The evidence base for MI is strong in the areas of addictive and health behaviors. Useful as a brief intervention in itself, MI also appears to improve outcomes when added to other treatment approaches (Hettema, Steele, & Miller, 2005). Kentucky will utilize the MI manual, Motivational interviewing: Helping people change (Miller, & Rollnick, 2012). Kentucky will not use any adaptations to the MI model.

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The target population is 12 to 17 year olds who are at risk of out-of-home placement due to delinquent behavior. MST is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will use the MST manual, Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Kentucky will not use any adaptations to MST.

Parent-Child Interaction Therapy

Parent and Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children and their parents or caregivers that focuses on decreasing externalizing child behavior problems, increasing child social skills and cooperation, and improving the parent child attachment relationship. The target population is children ages two to seven years of age and their caretakers. PCIT is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will use the PCIT manual, Parent-Child

Interaction Therapy Protocol (Eyberg, & Funderburk, 2011). Kentucky will not use any adaptations to PCIT.

Trauma Focused-Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The target age is three to 18 years old. TF-CBT is rated Well-Supported and "High" for child welfare relevance per the CEBC. TF-CBT is rated promising with the Title IV-E Prevention Services Clearinghouse. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

The majority of Kentucky providers in community mental health centers, private foster care agencies, and residential programs utilize TF-CBT. There are several journal reviews discussing the efficacy of TF-CBT (Cohen, Mannarino, & Iyengar, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Results indicated that TF-CBT, regardless of the number of sessions or the inclusion of a Trauma Narrative (TN) component, was effective in improving participant symptomatology as well as parenting skills and the children's personal safety skills. The eight-session condition that included the TN component seemed to be the most effective and efficient means of reducing parents' abuse-specific distress as well as children's abuse-related fear and general anxiety (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Among treatment completers, TF-CBT resulted in significantly greater improvement in anxiety, depression, sexual problems, and dissociation at six-month follow-up and in PTSD and dissociation at 12-month follow-up. Intent-to-treat analysis indicated group x time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems (Cohen, Mannarino, & Knudsen, 2005). Kentucky will use the TF-CBT manual, Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen, Mannarino, & Deblinger, 2006). Kentucky will not use any adaptations to TF-CBT.

Sobriety Treatment & Recovery Team

Sobriety Treatment and Recovery Team (START) is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START serves families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. Families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor START pairs child protective services (CPS) workers trained in family engagement with family mentors

(peer support employees in longterm recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS workermentor dyad has a capped caseload of 15 families, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity. START is rated promising with "High" child welfare relevance per the CEBC. Kentucky first implemented START in 2007 and has gradually expanded since that time, investing in the staff, collaboration, infrastructure, and outcome studies of START.

START is listed on the California Evidence-Based Clearinghouse (CEBC) site as a promising practice. An impact study (Huebner, Willauer, & Posze, 2012) found that 21% of children in families who received START ($n=451$) entered out-of-home care (OOHC) compared to 42% of children from a matched comparison group ($n=359$) who received usual child welfare services ($\chi^2 (1) = 42.63$; $p = <.01$) had a medium effect size (0.23). In a subsequent impact study (Hall et al, 2015) with a matched comparison in a rural Appalachian County, findings indicated no significant differences in OOHC placement rates, but significantly less recurrence of child maltreatment within six months, and reentry into foster care within 12 months (0% vs. 13.2%). Finally, an evaluation of START as part of the Children's Bureau Regional Partnership Grant Round II found that 21% of children in families served by START entered out-of-home care within 12 months compared to 31% of a propensity score-matched comparison group. In summary, two independent evaluations of START report that 21% of children in families served by the program enter out-of-home care within 12 months, a rate that is significantly lower than similar children receiving usual child welfare services.

Although not designed specifically as impact studies, outcomes research (Huebner, Posze, Willauer, & Hall, 2015) shows that stronger adherence to the START timeline (measuring quick access to treatment), results in children ($n = 717$) remaining with their parents throughout treatment (31.7% to 47.4% with stronger fidelity) without any time placed with relatives or in OOHC. Both mothers ($n=331$) and fathers ($n=219$) achieved higher rates of sobriety and early recovery (as measured by drug tests, engagement in treatment and community recovery supports and progress on CPS goals with 66.3% of mothers achieving sobriety - far above the 37% of CPS mothers completing one treatment modality in Treatment Episode Data Set (TEDS) data. Published studies on non-waiver Kentucky START families (Huebner, Willauer, Posze, Hall, & Oliver, 2015) explored rates of recurrence among START-served children ($n=866$) and found rates far below the state rate of recurrence. Studies have explored the outcome of the family mentor in START (Huebner, Hall, Smead, Willauer, & Posze, 2018) and aligned the practices of START with family-centered practices and outcomes (Huebner, Young, Hall, Posze, & Willauer, 2017).

With two additional impact studies in progress and multiple outcome studies that demonstrate START effects, we anticipate that START will be rated as a well-supported intervention in the future. Building a solid evidence base of impact studies that match the Clearinghouse Standards takes time and commitment. Kentucky is committed to sustaining that effort through fruition. START is an intensive child welfare program for families with cooccurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.

Kentucky will use the START implementation manual, Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual (Willauer, Posze, & Huebner, 2018). Kentucky will not use any adaptations. Kentucky is requesting approval to claim transitional payments for START due to it not currently being reviewed or rated by the Title IV-E Prevention Services Clearinghouse. Public Consulting Group (PCG) completed a systematic review of START to support this request, proposing a promising rating. Please see Appendix O.

Table 3: All DCBS Proposed Prevention Services

Prevention Program Category	Intervention	Title IV-E Prevention Services Clearinghouse Rating/Systematic Review Rating	Target Population	Book, Manual, Program Documentation	Relevant Past Research	
In-Home Skill-Based Parenting Programs	Homebuilders® *	Well-Supported	Families with children (birth to 18) at imminent risk of placement into foster care (or recently reunified from foster care)	Booth, C. (2017). <i>Keeping families together: The Homebuilders model</i> . Routledge.	Walton (1998)	
In-Home Skill-Based Parenting Programs	Substance Abuse Treatment and Prevention	START*	Promising	Caregivers with substance use disorders; households with young children (birth – 6 years) at risk of placement into foster care	Willauer, T., Posze, L., & Huebner, R.A. (Eds.). (2018). <i>The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual</i> . Forest Park, CA: Children and Family Futures.	Huebner, Willauer, & Posze (2012)

Mental Health Treatment	CBT*	To Be Determined	Adults (18+ years) diagnosed with co-occurring mood and/or anxiety disorders and substance use	Beck, J. S. (2011). <i>Cognitive behavioral therapy: Basics and beyond.</i> New York, NY. Guilford press.	Cristea et al. (2015)
Mental Health Treatment	FFT	Well-Supported	Youth (ages 11 to 18 years old) with behavioral or emotional problems and their families	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems.</i> Washington, D.C. American Psychological Association.	Humayun et al. (2017)
Mental Health Treatment	TF-CBT	Promising	Children and adolescents who have experienced severe trauma and their families	Cohen, J. A., Mannarino, A.P., & Deblinger, E. (2006). <i>Treating Trauma and Traumatic Grief in Children and Adolescents.</i> New York, NY. Guilford Press.	Smith et al. (2007)
Mental Health Treatment	PCIT	Well-Supported	Families with children between two and seven years old; children with emotional and behavioral problems that are frequent and intense.	Eyberg, S. & Funderburk, B. (2011) <i>Parent-Child Interaction Therapy Protocol: 2011.</i> PCIT International, Inc.	Bjørseth & Wichstrøm (2016)
Mental Health	Substance Abuse	MST	Youth between	Henggeler, S. W., Schoenwald, S. K.,	Vidal et al. (2017)

Treatment	Treatment and Prevention			the ages of 12 and 17 who are at risk for delinquent behavior/out of home care placement and their families.	Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). <i>Multisystemic Therapy for Antisocial Behavior in Children and Adolescents</i> (2 nd ed.). New York, NY. Guilford Press.	
Substance Abuse Treatment and Prevention	MI	Well-Supported	Adults (18+ years) with behavioral health diagnoses; has shown promising evidence with adolescents	Miller, W. R., & Rollnick, S. (2012). <i>Motivation Interviewing: Helping people change</i> . New York, NY. Guilford press.	Shah et al. (2019)	

*As rated by the Public Consulting Group Independent Systematic Review

Interventions for future consideration

Kentucky Strengthening Ties and Empowering Parents (KSTEP)

KSTEP, developed as part of Kentucky's Title IV-E Waiver, is not included in Kentucky's first submission of our State Prevention Plan. However, due to KSTEP's demonstrated success in recent years, Kentucky plans to pursue steps necessary to submit KSTEP in future Prevention Plan revisions as its manual is developed and evaluation efforts continue. Participation in KSTEP yielded significant improvement for families and individuals in both the Addiction Severity Index (ASI) and North Carolina Family Assessment Scale (NFCAS) at the submission of the Waiver Interim Evaluation Report (May, 2018). KSTEP also maintains a 90% success rate in maintaining children safely in their home of origin. The KSTEP intervention uses quick access to substance abuse treatment, intensive in-home services, client transportation, weekly contact between the child welfare agency, treatment provider, and in-home service provider, and joint decision making with all partners. KSTEP is a multi-faceted model that includes within its service delivery approach several distinct EBPs, including PCIT, CBT, and MI. Taken together, this integrated approach to service delivery is designed to achieve a discrete set of outcomes including reducing the number of children entering care, increasing parental sobriety and improving parental protective capacities.

Kentucky's in-home service delivery model

Kentucky's contracted prevention services are primarily provided through the Family Preservation Program (FPP), an in-home services program. There are seven FPP service providers throughout the State who utilize various EBPs in their work with families. In SFY2019, 96% of the children serviced through an FPP provider were maintained safely in their homes at the end of the intervention. A performance outcome of 75% of children maintained safely in their home at the end of an FPP intervention has been embedded in the FPP contracts for many years. This outcome standard has been exceeded by all providers, with most recent years exceeding a 90% success rate of families remaining safely intact together in their homes. Kentucky will be utilizing Family First as a lever to continue the impressive work of the FPP program by expanding services and the provider network. Current FPP providers offer a varied array of EBPs proposed in this five-year prevention plan. Additionally, a variety of intensity and duration exist within FPP programs that have the opportunity adjusted based on the strengths and needs of the family.

In addition to FPP, DCBS has funded two in-home and community based prevention programs through its Title IV-E waiver demonstration project (START and K-STEP) to address the needs of families struggling with substance use disorders. Those programs utilize a variety of EBPs throughout the State as well.

Table 4 reflects a summary of EBPs administered by DCBS' in-home service providers. This includes the FPP providers as well as START and K-STEP. While START and KSTEP each represent a comprehensive and unified program model, discrete EBPs are made available to families as part of the models' service delivery approach.

Table 4: Evidence-Based Practices administered by DCBS in-home service providers

	Cognitive Behavioral Therapy	Functional Family Therapy	Motivational Interviewing	Multi-systemic Therapy	Parent-Child Interaction Therapy	Trauma Focused-Cognitive Behavioral Therapy	Sobriety Treatment and Recovery Team	Home-builders
FPP	X		X		X	X		X
KSTEP	X	X	X		X	X		
START	X		X			X	X	
TBD				X				

Ensuring trauma-informed service provision

All evidence-based interventions included in Kentucky's array of in-home services are administered within a trauma-informed framework. All new evidence-based interventions that Kentucky plans to implement under Family First will also be administered within a trauma-informed framework. This is a requirement in current contracts, and will remain a requirement in all future contracts.

Additionally, DCBS has worked closely with the Department for Behavioral Health and Developmental and Intellectual Disabilities (BHDID) to support the provider network with additional trauma informed care (TIC) training. TIC training provides a foundational understanding of the knowledge and skills needed to deliver trauma informed, family preservation services. This includes understanding and recognizing traumatic stress; the impact of trauma on brain development and subsequent functioning; how traumatic stress manifests in social, emotional and cognitive functioning and behaviors; the importance of the caregiving relationship; strategies FPP workers can model and teach caregivers to help them support youth who have experienced trauma; and the impact of working with trauma exposed youth on staff. BHDID has served on several workgroups in preparation for Family First and will be supporting providers as needed to ensure training and ongoing support for a trauma informed framework within each agency.

FPP also ensures all Master's level staff have received training in Trauma Affect Regulation Guide for Education and Therapy for Adolescents (TARGET), a promising intervention. TARGET is an educational and therapeutic intervention designed to prevent and treat traumatic stress disorders, co-occurring addictive, personality, or psychotic disorders, and adjustment disorders related to other types of stressors, for youth 10 to 18 years of age.

Elements of START's trauma-informed framework are particularly notable. Each staff-person in START is trained on how trauma impacts the families served knowing that trauma is strongly correlated with substance use disorders (SUD) and that treating trauma and SUD concurrently is best practice. START Service Coordinators assess for trauma and SUD in both mothers and fathers and link clients with SUD treatment that addresses trauma when needed. START funds have been used to provide training for clinicians in each START community on trauma-specific treatments such as Seeking Safety. START behavioral health providers utilize trauma specific evidence-based practices as indicated. Families are provided Seeking Safety, Child Parent Psychotherapy, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) as clinically indicated.

START utilizes shared decision-making, collaborating with families and empowering them to be active participants in decision-making and plan development for their family. As a family-centered model, START children are screened for social-emotional delays, which are often a result of the trauma experienced by children who are abused or neglected. With its two-generation approach, START attempts to break the cycle of trauma, knowing that keeping families intact and providing early intervention for children's mental health issues can help prevent those children from developing adulthood substance use and mental health disorders.

DCBS is committed to furthering the extent to which the agency is promoting a trauma-informed and trauma-responsive child welfare system. As Kentucky moves forward with Family First implementation, including its expansion of prevention services, all agencies will be required to operate within a trauma-informed framework in order to contract with DCBS.

See Appendix H for DCBS' signed assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma informed organizational structure and treatment framework.

Implementation approach

Responsibility for the development and implementation of the Title IV-E Prevention Plan rests with the Prevention Supports Workgroup within the broader DCBS Child Welfare Transformation Governance Structure. This group is comprised of key internal and external stakeholders and subject matter experts who guide the planning and decision-making process, including an Evidence-Based Practice Subgroup. The Evidence-Based Practice Subgroup led the process to identify the EBPs included in this Title IV-E Prevention Plan and they will retain responsibility for overseeing their implementation and/or expansion.

Kentucky will implement Family First initially utilizing existing contracted prevention providers. Kentucky will expand relationships and provider contracts with existing private agency partners, to also include congregate care providers expanding their business models to include preventive services. Current prevention providers have identified additional capacity and more importantly, a willingness and interest in expanding their services to meet the identified needs of the candidate population as increased resources become available.

Current contracted providers have established relationships with trainers and purveyors of current EBPs. Kentucky will examine and modify these existing relationships as necessary to accommodate additional training needs moving forward. In addition, Kentucky will utilize Learning Collaboratives to strengthen the quality of implementation and provide peer-learning opportunities for contracted agencies. Experienced providers may serve as facilitators and mentors in quarterly provider meetings to coach and mentor newly contracted agencies.

DCBS staff will provide support and technical assistance to provider agencies related to recruitment; training; coaching; outcomes management, and fidelity monitoring. Strengthening the infrastructure and quality of service provision with existing providers will well-position DCBS to expand contracts and build even greater EBP service delivery capacity within the Commonwealth.

Kentucky will continue to conduct regular gap analyses between the services available in the Commonwealth and the needs indicated within the candidacy population. The EBP and Evaluation subcommittees of the Prevention Supports workgroup will continue to review data on service availability, gaps, family risk factors, and community readiness to determine geographic areas for service expansion. Using that data, Kentucky will expand contracts or issue new RFPs to continually expand service capacity. A staged approach to service expansion will allow time for continuous quality improvement processes to be developed, tested, and modified for each EBP before going to scale.

Family First liaisons represent another strategy for promoting sound implementation of this prevention plan. Family First liaisons will be regional experts with specialized knowledge of the Family First legislation and the implications for implementation within the Kentucky child welfare context. The Family First liaisons will be available to provide consultation and support to regional child welfare staff across a wide range of policy and practice issues, including candidacy determination or redetermination of candidacy, model selection, model fidelity, and performance monitoring.

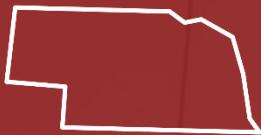
Additionally, the Division of Protection and Permanency (DPP) through its Prevention branch will provide policy, procedure and consultation supports statewide through its branch manager and social services specialists.

To ensure tracking of prevention services for appropriate Title IV-E claiming, information technology staff have been an integral part of preparation for Family First implementation. System enhancements for candidacy identification, EBP selection, and billing processes are occurring to support workforce both in the public and private agencies. Kentucky's contracted providers will provide monthly invoices to both programmatic and financial staff for review.

Kentucky is collaborating with Public Consulting Group (PCG) to develop an invoice template to include the potential candidate, date of service, EBP utilized, and amount billed with each EBP, for Family First funds. An accounting code will be assigned for each EBP billed and for each agency. This will assist financial management staff in managing funds appropriately.

To monitor implementation fidelity, CHFS will use its existing Continuous Quality Improvement (CQI) process, CQI process specific to well-supported interventions, and contract monitoring staff within the Division of Protection and Permanency to engage providers in a standardized quality assurance process. This fidelity monitoring will include regular contact and communication between CHFS staff and providers; standardized reporting of performance measures for fidelity by each provider; and establishing provider outcome goals. In addition to measuring progress on the outcomes that the EBPs are designed to impact, outcomes monitoring will also include the retention of clients in the services, the count/proportion of clients completing service treatment plan, tracking of referrals of clients to additional needed services, and tracking of clients who have change of status either from out of home care to parent or parent to out of home care.

To implement Family First in Kentucky, DCBS will continue to communicate and collaborate with other partner agencies, both governmental and community. Resources will be used to develop and implement training and educational opportunities for all agencies working with child welfare families (Courts, Department of Juvenile Justice, Education, Behavioral Health, Private Child Care, Foster Care, etc.). The transformation occurring within the child welfare system is not led in isolation by DCBS, the child welfare agency. From a macro statewide approach, support will also be provided by the State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) in the form of continued policy development related to community needs assessments and provisions. This council serves to enlist the input of a statewide group of stakeholders including youth, biological parents, service providers, and other professionals to ensure the most robust and appropriate system of care within the Commonwealth. All Regional Interagency Councils (RIAC) and the SIAC have received training on Family First and play an integral role in the support of its implementation.



Nebraska

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Program Selection

Program selection for this Plan has been a continuous process using data evaluation and program research. Prior to the Federal Clearinghouse rating programs, the process began through a CFS-facilitated external stakeholder workgroup that helped identify existing evidence-based programs (EBPs) in Nebraska (Attachment B). The process was useful and a complete scan of existing EBPs available in Nebraska had not been conducted previously. Key information such as outcomes, target population, child welfare relevance, and Medicaid eligibility were identified for each program in the selection process.

CFS proposes a service array that demonstrates a high level of evidence according to the ratings from independent, rigorous evaluations, the California Evidence Based Clearinghouse (CEBC) and Federal Clearinghouse, rated as promising, supported, or well-supported:

- *Promising*. A program has results or outcomes of at least one study determined to be well designed and well executed, as rated by an independent review and utilized some form of control group.
- *Supported*. A program has results or outcomes of at least one study that show it to be well designed and well executed, as rated by an independent systematic review. Additionally, the study involved a rigorous random controlled trial, was carried out in a usual care-of-practice setting, and has a sustained effect for at least 6 months beyond the end of service.
- *Well-Supported*. A program has results or outcomes of at least two studies that show it to be well designed and well executed as rated by an independent systematic review. Additionally, the studies involved a rigorous random controlled trial (or, if not available, a study using a rigorous quasi-experimental research design), were carried out in a usual care-of-practice setting, and have a sustained effect for at least 12 months beyond the end of service (as demonstrated by at least one study).

The workgroups considered programs not currently established in Nebraska. The workgroups began researching geographic access and capacity for programs within the State and planned to conceptualize all relevant information into a map, so that it could be better understood where service gaps existed and for what types of services and population.

To prepare for FFPSA implementation on October 1, 2019, CFS issued a Request for Qualifications (RFQ) for evidence-based In-Home Parenting Skills Services and Substance Abuse and Mental Health Services in May 2019. Submissions included key program information such as geographic access, capacity and fidelity to model. Providers were required to show they have trained staff and can immediately offer EBP services to families. For contracts beginning October 1, 2019, RFQs submittals were due by June 30, 2019. The RFQ process will be continuous, allowing providers to submit new or additional proposals, as they implement new programs. CFS will amend Nebraska's Plan as new programming is available.

Healthy Families America (HFA) was selected as a program for part of Nebraska's Plan due to already being available and implemented in Nebraska. MST, PCIT and TF-CBT were selected as programs for part of Nebraska's Plan following the RFQ that CFS issued in May 2019, to prepare for FFPSA implementation. The programs submitted, met the minimum required score, are currently rated by the Federal Clearinghouse and were already available in Nebraska. FCT was selected as a program for Nebraska's Plan as CFS was already offering the program in Nebraska and the program has been approved for transitional payments. FFT, Homebuilders, MI and PAT, are either not currently existing in Nebraska, or are provided in Nebraska but not to model fidelity. Nebraska will collaborate with the National Office for each of the services, to understand the program more and ensure providers are equipped to deliver the models to fidelity. Nebraska plans to develop the service array for FFT, Homebuilders, MI and PAT in the coming months and years.

Through Nebraska's RFQ process in May 2019, the number of providers that responded and geographical capacity are listed in the chart below:

EBP Interventions:	Geographical Access	Number of providers who submitted to Nebraska's May 2019 RFQ
MST	Douglas, Sarpy, Dodge, Washington, Burt, Saunders, Cass	2
PCIT	Buffalo, Butler, Cass, Cuming, Dodge, Douglas, Gage, Hamilton, Hall, Kearney, Lancaster, Otoe, Polk, Saline, Sarpy, Saunders, Seward, Washington, York	6
FFT	Douglas, Sarpy, Dodge, Cass, Washington and Cuming Counties	1
FCT	*Please refer to map pictured on page 28	2
TF-CBT	Burt, Butler, Cass, Colfax, Cuming, Dodge, Douglas, Fillmore, Gage, Jefferson, Johnson, Lancaster, Madison, Merrick, Nance, Nemaha, Otoe, Pawnee, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Seward, Stanton, Thayer, Washington, York	6
Homebuilders	Douglas, Sarpy, and Lancaster counties	1
MI	Adams, Butler, Cass, Colfax, Cuming, Dodge, Douglas, Fillmore, Gage, Greeley, Lancaster, Merrick, Nance, Nemaha, Otoe, Pawnee, Platte, Polk, Richardson, Saline, Sarpy, Saunders, Hall, Hamilton, Jefferson, Johnson, Kearney, Seward, Webster, York	6
HFA	Lancaster, Douglas, Sarpy, Scottsbluff, Morrill, Box Butte, Otoe, Johnson, Nemaha, Pawnee, and Richardson	*Providers not required to submit to the RFQ due to existing partnership with Division of Public Health
PAT	None at this time	0

CFS is submitting Nebraska's plan with the inclusion of nine programs that are: 1) rated and/or pending rating on the Federal Clearinghouse, 2) currently available in Nebraska, and 3) included in contracts awarded based on the RFQ. CFS is also including FCT, an existing CFS contracted program. Given the costs associated with implementing or expanding EBPs, CFS has secured additional funding to assist in these efforts.

Nebraska currently provides four of the prevention programs rated by the Federal Clearinghouse (kinship programs excluded): HFA, MST, PCIT and TF-CBT, along with FCT, a prevention program that is pending formal review by the Federal Clearinghouse. Additional programs such as FFT, Homebuilders, PAT and MI have been approved by the Federal Clearinghouse, but are not yet provided through a CFS contract in Nebraska.

Of the nine programs listed in Nebraska's Plan, MST, PCIT, FFT and TF-CBT are Medicaid eligible and have specific codes for which they are billed. It is important to assess which services are able to be billed to Medicaid as approximately 80% of all children CFS works with in an ongoing services case have Medicaid insurance. One additional program, FCT, is Medicaid eligible, however, Nebraska Medicaid does not have a specific billing code for this EBP. This is due to providers using the EBP and billing with other codes, since providers do not bill by specific EBP. The other four programs, HFA, Homebuilders, PAT and MI, are not approved Medicaid services.

See Attachments Section for **Attachment III: State Assurance of Trauma-Informed Delivery.**

Nebraska Title IV-E Prevention Services							
	Evidence Based Program	Target Population in Years	Average Length of Service ⁹	Outcomes (CEBC and/or Federal Clearinghouse) ¹⁰	Federal Clearinghouse Rating	CEBC Rating	Requesting Transitional Payments ¹¹
In-Home Parenting	1. Healthy Families America	Parents of children, beginning prenatally or within 24 months of birth (HFA Child Welfare Protocol)	Up to three years	Cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors.	Well-supported	Well-supported	n/a
	2. Homebuilders-Intensive Family Preservation and Reunification Services	Families with children, birth to 18 years of age	4-6 weeks	Prevent out of home placements and achieving reunifications while using research based intervention strategies to teach new skills and facilitate behavior change.	Well-supported	Supported	n/a
	3. Motivational Interviewing	A range of target populations for a variety of problem areas	1-3 sessions	Promote behavior change and improve physiological, psychological, and lifestyle outcomes.	Well-supported	Well-supported	n/a
	4. Parents as Teachers	New and expectant parents, starting prenatally and continuing until the child reaches kindergarten	2 years	Increase parent knowledge of early childhood development; improve parenting practices; provide early detection of developmental delays and health issues; prevent child abuse and neglect, and; increase children's school readiness and school success	Well-supported	Promising	n/a
Mental Health	5. Family Centered Treatment	Children 0-17 and their caregivers	6 months	Family stability, increased family functioning in the critical areas contributing to increased risk of family dissolution, increased effective coping, reduced harmful or hurtful behaviors, build upon strengths to sustain changes made	Not yet rated; Well-supported designation	Promising	yes
	6. Functional Family Therapy	Children 11-18	3 months	Eliminated youth referral problems (e.g., delinquency, oppositional behaviors, violence, substance use), improved prosocial behaviors (e.g., school attendance), improved family and individual skills	Well-supported	Supported	n/a
	7. Multisystemic Therapy	Children 12-17 and their caregivers	3-5 months	Youth: Reduced behavior problems Caregiver: increased ability to address parenting difficulties and empower youth	Well-supported	Well-supported	n/a
	8. Parent-Child Interaction Therapy	Children 2-7 and their caregivers	4-5 months	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem Parent: Increased ability to comfort child, improved behavior management and communication with child	Well-supported	Well-supported	n/a
	9. Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	3-5 months	Improved PTSD, depression, anxiety symptoms; reduced behavior problems; improved adaptive functioning improved parent skills; reduced parent distress	Promising	Well-supported	n/a

In-Home Parenting Skills Programs

Program 1: Healthy Families America

Evidence-based home visiting has been proven effective through decades of research and data to reduce risk of child maltreatment and improve health and self-sufficiency of vulnerable families who participate. Families build personal relationships and receive education and referral services, leading to decreased infant mortality rates, increased positive parenting skills, and decreased child abuse and neglect.

One such evidence-based home visiting program in Nebraska is the Healthy Families America (HFA) model. The HFA model, since its inception, has been focused on the prevention of child abuse and neglect through a voluntary, strengths-based approach. The program best serves families who are high-risk and overburdened, including those involved in the child welfare system. HFA is designed to engage families as early as possible, during pregnancy or at the birth of a baby.

HFA is well aligned with FFPSA and well suited for the State's needs. In Nebraska, 60% of children who enter foster care do so through neglect. Furthermore, almost half of all children who enter foster care are ages 0-5, and 14% of which are age 1 or younger. HFA was selected for Nebraska's Plan given the target population intersects with the age of the majority of children who enter foster care; its substantial research base showing program effectiveness; and the ability to expand or leverage the existing capacity in partnership with the Division of Public Health (PH).

PH receives federal Maternal, Infant & Early Childhood Home Visiting (MIECHV)¹² funds to implement the HFA home-visiting model. Through this funding, HFA is currently offered in 21 Nebraska counties. (See *Statewide Home Visiting Initiatives* map below.) CFS is working with PH to determine how to leverage existing funds and expand services using FFPSA dollars.

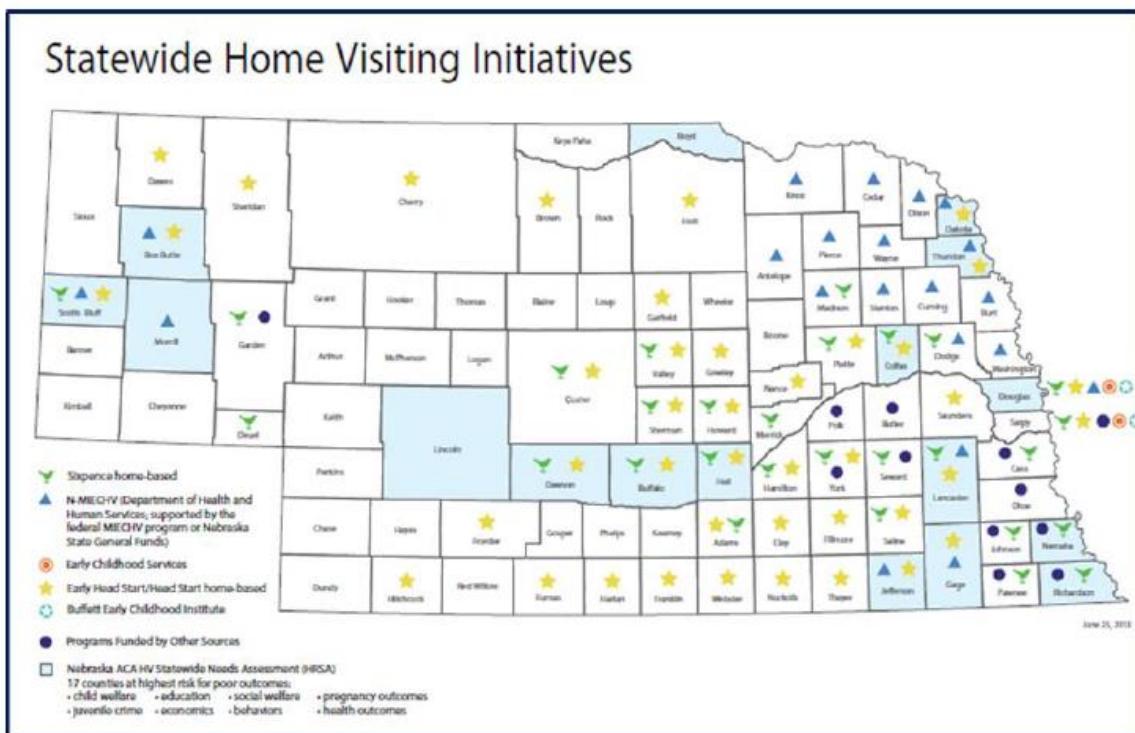
CFS intends to implement the HFA child welfare protocol to allow for the expanded enrollment criteria for children up to 24 months of age. HFA providers are accredited by the national office and will follow the Best Practice Standards that provides specificity in regards to enrollment, eligibility, and implementation.

Book/Manual: Per the Federal Clearinghouse HFA manuals are made available as a part of the training sessions. More information about trainings and access to manuals can be found through the HFA website, at: <https://www.healthyfamiliesamerica.org/hfa-training/>.

Additionally, HFA utilizes: Healthy Families America. (2018) *Best Practice Standards*. Prevent Child Abuse America. This is a copyrighted product of "Prevent Child Abuse America" and is made available to HFA sites upon accreditation.

Prevent Child Abuse America has a lengthy accreditation process for the HFA model that occurs every three years. The local sites are constantly reviewing their own processes, policy and procedure to

ensure fidelity in an evolving landscape. All of the HFA programs follow the *Best Practice Standards* which describe the expectations for fidelity to the HFA model. The best practice standards are structured around twelve research-based critical elements upon which HFA is based. The best practice standards also have a section on governance and administration which articulates expectations for effective site management. The governance and administration standards includes the requirement for each site to have a quality assurance plan to monitor and track quality of all aspects of implementation that includes performance measures, screening process, family acceptance, family retention, satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, supervision rates, etc. Please see www.healthfamiliesamerica.org for more information.



Program 2: Homebuilders: Intensive Family Preservation and Reunification Services

Homebuilders is an In-Home Parent Skill-based program. Per the Federal Clearinghouse, this well-supported model provides intensive, in-home counseling, skill building and support services for families who have children ages 0-18, who are at imminent risk of out of home placement or who are in placement and cannot be reunified without intensive in-home services. Nebraska does not presently have contracted providers, who offer Homebuilders. However, Nebraska arranged for a joint meeting between the Homebuilders National Office and the Nebraska Child Welfare provider community, regarding implementation of this model and to gauge interest amongst the providers. Nebraska intends to focus on the Homebuilder's Intensive Family Preservation provision; as the State increases its non-court involved cases and children remaining in the family home when it is safe to do so, there is a need for additional in-home parent skill-based services.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Homebuilders is: Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together: The HOMEBUILDERS model*. Taylor Francis.

Program 3: Motivational Interviewing

Per the Federal Clearinghouse Motivational Interviewing (MI) is rated as a well-supported service. MI can be used in a variety of settings such as, but not limited to, community agencies, clinical settings, care facilities or hospitals. MI can be used by itself or combined with other treatments when working with a client. Nebraska intends to provide MI within a variety of settings as part of Nebraska's family support services, case management services, and inclusion within mental health and substance use services.

MI is used within a range of target populations and for a variety of problem areas; it works to promote behavioral change and improve overall well-being. There are no required qualifications for providers to deliver MI, and can be used by many different professionals. Nebraska intends to utilize MI as a skill building and change service within Nebraska's In-Home Family Support service (IHFS).

IHFS is the most referred and authorized in-home service used within child welfare. Since 2018 to present time, over 3,000 referrals have been authorized for this service provision. Nebraska defines IHFS as face-to-face assistance, coaching, teaching and role modeling, by a trained professional in the family home. When the child(ren) remain placed in their home, the purpose of IHFS is to assist with the prevention of out-of-home placement of the child(ren) by maintaining and strengthening family functioning, and alleviating stresses in the home. IHFS also works to promote child and family well-being, enhancing protective factors within the home through increased knowledge of parenting and child development, building personal resilience by helping parent(s) to overcome obstacles, promotes meaningful social connections, provides concrete supports, and encourages social and emotional competence.

The common goal of MI and IHFS is promotion of behavioral change and enhancing well-being. Utilizing MI within this in-home service will support building upon IHFS' identified goals by adding MI as an additional tool to prevent children from entering out-of-home care.

Currently, CFS staff have been or are being trained by CCFL on MI, as a technique to better engage with the families being served. CCFL utilizes the manual and materials rated by the Federal Clearinghouse. Although Nebraska has not yet contracted with providers to provide MI, it is anticipated that this will occur in the future, therefore remaining in Nebraska's Plan. It would be Nebraska's intent to have CCFL provide this same training to contracted providers providing IHFS.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Motivational Interviewing is: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping*

people change (3rd ed.). Guilford Press. This provides an overview of the foundations and research support for the program, the program model, and guidance on the administration of MI.

Program 4: *Parents as Teachers (PAT)*

Per the Federal Clearinghouse, PAT is rated as a well-supported service. This home visiting model works with expectant and new parents on their skills to promote positive child development and prevent child maltreatment. The Federal Clearinghouse reports that PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success.

The target population for PAT are expectant and new parents, which can begin prenatally and up until the child reaches kindergarten. Nebraska does not have providers that provide PAT and meet model fidelity. However, it is the intent of Nebraska to have this service implemented within the next five years, therefore, PAT is proposed in the Plan.

Book/Manual: Per the Federal Clearinghouse, PAT has a Model Implementation Library available to those that have gone through the PAT training. Within this, the PAT Foundational Curriculum and PAT Foundational 2 Curriculum is available for use. These can be found at:

<https://parentsasteachers.org/resources-tools>.

Behavioral Health Programs (**Mental Health and Substance Abuse**)

Program 5: *Family Centered Treatment*

Family Centered Treatment (FCT) is a model of intensive in-home treatment services for youth and families, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's well-being through family value changes. FCT is designed to find simple, practical, and common sense solutions for families faced with disruption or dissolution of their family. This can be due to external and/or internal stressors, circumstances, or forced removal of their children from the home due to the youth's delinquent behavior or parent's harmful behaviors.

FCT has had successful outcomes in several states and jurisdictions working with families who have had multi-generational system involvement. Instead of addressing the symptoms of a behavior and obtaining compliance with a family plan, FCT treats the systemic trauma a family may have experienced and the underlying cause. FCT was recently designated as a Trauma Treatment Practice by the National Child Trauma Stress Network. FCT will positively impact families through the assessment process and strong family engagement, and by addressing the underlying trauma that has historically led the family to unsafe behaviors.

CFS worked with the Behavioral Health Region and the Lincoln County Community Collaborative to initiate a pilot of FCT in the North Platte-Lexington area and surrounding communities. This area was chosen due to lack of available in-home services and a high percentage of youth in out-of-home care. The implementation process for FCT began in spring of 2017 and the first six families began the service in January 2019. To enhance sustainability, CFS worked with system partners in Medicaid and the Behavioral Health Region to create a blended funding model. The treatment services are billed to Medicaid or private insurance and the non-treatment services are paid by one of three managed care organizations. CFS pays for families served and the Behavioral Health Region pays the non-treatment costs for families that are not involved with CFS but do meet income eligibility. The Lincoln County Collaborative also agreed to build funding into their budget to pay for at least one family who may not have insurance coverage, meet behavioral health income criteria, or be involved with child welfare. Since the submission of the first version of this Plan in October 2019, CFS has expanded the reach of the FCT program to more than 50% of Nebraska counties with continual expansion ongoing. Nebraska has two agencies licensed to provide FCT and additional agencies interested.

When FCT was first implemented in Nebraska, the target population was identified as 1) youth who had been placed out-of-home, had a mental health or serious emotional disturbance diagnosis, and had a permanency plan of reunification or 2) families with a youth who was at risk of an out-of-home placement due to the youth's medical necessity for a higher level of care. This narrower target population was identified based upon funding streams at the start-up of FCT. The funding streams for FCT prior to FFPSA, consisted of state general funds blended with Medicaid funds as well as some System of Care funding. Since implementation of FCT, successful outcomes have been demonstrated and Nebraska is expanding capacity to serve more families by broadening the target population as allowable within the fidelity of the model. The flexibility of the FCT model while adhering to fidelity and consistent outcomes makes FCT a great fit for Nebraska's frontier/rural areas where sustainability of programs has increased challenges. The new target population for FCT is:

1. Families who have an identified safety threat(s) and/or high/very high risk factors and whose children are at risk of an out of home placement or need intensive services to prevent out of home placement.
2. Families with youth who are transitioning home from a higher level of care.
3. Families with youth who have been placed out of home, have a permanency plan of reunification and are transitioning home.

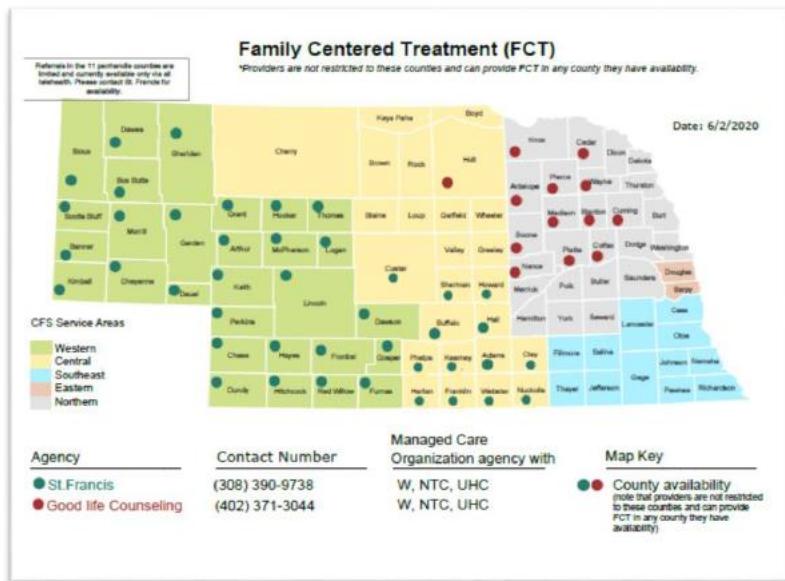
Although FCT may be referred in #2 and #3 above when the child is still in out of home care, the child is not an eligible FFPSA candidate until reunified.

FCT is rated promising and high for child welfare relevance on the California Evidence Based Clearinghouse and is pending review by the Federal Clearinghouse. FCT was submitted to the Federal Clearinghouse for review by the FCT Foundation (**Attachment D**). **Attachment E** includes an executive summary of the research conducted on FCT from 2004-2019. CFS is requesting transitional payments for FCT per ACYF-CB-PI-19-06 (**Attachments F, G.1 and G.2: Independent Review of Family**

Centered Treatment and Signed Conflict of Interest Statements. ACF has recently approved FCT with a well-supported designation thru the independent systematic review process, included in the State of Arkansas' Plan. Nebraska is including an independent review as additional validation of the well-supported rating in consideration of the official Federal Clearinghouse review.

Book/Manual: Per the Federal Clearinghouse, the following book/manual/other available documentation is proposed to be implemented as a result of the designation for transitional payments:

1. Painter WE, Smith MM. (2004). Wheels of Change—Family Centered Specialists Handbook and Training Manual. Richmond, VA: Institute for Family Centered Services.
2. Wood TJ, (2014) Family Centered Treatment® Design and Implementation Guide. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.



Program 6: Functional Family Therapy

Per the CEBC, Functional Family Therapy (FFT) is a family intervention program for dysfunctional youth with disruptive, externalizing problems. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out and substance abuse.

FFT targets youth aged 11-18. FFT has been rated well-supported by the Federal Clearinghouse.

Although Nebraska has learned that FFT is not currently available in the State, it is anticipated that it will be in the next five years and therefore remaining in Nebraska's Plan. Nebraska continues to have the RFQ process remain open, in an effort to have providers submit their request to implement an FFPSA service, such as FFT. Nebraska intends to coordinate with the FFT National Office and Nebraska's child welfare provider community, to discuss model fidelity requirements of FFT and what is required to implement this service in Nebraska. This also gives providers an opportunity to address any questions/concerns they may have regarding FFT.

Book/Manual: Per the Federal Clearinghouse, there are two manuals that provide overviews of the foundation and research support for the program, the program model and guidance on the implementation and administration of FFT. They are:

1. Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavioral problems*. American Psychological Association.
2. Sexton, T. L. (2010). *Functional Family Therapy in clinical practice: An evidence based treatment model for at risk adolescents*. Routledge.

Program 7: Multisystemic Therapy

Per the CEBC, Multi Systemic Therapy is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The target population is 12-17 year olds who are at risk of out-of-home placement due to delinquent behavior. In Nebraska, MST is a Medicaid-funded program and the target population are juvenile offenders and youth with either a substance use or behavioral health diagnosis. MST is rated well-supported on the Federal Clearinghouse.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Multisystemic Therapy is: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press. This is intended for clinical psychologists, psychiatrists, social workers, counselors, researchers, and students. It describes the principles of MST and provides guidelines for implementing the program. As of December 2019, the Division of Behavioral Health in Nebraska reported that MST was offered in forty-one of its ninety-three counties, primarily in the east central and east portions of the State, amongst a total of 7 provider organizations.

Program 8: Parent-Child Interaction Therapy

Per the CEBC, Parent Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children and their parents or caregivers focused on decreasing externalizing child behavior problems, increasing child social skills and cooperation, and improving the parent-child attachment relationship. The target population is children ages 2-7 years of age and their caretakers. PCIT is rated well-supported on the Federal Clearinghouse.

According to Nebraska's Division of Behavioral Health, PCIT is offered by twenty-eight individual therapists. Verification is being completed with the providers that submitted to the RFQ, to determine that they have completed or are intending to complete the model fidelity PCIT training, as identified by the Federal Clearinghouse.

Book/Manual: Per the Federal Clearinghouse, the manual available for Parent Child-Interaction Therapy is: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011*. PCIT International, Inc. This manual is designed for PCIT-trained therapists and includes session outlines, forms, handouts, and teacher information.

Program 9: Trauma-Focused Cognitive Behavioral Therapy

Per the CEBC, Trauma-Focused Cognitive Behavioral Therapy is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The target age is 3-18. TF-CBT is rated well-supported and high for child welfare relevance on the CEBC. TF-CBT is rated promising on the Federal Clearinghouse.

Book/Manual: Per the Federal Clearinghouse, the book/manual/available documentation for Trauma-Focused Cognitive Behavioral Therapy is: Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press. This provides information about the TF-CBT approach, with guidance broken down into different implementation scenarios. It also includes handouts and training information.

Improved Outcomes for Children & Families

Each evidence-based program selected for Nebraska's plan has intended outcomes. CFS believes that FFPSA, along with other current CFS initiatives focused on improving outcomes for youth and families, will be a catalyst for sustained positive impact for Nebraska children and families.

CFS is in the process of implementing Safety Organized Practice® (SOP®). SOP® is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP® aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief of SOP® is that all families have strengths.

SOP® aligns well with CFS' efforts towards emphasizing a family's voice and choice while involved with the child welfare system. CFS aims to improve its engagement with families served by ensuring their opinion is valued and they are empowered to make decisions for their family. SOP® assists the family, case manager and the family's safety network, to identify the specific behavioral changes that the parents and caregivers need to demonstrate over time to ensure the safety of their child(ren). The identification of the specific danger and harm, as well as the safety, case plan goals and foster care prevention plan goals, help drive the correct intervention of EBP's that can assist the family in achieving their goals and sustain child safety over time that will prevent the child from entering out-of-home care. CFS believes that implementing FFPSA, along with SOP® and family voice and choice, will lead to better family engagement, improved workforce retention and better outcomes for families.

The EBP's that Nebraska is choosing to implement as part of the Plan along with SOP®, all carry the tenants of ensuring for one's safety and well-being. With the use of SOP® combined with an aforementioned EBP, it is anticipated the work being done between CFS and the family will be through a trauma-informed practice; a shared focus to guide those involved in the case; enhancing one's physical and mental safety; solution focused outcomes; and joint collaboration.

Eastern Service Area Ongoing Case Management Contractor

The Department has transitioned ongoing case management services from PromiseShip to Saint Francis Ministries in Douglas and Sarpy counties, comprising the CFS Eastern Service Area. As part of the contract, Saint Francis will deliver evidence-based models in compliance with FFPSA with at least 50% of all prevention service expenditures on well-supported programs. CFS partners with Saint

Francis to ensure aligned efforts in work with children and families, including needed services. CFS continues to work closely with Saint Francis Ministries to ensure FFPSA readiness. More information on the *Eastern Service Area Case Management Transition* can be found [here](#).

Saint Francis Ministries currently offers the following services in their current service array: Healthy Families America (HFA) , Motivational Interviewing (MI), Family Centered Treatment (FCT), Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interaction Therapy (PCIT) and Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

1. Omaha Home for Boys- Trauma Focused CBT;
2. Paradigm-Trauma Focused CBT, PCIT, and MST;
3. Heartland Family Service-PCIT;
4. KVC-PCIT;
5. OMNI-PCIT;
6. SFM-PCIT and FCT;
7. Nebraska Children's Home Society- Healthy Families America;
8. Father Flanagan-MST

Saint Francis Ministries will authorize these services using the appropriate NFOCUS codes developed by the Department for FFPSA services. All the treatment services currently have a rate set by the Managed Care Organizations (MCO) currently. Additional authorizations may be provided by Saint Francis Ministries to participate in family team meetings, court hearings etc.

Provider meetings are held to discuss implementation of FFPSA. A review of Pathways to Permanency is occurring to identify what evidenced based models are within this bundled service. Saint Francis Ministries has developed a provider handbook which will outline contracted services within Eastern Service Area. It will be issued once it is approved by their corporate office.

Saint Francis Ministries is developing a referral matrix based on the EBPs available in the Eastern Service Area which will be used to educate case managers on when to engage families in the discussion about these various models.

Saint Francis Ministries is looking at performance based data information that it currently has and will continue to meet with its provider network to build additional FFPSA services. Saint Francis Ministries has requested the rate methodology for the Homebuilders model, Healthy Families America and KinTech since contractually they are required to pay a rate the same as or less than the DHHS for services.



Washington State

Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Evidence-Based Service Description and Oversight Pre-print Section 1

The Washington State Department of Children, Youth, and Families will contract through performance-based contracting to provide mental health, substance abuse treatment and prevention, and in-home parent skills-based services to children and parents where these services may safely prevent entry into foster care for those at imminent risk.

DCYF has chosen an initial set of EBPs based in part on contracts DCYF already has in place for prevention, as well as stakeholder and partner feedback and federal guidance. Washington State intends that the list of evidence-based family services available to children and families served under this plan will be more than eight; however, the other services under consideration by DCYF have not yet been reviewed by the Title IV-E Prevention Services Clearinghouse or are currently under review.

Table 2 below lists the initial seven evidence-based family services that DCYF will implement as a part of this Prevention Plan. The FFPSA Clearinghouse for Evidence-Based Practices has reviewed and rated all eight of these practices.

Table 2. DCYF Proposed EBPs for Initial FFPSA Prevention Plan

	Practice	Type of Service	Title IV-E Clearinghouse Rating
1	Functional Family Therapy (FFT)	mental health	well-supported
2	Motivational Interviewing	mental health substance abuse	well-supported
3	Multi-Systemic Therapy (MST)	mental health substance abuse	well-supported
4	Nurse-Family Partnership (NFP)	parent skill-based	well-supported
5	Parents as Teachers (PAT)	parent skill-based	well-supported
6	Homebuilders	parent skill-based	well-supported
7	SafeCare	parent skill-based	Supported
8	Child-Parent Psychotherapy	Mental health	Promising

While Motivational Interviewing and Multi-systemic therapy are substance abuse interventions, DCYF recognizes that there will be opportunities for further developing substance abuse prevention services in Washington. To that end, DCYF continues to meet with the Health Care Authority to plan additional substance abuse programs and resources.

The Children's Bureau Program Instruction ACYF-CB-PI-19-06 on Transitional Payments for the Title IV-E Prevention and Family Services and Programs describes the process by which states may review and rate a program or services until the Title IV-E Prevention Services Clearinghouse can review and rate the program or service. The independent systematic reviews of prevention services and programs described in this program instruction represent substantial new (and unanticipated) work for Washington State to complete. Therefore, DCYF will contract with qualified independent reviewer(s) to conduct the evidentiary review described in ACYF-CBPI-19-06 following submission of this State Prevention Plan, then submit an amendment to the plan with additional reviewed services sometime in mid-2020.

Washington State EBP Environment. In 2012, Washington State enacted House Bill (HB) 2536, requiring that state agencies serving children move toward greater use of Evidence-Based Practices (EBPs) in their service portfolios. The affected state agencies included two of the three DCYF agencies of origin – the former Children's Administration (the former state child welfare agency) and the former Juvenile Rehabilitation Administration (the former state juvenile justice agency). HB 1661, enacted in

2017, brought these two former Administrations together with the Department of Early Learning, to form the current Department of Children, Youth, and Families.

Because of HB 2536, Washington State has a rich tradition of EBPs, including evidentiary review and program evaluation, on which to expand voluntary prevention services. Since 2012 the Washington State Institute for Public Policy (WSIPP) has published updated evidentiary reviews and inventories of practices used by child-serving agencies, both in direct services and in contracts.

Service Ramp Up. DCYF would like to expand voluntary prevention services among the identified candidacy groups. In order to support this increase, the agency will need to invest in additional resources and develop an infrastructure to support expansion. A slow and steady ramp-up in expansion of services, guided by implementation science, is needed to avoid the unintended consequence of displacing existing services for families with children in foster care and to support the necessary focus on state caseworkers, training and fidelity for EBP providers, curation of network providers and program administration.

The eight evidence-based prevention practices listed in Table 1 above are all practices for which DCYF already holds contracts, with one exception (Motivational Interviewing). DCYF intends to take an incremental approach with service expansion – with multiple rounds of expanding priority services in targeted geographic areas and onboarding new service providers. Additionally, this plan provides for the substantial additional capacity that the agency will need to build in contract management and monitoring, CQI and evaluation.

DCYF will align oversight of new and expanded EBPs implemented as a part of this plan with nascent efforts in the new agency around outcomes-oriented Performance-Based Contracting (PBC) requirements. State legislation enacted in 2017 that created the new DCYF, requires the new agency to implement outcomes-oriented Performance-Based Contracting for all client service contracts. The intent is to align contracts with priority outcomes for children, youth and families in order to leverage the state's substantial investment in client services as an important tool to drive improvements in outcomes. In 2018, DCYF began intensive work with an initial set of four contract groups and will continue to add three to four contract groups per year to this effort until all client service contracts are converted to performance-based (estimated five to six years in all). Each contract group will go through an initial year of intensive planning, working with consultants and an assigned research/data consultant to closely examine existing data on program effectiveness. Based on analyses of available data, the contract groups choose specific quality and outcome metrics, aligned with the goals of the agency, to begin including in contracts. During the second year of engagement, the contract groups will work with contractors to implement the new contract measures, set up data monitoring and put continuous quality improvement practices in place.

Motivational Interviewing (MI). Motivational Interviewing is the single practice in Table 1 for which the agency does not currently have a contract. MI has emerged as a prominent case management tool in the field of child welfare beyond substance abuse. Research and evaluation to date have highlighted MI as an effective service delivery strategy with both adult and youth populations, making it an ideal fit for DCYF's prevention candidates

The goal of implementing MI is to assure improved engagement and participation of children, youth and families to support and services offered. Through increased engagement, we anticipate better service matching to the needs of each child and family. MI's client-centered approach will support sustainment of the family's motivation toward progress, so each child and family is able to continue to receive an appropriate dose and level of support and service.

Our goal is to have MI used at each encounter with our families. This will require community-based service providers, caseworkers and supervisors to be trained in the use of MI. Supervisors will provide critical support to caseworkers in using MI in the development and monitoring of the Prevention Plan. Community-based service providers will use MI in developing the assessment and delivering services.

DCYF workers and FFPSA Prevention community-based service providers will practice motivational interviewing with five fundamental principles:

- Express empathy through reflective listening.
 - Empathy involves seeing the work through the families' eyes.
- Develop discrepancy between families' goals or values and their current behavior.
 - Motivation for change occurs when people perceive a mismatch between "where they are and where they want to be".
- Adjust to family resistance rather than opposing it directly.
 - Roll with resistance.
- Support self-efficacy and optimism.
 - Strengths-based approach that believes that families have within themselves the capabilities to change successfully.

DCYF will progressively train DCYF workers and community-based prevention providers in Motivational Interviewing (MI). Motivational Interviewing will be incorporated as a part of a comprehensive DCYF practice model in alignment with utilization of the Child and Adolescent Needs & Strengths – Family Screener (CANS-F Screener) and Child and Adolescent Needs & Strengths – Family (CANS-F). DCYF will employ a phased training approach initially focusing on the prevention workforce. In consultation and collaboration with the University of Washington Alliance for Child Welfare Excellence, DCYF will train its prevention workforce with MI with fidelity monitoring.

DCYF will consult and partner with its existing provider network and initiate proof of concept projects on a voluntary basis with community-based service providers that already include MI as a part of their practice model. DCYF and the providers then will review and select a most effective framework incorporating MI with the family support service set to be replicated across the state.

Prevention Evidence-Based Practices at DCYF

Table 3 provides an overview of the selected EBPs, including service category, target population, their rating on the Title IV-E Prevention Clearinghouse, model information, outcomes and fidelity measures. The outcomes specified in Table 3 are those found in published research on these programs, and will not necessarily be measured in DCYF's evaluation of the programs. The Evaluation Strategy section of this plan provides additional information regarding how each service will be evaluated.

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
Nurse-Family Partnership	Nurse-Family Partnership enrolls vulnerable first-time moms to transform their lives and create better futures for themselves and their babies. Research shows that Nurse-Family Partnership succeeds in: keeping children healthy and safe and improving the lives of moms and babies. Nurse-Family Partnership works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, continuing through the child's second birthday. At the same time, new moms develop a relationship with a nurse and is a trusted resource for guidance on everything from safely caring for their child to taking steps to provide a stable, secure future for their new family. Throughout the partnership, the nurse provides	Well-Supported	Parent-skill based	<ul style="list-style-type: none"> • Child Development • Family Economic Self-Sufficiency • Reduced Arrests for Mother • Positive Parenting Practices (Parent-Child Interaction) • Reductions in Child Maltreatment • Reduction in preterm delivery for mothers who smoke 	Currently, NFP services enroll families during the prenatal period until the child turns age two.	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio no more than 1:6 • Caseload limit 1 nurse: 25 clients • Visit completion rate in each phase

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	new moms with confidence and tools to support a healthy start for their babies and to envision a life of stability and opportunities for success for the family.					
Homebuilders	Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting and treatment planning.	Under Review	Parent-skill based	<ul style="list-style-type: none"> • Reduce child abuse and neglect • Reduce family conflict • Reduce child behavior problems • Teach families the skills they need to prevent placement or successfully reunify with their children 	Families with children (birth to 18) at imminent risk of placement into or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals or juvenile rehabilitation facilities	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio • 24-hour availability • Services provided in their natural environment • Caseload limit 1 staff: 18 to 22 families/year • Supervisor availability
Child-Parent Psychotherapy	CPP is a treatment for trauma-exposed children aged birth to 5. Typically, the child is seen with his or her primary caregiver and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's	Under Review	Mental health	Child Domains <ul style="list-style-type: none"> • PTSD symptoms • Comorbid diagnoses, including depression • General behavior problems, including aggression and attentional difficulties 	Children age birth to 5, who have experienced trauma and their caregivers	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent therapeutic content (ex: convey hope, develop an

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<p>developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration-related stressors) and respects the family and cultural values. Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.</p> <p>Together, these approaches for Child-Parent Psychotherapy serve</p>			<ul style="list-style-type: none"> • Capacity to regulate emotions • Cognitive functioning <p>Relational Domains</p> <ul style="list-style-type: none"> • Children's perceptions of caregivers and themselves • Children's and caregivers' attachment relationships <p>Caregiver Domains</p> <ul style="list-style-type: none"> • Caregivers' PTSD symptoms • Caregivers' general symptoms • Caregivers' empathy towards children • Caregivers' ability to interact in positive ways with children 		<p>empathetic relationship with family members, etc.)</p> <ul style="list-style-type: none"> • Consistent reflective practice • Consistent use of trauma framework

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	to support families to reach the following primary goals: 1. Restore and protect the child's mental health. 2. Support family strengths and relationships, helping families heal after stressful experiences.					
				•		•
Functional Family Therapy (FFT)	FFT is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out and substance abuse. While FFT targets youth aged 11 to 18, younger siblings of referred adolescents often become part of the intervention	Well-supported	Mental Health	<ul style="list-style-type: none"> • Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e., school attendance) • Improve family and individual skills 	1 to 18-year-olds with very serious problems such as conduct disorder, violent acting-out and substance abuse	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Rate of meetings/progress notes • Family Self Report (FSR) and Therapist Self Report (TSR) • Rate of staffing and consultations with supervisors • Global Therapist Rating (GTR)

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases that organize the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention and therapist skills necessary for success.					<ul style="list-style-type: none"> • Family, client and therapist exit survey
Motivational Interviewing	MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to	Well-supported	Mental Health & Substance Abuse	<ul style="list-style-type: none"> • Enhance internal motivation to change • Reinforce this motivation 	Caregivers of children referred to the child welfare system. Has been used with adolescents	<ul style="list-style-type: none"> • Staff successful completion of required model training: initial and booster

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.			<ul style="list-style-type: none">Develop a plan to achieve change		<ul style="list-style-type: none">Case documentation: Frequency and consistencyCase review: thorough and adequateCounselor competence/model adherence: collaboration, evocation and autonomyCounselor skill demonstration: empathy
Multi-Systemic Therapy (MST)	Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically-based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts;	Well-supported	Mental Health & Substance Abuse	<ul style="list-style-type: none">Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s)Empower parents with the skills and resources needed to:Independently address the inevitable difficulties that	Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system (some other restrictions exist,	<ul style="list-style-type: none">Staff qualificationsStaff successful completion of required model training24-hour availabilityServices provided in the family's home or other places convenient to the familyServices are intensive, with intervention sessions being

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	(b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.			<ul style="list-style-type: none"> arise in raising children and adolescents Empower youth to cope with family, peer, school, and neighborhood problems 	see the Essential Components section for more details)	<ul style="list-style-type: none"> conducted from once per week to daily Caseload: Maximum 6 families/year per therapist Case length: 3 to 5 months
Parents as Teachers (PAT)	<p>There are four dynamic components to the Parents as Teachers model:</p> <ul style="list-style-type: none"> Personal visits (home visits) Group connections Resource network (referrals and connections to services) Child screening (and caregiver screening) <p>Together, these four components form a cohesive package of services with four primary goals:</p> <ol style="list-style-type: none"> Increase parent knowledge of early childhood development and improve parent practices. 	Well-supported	Parent-skill based	<ul style="list-style-type: none"> Child Development and School Readiness Family Economic Self-Sufficiency Positive Parenting Practices (Parent-Child Interaction) Reductions in Child Maltreatment 	Currently, PAT service enrolls families from pregnancy until Kindergarten entry.	<ul style="list-style-type: none"> Staff qualifications Staff successful completion of required model training Reflective supervision Staff: supervisor ratio not more than 1:12 Consistent use of family-centered assessment Consistent documentation of parent goals Consistent use of standard curriculum and visit plans

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<ol style="list-style-type: none"> Provide early detection of developmental delays and health issues. Prevent child abuse and neglect. Increase children's school readiness and success. <p>The PAT model for providing services to families with children from the prenatal period to kindergarten. Affiliates follow the essential requirements of the model, which provide minimum expectations for program design, infrastructure and service delivery. PAT provides support for affiliates to meet those requirements as well as further quality standards that represent best practices in the field.</p> <p>The PAT model book/manual is proprietary and available to trained and approved affiliates. There is only one Tribal specific local program currently funded with an approved adaptation, all other programs are implementing the program as designed.</p>					<ul style="list-style-type: none"> Visit completion rate Caseload limit FT staff no more than 48 visits/month in first year and no more than 60 visits/month thereafter

Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
SafeCare	SafeCare® is an in-home parent training program that targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas: (1) how to interact in a positive manner with their children, to plan activities and respond appropriately to challenging child behaviors, (2) to recognize hazards in the home in order to improve the home environment and (3) to recognize and respond to symptoms of illness and injury, in addition to keeping good health records.	Under Review	Parent-skill based	<ul style="list-style-type: none"> Reduce future incidents of child maltreatment Increase positive parent-child interaction Improve how parents care for their children's health Enhance home safety and parent supervision 	Parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse	<ul style="list-style-type: none"> Staff qualifications Staff successful completion of required model training Consistent use of parent-infant/child interaction assessment and training Consistent use of home safety assessment and training Consistent use of child health assessment and training
				•		•

Manual-Version for Evidence Based Practices**Table 4. Manual-Version for Evidence Based Practices**

Functional Family Therapy (FFT)	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i> . Washington, D.C.: American Psychological Association.
Motivational Interviewing	Miller, W.R. & Rollnick, S. (2012). <i>Motivational Interviewing, Third Edition: Helping People Change</i> . Guilford Press.
Multi-Systemic Therapy (MST)	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). <i>Multisystemic Therapy for Antisocial Behavior in Children and Adolescents</i> (2 nd ed.). New York: The Guilford Press.
Nurse Family Partnership (NFP)	Visit-to-Visit guidelines and other materials are available to those who attend the NFP trainings.
Parents as Teachers (PAT)	PAT Foundational Curriculum to support families prenatal to 3. AND PAT Foundational 2 Curriculum to support families 3 through Kindergarten.
Child-Parent Psychotherapy	Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). <i>Don't hit my mommy: A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma, Second Edition</i> . Washington, DC: Zero to Three.
Homebuilders	Kinney, J., Haapala, D. A., & Booth, C. (1991). <i>Keeping Families Together: The HOMEBUILDERS Model</i> . New York, NY: Taylor Francis.
SafeCare	Lutzker, J.R. (2016). <i>Provider Manual</i> , version 4.1.1.

Evidentiary Review of Additional Evidence-Based Practices

In planning for implementation of FFPSA prevention services, DCYF has identified a number of additional evidence-based practices that have not yet been reviewed by the FFPSA Clearinghouse but have substantial evidence to support their effectiveness and the agency believes would help to meet the needs of Washington's diverse candidacy populations. Thus, following submission of this plan, Washington intends to proceed with evidentiary review of these additional practices under Program Instruction ACYF-CB-PI-19-06. If the evidentiary review finds that those additional practices meet criteria for inclusion in the FFPSA Prevention Plan, Washington will submit an amendment to this plan to include additional EBPs. DCYF has already engaged in discussions with the Washington State Institute for Public Policy (WSIPP), to contract to conduct a number of these reviews in early 2020. WSIPP is the state entity designated by the Washington legislature to conduct an evidentiary review and determine the level of evidence for child-serving state agencies. While the standards WSIPP uses for Washington State reviews are somewhat different, they have expressed confidence in their ability to apply the required Clearinghouse standards to the review requested by DCYF.

In addition, in planning for expansion of prevention services for approved candidacy groups under this Prevention Plan, DCYF has engaged in consultation with the federally recognized tribes who serve as sovereign nations. DCYF views engagement of our tribal partners in prevention as an essential element in the success of our Prevention Plan, given that American Indians/Alaska Natives in Washington are disproportionately represented in the state's child welfare system. DCYF staff engaged in extensive discussion during two dedicated Tribal Policy Advisory Committee meetings throughout our planning year (in December 2018 and August 2019). In addition, the DCYF Director of Tribal Relations conducted a survey of Washington tribes in March 2019 to inquire about prevention practices embraced in tribal communities, that tribal communities find effective and that they would like DCYF to consider; including in its state Prevention Plan. Those discussions and the survey resulted in four prevention practices (Family Spirit, Positive Indian Parenting, Healing of the Canoe and Healing Circles) that the tribes requested DCYF consider and they additionally requested that the agency work with an AI/AN researcher to conduct the evidentiary reviews. In response, DCYF has investigated the evidence on the identified four practices and has located a qualified AI/AN researcher at the University of Washington who is interested and available to conduct the evidentiary reviews according to the FFPSA Clearinghouse standards and the Program Instruction ACYF-CB-PI-19-06. DCYF intends to contract for this review in early 2020 and is prepared to add the qualifying practices to our Prevention Plan in a subsequent amendment to address the racial disproportionality and disparity experienced by tribal populations in child welfare.

Prevention Pathway Implementation

We see the implementation of FFPSA as a multi-year, multi-phased initiative that will focus on building various pathways for prevention. Changes to processes, procedures, policies, as well as technical changes, will be necessary in order to successfully comply with FFPSA requirements.

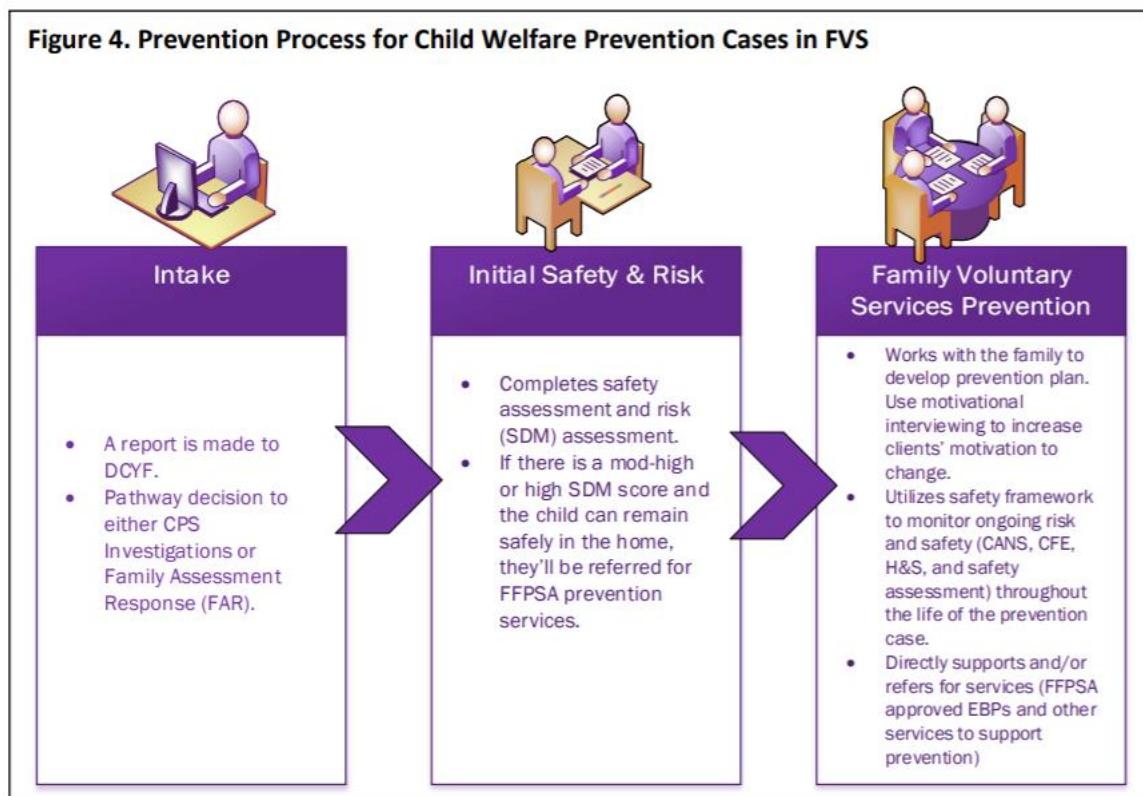
FFPSA has several requirements that prevention cases must implement, regardless of the pathway. FFPSA requires that a child who is eligible for prevention services must have a written prevention plan. The written prevention plan must identify the foster care prevention strategy for the child so that the child may remain safely at home. Additionally, the prevention plan must list the services to be provided to or on behalf of the child to ensure the success of that prevention strategy. The prevention plan for pregnant or parenting foster youth must also be included in their care case-plan and describe the foster care prevention strategy for any child born to the youth. In addition to the written prevention plan, prevention cases must monitor and oversee safety, and conduct periodic risk assessments for each child with a prevention plan. There is also required data to be tracked and submitted to the federal government on a six-month basis. The section "Monitoring Child Safety and Risk" details how safety and risk are monitored throughout the life of the prevention case.

Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention. FAR works with families to support them when they are in crisis and help them connect with their communities without finding parents responsible for child abuse or neglect.

Currently, FAR cases that provide services remain open no more than 120-days. An FFPSA Prevention case can remain open for up to 12 months and require additional monitoring and case management than what is currently required by caseworkers. In order to better understand the workload impacts of adding additional tasks in order to meet the FFPSA requirements (i.e. development of a prevention plan, offering and tracking services for up to 12 months, monthly health and safety, periodic risk assessments) on FAR caseloads, DCYF is interested in conducting FFPSA pilots with several FAR units throughout Washington State. The pilot information will be critical to understanding the impact on caseloads and to identifying strategies needed to align with FFPSA.

Family Voluntary Services (FVS) allows parents to choose to participate in services to meet their children's safety, health and well-being needs. The goal of FVS is to keep children safe and meet their needs while strengthening and keeping families together. A family is referred to FVS if, after the CPS investigation: (1) the family is identified as being moderately-high or high risk (based on the Structured Decision Making risk score) for future abuse or neglect and (2) the child(ren) can remain safely in the home with a safety plan.

Figure 4. Prevention Process for Child Welfare Prevention Cases in FVS



Changes to the FVS program will be required in order to implement FFPSA requirements for Prevention cases. As part of the initial implementation to meet FFPSA requirements, DCYF's FVS workers will work with families to develop a prevention plan, which will identify prevention strategies to keep children safe and make sure children, youth and families have the services they need.

The prevention plan is developed with input from the assessments, risk and needs screening and Family Team Decision Making (FTDM) meeting. Updated risk/needs assessments may be used to inform the plan review. FVS teams will routinely reexamine prevention plans to help monitor and track the child and parent or guardian progress during the provision of services. If a child's risk of entering foster care does not improve at a reasonable rate during or following the provision of services, the prevention plan will be re-assessed and changed as needed.

Washington is including two groups of adolescents on its candidacy list – those engaged with the agency's Family Reconciliation Services and youth exiting the state's Juvenile Rehabilitation system. High-risk adolescents in these categories are at risk of entering or reentering the foster care system and present similar needs for behavioral health and parent engagement supports. Many of these youth would benefit from the evidence-based practices on the Washington list to prevent entry/re-entry into foster care such as Family Functional Therapy (FFT), Multi-Systemic Therapy (MST) and others. In April 2019, DCYF released a policy report entitled Families and Youth in Crisis³, in response to legislative

concern about these highneed youth. In that report, the agency identified best practices for service delivery to similar youth and their families in Washington, in other states and internationally.

A pathway for substance-abusing pregnant women, Washington's Plan of Safe Care Initiative involves an interdisciplinary approach to providing support during and after pregnancy to mothers and their infants who are at risk of substance use and substance exposure. This initiative is sponsored by DCYF in collaboration with the Washington State Department of Health, the Washington Health Care Authority and the National Center on Substance Abuse and Child Welfare. The Plan of Safe Care is designed to take a highly collaborative, proactive and preventive approach to help keep families together, safe and healthy.

In early December 2019, the sponsors of Plan of Safe Care held an event to discuss strategy for implementing Plans of Safe Care in Washington. Participants included stakeholders involved with families in pregnancy, birth and early childhood to inform efforts including medical and public health, substance use treatment, medication assisted treatment, early intervention, child welfare and court professionals. As part of this work, collaborating agencies will plan prevention services to the FFPSA candidacy group: screened out pregnant women with substance use disorder.

A future community pathway is through Washington's Kinship Navigator (KN) program, managed by the Department of Social and Health Services Aging and Long Term Support Administration (ALTSA). The Kinship Navigator program currently serves 30 of 39 counties, seven tribes and supports kinship navigators in connecting relatives and unrelated kin raising children with federal, state and community resources. Kinship navigators provide information and referral services, which address specific needs and support greater stability, self-sufficiency and permanency. The KN program connects to a legislatively-mandated committee, the Kinship Care Oversight Committee (KCOC). KCOC links state agencies that serve kin with local groups and agencies that assist the same population, promoting coordination and seamless services for families. These collaborative working relationships enhance service delivery for kinship care families.

In order to access Title IV-E funds, the programs must meet the minimum evidence-based standards defined by the Title IV-E Prevention Services Clearinghouse. Currently, there are no Kinship Navigator programs that meet the required evidence-based standards. Washington State's KN program is uniquely situated for evaluation and DCYF partnered with ALTSA to hire the University of Washington's Partners for Our Children (POC) to complete the program evaluation.

The Kinship Navigator program is currently under evaluation and anticipates that the program could submit the required evaluation reports and elements to the Administration for Family and Children and

the Title IV-E Prevention Services Clearinghouse in late 2022. When this program is approved and rated by the Clearinghouse, we will submit an amended plan to include this evidence-based practice in our FFPSA Prevention plan.

Implementation Considerations

Implementation of FFPSA Prevention in Washington State is a huge transformation effort that will take multiple years to fully implement. Establishing an infrastructure that will properly support this ongoing work will be critical to our success.

DCYF will use formal program and agile project management methodologies to support this initiative. Following project management best practices will keep work focused and on task. Additionally, project management will provide visibility to the ongoing work and allow for alignment with other initiatives occurring in the department.

Extensive Change management support will also be essential to supporting FFPSA Prevention implementation. Integrating formal change management principles into the implementation work will be critical for supporting our staff and external partners through the changes. DCYF's enterprise change management office is a resource to assist with this transformational change. DCYF has trained staff in Prosci Change Management practices and tools.

Several technical changes are required to meet FFPSA requirements. To ensure tracking of prevention services for appropriate Title IV-E claiming, information technology (IT) staff are an integral part of preparation for Family First implementation. System enhancements for candidacy identification, EBP selection, prevention plan identification and plan outcomes, and billing processes will need to occur to support DCYF staff and providers. Through the DCYF IT prioritization process, these changes will be prioritized along with all change requests for FamLink. We are working closely with technology services to identify timelines and resources needed to implement these technical changes.

Ongoing engagement and communication is critical to the success of FFPSA Prevention. In order to ensure ongoing collaboration, DCYF will continue to partner closely with internal staff, tribes, community providers, constituents, external partners and stakeholders and different groups that represent the youth and families with whom we work. DCYF will also make use of its website and other communication channels to provide up-to-date information.

Focusing on business readiness will be at the forefront of the implementation work. There will be a significant amount of work to ensure DCYF staff are trained and supported - streamlining processes,

training on new tools, incorporating motivational interviewing in the practice model, and more. Ensuring agency staff has the proper training, coaching and ongoing support is vital.

There are significant resource needs in order to implement FFPSA requirements. Family prevention services are time-consuming and take connection and engagement to families. Prevention cases can remain open for up to 12 months and require additional tasks and with already high workloads, it will be important that we consider the impact on caseloads. Additional staffing requirements will be determined as DCYF begins implementation planning in the coming months.



North Dakota

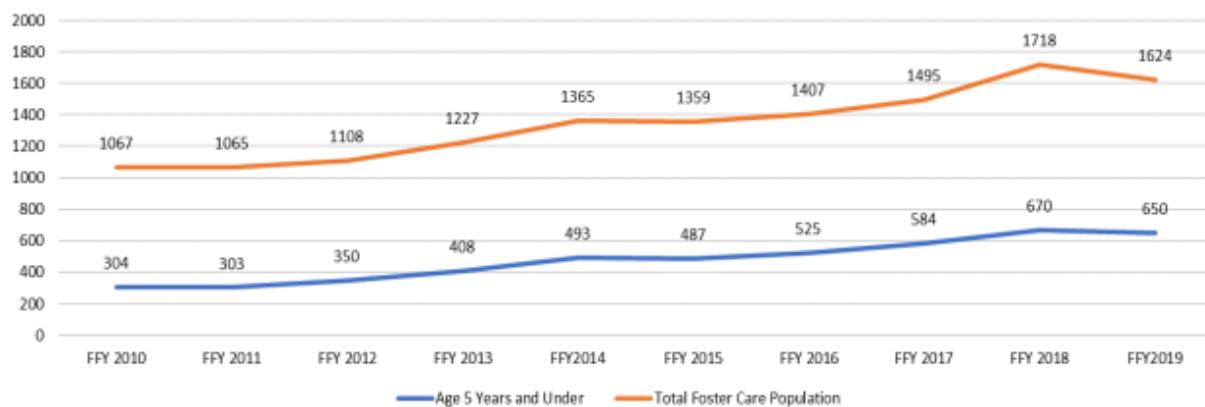
Status: Approved

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Service Description and Oversight In-Home Parent Skill-based Programs

North Dakota saw a 52% increase in the number of children in foster care over the last ten years. Of the children in foster care, the percentage under the age of 5 years has steadily risen from 28% to 40% during the same timeframe (Figure 3.) North Dakota will build the service array of the approved well-supported In-home parent skill-based programs to target this population.

Figure 3. North Dakota Foster Care Census and Those Age 5 Years and Under for Federal Fiscal Year 2010-2019



Through the Title IV-E Prevention Plan, North Dakota plans to expand/implement the following programs:

Healthy Families	
Service Description	Details
	<p>Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.</p> <p>Healthy Families North Dakota (HFND) offers services until the child is five years old. During the first six months following a child's birth or following enrollment (whichever is later), in-home visits are offered weekly. After six</p>

	months, families receive visits less frequently depending on their needs and progress.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category Version of Book or Manual	<p>In-Home Parent Skills-Based Programs and Services</p> <p>Healthy Families North Dakota (HFND) has been approved by Healthy Families America (HFA) for adaptation. The adaptation allows for enrollment of a child up to age 2 years, when the family is involved with the child welfare system. This approved adaptation will also be implemented with this plan.</p> <p>The Healthy Families America Site Development Guide (rev. 2014) is a guidebook that provides information for sites on planning, developing, and implementing an HFA site. The HFA Best Practice Standards (rev. 2017) offer specific guidelines on HFA model implementation.</p>
Plan to Implement	<p>Healthy Families North Dakota is in 11 counties of the state. HFND has targeted at risk children through 20 years of providing services in the state. Through the expansion, HFND will engage families directly involved in the child welfare system that qualify as a prevention candidate. North Dakota's plan for implementation includes:</p> <ul style="list-style-type: none"> • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	<p>Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for HFA, North Dakota expects to see the following outcomes for children and families receiving this service:</p> <ul style="list-style-type: none"> • Reduce child maltreatment • Improve parent-child interactions and children's social-emotional wellbeing • Increase school readiness • Promote child physical health and development • Promote positive parenting • Promote self-sufficiency • Increase access to primary care medical services and community services • Decrease child injuries and emergency department use
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure HFND's fidelity to the model and progress measures meet the standards established. HFND

	<p>must meet the threshold of national accreditation. Completion of this process is required to confirm fidelity to the Model as set forth by HFA.</p> <ul style="list-style-type: none"> • Collect and analyze data for outcome and process measures and for required reporting. • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected HFA to be included in the state's prevention service array.
Target Population	Families are eligible to receive Healthy Families services beginning prenatally or within three months of birth; when referred from child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences.
Assurance for Trauma Informed Service Delivery	<p>See Appendix C: State Assurance of Trauma-Informed Service-Delivery.</p> <p>HFND requires that all staff participate in HFA Core Training, which is aligned with 3 major principles: 1) trauma-informed 2) attachment/relationship focused, and 3) grounded in reflective practice. Additionally, all staff receive intensive training on using the evidence-based curriculum, Growing Great Kids, and are required to participate in NEAR (Neuroscience, Epigenetics, Adverse Childhood Experience and Resilience) training, which supports the understanding of trauma and its impacts.</p>
How Evaluated	<p>HFND will include the required participation in a self-study, national peer reviewed site visit, implement a quality assurance plan, and subsequent quality improvement efforts in order to continue to meet the threshold of accreditation. Completion of this process is required to confirm fidelity to the Model as set forth by HFA.</p> <p>North Dakota is requesting a waiver for evaluation of HFA, which has been designated by the Title IV-E Prevention Services Clearinghouse as "WellSupported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice</p>

Homebuilders	
Service Description	<p>Homebuilders provides intensive, in-home counseling and support services for families who have a child 0-17 years old at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive inhome services. Homebuilders uses behavioral assessments to determine outcome-based goals and help families identify strengths and problems associated with child safety and intervention maintenance of change. It aims to support families during crises using tailored intervention strategies and a diverse range of services, such as support with basic needs, service navigation, and psychotherapy. Providers use cognitive and behavioral practices to teach family members new skills and facilitate behavior change.</p> <p>Homebuilders services are concentrated during a period of four to six weeks with the goal of preventing outof-home placements.</p> <p>Homebuilders therapists typically have small caseloads of two families at a time. Families typically receive 40 or more hours of direct faceto-face services. The family's therapist is available to family members 24 hours per day, 7 days per week. Treatment services primarily take place in the client's home. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience.</p>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	A manual is available for Homebuilders. Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.
Plan to Implement	<p>North Dakota's plan for implementation includes:</p> <ul style="list-style-type: none"> • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	<p>Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for Homebuilders, North Dakota expects to see the following outcomes for children and families receiving this service:</p> <ul style="list-style-type: none"> • Child safety • Child Permanency • Improved parent/caregiver mental/emotional health • Economic and housing stability

Plan to Monitor for Fidelity	<p>See Section 2. Continuous Quality Improvement</p> <p>North Dakota will conduct ongoing contract monitoring to ensure Homebuilders fidelity to the model and progress measures meet the standards established. Providers of Homebuilders implement fidelity monitoring and outcome measurement using the Homebuilders quality enhancement system, known as QUEST. QUEST is designed to assure quality through the development and continual improvement of the knowledge and skills necessary to obtain model fidelity and service outcomes. QUEST activities focus on providing training and creating an internal management system of on-going evaluation and feedback.</p>
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup, consisting of subject matter experts from child welfare, behavioral health, and juvenile justice, reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected Homebuilders to be included in the state's prevention service array.
Target Population	Homebuilders serves families who have a child 0-17 years old at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	North Dakota is requesting a waiver for evaluation of Homebuilders, which has been designated by the Title IV-E Prevention Services Clearinghouse as "WellSupported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Nurse Family Partnership	
Service Description	Nurse- Family Partnership (NFP) is a home-visiting program that has specially trained nurses regularly visit first-time moms-to-be, who are 28 weeks or less, meet income requirements and continuing through the child's second birthday. The primary outcomes of NFP are to improve the health, relationships, and economic well-being of mothers and their children. The content of the program can vary based on the needs and requests of the mother. Mothers, babies, families and communities all benefit. Through the partnership, the nurse provides new moms with the confidence and the tools they need not only to assure a healthy start for

	their babies, but to envision a life of stability and opportunities for success for both mom and child.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	https://www.nursefamilypartnership.org/wp-content/uploads/2018/12/NFP-Initial-Education-Policy-07.24.2018.pdf
Plan to Implement	NFP is a prevention service that is currently available in seven counties in North Dakota. To implement NFP as a service under the Title IV-E prevention program plan, North Dakota's plans for implementation include: <ul style="list-style-type: none"> • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for NFP, North Dakota expects to see the following outcomes for children and families receiving this service: <ul style="list-style-type: none"> • Improved maternal health • Improved child health • Reduction in child maltreatment • Increased positive parenting practices • Improved family self-sufficiency
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement The NFP program will maintain fidelity to its model by using their web-based performance management system designed to collect and report characteristics, needs, services provided and progress towards goals. North Dakota will conduct ongoing contract monitoring to ensure NFP fidelity to the model and progress measures meet the standards established.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected NFP to be included in the state's prevention service array.

Target Population	NFP is intended for first-time moms-to-be, who are 28 weeks or less, meet income requirements and continuing through the child's second birthday. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	North Dakota is requesting a waiver for evaluation of NFP, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice.

Parents as Teachers	
Service Description	<p>Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components:</p> <ul style="list-style-type: none"> • Personal home visits, • Supportive group connection events, • Child health and developmental screenings, and • Community resource networks. <p>PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, child-care centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training. North Dakota participates in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which funds the Parents as Teachers program at Turtle Mountain Nations in North Dakota, through Prevent Child Abuse North Dakota (PCAND).</p>
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)

Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	PAT will be implemented without adaptation. PAT has a Model Implementation Library with resources available to those who receive PAT training. Depending on the ages of the families served, the PAT Foundational Curriculum is available to support families with children prenatal to age 3, and the PAT Foundational 2 Curriculum is available to support families with children ages 3 through Kindergarten.
Plan to Implement	PAT program is a primary prevention service that is available in only one site in North Dakota. To implement PAT as a service under the Title IV-E prevention program plan, ND's plans for implementation include: <ul style="list-style-type: none"> • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PAT, North Dakota expects to see the following outcomes for children and families receiving this service: <ul style="list-style-type: none"> • Increased child safety • Improved child behavioral and emotional functioning • Increased positive parenting practices • Improved parent/caregiver mental or emotional health
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement The PAT program will maintain fidelity to its model by implementing and replicating the 20 fundamental and essential requirements set out by the Parents as Teachers National Center. North Dakota will conduct ongoing contract monitoring to ensure PAT's fidelity to the model and progress measures meet the standards established.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected PAT to be included in the state's prevention service array.
Target Population	PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as

	teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	North Dakota is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "WellSupported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Mental Health and Substance Abuse Prevention and Treatment Services

Brief Strategic Family Therapy	
Service Description	Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents 6 to 17 years old who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. There are three interventions components; (1) counselors establish relationships with family members to better understand and join the family system; (2) counselors observe how family members behave with one another in order to identify interactional patterns that are associated with problematic youth behavior; and (3) counselors work in the present, using reframes, assigning tasks and coaching family members to try new ways of relating to one another to promote more effective and adaptive family interactions. BSFT is delivered by trained therapists and are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral intervention and family systems theory. BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). Brief Strategic Family Therapy for Adolescent Drug Abuse. NIH Pub. No. 03-4751. Bethesda, MD: National Institute on Drug Abuse. Developers proprietary manual: http://www.bsft.org/documents/BSFTNIDATherapyManual.pdf

Plan to Implement	ND's plans for implementation include: <ul style="list-style-type: none">• Providers apply to be an approved IV-E prevention services provider.• Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for BSFT, North Dakota expects to see the following outcomes for children and families receiving this service: <ul style="list-style-type: none">• Improved child behavioral and emotional functioning• Decreased child substance use• Decreased parent/caregiver substance use• Decreased child delinquent behavior and substance use• Improved family functioning
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement The PAT program will maintain fidelity to its model by implementing and replicating the 20 fundamental and essential requirements set out by the Parents as Teachers National Center. North Dakota will conduct ongoing contract monitoring to ensure BSFT's fidelity to the model and progress measures meet the standards established. BSFT training sites are initially required to demonstrate readiness for integrating the BSFT program, implementation trainings and supervision which meet certain fidelity requirements.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected BSFT to be included in the state's prevention service array.
Target Population	Families with children or adolescents 6 to 17 years who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	North Dakota is requesting a waiver for evaluation of BSFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as

	"WellSupported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice
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Functional Family Therapy	
Service Description	Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in five phases that consist of: (1) developing a positive relationship between therapist/program and family; (2) increasing hope for change and decrease blame/conflict; (3) identifying specific needs and characteristics of the family; (4) supporting individual skill-building of youth and family; and (5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months. Master's level therapists provide FFT, are part of an FFT-supervised unit and receive ongoing support from their local unit and FFT LLC.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Functional Family Therapy for Adolescent Behavioral Problems. Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association.
Plan to Implement	ND's plans for implementation include: <ul style="list-style-type: none">• Providers apply to be an approved IV-E prevention services provider.• Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, North Dakota expects to see the following outcomes for children and families receiving this service: <ul style="list-style-type: none">• Improved family functioning and skills• Reduced family conflict• Improved youth behavior• Reduced youth recidivism• Reduced alcohol and drug use
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement

	<p>North Dakota will conduct ongoing contract monitoring to ensure FFT's fidelity to the model and progress measures meet the standards established. Fidelity to the model and outcomes measures will be reviewed with FFT LLC as well as:</p> <ul style="list-style-type: none"> • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected FFT to be included in the state's prevention service array
Target Population	Justice involved youth with Emotional Disorders
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	Collaborate with FFT LLC to complete Fidelity Reviews annually and review Service Outcomes at least annually. North Dakota is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "WellSupported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

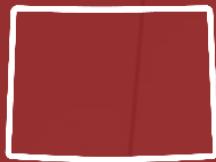
Multisystemic Therapy	
Service Description	Multisystemic Therapy (MST) is an intensive family and community-based treatment program for youth 12 to 17 years old delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and substance use in youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Multisystemic Therapy (MST) Multisystemic Therapy for Antisocial Behavior in Children and Adolescents, Second Edition is intended for clinical psychologists, psychiatrists, social workers, counselors, researchers, and students. It describes the principles of MST and provides guidelines for implementing the program <u>Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for Antisocial Behavior in Children and Adolescents (2nd ed.). New York: The Guilford Press.</u>
Plan to Implement	ND's plans for implementation include: <ul style="list-style-type: none">• Providers apply to be an approved IV-E prevention services provider.• Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for MST, North Dakota expects to see the following outcomes for children and families receiving this service: <ul style="list-style-type: none">• Improve child behavioral and emotional functioning• Improve child social functioning• Improve child functions and abilities• Decrease child substance use• Decrease child delinquent behavior• Improve positive parenting practices• Improve parent mental/emotional health• Improve family functioning
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure MST's fidelity to the model and progress measures meet the standards established. MST is delivered by therapists who work for licensed MST teams and organizations. Clinically focused booster sessions aim to refresh MST skills and weekly consultations provided by MST experts. MST teams use a structured fidelity assessment approach to ensure clinical service delivery is consistent with the MST model.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved

	well-supported evidencebased prevention programs in North Dakota and selected MST to be included in the state's prevention service array.
Target Population	Families of youth 12-17 years old who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	<p>It is recommended if MST is implemented to continue technical assistance from the creator of the program.</p> <p>North Dakota is requesting a waiver for evaluation of MST, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice</p>

Parent Child Interaction Therapy	
Service Description	Parent-Child Interaction Therapy (PCIT) is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach parents and caregivers in skills such as child centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents and caregivers from behind a one way mirror or with same room coaching. Parents and caregivers progress through treatment as they master specific competencies, thus, there is no fixed length of treatment. Most families can achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and their parents or caregivers.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	The Parent-Child Interaction Therapy Protocol. Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011. PCIT International, Inc PCIT will be implemented without adaptation
Plan to Implement	ND's plans for implementation include: <ul style="list-style-type: none"> Providers apply to be an approved IV-E prevention services provider.

	<ul style="list-style-type: none"> Establish contracts with qualified provider, using billing codes to capture required client and payment data
Outcome Expected to Improve	<p>Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, North Dakota expects to see the following outcomes for children and families receiving this service:</p> <ul style="list-style-type: none"> Improved parenting knowledge Increased positive parenting practices Improved parent and child interactions Decreased child behavior and attention problems Improved parent/caregiver emotional health
Plan to Monitor for Fidelity	<p>See Section 2. Continuous Quality Improvement</p> <p>North Dakota will conduct ongoing contract monitoring to ensure PCIT's fidelity to the model and progress measures meet the standards established. Providers of PCIT are required to implement fidelity monitoring and outcome measurement using these PCIT tools, which are available through PCIT International.</p>
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup, made up of subject matter experts from child welfare, behavioral health, and juvenile justice, reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected PCIT to be included in the state's prevention service array.
Target Population	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	North Dakota is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice



Colorado

Status: Submitted

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Title IV-E Prevention Services Array

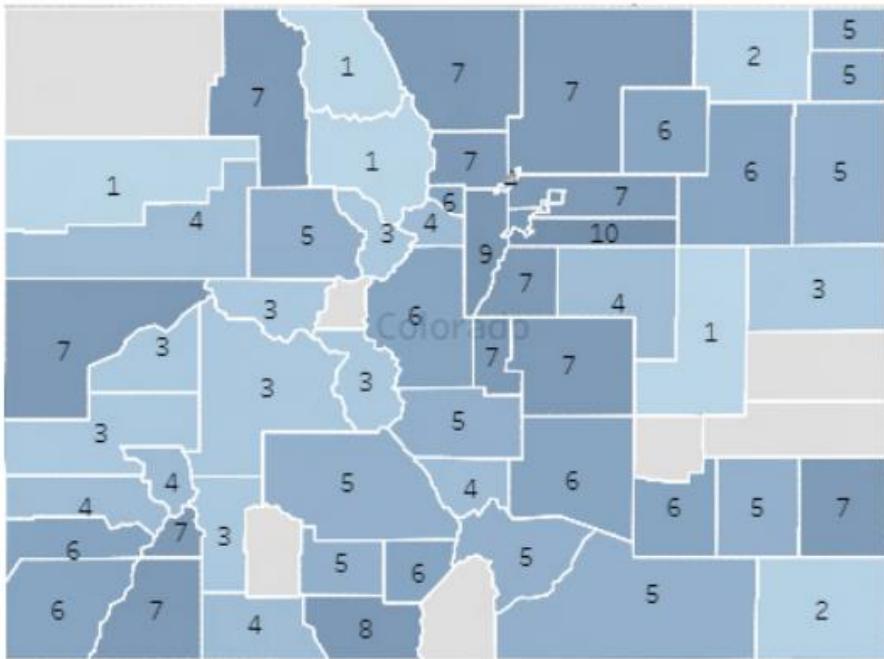
One of the key workgroups of the Colorado Family First Implementation Team is the Services Continuum workgroup, made up of diverse members representing CDHS, counties, service providers, and community partners. The long-term objective of the workgroup is to define a comprehensive continuum of care in Colorado spanning primary prevention, early intervention, stabilization, permanency, reunification, and re-entry. In the short term, the purpose of the workgroup was more narrowly focused on understanding and identifying opportunities for Colorado to access IV-E funding for current and future placement prevention services. Additionally, with the support of Casey Family Programs, the workgroup has mobilized research and university partners statewide in developing a coordinated Colorado-focused research agenda to strategically build evidence for prevention services.

The workgroup strongly recommended that the state prioritize the evidence-based services that are currently in place and being implemented successfully in Colorado. This strategy will allow the state to build upon existing capacity, continue to assess program efficacy, make efforts to scale where appropriate, and minimize start-up costs for initial implementation. All of Colorado's proposed prevention services, therefore, are currently being implemented in the state, although to varying degrees. Simultaneously, Colorado will continue to look at evidence-based services that are not currently present in Colorado to understand how they align with the state's resources and the needs of target populations, including partnering with Tribes.

The workgroup compiled a snapshot of the approved services in the Title IV-E Prevention Services Clearinghouse (Clearinghouse) being provided in Colorado—both in terms of prevalence and geographic reach. Currently, 10 of the 12 rated Clearinghouse services (as of March 2020) are being implemented in Colorado. The map below shows the number of Clearinghouse services available in each of Colorado's 64 counties.

Colorado is formally proposing nine practices in this initial five-year plan. Seven are rated well-supported, one is rated supported with a rigorous evaluation plan, and one is the result of an independent systematic review with documentation included in this plan. Colorado is continuing to develop rigorous evaluation plans for two additional promising practices, and has two additional independent systematic reviews pending.

County-Level Map of Available Clearinghouse Services



The Most Vulnerable: Children Ages Zero to Five

Collectively, Colorado understands a great deal regarding the specific risk factors that increase children and youth's vulnerability to maltreatment and subsequent removal, including age (younger than four), parental challenges (substance abuse, mental health issues, intimate partner violence), parental characteristics (young age, low income, low education), and social isolation. Most notably, Colorado knows that infants and young children are the most vulnerable. Nationally, children in their first year of life have the highest rate of victimization at 24.8 per 1,000 children.³ In comparison, the national rate of child maltreatment victimization across all ages is nine per 1,000 children. Children who die from abuse and neglect are overwhelmingly young. For SFY 2017-2018 in Colorado, 41.9% of maltreatment fatalities were under the age of one and 64.5% were under the age of five; 56.5% of near fatalities were under the age of one and 87% under the age of five.

Data show that children ages zero to five are disproportionately represented deeper in the child welfare system:

In Colorado SFY 2017-2018, of 109,795 referrals to counties, 12.9% were for children under the age of one and 32.6% were under five. • 20.3% of assessments were for children under the age of one and 43.9% were under the age of five. • Over 30% of all open cases were children under the age of one and 51.3% were under the age of five.⁵ Thus, it is vital to proactively identify and support families with infants and young children who are at risk of maltreatment and/or out-of-home placement. The child welfare system cannot prevent maltreatment alone, but through multi-system coordination, substantial progress can be made. Up to 88% of all child fatalities were not known to child protective services before death, but many were seen by other professionals (e.g., health care).

Within the Family First context, Colorado's initial proposed service array includes Nurse-Family Partnership® (NFP) and Parents as Teachers (PAT). Both interventions are well-supported home visiting programs, targeting at-risk families with infants or young children under five years old. Both programs, however, will require additional

state efforts to fully align with the requirements of Family First. NFP has already been brought to scale in Colorado, with more than 25,000 families served since 1998. The program is currently available in all of Colorado's 64 counties. NFP sites in the state receive funding from the Tobacco Master Settlement Agreement per Colorado statute, and three NFP sites in the Denver metro area also receive federal funding through the Maternal, Infant, and Early Childhood Home Visiting Program. The voluntary program has strict eligibility standards, and a majority of participants are not involved with the child welfare system and therefore do not have client data in Colorado's Trails system. PAT is currently provided in 10 Colorado counties with similar technical challenges regarding implementation to populations outside child welfare. For both programs, Colorado is actively developing technological solutions to ensure sufficient safeguards around client data while allowing CDHS, as the IV-E agency, to track and report on prevention activities provided outside the child welfare system.

Colorado is including Healthy Families America in its proposed service array as another home-visiting model targeting at-risk families of infants and young children. Currently, only two Colorado counties are implementing this program, but Colorado looks forward to continuing to assess its efficacy and potential for expansion in the state.

SafeCare® is also being proposed, pending acceptance of Colorado's rigorous ongoing evaluation plan. SafeCare® was rated as a supported practice by the Clearinghouse and will complement NFP, PAT, and Healthy Families America well with this target population. SafeCare® is a nationally recognized, evidence-based, in-home parent education program that provides direct skills training to parents and caregivers in the areas of parenting, home safety, and child health. SafeCare® is being implemented in Colorado through a partnership between the Office of Early Childhood and county departments of human/ social services. The program is a voluntary service for families aimed to prevent entry or re-entry into the child welfare system for families with children ages zero to five who are at risk of abuse or neglect. Thirty counties in Colorado and one Tribe currently provide SafeCare® as a resource for families. One difference between SafeCare® and NFP/PAT is that, in Colorado, SafeCare® was specifically designed to serve the PA3 population (screened out referrals and closed child welfare cases). While the program currently serves a broader population, about 50% of SafeCare® clients are child welfare referrals with data already in Trails.

Finally, Colorado is striving to diversify the services provided to at-risk families with infants or young children under five years old to minimize risk to the child and prevent out-ofhome placement. For example, beyond intensive home-visiting models, Colorado is assessing a variety of other programs that provide a "lighter touch" to families by building parenting skills (e.g., Nurturing Parenting).

Reducing the Negative Effects of Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood. ACEs include aspects of a child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance misuse or mental health issues. ACEs can have lasting, negative effects on health, well-being, and opportunity. These effects can also be passed on to future generations.

In addition to focusing on infants and young children, Colorado will also prioritize children and youth who are at risk of entering or re-entering foster care, many of whom have experienced multiple ACEs. During CYs 2014-2018, there were 15,874 removals related to substance use, and this represents a specific area Colorado intends to target through prevention services. Colorado has further identified runaway youth as a subcategory of youth at high risk of entry into the child welfare or juvenile justice system. Through an analysis of a statistically significant random sample of runaway youth between the ages of 10 and 17, Colorado found that approximately 55% of youth who run away are not system involved at the time of the run. However, of those "non-system"-involved youth, half go on to formally enter the child welfare or juvenile justice system within 18 months.

Colorado is proposing to include Multi-Systemic Therapy (MST) in its service array to provide evidence-based treatment for youth between the ages of 12 and 17. MST aims to promote pro-social behavior and reduce criminal activity, mental health symptomatology, out-of-home placements, and illicit substance use. Colorado will be able to leverage an MST pilot that was launched in 2019 to expand the availability of the intervention to underserved regions of Colorado.

Additionally, Colorado has included Functional Family Therapy (FFT) in its service array to serve this population. FFT is a well-supported, short-term family therapy intervention that helps children who are at risk and supports young people to overcome behavioral problems, conduct disorder, substance abuse, and delinquency. This service is currently implemented in 10 Colorado counties.

Colorado has conducted an independent systematic review of High Fidelity Wraparound (HFW) and has found it to meet evidence standards of a promising practice. (Please see attachment for full documentation of this review.) HFW is an evidence-based team process to manage care for families with complex needs who are involved in multiple systems. It is designed for the most complex families to reduce out-of-home placement and youth homelessness. In the wraparound process, the child, youth, and family vision is what drives the plan; it is not just about agencies deciding how to work together to coordinate the family's services. Emphasis is placed on natural and informal supports and the goal is to have a single, unified plan for the family that everyone on the team works together to achieve. Currently, HFW is implemented in 13 counties. Between October 1, 2016, and September 30, 2018, a total of 290 individuals participated in HFW. Subsequently, children and youth involved in HFW saw a 63% reduction in the total number of nights spent in out-of-home care.

While Methadone Maintenance Therapy (MMT) is currently being utilized in Colorado, assessment continues to determine whether there is enough usage to invest in ongoing rigorous evaluation and formally propose this service in the prevention plan.

Focus on Engagement

To truly realize the sustained impact of Title IV-E prevention services, effective family engagement strategies will be critically important. Colorado is currently utilizing Motivational Interviewing (MI) in various ways throughout the child welfare system, and some EBPs included in this plan incorporate MI training for providers. In addition, Colorado is actively assessing how to integrate this well-supported practice more intentionally and consistently

as a key component of casework practice in the state. While Colorado is starting from a strong foundation of existing evidence-based prevention services, MI would help ensure that families have the support and motivation needed to sustain engagement in these service interventions and achieve lasting behavior change.

Colorado is also conducting an independent systematic review and hopes to eventually propose the Colorado Differential Response Model (DR), which is an innovative system reform that allows for more than a one-size-fits-all approach to families who become involved with child welfare. DR offers a dual track response when counties receive allegations of abuse and neglect: a family assessment response (FAR) and a high risk assessment (HRA). Colorado has found that the DR philosophy and model creates more opportunity to engage and work with families to identify support systems and services and prevent deeper penetration into the child welfare system. This is a shift in practice from being incident-focused and compliance-driven to being behaviorally based and solution-focused.

Colorado has worked with Colorado State University (CSU) to provide ongoing research of its DR model. CSU has completed three studies since the 2009 DR pilot. Each of the studies has evaluated the same outcomes over time, including Child Safety, Family Well-being, Family Engagement, Caseworker satisfaction, Cost and Community Buy-in. The Colorado DR model aligns with Family First as an in-home parent skills-based program. Often the caseworker is the “intervention” that helps connect the family with services and supports to build strengths and protective capacities. DR can also provide case management while other prevention services are being provided to families. In Colorado, there are currently 41 counties that use the DR practice model when dispositioning allegations of abuse and neglect with low to moderate risk, and nine additional counties are in the process of adopting this practice. Furthermore, Colorado’s Child and Family Services Plan promotes expanding DR as a statewide intervention.

Comprehensive Continuum of Care

To round out Colorado’s proposed service array, ParentChild Interaction Therapy (PCIT) is included in this plan and a rigorous evaluation plan for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is being developed for future submission. In addition, Colorado is committed to building evidence for Colorado Community Response (CCR). CCR is currently provided as a prevention service for screened-out referrals and offers comprehensive family-focused services that include family engagement, case management, direct services, resource referral, home visits, collaborative goalsetting, financial decision-making assistance and coaching, and group-based parent education. It is currently being delivered at 24 sites encompassing 34 counties in rural and suburban areas across the state.

An evaluation of CCR in Colorado was completed by the Kempe Center at the University of Colorado Denver, under subcontract to CSU. CCR participants had significantly fewer founded assessments and out-of-home placements during a one-year follow-up period than did families with similar demographics and case characteristics who did not complete CCR. The protective factor domains of Resiliency, Social Support, Concrete Support, Nurturing and Attachment, and Child Development/Knowledge of Parenting increased for participating families. There is already a plan in place for further evaluation of CCR in Colorado, with a randomized controlled trial currently underway.

In selecting services to propose for Colorado's initial five-year plan, it was important to look at these services collectively as part of a broader continuum of care. While Colorado's proposed service array focuses on the early critical years, Colorado also acknowledges that evidence-based prevention services are needed at every life stage for families. The Prevention Services Continuum represents both the prevention continuum and the life span continuum, and where Colorado's current proposed and future services align.

The chart that begins on page 20 provides an overview of Colorado's proposed service array, including the target population for each service, level of effectiveness assigned by the Clearinghouse, and intended outcomes. Also included are those services that Colorado hopes to include in a revised version of this plan in the near future.

As Colorado is limited to the services currently rated by the Clearinghouse and those that meet the standards of evidence for transitional payment, the collection of services presented here does not adequately address all the nuances in a full continuum of care. However, implementation is an ongoing process. Colorado is certain that the current landscape will continue to change as services are added to the Clearinghouse, Family First is implemented across the state, and the makeup and needs of children, youth, and families evolve. Moving forward, Colorado's Services Continuum workgroup will continue to meet to evaluate and build upon the current service array, and CDHS will submit amendments to this initial plan to add services as they are approved by the Clearinghouse. The workgroup will be addressing three primary questions:

1. For the 10 rated services currently being implemented in the state, how does Colorado strategically increase capacity and expand service reach across the state?
2. Where are there gaps in services (along the prevention services continuum, life span continuum, and/or geographically) and how are these best addressed?
3. In addition to the services being reviewed by the Clearinghouse, in which services does Colorado want to invest additional research and evaluation to build evidence for eventual federal financial reimbursement?

One data source that the workgroup will draw on is the annual report that counties and Tribes submit as part of Colorado's Core Services Program. Each year, counties and Tribes are asked about the availability, capacity, and accessibility of services in their communities. This data is helpful for identifying gaps in services, inequities in access, and opportunities for expansion. For example, based on preliminary data from CY 2018, over 20% of participating counties and Tribes reported that they had inadequate capacity for substance abuse treatment, 17% had inadequate capacity for mental health services, and 28% reported a lack of day treatment facilities/services.

COLORADO INITIAL PROPOSED SERVICE ARRAY				
Program or Service	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
In-Home Parent Skill-Based Programs and Services				
Nurse-Family Partnership (NFP)	First-time, low-income mothers. Participation of fathers and other family members encouraged.	Mothers enroll early in pregnancy and may continue until child turns two. One-on-one visits by registered nurses in the home or a location of the mother's choice. Goal is to complete 60 visits, lasting 60-90 minutes each.	Well-Supported	<ul style="list-style-type: none"> Child safety Child well-being: Cognitive functions and abilities Child well-being: Physical development and health Adult well-being: Parent/caregiver physical health
Parents as Teachers (PAT)	Families with an expectant mother or parents of children up to kindergarten entry (usually five years) in possible high-risk environments.	Starts prenatally and continues until child reaches kindergarten. Parent educators meet with families, usually in the home, biweekly to monthly based on need. Recommended duration is at least two years.	Well-Supported	<ul style="list-style-type: none"> Child safety Child well-being: Social functioning Child well-being: Cognitive functions and abilities
Healthy Families America	New and expectant families with children at risk for maltreatment or adverse childhood experiences.	Home-visiting services begin as early as prenatally and continue until child is three to five years old.	Well-Supported	<ul style="list-style-type: none"> Child safety Child well-being: Behavioral and emotional functioning Child well-being: Cognitive functions and abilities Child well-being: Educational Achievement and Attainment Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health Adult well-being: Family functioning

COLORADO INITIAL PROPOSED SERVICE ARRAY				
Program or Service	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
SafeCare® <i>*Pending finalization and acceptance of rigorous ongoing evaluation plan</i>	Parents of children ages zero to five at risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse.	Weekly sessions of approximately one to 1.5 hours for a duration of 18-20 weeks. Typically conducted in the home.	Supported	<ul style="list-style-type: none"> Child safety Child well-being: Behavioral and emotional functioning Child well-being: Cognitive functions and abilities Child well-being: Educational Achievement and Attainment Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health Adult well-being: Family functioning
Substance Abuse Programs and Services				
Multisystemic Therapy (MST)	Youth between the ages of 12 and 17 and their families. Youth have possible substance abuse issues and are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system.	Intensive family and community-based treatment. Multiple weekly visits between the therapist and family, over an average of three to five months. Intensity of services varies based on clinical needs.	Well-Supported	<ul style="list-style-type: none"> Child permanency Child well-being: Behavioral and emotional functioning Child well-being: Delinquent behavior Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health Adult well-being: Family functioning
Cross-Cutting Programs and Services				
Motivational Interviewing (MI)	Colorado considers MI a cross-cutting intervention that can be used to promote behavior change with a range of target populations and for a variety of problem areas.	MI is typically delivered over one to three sessions, and ongoing through the life of a case. There are no minimum qualifications, and MI can be used by a variety of different professionals.	Well-Supported	<ul style="list-style-type: none"> Adult well-being: Parent/caregiver mental or emotional health Adult well-being: Parent/caregiver substance use

COLORADO INITIAL PROPOSED SERVICE ARRAY				
Program or Service	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
Mental Health Programs and Services				
Functional Family Therapy (FFT)	At-risk youth ages 11 to 18 who have been referred for behavioral or emotional problems, and their families.	Therapists spend 90 minutes face-to-face and 30 minutes over the phone with each family weekly. Average duration is three to five months.	Well-Supported	<ul style="list-style-type: none"> Child well-being: Behavioral and emotional functioning Child well-being: Substance use Child well-being: Delinquent behavior Adult well-being: Family functioning
Parent-Child Interaction Therapy (PCIT)	Children ages two to seven with behavior and parent-child relationship problems.	Typically delivered in playroom settings where therapists can observe behaviors via one-way mirror and provide verbal direction and support to caregiver. Average number of sessions is 14.	Well-Supported	<ul style="list-style-type: none"> Child well-being: Behavioral and emotional functioning Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health
High Fidelity Wraparound (HFW) *Pending approval of independent systematic review and ongoing rigorous evaluation plan	Children and youth (ages four to 17) with severe emotional, behavioral, or mental health difficulties and their families.	Typically delivered in home, foster care, or community-based organization over an average of 14 months. Engagement is more intensive in the early stages (one or more meetings per month) and decreases thereafter.	Promising	<ul style="list-style-type: none"> Adult well-being: family functioning

SERVICES PENDING EVALUATION PLAN OR FURTHER ASSESSMENT				
Trauma-Focused Cognitive Behavioral Therapy	Children and youth (ages three to 18) who have experienced trauma and their caregivers.	Includes separate and then conjoint psychotherapy sessions for child and parent. Weekly sessions over 12 to 18 weeks.	Promising	<ul style="list-style-type: none"> Child well-being: Behavioral and emotional functioning Child well-being: Social functioning Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health

COLORADO INITIAL PROPOSED SERVICE ARRAY				
Program or Service	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
Methadone Maintenance Therapy	Individuals who have an opioid use disorder, typically at least 18 years old.	Medication-assisted treatment that must be administered by clinicians in federally certified and licensed treatment programs. Includes counseling and social support services. Methadone dosage and the length of treatment vary according to needs. Most people receive methadone once per day for at least one year.	Promising	<ul style="list-style-type: none"> Adult well-being: Parent/caregiver substance use
SERVICES PENDING FURTHER EVALUATION/INDEPENDENT SYSTEMATIC REVIEW				
Colorado Differential Response (DR)	Families (with children under the age of 18) who were reported for child abuse or neglect and have a low to moderate risk of maltreatment.	Provides comprehensive case management by connecting the family with services and supports to build strengths and protective capacities. The seven key organizational processes and social work practices of DR include: support planning, group supervision, enhanced screening, solution-focused engagement skills, front-loaded services, facilitated family engagement, and RED Teams.	Pending	<ul style="list-style-type: none"> Child safety Adult well-being: family functioning Adult well-being: Parent/caregiver mental or emotional health
Colorado Community Response (CCR)	Families that have been reported for child abuse or neglect but are either screened out or have their cases closed following assessment.	Comprehensive case management services with a focus on assisting families to access concrete services, including one-time cash assistance (i.e., flex funds), by leveraging both formal systems and informal resources.	TBD	<ul style="list-style-type: none"> Child safety Adult well-being: family functioning Adult well-being: Parent/caregiver mental or emotional health



Maine

Status: Submitted

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Building a Comprehensive Prevention Service Array



The building of a comprehensive prevention service array in Maine started with the formation of an Evidenced Based Practice FFPSA Stakeholder Workgroup in conjunction with the evidenced based practices strategic priorities of OCFS' Children's Behavioral Health Services (CBHS) team. Secondary to this, an examination of Maine's child welfare and children's behavioral health data as well as Maine's existing service array was crucial to identifying gaps and opportunities. This included provider surveys, stakeholder engagement, and the creation of a state agency service inventory. Of vital importance was the engagement of parents/caregivers and youth to assess for the needs of families in Maine. The

common themes that surfaced through all of these efforts included the need for availability of, access to, and knowledge of services for families in Maine. In response to the identified needs, OCFS is utilizing an opportunity to work with other state agencies to implement a comprehensive gap analysis of service locations and needs to be conducted in the early spring of 2021. The goal of this analysis will be to identify geographical gaps as well as gaps in service needs for families for both new and existing services. This will ensure that prevention services for Maine families is strengthened. In addition, OCFS will work collectively with other state agencies to develop a Family Services Resource Guide that would be an available tool for families, service providers across Maine, and child welfare staff to meet a goal of increasing the knowledge about behavioral health and supportive services available to families in Maine.

Continuum of Prevention Services

The preparation and planning for FFPSA has provided significant insights into the gaps and need of services to support families and children in Maine, and the identification of ways that providers and state agencies can work together to address these needs was evident. Through the State Agency Partnership for Prevention and the collection of service data, a service array was identified of existing services for families in the state as demonstrated in Section 1. While the inventory is extensive, there remains gaps in services that can address the barriers to child safety. Enhancing the existing continuum of prevention services will be key to filling these gaps. Preventing the need for foster care placements begins with primary prevention and extends through tertiary prevention. While Title IV-E funds will not be utilized to fund services in primary and secondary prevention, the existence of these resources in Maine are critical to the prevention services infrastructure and are significant to the success of supporting families in Maine. OCFS will work to increase the knowledge of these services for maximum utilization.

Primary and Secondary Prevention in Maine

Primary and secondary prevention strategies include services and supports to individuals and families to prevent the initiation of a problem from occurring. Often, these strategies are implemented without direct knowledge to the recipient as the individuals receiving these services may have little to no risk factors for a given problem or they are receiving messages that support safe and healthy behaviors for all. This type of "upstream" prevention includes childcare, education, mass reach health communications, primary care, mentoring, policy changes, and information sharing. Further downstream, secondary prevention includes interventions that are provided to those who may show some risk factors and problematic behaviors. These interventions may include screening and enhanced education related to presenting risk. There are multiple primary and secondary prevention initiatives being implemented across state agencies as described in the State Agency Partnership for Prevention diagram in Section 1. Below are additional prevention strategies supported by OCFS that are essential to the continuum of prevention and implementation of FFPSA in Maine.

Statewide Prevention Councils: As mentioned in Section 1, existing legislation found in Maine statute establishes statewide Child Abuse and Neglect Prevention Councils (Prevention Councils) that align with national best practices and focus on strengthening families and the needs of children and families through primary and secondary prevention strategies. Through a contract with the Office of Child and Family Services, Maine Children's Trust (MCT) provides statewide funding, public awareness, technical assistance, leadership, coordination, and collaboration of efforts to prevent child abuse and neglect. This is accomplished through MCT's subcontracts with Prevention Councils that support their statutory role as the county-level coordinating entities to lead and deliver child abuse prevention efforts.

MCT provides a centralized data system, core programming training and technical assistance to ensure consistency in service delivery, as well as model fidelity for all Prevention Councils. Annual community needs assessments, community and advisory board input, and OCFS child maltreatment data are used to develop annual Prevention Plans that captures selected approved evidence-informed parent education, supports and strategies. Supports and services are free to community members and vary from county to county based on community identified needs. Prevention Councils use the Center for the Study of Social Policy's Strengthening Families framework to promote protective factors in families to connect to one another, learn about how their child grows and develops, how to overcome life's obstacles, how to find help, and how to help children understand their emotions. Prevention Council services include parenting support groups, playgroups, parenting education, community events, and referrals for other needed services. Prevention Councils also serve special populations and offer programming for fathers, substance-affected families, co-parenting/separated families, and prenatal families, as well as offering education in child sexual abuse prevention. Professional training in Safe Sleep, Period of PURPLE Crying, Protective Factors, and Mandated Reporting are required trainings provided by each Prevention Council. MCT will continue to provide these services to families in Maine and the increased awareness of these services for child welfare staff will be important and is planned. MCT has engaged in FFPSA planning and collaboration which will continue to ensure services are collaborative with tertiary prevention services implemented through FFPSA.

Early Childhood Mental Health Consultation: In line with primary prevention, OCFS has made significant progress in implementation of Maine's Early Childhood Consultation Partnership (ECCP) as described in Section 1 of this State Plan. By focusing such significant effort on younger children, the hope is to reduce the need for more intensive behavioral health interventions in the future. By recognizing and addressing needs early, it allows the adults around a child to form an understanding of their needs and how best to meet them both at home and in an educational setting. Parents and caregivers are able to develop coping skills and

strategies to address problematic behavior to ensure there is a consistent approach to supporting the child at home and school.

Child Care Subsidy Program: Also supporting primary prevention, OCFS implements Maine's child care subsidy program that provides support for children and their families by paying for child care that will fit the needs of the child, prepare the child to succeed in school, and also provide parents the opportunity to work, go to school or participate in a job training. This statewide program is supported through the Child Care and Development Fund (CCDF) federal block grant and provides families with a resource to strengthen the family unit on multiple levels.

Tertiary Prevention Services: Expansion through Family First Prevention Services As described in Section 1, there are multiple state agencies funding tertiary prevention services in Maine including but not limited to behavioral health treatment, recovery, vocational services, and education. Through the State Agency Partnership for Prevention, agencies have identified that the knowledge of these services and existence in rural areas of the state are gaps that can be filled through collaboration and implementation of the FFPSA. OCFS has identified opportunities to meet the needs of families through the increased knowledge and expansion of existing services in Maine. Tertiary Prevention Services through the FFPSA will include the utilization of existing programs, expansion of MaineCare funded programs, and development of new prevention programs that Title IV-E can support moving forward in the categories of Substance Use Disorder, Mental Health, and In-Home Skill Based Parenting Support services.

Substance Use Disorders Services

In Maine, the Office of MaineCare Services (the state's Medicaid office) and federal grant dollars currently fund the identified evidenced based practice on the Title IV-E Prevention Services Clearinghouse: Methadone Maintenance Therapy.

Methadone Maintenance Therapy is listed as a promising practice on the Title IV-E Clearinghouse. This is currently being implemented in Maine through funding from the Office of MaineCare Services (OMS) and is listed in rule as Medication-Assisted Treatment (MAT) with Methadone. This is a treatment program for substance use disorder that bundles assessment, planning, counseling, substance use testing, and medication administration supporting individuals through three phases of recovery including induction, stabilization, and maintenance. Medication-Assisted Treatment services assist the stabilization of symptoms of addiction and co-occurring behavioral health conditions. In collaboration with OMS, the Office of Behavioral Health (OBH) utilizes federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) to support individuals in Maine who do not have insurance or other means to pay for this level of service. There are currently (10) ten Methadone Maintenance Clinics in Maine with over 4,000 individuals enrolled in services as of August 2020.

Rationale and Proposed Implementation of Substance Use Disorder Services:

The Title IV-E Clearinghouse includes a limited number of Substance Use Disorder (SUD) prevention and treatment programs that are evidenced based, limiting the opportunities for Maine to utilize Title IV-E dollars for prevention services in this category. While OCFS will not be utilizing Title IVE dollars for the implementation of Methadone Maintenance Therapy, addressing Maine's opiate crisis is a priority for the current administration in Maine and as the data shows, a significant number of child welfare cases have substance use as a risk factor. As indicated in the Maine Opiate Strategic Plan, there are ongoing initiatives to reduce the crisis and the impact on families in Maine which includes increased access to prevention,

treatment, and recovery resources. OCFS will work collaboratively with these initiatives and through the State Agency Partnership for Prevention to ensure that all services offered in Maine are known to child welfare staff for referral and support to families through the Family Services Resource Guide. OCFS is also engaged in a most recent grant initiative through MaineCare titled Support for ME which was established under the SUPPORT Act. This planning grant aims to increase MaineCare providers' capacity to deliver Substance Use Disorder (SUD) treatment and recovery services. Currently work is being conducted to create an inventory of SUD services in Maine that will compliment and coordinate with the work of OCFS through FFPSA. In addition, OCFS intends to work with a newly created Behavioral Health and Supportive Services Workforce Stakeholder workgroup to identify training and education strategies that can be utilized to increase the knowledge and skills of Maine's behavioral health and supportive services workforce in working with families and youth impacted by SUD. Through collaboration, resource sharing, and education, the goal is to have a knowledgeable, understanding, and competent workforce to address the needs of families impacted by substance use.

Mental Health Services

There are several mental health service programs in the state of Maine that are currently being funded through the Office of MaineCare Services. Two mental health service programs historically established in rule and funded by MaineCare are Multisystemic Therapy (MST) and Functional Family Therapy (FFT.) Recently approved programs (July 2020) for MaineCare reimbursement includes Trauma Focused-Cognitive Behavioral Therapy, Incredible Years, Parent Child Interaction Therapy (PCIT), and Triple P Positive Parenting Program.

Multi-Systemic Therapy (MST) is a well-supported substance use and mental health evidenced based practice on the Title IV-E Clearinghouse. MST is defined in the current MaineCare rule as an intensive family-based treatment that addresses the determinants of serious disruptive behavior in individuals and their families. This short-term treatment approach usually takes three (3) to six (6) months and typically includes three (3) to six (6) hours per week of clinical treatment. MST therapists must be highly accessible to clients, and typically provide twenty-four (24) hour a day, seven (7) days a week coverage for clients which may include non-face-to-face and telephonic collateral contact. MST services must maintain treatment integrity and meet the fidelity criteria developed by MST Services, Inc. MST therapists must be certified by MST Services, Inc. In Maine, there are eighteen (18) MST certified therapists, with gaps in geographical coverage areas with significant wait lists in some coverage areas.

Functional Family Therapy (FFT) is a well-supported evidenced based practice on the Title IV-E Clearinghouse. MaineCare rule defines this as a family strengths-based clinical assessment and intervention model that addresses risk and protective factors within and outside of the family that impact adolescents and their adaptive development between the ages of eleven (11) and eighteen (18). FFT consists of five major components: engagement, motivation, relational assessment, behavior change, and generalization. The intervention averages eight (8) to twelve (12) sessions for mild to moderate needs and up to thirty (30) sessions for those with complex needs. FFT must meet fidelity criteria developed by FFT, LLC. FFT therapists must be certified by FFT, LLC. In Maine, there are only eight (8) FFT trained therapists

Rationale and Proposed Implementation of MST and FFT: In the past two years, OCFS has worked collaboratively with the Office of MaineCare Services to complete a rate study for MST and FFT at which time a new increased rate was established. Additionally, the reimbursement structure for these services was moved from 15-minute billing to a weekly case rate. Both MST and FFT have a limited number of therapists

certified with few areas of the state covered by this service. OCFS will not be utilizing Title IV-E dollars for the implementation of MST and FFT; however, Maine is proposing to assess the availability of these services during the service gap analysis and utilize Title IV-E dollars in year two (2) and/or three (3) of this State Plan, to expand the availability of MST and FFT in Maine (pending state match availability) through training more clinical providers in this model. Training will include an emphasis on working with families involved with the child welfare system. The increased awareness of availability of these services for child welfare staff as a resource for prevention will be a priority.

Recently Funded Mental Health Services: In August 2020, new MaineCare rules were passed to include enhanced reimbursement for Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Incredible Years, Parent Child Interaction Therapy (PCIT), and Triple P- Positive Parenting Program. This exciting development provides significant opportunity for increased access and availability of evidence-based mental health services for families in Maine who are insured by MaineCare. Ensuring child welfare staff are aware of these services will be critical.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is a promising practice under the Title IV-E Clearinghouse and was recently defined in MaineCare rule as a modality of outpatient therapy using a targeted psychotherapeutic approach that helps children and adolescents address the negative effects of traumatic stress. TF-CBT is a structured therapy model that incorporates psychoeducation, affect regulation and cognitive-behavioral techniques, coping skill development, reprocessing of traumatic memories, and family therapy. TF-CBT incorporates the opportunity for conjoint therapy with parents/caregivers and the child, in which parents and caregivers can learn about the impact of trauma on children, learn how to support positive coping and affect regulation skills in their child, develop effective communication with their child, support the child in processing traumatic memories, and enhance the child's sense of safety.

Through the collaboration between OCFS and the Children's Cabinet, the need to improve the availability and quality of TF-CBT was recognized. In the summer of 2020, OCFS funded a contract with a nationally certified TF-CBT trainer who is providing training to 123 clinicians in Maine for them to work towards become nationally certified. Clinicians are reimbursed for their time spent on the training and will receive ongoing clinical support, training, and consultation. OCFS has also worked to develop a system of tracking fidelity to the model to ensure youth and families can benefit fully from this service. There was a recent rate study that developed a specialized rate for TF-CBT as it previously reimbursed under standard outpatient services.

The Incredible Years: Some versions of The Incredible Years program are listed as a promising practice under the Title IV-E Clearinghouse and all versions have been recently approved for funding under MaineCare. MaineCare rules define The Incredible Years Series as "a set of interlocking and comprehensive training programs for parents, teachers, and children with the goals of treating aggressive behavior and disruptive behavior disorders. The program aims to prevent conduct problems, delinquency, violence, and substance use through promotion of child social competence, emotional regulation, positive attributions, academic readiness, and problem solving." The Incredible Years has five parenting programs that target key developmental stages and the appropriate program is chosen based on the developmental age of the child. Each program consists of groups of 10-14 participants and two leaders meeting weekly for two hours.

Parent Child Interaction Therapy (PCIT)- Parent Child Interaction Therapy is a well-supported mental health services program on the Title IV-E Clearinghouse. This program is defined by MaineCare as "a treatment for young children with disruptive behavior disorders that places emphasis on improving the quality of the

parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT and most of the session time is spent coaching caregivers in the application of specific therapy skills. PCIT uses a combination of behavior therapy, play therapy, and parent training to improve the parent-child relationship, and aims to teach parents/caregivers effective, positive discipline skills. PCIT is a short-term intervention, completed in approximately 14-20 sessions, depending on the needs of the child. PCIT can be used to treat behavioral problems associated with disruptive behavior disorders, aggressive behaviors, temper tantrums, negative attention seeking behaviors, and whining." Treatment is broken into two phases, each with skill building coaching sessions: Phase 1 - Child-Directed Interaction (CDI) and Phase 2 - Parent Directed Interaction (PDI). Completion of treatment is based on the parent/caregiver's mastery of CDI and PDI skills.

Triple P- Positive Parenting Program: The Triple P Positive Parenting Program is listed as a promising practice on the Title IV-E Clearinghouse and is defined in current MaineCare rule as "a parenting and family support system designed to prevent and treat social, emotional and behavioral problems in children. Triple P interventions are organized into five levels of intervention intensity and are based upon social learning, cognitive-behavioral, and developmental theories and research on risk factors associated with social and behavioral problems in children. The program aims to equip parents with the skills and confidence they need to be able to successfully and self-sufficiently manage family issues within a self-regulatory model (i.e. without ongoing support). Triple P aims to prevent problems in the family, school, and community while helping to create family environments that encourage children to reach their potential." Triple P's interventions are organized into five levels of intervention intensity in order for services to be rendered according to a family's need, time constraints, and desire for support. Each level of intervention has a choice of delivery methods to allow for flexibility to meet the needs of individuals in their communities. All interventions are considered brief, timelimited, and highly efficacious.

Mental Health Services Rationale and Plan for Implementation: As of October 2020, there were 3,372 individual children and youth waiting for behavioral health services in Maine. The number of providers in Maine available to implement these services is limited with additional barriers to access in the most rural areas of Maine. Increasing the access and availability of behavioral health services for families through FFPSA will help to fill the needs identified above. The implementation of The Incredible Years, Parent Child Interaction Therapy, and Triple P in Maine is currently limited, and a full assessment of current providers and service area needs is necessary to ensure that all families in Maine can access these services, most importantly those families meeting the candidacy criteria for prevention services. OCFS intends to build the number of providers in Maine implementing these services by using Title IV-E and state funds to train providers for these three programs. Providers would then bill MaineCare for the provision of the service. In instances where the family is not covered under MaineCare and OCFS has identified them as a candidate, state and Title IV-E funds would pay for implementation. As part of the services gap analysis described earlier, the gaps and needs for these services including TF-CBT will be determined in the spring of 2021. OCFS proposes to train new providers in July of 2021, with implementation to begin in the fall of 2021, depending on length of training needs for each program. Providers of these services must hold proper certification through the developer of the model in order to perform and bill through MaineCare. per MaineCare rule.

In-Home Skill-Based Parenting Support Services

Maine is proposing to implement two new initiatives related to in-home skill-based parenting support: Parents as Teachers and Homebuilders. Additional initiatives will be assessed as more programs become available on the Title IV-E Clearinghouse. Services.

Parents as Teachers (PAT): Parents as Teachers is a well-supported evidenced based in-homeskill based parenting support program in the Title IV-E Clearinghouse. The program is a home visiting model that works with families with children prenatally through kindergarten (ages 0 to 5) with the goals to increase parent education about child development, health, and safety, prevent child abuse and neglect, and increase school readiness for children. Currently in Maine, PAT is being implemented through a state contract between the Maine Center for Disease Control and Prevention (Me CDC) and the Maine Children's Trust to provide statewide management and administration of PAT at the community level. This is also in conjunction with the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) national home visiting initiative administered by the Health Resources and Services Administration (HRSA).

PAT is currently implemented in Maine for children ages zero (0) to three (3) via a statewide network of Local Implementing Agencies (LIAs) that are subrecipients of the Maine Children's Trust. Targeted outcomes include improved maternal and child health; prevention of child injuries, child abuse or neglect; reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime and/or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. Through this existing contract, services are being provided in all counties of the state, with some counties having wait lists for services. The current PAT model in Maine serves over 1,100 families per year. Maine Children's Trust is responsible for conducting Quality Assurance (QA) and Continuous Quality Improvement (CQI) oversight for the PAT program to ensure the program is implemented with fidelity.

Rationale and Proposed Implementation of PAT: OCFS data shows that over half the children entering foster care in Maine are ages 0 to 5 and over half the families involved in child welfare have substance use as a contributing factor. Through the use of state and IV-E federal funds as well as the existing Home Visiting infrastructure in Maine, OCFS proposes expanding the Parents as Teachers program in Maine to serve children and families up to age 5, with the goal of reaching more families in the target population for prevention. OCFS intends to work with the Maine CDC and the Maine Children's Trust to expand this program to ensure there is availability of providers to receive referrals for OCFS candidates for prevention services. Through data collection, OCFS has determined the counties in Maine with the highest number of children in care and highest number of service cases. Existing evaluation services of the PAT model in Maine have been conducted and additional data review will reveal the communities in Maine that OCFS will bolster growth in more home visitor staff. Focus groups with existing LIA was conducted in October 2020 and revealed the need to ensure data collection, referrals, and caseloads are all considered. Maine CDC, OCFS, and Maine Children's Trust have been meeting monthly to discuss implementation and LIA will be joining planning meetings in January 2021. It is expected that 200 families meeting candidacy criteria will be served by PAT through this expansion. OCFS proposes all current Home Visitor staff will be trained in the 0 to 5 model. Planning for the expansion of the program will continue to take place through the summer of 2021, with implementation of the program expansion beginning October 1, 2021.

Homebuilders: The Homebuilders program is an intensive family-based preservation service that is ranked as well-supported on the Title IV-E Clearinghouse. This program is designed to prevent the need for out-of-home placements and provides an intense amount of in-home support to families who have high risk factors in an effort to remove risk instead of removing the child from the home. The program works with families with children birth to age seventeen (17) who are involved with child welfare services. The service intensity includes 24-hour on call availability of support to families with each clinician spending an average of 40 to 50 direct contact hours with families over the course of 4 weeks. Each family receives crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy interventions through this program.

Rationale and Proposed Implementation for Homebuilders: Homebuilders is not a program that currently exists in Maine, but prior implementation of family preservation services have been successful in the past, with some lessons learned. OCFS proposes using state and Title IV-E funding to implement Homebuilders through a competitive bidding process at which time OCFS would secure an agency to implement this program statewide. Each of the eight (8) child welfare districts in the state will have one team of four (4) to five (5) practitioners and 1 supervisor. Two (2) team managers will cover three districts and one team manager will cover two (2). The goal is to have 750 families served per year through this structure. As Maine develops this program and secures additional state funding, the goal is to have additional implementation teams across the state depending on family and community needs. This will be assessed on an ongoing basis. Through the use of state funds and Title IV-E federal funds, training for new providers would take place in August of 2021 with implementation to begin October 1, 2021.

Kinship Navigator Services

While there are no specific evidenced based, Title IV-E Clearinghouse approved, Kinship Navigator programs at this time, Maine intends to continue to support kinship and foster families with state funds through a longstanding contractual relationship with the Adoptive and Foster Families of Maine, Inc. & The Kinship Program (AFFM). AFFM provides support services for all adoptive and foster parents, and kinship providers across the state through kinship specialists in the form of training, guidance, knowledge, and resources needed to handle complex issues. Kinship specialists are certified Grandfamily Leaders and can assist families in navigating an array of systems that can be difficult to manage as they provide care for the children in their homes. Referrals can be self-directed or come from public, private, faith-based, and community groups. OCFS provides AFFM with a monthly listing of all the kinship families who have received placement of a relative child who has entered foster care at which time the kinship specialist reaches out to the identified kinship families to inform them of the services available.

The Kinship Program provides respite opportunities for families through monthly support groups with onsite childcare as well as summer camperships. Referrals may be provided to other respite programs, support groups and agencies which may include but not be limited to; faith-based organizations, public assistance, mental health providers, community agencies, private agencies, food banks and state programs. Kinship specialists follow up with the family as needed over the course of a 90-day service period.

OCFS intends to continue with this partnership to support kinship and resource families in Maine and will explore additional evidenced based kinship navigator programs as they become available on the Title IV-E

Clearinghouse. At this time, no Title IV-E dollars will be used to support existing kinship navigator supports.

Below is a graph depicting the Prevention service array that Maine is proposing to implement through the use of both state and Title IV-E funds.

Evidence Based Service	Target Age	Rating IV-E Clearinghouse	Funding Details	Implementation
Substance Use Disorder Services				
Methadone Maintenance Therapy	Age 18+ Under 18 consent	Promising	-MaineCare funds service delivery. -Funded by Federal Grant Funds and State Funds for uninsured.	Office of Behavioral Health provides oversight of programs and payment for those not covered by MaineCare.
Mental Health Services				
Functional Family Therapy (FFT)	11-18 years old	Well-Supported	-MaineCare funds service delivery. -Future consideration of Title IV-E and State General Funds for expansion.	Consider expansion of providers in Maine through assessment of geographical and population needs in year 3 of this 5-year plan.
Multisystemic Therapy (MST)	12-17 years old	Well-Supported	-MaineCare funds service delivery. -Future consideration of Title IV-E and State General Funds for expansion.	Consider expansion of providers in Maine through assessment of geographical and population needs in year 3 of this 5-year plan.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	5-17 years old	Promising	-MaineCare funds service delivery. -State funds supported training.	123 Providers in Maine were trained in 2020 and are completing certification.
The Incredible Years	4-8 years old	School Aged & Toddler Basic: Promising	-MaineCare funds service delivery. -IV-E and State General Funds- to fund training for child welfare cases.	Expand providers in Maine through assessment of geographical and population need to serve child welfare cases.
Parent Child Interaction Therapy (PCIT)	2-7 years old	Well-Supported	-MaineCare funds service delivery. -IV-E and State General Funds- to fund training for child welfare cases.	Expand providers in Maine through assessment of geographical and population need to serve child welfare cases.
Triple P- Positive Parenting Program	0-16 years old	Promising (some models)	-MaineCare funds service delivery. -IV-E and State General Funds- to fund training for child welfare cases.	Expand providers in Maine through assessment of geographical and population need to serve child welfare cases.
In Home Parent Skill Building Services				
Parents as Teachers (PAT)	0-5 years old	Well-Supported	-Title IV-E and State General Funds to fund service delivery and training.	Currently PAT is provided through MIECHV (0-3). Expand service delivery to serve 0-5.
Homebuilders	0-18 years old	Well-Supported	-Title IV-E and State General Funds to fund service delivery and training.	Development and implementation of this new program statewide.
Kinship Navigator Services				
No programs are being proposed at this time.	N/A	None	-Use of IV-E and State General Funds to fund in the future.	Once evidenced based Kinship Navigator Services are identified, Maine will explore implementation through IV-E.

Oversight and Monitoring of Prevention Services

Services funded under MaineCare are provided by certified professionals in agencies licensed by the State of Maine. Through site visits, agencies are monitored to ensure compliance with licensing rules. For services procured by the State of Maine, performance measures are incorporated into contracts and monitored by state staff to ensure that services are implemented as purchased. Program fidelity of services that are implemented as part of the FFPSA will be evaluated and discussed in Section 7.

OCFS will continue to monitor the Title IV-E Clearinghouse for future opportunities to expand Maine's service array in an effort to continue to support families and prevent the need for out of home placement. Along with this monitoring will be ongoing data analysis to ensure that the services selected are meeting the needs of families in Maine.

Trauma Informed Care

In 2003, Maine implemented a System of Care grant at which time the THRIVE initiative began in Maine. This initiative was dedicated to improving community responses to families, youth and trauma survivors through the integration of trauma knowledge and system of care principles in service systems. While the grant has since ended, through this project, significant resources and supports were developed to assist agencies in becoming trauma informed. This included several trainings and webinars along with the development of a Guide to Trauma Informed Organizational Development as well as a Trauma Informed Care Agency Assessment Tool. The Guide to Trauma-Informed Organizational Development is designed to help agencies develop strategies to create and enhance trauma-informed system of care service approaches. It is not all inclusive, nor is it intended to be a "one size fits all" approach to becoming trauma informed. The intent is to provide agencies with information on the options and approaches currently available in the children's mental health field on trauma informed service delivery. The Trauma Informed Care Agency Assessment Tool scores agencies on six key domains of the traumainformed approach including: Physical and Emotional Safety; Youth and Family Empowerment, Choice and Control; Trauma Competence; Trustworthiness; Commitment to Trauma-informed Approach; and Cultural Subpopulations and Trauma. Each of these domains has a set of standards associated with it which is assessed through the questions in the tool. The purpose of the assessment is to improve the entire system that is dedicated to meeting the mental health needs of Maine's youth and families. Agency staff, parents, and youth all complete the tool and answers are aggregated to develop an agency profile. This profile is used to identify areas where the agency is doing well, and to guide next steps for making agency improvements. This tool was once a mandatory practice for all programs contracting with OCFS but due to the grant ending and a lack of resources to support the continued use of the tool, the mandate was dissolved.

Through the FFPSA initiative in Maine, as well as a newly acquired Systems of Care grant described in Section 1, OCFS intends to resume the required use of these tools to help agencies assess current practice and make changes based on the assessment results. Through the utilization of these tools and collaboration with the System of Care (SOC) grant, a Trauma Informed Care Agency Guide will be created that includes an updated list of recommended resources to assist agencies with building a trauma informed system of care. The Trauma Informed Care Agency Assessment Tool will become required of all behavioral health and in- home supportive services providers contracted with OCFS on an annual basis through incorporation into the Medicaid rule.

In addition, OCFS will be convening a Trauma Informed Care workgroup beginning in February 2021 that will include OCFS staff, other state agency partners, and community members to work towards developing additional tools and resources that align with the SOC grant and FFPSA. OCFS also intends to continue collaboration with other community and state programs focusing on trauma and resilience including but not limited to the Maine Resilience Building Network (MRBN), an agency with a mission to promote resilience in all people by increasing the understanding of the impacts of Adverse Childhood Experiences (ACEs) and the importance of building resilience through protective factors. MRBN network meetings, trainings, and professional development opportunities support OCFS efforts for trauma informed cultures.



Oregon

Status: Submitted

Section III: Title IV-E Prevention Services (Service Description and Oversight)

Section 3: Title IV-E Prevention Services Description and Oversight Service Description and Selection Process

Eligibility for federal reimbursement requires prevention services in the categories of mental health, substance use disorder treatment and in-home parenting skills to be evidence-based, trauma-informed and rated as "promising," "supported" or "well-supported" by the title IV-E Prevention Services Clearinghouse.

To ensure the selection of evidence-based practices (EBPs) and prevention services for the Family First Prevention Plan match the needs of the identified candidacy populations, Oregon used data and qualitative information to:

- Map and assess the scope, quality, and volume of Oregon's existing service array relevant to Family First (i.e., parenting, substance use disorder, and mental health services)
- Identify specific EBPs within the current service array that might align with the needs of the candidacy population
- Conduct a gap analysis and recommend additions to the service array that will fill unmet needs of children and families identified as candidates, and
- Address barriers and identify strategies for procuring or scaling the service array to meet needs

In assessing the needs of the six candidacy populations described in Section 2, Oregon identified several subgroups of children whose needs should be further differentiated and/or prioritized to assist in the process of service matching. These subpopulations, which also include the service needs of children's parents, are:

- Children 0-5 years old
- Children 6-12 years old
- Children whose parents have a substance use disorder
- Children whose parents have intellectual and developmental disabilities, and
- African American, American Indian/Alaska Native and Latinx children

These subpopulations of children and families were selected because they may require a specialized type of service model due to their age or demonstrated need for culturally responsive, culturally-specific or specialized services. The needs of African American, American Indian/Alaska Native and Latinx families and parents with intellectual and developmental disabilities are disproportionately represented in the Child Welfare population and may require a specialized service array to meet their needs. Additionally, children whose parents have a substance use disorder have a significant need for prevention services because parent/caregiver drug or alcohol use is the single highest family stressor identified in a founded CPS allegation for children removed from home.

After considering all the options, Oregon has selected the four EBPs in Table 4 below for title IVE claiming in the initial phase of implementation.

	Service, Description & Version	Target Population	Title IV-E Clearinghouse Rating	Intended Outcomes	Rationale for Selection
Mental Health	<p>Parent-Child Interaction Therapy (PCIT) is a dyadic therapy that serves parents and children together to meet the parenting needs of the caregiver and improve the child's behavioral functioning. It is administered in an office setting where a therapist monitors parent and child interactions through a two-way mirror and communicates with the parent via a wireless communication device.</p> <p><u>Version:</u> Eyberg, S. & Funderburk, B. (2011). <i>Parent-Child Interaction Therapy Protocol: 2011</i>. PCIT International, Inc.</p>	Children 2-7 and their parents/ caregivers	Well-supported	<ul style="list-style-type: none"> • Improved child behavioral and emotional functioning • Improved child social functioning • Increased positive parenting practices • Improved parent/caregiver emotional and mental health • Improved family functioning 	PCIT was selected because it is designed to meet the needs of caregivers with young children who have emotional and mental health needs. Oregon has significant infrastructure for training and expansion of this service, including an annual PCIT conference hosted in Oregon. PCIT is also culturally responsive and can be provided in multiple languages. It has demonstrated similar outcomes with parents who are impacted by intellectual and/or developmental disabilities.
	<p>Functional Family Therapy (FFT) is an intervention directed at adolescents who have behavioral and conduct needs. It combines individual and family interventions to address behavioral health needs for youth and positive parenting capabilities for families and caregivers. It is especially effective for youth who have been, or are at risk of, being involved with the juvenile justice system.</p> <p><u>Version:</u> Alexander, J.F., Waldron, H.B., Robbins, M.S., & Neib, A.A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i>. Washington, D.C.: American Psychological Association.</p>	Children 11-18	Well-supported	<ul style="list-style-type: none"> • Improved child behavioral and emotional functioning • Decreased child substance use • Decreased child delinquent behavior • Increased positive parenting practices • Improved family functioning 	FFT was selected because it is expected to prevent the need for foster care placement for families seeking support and intervention for youth with behavioral health needs. FFT may divert youth from both juvenile justice and child welfare involvement. Oregon currently has some juvenile departments that utilize Functional Family Probation for youth on formal probation. Functional Family Probation is compatible with FFT, which will allow for continuity of services within local systems.

EBPs of Interest for Future Phases of Implementation

Oregon has also identified several EBPs of interest for future phases of implementation, as listed in Table 5 below. Although not on the list of EBPs that are eligible or likely eligible to receive title IV-E prevention funding in the near future, this list includes a number of culturally specific EBPs, Oregon Tribal Best Practices and other specialized services that Oregon has identified as being effective in addressing racial disparities and/or the needs of underserved, vulnerable populations. Those populations include African American, American Indian/Alaska Native and Latinx families, and parents with intellectual and/or developmental disabilities. Because these services and practices meet such critical needs in Oregon, they have been included in the Prevention Plan and will be an integral part of Oregon's larger prevention service array regardless of when eligibility for title IV-E funding occurs.

Table 5. EBPs of interest for future phases of Oregon's prevention transformation

	Service & Description	Target Population	Title IV-E Clearinghouse Rating
Mental Health	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) uses a cognitive behavioral approach to treat children and adolescents who have experienced severe trauma. TF-CBT focuses on building the youth's self-regulation skills and the parent's behavior management and supportive care abilities. It combines with other interventions and treats severe trauma which, in turn, reduces severe externalizing behaviors.	Children 3-18 and their parents/caregivers	Promising
	Parents Anonymous is a largely peer-driven program that supports caregivers in their substance abuse treatment while also helping them to maintain children in the home. It seeks to build on family strengths and enhance well-being by increasing protective factors through trauma-informed practices.	Children 0-18 and their parents/caregivers	Pending review
	Parent Management Training Oregon (GenerationPMTO) is an intensive in-home parent training service that focuses on strengthening families at all levels by promoting parenting and social skills.	Children 2-18 and their parents/caregivers	Pending review
Substance Use	Sobriety Treatment and Recovery Teams (START) is a family-based intervention that maintains an in-home placement while supporting a parent's recovery needs. This intervention relies heavily on peer support and system navigation to ensure that families access the appropriate services and remain engaged.	Children 0-5 and their parents/caregivers	Promising
	FAIR (Families Actively Improving Relationships) is a treatment individualized to fit the unique circumstances and needs of families presenting with opioid, methamphetamine, and other substance use disorders. FAIR clinicians coordinate with child welfare staff to ensure that parents are meeting their treatment plan goals. FAIR matches well with GenerationPMTO, which is included as an in-home parent skill-based intervention for future implementation.	Children 0-18 and their parents/caregivers	Not yet selected for review
Oregon Tribal Best Practices			
	Tribal Youth Conference is an alcohol- and drug-free gathering of tribal youth. Examples include Westwind Youth Gathering and He He Gathering.	American Indian/Alaska Native adolescents	Not yet selected for review

	Service & Description	Target Population	Title IV-E Clearinghouse Rating
In-Home Parent Skill-Based	Healthy Families America (HFA)/Healthy Families Oregon (HFO) is a home visiting program that aims to cultivate and strengthen nurturing parent/child relationships, promote healthy childhood development, and enhance family functioning by reducing risk factors and building protective factors.	Children prenatal – 5 and their parents/caregivers	Well-supported
	Nurse-Family Partnership (NFP) is a home visiting service provided by trained nurses to support individualized goal setting. It emphasizes preventative health practices, parenting skills and educational/career planning, and includes regular in-home work to develop strong parent/child relationships.	Children prenatal – 2 and their parents/caregivers	Well-supported
	Youth Villages – Intercept is an intensive in-home service that focuses on stabilizing home living situations by addressing both behavioral health and family system needs. The model includes 24-hour crisis supports, skills training and therapeutic interventions to address treatment goals and home stability.	Children 0-18 and their parents/caregivers	Supported
	Parent Management Training Oregon (GenerationPMTO) is an intensive in-home parent training service that focuses on strengthening families at all levels by promoting parenting and social skills.	Children 2-18 and their parents/caregivers	Pending review
	Self Enhancement Model (SEM) is a community partnership that works with African American families to provide skill development services in a culturally appropriate manner. This program also focuses on educational and mentor relationships to help African American adolescents develop skills to meet their own needs.	African American adolescents and their parents/caregivers	Not yet selected for review
	Make Parenting a Pleasure (adapted) is a comprehensive curriculum designed to strengthen parenting skills and provide support to highly stressed parents.	Children 0-8 and their parents/caregivers who have cognitive limitations	Not yet selected for review
	Community Healing Initiative (CHI) is a community-centered model that uses culturally-appropriate targeted supervision, intervention and prevention strategies for Latinx families with probation youth. A Youth, Family and Community Team plans and implements activities focused on positive youth development, family support and community protection.	Latinx adolescents and their parents/caregivers	Not yet selected for review
	Sobriety Treatment and Recovery Teams (START) is a family-based intervention that maintains an in-home placement while supporting a parent's recovery needs. This intervention relies heavily on peer support and system navigation to ensure that families access the appropriate services and remain engaged.	Children 0-5 and their parents/caregivers	Promising

	Service, Description & Version	Target Population	Title IV-E Clearinghouse Rating	Intended Outcomes	Rationale for Selection
Cross-Cutting	<p>Motivational Interviewing (MI) is a method of counseling that is designed to promote behavioral change and to improve physiological, psychological and lifestyle outcomes by identifying ambivalence and increasing motivation to change. MI can be applied to many different treatment settings and can be implemented as part of casework practice. This practice can also be integrated within other service models as a driving curriculum.</p> <p><u>Version:</u> Miller, W.R. & Rollnick, S. (2012). <i>Motivational Interviewing, Third Edition: Helping People Change</i>. New York: The Guilford Press.</p>	Adolescents and parents/caregivers	Well-supported	<ul style="list-style-type: none"> Enhanced internal motivation to change Increased family engagement and retention in services Decreased substance use disorder 	MI was selected because it is an easy model to access and can be added to existing services to improve outcomes. It has also demonstrated effectiveness in meeting the needs of caregivers with substance abuse treatment needs and can be integrated with casework practice models.
In-Home Parent Skill-Based	<p>Parents as Teachers (PAT) is a curriculum that has demonstrated ability to assist parents in developing positive parenting skills. It aims to increase parent knowledge of early childhood development and prevents child maltreatment by improving parenting practices. PAT ensures early healthy childhood development and promotes early detection of developmental delays.</p> <p><u>Version:</u> Depending on the ages of children in the families served, <i>Foundational Curriculum</i>. Parents as Teachers National Center, Inc. (2016) and/or <i>Foundational 2 Curriculum: 3 Years Through Kindergarten</i>. Parents as Teachers National Center, Inc. (2014) will be used.</p>	Children prenatal – 5 and their parents/caregivers	Well-supported	<ul style="list-style-type: none"> Reduced children maltreatment Improved child social and cognitive functioning Improved child physical health and development Increased positive parenting practices Improved family functioning 	PAT was selected because the curriculum can be applied to existing prevention services that Oregon has already invested in and there is broad capacity for expansion of this service in Oregon. In addition, the PAT curriculum has a demonstrated impact on improving outcomes for families at risk of child welfare involvement. It is culturally responsive and has shown effectiveness with non-white populations.

Oregon Tribal Best Practices		
Family Spirit is a culturally-specific home visiting service for mothers and their young children living in tribal communities. This program seeks to meet cultural and parenting needs by engaging participants in a culturally-appropriate manner to ensure positive parenting and healthy child development.	American Indian/Alaska Native children prenatal – 3 and their mothers	Pending review
Positive Indian Parenting is an eight-session course for tribal families that focuses on culturally-specific traditions and values and connects with modern parenting skill development.	American Indian/Alaska Native children and their parents/caregivers	Not yet selected for review

	Service & Description	Target Population	Title IV-E Clearinghouse Rating
	Trauma Recovery and Empowerment Model (TREM) is a fully manualized 24- to 29-session group intervention for women who have survived trauma and have substance use and/or mental health conditions. This model draws on cognitive-behavioral, skills training and psychoeducational techniques to address recover and heal from abuse.	Women who have a history of sexual, physical and/or emotional abuse	Not yet selected for review
	Canoe Journey – Family teaches and role models proper etiquette and tribal values associated with the tradition of canoe carving and paddling as a basic element of survival for tribal communities.	American Indian/ Alaska Native children and their parents/caregivers	Not yet selected for review
	Ceremonies and Rituals that are important to the traditional and spiritual beliefs of tribal communities.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Cradle Boards focuses on a strategy of returning back to traditional ways by returning the baby "back to their backs" using a form of a cradleboard indigenous to the tribal community in order to reduce incidents of SIDS (sudden infant death syndrome) and the use of alcohol and drugs, including tobacco.	American Indian/ Alaska Native children prenatal – infancy and their parents/ caregivers	Not yet selected for review
	Cultural Camp are summer culture camps for tribal students that include gender specific activities. Examples of activities include rite of passage; Elders and storytelling; and instruction in berry picking, fishing, bead work, arts and crafts, carving, drumming, singing, dancing, stick games, native language, canoe building, archery and horseback riding.	American Indian/ Alaska Native adolescents	Not yet selected for review
	Domestic Violence Group Treatment for Men is a program is designed for men over the age of 18 who have a record of violent behaviors and are court ordered or referred by child welfare for treatment. It includes tribal practices like smudging and peace pipe led by Elders.	American Indian/ Alaska Native adult men	Not yet selected for review
	Family Unity empowers tribal families by defining their strengths, thus creating a support system that promotes self-sufficiency and leads to positive and healthy lifestyle choices. The family's needs are identified with all supporting family members and service providers together and everyone is clear about what needs to be done in order to meet the strengths and needs of the family.	American Indian/ Alaska Native adolescents and their parents/ caregivers	Not yet selected for review
	Healthy Relationship Curriculum is a tribal-based curriculum to help build healthy relationships within a community. The program includes eight subject chapters with teachings, activities, icebreakers and stories.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Native American Community Mobilization focuses on the mobilization of a community or building of a coalition to: SEE what is happening in your community (data collection and assessment), FEEL by acknowledging and taking ownership of what you are seeing (capacity building), THINK by taking what you SEE and FEEL into a plan of action (planning), and DO by putting your plan into action (performing and implementation).	American Indian/ Alaska Native children and adults	Not yet selected for review
	Powwow is a tribal celebration of drumming, dancing and singing in a safe and drug- and alcohol-free environment to build community, <small>multiple identities and orientations</small>	American Indian/ Alaska Native children and adults	Not yet selected for review

	Service & Description	Target Population	Title IV-E Clearinghouse Rating
	Tribal Crafts give community members the opportunity to create a craft under the supportive supervision and instruction of knowledgeable instructors including youth, adults, community leaders and elders.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Tribal Family Activities are alcohol- and drug-free family and community gatherings that are promoted by all nine Oregon Tribes at various times throughout the year, especially during traditional food gathering seasons.	American Indian/ Alaska Native children and adults	Not yet selected for review
Oregon Tribal Best Practices			
	Adventure Based Practices provides organized outdoor activities for both prevention and treatment programs. Most common examples are kayaking trips, rope courses, skiing trips and whitewater rafting.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Horse Program improves attitudes, behavior, mood management, sense of responsibility, communication and relationship skills in partnership with horses, tribal youth and families. Regular individually mentored and small group sessions include equine care, ground work and riding training sessions.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Native American Storytelling is the purposeful use of learning and retelling stories for reconfiguration of an individual or group life condition through metaphysical meanings within traditional and personal story telling. Storytelling enables the listener to learn and apply things that have happened or may happen.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Round Dance is an alcohol- and drug-free one-day traditional community-wide ceremony.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Sweat Lodge ceremonies promote renewal and return to traditional healing methods.	American Indian/ Alaska Native children and adults	Not yet selected for review
	Talking Circle is a culturally-based spiritual discussion and support group.	American Indian/ Alaska Native children and adults	Not yet selected for review

Trauma-Informed Framework

In 2019, ODHS implemented policy establishing standards and expectations as a traumainformed organization. This included a commitment to building resiliency in agency staff and interacting with service recipients and one another in a way that is aware of and responsive to the impact of trauma in the lives of individuals. This trauma-informed policy and its related training, tools and resources created a framework to guide ODHS in becoming a traumainformed organization. It also set minimum requirements for all staff training and standards for all ODHS programs including Child Welfare and Self-Sufficiency, the state agency responsible for cash assistance programs.

Consistent with Oregon's Child Family Service Plan (CFSP) 2020-2024, trauma-informed practice and service-delivery has been interwoven into many practices, services, policies and training opportunities in Child Welfare. Some of the core impacts are:

- Creating safety
- Creating trustworthiness and transparency
- Providing peer support • Promoting collaboration and mutuality
- Promoting empowerment, voice, and choice
- Attending to cultural, historical, and gender issues
- Addressing secondary trauma for the workforce, and
- Trauma-informed practices

Oregon is mobilizing to ensure anti-racist and anti-bias knowledge and training is a foundational component of trauma-informed practice. Oregon plans to use trauma-informed, gender specific or non-conforming, and culturally responsive engagement skills when addressing the needs of children and young adults.

In the process of considering EBPs for the Prevention Plan, a key requirement for selection was that the service model itself had a trauma-informed approach. Oregon has ensured that the training models and curriculum for

each selected EBP included trauma-informed elements throughout. Providers will be expected to implement all EBPs to fidelity which will include monitoring of trauma-informed elements in the practice.

In the initial phase of implementation, Oregon will build contract requirements for anti-bias and anti-racist and trauma-informed service delivery. Contracting processes will require each EBP provider to have policy and implement training on trauma-informed care that they will be required to report on. Through system partners, like Trauma informed Oregon (<https://traumainformedoregon.org/>), Child Welfare has access to training resources that can be leveraged to increase providers' competence to deliver trauma-informed care.

Implementation Plan

In considering which EBPs to prioritize for title IV-E claiming during the initial phase of implementation, in addition to alignment with the needs of our candidacy populations, Oregon conducted an achievability and impact analysis. This analysis rated each of the EBPs under consideration either high or low for its achievability in terms of implementation and potential impact.

- EBPs with high achievability were those that: (1) are likely to qualify for an evaluation strategy waiver because of the strength of their evidence, (2) possess existing fidelity and outcomes metrics by the proprietor or developer, and (3) already include a robust in-state infrastructure, including resources to collect and share fidelity and outcomes information.
- Taking into account considerations of equity and culturally-responsive services, EBPs with high impact were those that: (1) already have the potential to serve a large number of families, (2) cover a significant geographic area in Oregon, and (3) include a broad intervention target population relative to the candidacy populations.

This framework guided the selection of the initial four services for Oregon's Prevention Plan: Parent Child Interaction Therapy (PCIT), Parents as Teachers (PAT), Functional Family Therapy (FFT) and Motivational Interviewing (MI). Oregon looks forward to adding more services through amendments to the Prevention Plan using a similar framework to guides our understanding of alignment with needs, achievability and fit.

The four selected interventions differ in terms of their level of existing or planned implementation as follows:

- PCIT is already a well-established intervention in Oregon, with 66 service providers in 23 of the state's 36 counties. Oregon plans to scale up PCIT to serve additional eligible families via the Prevention Plan.
- PAT is currently offered by three official affiliates and the Prevention Plan offers an opportunity to establish new sites in additional locations.
- FFT is authorized in four sites which serve urban, rural, and quasi-rural areas. These sites have been primarily serving a juvenile justice population and Oregon will be working with them to expand upstream into the community to reach the prevention model. In addition, Oregon will be working with the FFT organization to expand FFT authorized sites based on community need, community readiness and community providers' ability to reach the authorized service level.
- MI is used by many therapists and practitioners as well as by ODHS staff. Oregon's intention is to standardize the use of MI to fidelity within existing contracts for Strengthening, Preserving and Reunifying Families (SPRF) and In-Home Safety and Reunification Services (ISRS). In particular, Oregon wants to use MI as an adjunctive service for families with substance use disorder and mental health issues to support their engagement in preservation services.