



Nebraska's Five-Year Title IV-E Prevention Program Plan

2020

(3rd edition)



Table of Contents

ACRONYMS & TERMS	5
INTRODUCTION	7
CONSULTATION AND COORDINATION	10
Consultation with Other Agencies to Develop Continuum of Care	10
Family First Prevention Service Coordination with Other IV-B Plan Services	13
SERVICE DESCRIPTION AND OVERSIGHT	14
Nebraska's Landscape	14
Definition of Candidacy	15
Assessing Children and their Parents for Eligibility	17
Program Selection	17
Nebraska Title IV-E Prevention Services Chart	21
In-Home Parenting Skills Programs	24
Program 1: Healthy Families America	24
Program 2: Homebuilders: Intensive Family Preservation and Reunification Services	26
Program 3: Motivational Interviewing	26
Program 4: Parents as Teachers (PAT)	27
Behavioral Health Programs (Mental Health and Substance Abuse)	28
Program 5: Family Centered Treatment	28
Program 6: Functional Family Therapy	30
Program 7: Multisystemic Therapy	31
Program 8: Parent-Child Interaction Therapy	31
Program 9: Trauma-Focused Cognitive Behavioral Therapy	32
Improved Outcomes for Children & Families	32
Eastern Service Area Ongoing Case Management Contractor	33
Continuous Quality Improvement	34
EVALUATION STRATEGY	45
Evaluation Intent and Approach	45
Ability to Conduct an Evaluation of Prevention Programming	45
EVALUATION WAIVER	45
Evidence of Effectiveness	45
CHILD WELFARE WORKFORCE SUPPORT	51
CHILD WELFARE WORKFORCE TRAINING	54
MONITORING CHILD SAFETY	58
PREVENTION CASELOADS	59
ASSURANCE ON PREVENTION PROGRAM REPORTING	60
FUTURE PLANNING	60
STATE CONTACT	61
ATTACHMENTS	62
Attachment A: CFS Standard Work Instruction for Foster Care Prevention Plan	63

Attachment B: Draft Nebraska Evidence-Based Programs	78
Attachment C: Healthy Families America Protocols for Working with Child Welfare Families	88
Attachment D: Letter from Family Centered Treatment (FCT) Foundation's Executive Director	89
Attachment E: Research Publications, Independent Reports and Published Articles Regarding FCT 2004-2019	100
Attachment F: Independent Review of Family Centered Treatment (ACYF-CB-PI-19-06)	107
Attachment G.1: Signed Conflict of Interest Statement from The Stephen Group (FCT Independent Review)	144
Attachment G.2: Signed Conflict of Interest Statement from MEF Associates (FCT Independent Review)	145
Attachment H: Evaluation Strategy	146
Attachment I: N-MIECHV 2019 CQI Plan	195
Attachment J: N-MIECHV User Friendly Benchmark Plan	210
Attachment K: CFS Standard Work Instruction for Mandatory Monthly Visits	213
Attachment L: CFS Standard Work Instruction - Initial Assessment	220
Attachment I: State Title IV-E Prevention Program Reporting Assurance	231
Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice	232
Attachment III: State Assurance of Trauma-Informed Service-Delivery	239
Attachment IV: State Annual Maintenance of Effort (MOE) Report	240

PLAN VERSION HISTORY

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ACRONYMS & TERMS

BH	Division of Behavioral Health
CAN	Child Abuse and Neglect
Case Manager	CFS Child & Family Services Specialist (CFSS)
CEBC	California Evidence-Based Clearinghouse ¹
CFS	Division of Children & Family Services
CFSP	Child & Family Services Plan ²
CQI	Continuous Quality Improvement
Department	Nebraska Department of Health & Human Services
EBP	Evidence-Based Practice
FCT	Family Centered Treatment
FCPP	Foster Care Prevention Plan
FFPSA	Family First Prevention Services Act
Federal Clearinghouse	Title IV-E Prevention Services Clearinghouse ³
FFT	Functional Family Therapy
HFA	Healthy Families America
HRSA	Health Resources and Services Administration
ICCTC	Indian Country Child Trauma Center
IFP	Intensive Family Preservation
IHFS	In-Home Family Support
LIA	Local Implementing Agency
N-MIECHV	Nebraska Maternal, Infant & Early Childhood Home Visiting ⁴
MI	Motivational Interviewing
MST	Multisystemic Therapy
OJJDP	U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention
PAT	Parents As Teachers
PCIT	Parent-Child Interaction Therapy
PH	Division of Public Health
PIP	Performance Improvement Plan
Plan	Nebraska's Five-Year Title IV-E Prevention Program Plan
PPI	Provider Performance Improvement
RFP	Request for Proposal

¹ <https://www.cebc4cw.org/>

² <https://www.acf.hhs.gov/cb/programs/state-tribal-cfsp>

³ Title IV- E Prevention Services Clearinghouse was established by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS); <https://preventionservices.abtsites.com/>

⁴ <http://dhhs.ne.gov/Pages/MIECHV-Programs.aspx>

RFQ	Request for Qualifications
SDM®	Structured Decision Making
SFA	Strengthening Families Act
SOP	Safety Organized Practice
SOC	Society of Care
SACWIS	State Automated Child Welfare Information System
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

INTRODUCTION

The Nebraska Department of Health and Human Services mission is to “Help people live better lives.” The vision of the Division of Children & Family Services (CFS) includes utilizing the Family First Prevention Services Act to improve prevention services and remove fewer youth from the parental home, while providing more comprehensive, evidence based services to children in their own homes, with their family, with reduced levels of secondary trauma. Families will progress more efficiently and more timely within the child welfare system.

CFS is focused on retention of staff to ensure staff feel supported and satisfied, while continuing to be proficient at their work. CFS staff seek to engage the family to ensure the family and youth voice and choice is heard and understood, and that families will have the same case worker through the life of the case as often as possible. To achieve this vision, CFS efforts to improve collaboration, information sharing, continuity, and performance within CFS, with the families served, and all parties within the Nebraska child welfare system.

To help people live better lives, CFS will employ the Family First Prevention Services Act (FFPSA) to grow and improve prevention services for families, providing comprehensive, evidence-based services to children in their own homes, with their family, with reduced levels of secondary trauma. This will include the use of family voice and family choice and increase in parental protective factors, while ensuring the safety, permanency and well-being of Nebraska’s children remains our #1 priority; valuing and respecting the children and families served; valuing partnerships with our stakeholders; and achieving measurable outcomes.

To ensure successful implementation of CFS’s vision, Nebraska is using three documents to guide the next five years of the child welfare system: the approved Children and Family Services Review (CFSR) Performance Improvement Plan (PIP), the approved Child and Family Services Plan (CFSP) and the approved Family First Prevention Services Plan. These three documents encompass goals, strategies, anticipated timelines, and measures of progress directed to move the whole system forward. Highlights to enact CFS priorities from the combined plans are below:

Activities for Year 1 and 2:

- Refer to goals and strategies identified in the CFSR PIP aimed at continuous quality improvement.
- CFS will begin implementation of the Family First Prevention Services Act. Refer to this FFPSA Five Year Plan for prevention services details.
- Nebraska will have at least one Qualified Residential Treatment Program (QRTP) in accordance with FFPSA requirements.
 - Implementation supports will include: partnerships with congregate care providers, court officials, Court Improvement Project, the Division of Behavioral Health (BH), the Division of Medicaid and Long-Term Care

and Managed Care Organizations; training for DCFS case managers and court officials; changes to NFOCUS to build in logic for claiming IV-E accurately; regular and ongoing communication with stakeholders to address concerns and celebrate successes.

Activities for Year 3:

- Review data from NFOCUS and follow a continuous quality improvement framework to evaluate the implementation of FFPSA. Share data with CFS case workers, supervisors, administrators, and external stakeholders, including families, to receive various perspectives and feedback on the first two years of implementation of new evidence based practices (EBP). Create an ongoing plan for improvement in FFPSA implementation and sustainability of the new service array in collaboration with stakeholders.
- Re-submit Nebraska's Five-Year Title IV-E Prevention Program Plan (Plan) to federal partners with any necessary or identified changes.

Activities for Year 4 and 5:

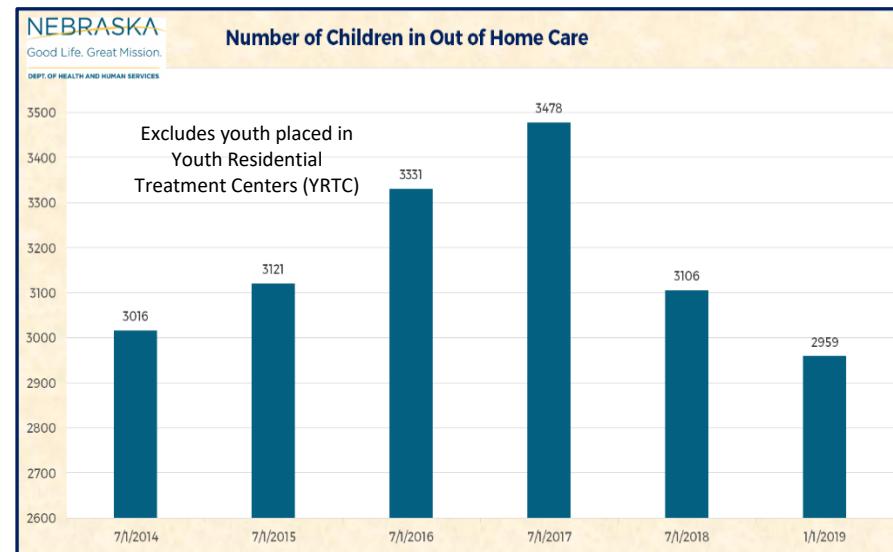
- Continue FFPSA implementation and make modifications as necessary, based off of internal and external feedback.
- Nebraska will have Qualified Residential Treatment Programs available to meet the needs of youth eligible for this treatment.
 - Implementation supports will be similar to supports identified in the activities for years one and two.

In these activities, child safety will be a top priority. All CFS goals enhance families' protective capacity and assist families in keeping children safe. CFS utilizes Structured Decision Making® (SDM®) as an evidence based practice tool. By providing CFS Supervisors with advanced SDM training, supervisors have increased critical thinking skills. As Nebraska has focused on improved practice, CFS has implemented the practice of Safety Organized Practice® (SOP®). Through the use of SOP®, CFS Specialists will have increased knowledge and skill in engaging families. The more engaged a family is in a service, the higher the probability of being successful. Partnerships with families and other stakeholders are valued by regular and ongoing communication and conversation. When families are respected and are responsible for the development of their service plans, families are engaged and child safety is increased.

CFS works for a system focused on reducing entry into foster care and improved child and family well-being. With the implementation of evidence based mental health, substance abuse and in-home parenting practices, families and children will receive effective services that meet their identified needs. A focus on CFS workforce stability ensures staff receive interventions to mitigate vicarious trauma which lessens the number of case workers a family has and increases child safety and permanency.

Over the past several years, CFS has committed to a cultural shift that focuses on serving families through *prevention* rather than *intervention*.

From 2017-2019, CFS safely reduced the number of children in out-of-home care by 15%. Further, for children in out-of-home care since 2014, CFS has increased use of relative/kinship resource homes by 12% and decreased congregate care



placements by almost 3%. Implementation of Family First Prevention Services Act (FFPSA) will help further the Nebraska's efforts to serve more families in the home with improved preventative and evidenced-based programs.

Implementation of FFPSA aligns with Nebraska's *Performance Improvement Plan (PIP) Goal #5*, which is to enhance current service array to ensure appropriate and individualized services are accessible. As noted in the Nebraska PIP, *Item 29: Array of Services*, families in rural and frontier areas of the state face a lack of social service resources. Access to substance abuse and specialized mental health services are notable challenges, as Nebraska has a vast rural and frontier landscape in the western 2/3 of the State. In the western area of Nebraska there is a decline in population and CFS service array. This proves to be challenging as it places a number of miles between providers and/or has a limited number of providers who are available and willing to serve in these geographical regions. Nebraska expects implementing the FFPSA Plan will improve in-home service quality and array of available services, and reduce the demand for foster care services that are often not readily available, particularly in rural Nebraska.

CFS is working to ensure that execution of FFPSA supports and encourages innovation, while also having processes in place to mitigate potential disruptions to the plan. FFPSA is an opportunity through which federal funding will help support expansion and new prevention efforts and drive improved outcomes for the families in Nebraska. This new opportunity is met with the commitment of Nebraska's child welfare system to embrace an improved way of working with families.

CONSULTATION AND COORDINATION

Consultation with Other Agencies to Develop Continuum of Care

CFS held an external stakeholder meeting in June of 2018, inviting child welfare stakeholders to participate in an implementation workgroup. The Prevention Services and Programs Plan Committee was established to develop this Plan. Stakeholders included the Nebraska Legislature, legal community, service providers, Tribal partners, Managed Care Organizations, various community organizations, and representatives from other DHHS divisions. CFS co-lead this external workgroup with the Nebraska Children and Families Foundation (NCFF). As the Community-Based Child Abuse Prevention agency in Nebraska, NCFF is a strong partner in the FFPSA planning given their expertise in community engagement and prevention portfolio. Committee meeting agendas, notes, and workgroup members can be found [here](#). This work continues with providers to ensure readiness and capacity of the provider network to expand to prevention services. Recently, providers were surveyed to determine readiness and capacity by the provider associations in Nebraska. The findings were reviewed with CFS and provider networks and prioritizing the training support needed by providers will be finalized in the coming weeks. Behavioral Health is a key support to building the capacity of the provider network and assists in the planning and development of needed resources.

This Plan was posted on the Department's public website and widely distributed for input. Feedback and additions/corrections were requested to be sent to DHHS.FamilyFirst@Nebraska.gov, the CFS global email address for any FFPSA related questions.

DHHS is comprised of five divisions: CFS, Medicaid and Long-Term Care, Behavioral Health, Developmental Disabilities and Public Health. CFS engaged in and continues internal planning for FFPSA with these other divisions, to provide greater access to evidence-based prevention and treatment programs by better leveraging existing opportunities across DHHS.

CFS is working with Juvenile Probation to provide education and communication between CFS and probation officers working with youth who may be candidates for foster care. Combined efforts to assess needs and strengths of families will capitalize aide efforts in allowing youth to remain in the family home. The goal is to ensure appropriate, not duplicative, programs are provided to the juvenile and their family while maximizing the effectiveness of EBPs used to prevent further involvement in either system.

At this time, Juvenile Probation provides evidence based services, such as MST to a number of youth, but are unable to seek reimbursement under FFPSA as Juvenile Probation in Nebraska is not a Title IV-E agency. Nebraska Revised Statute §29-2260.02, which can be found at: <https://nebraskalegislature.gov/laws/statutes.php?statute=29-2260.02>, provides an opportunity for the Office of Probation Administration to enter into a Title IV-E interagency agreement with DHHS. Through an interagency agreement, DHHS and Probation would

collaborate on the provision of FFPSA evidence based services for probation youth jointly involved with CFS and probation and those only involved with probation. Both agencies are focused on children and youth from entering foster care.

Nebraska has collaborated with Casey Family Programs and the Court Improvement Project to design data that will support the understanding of where disparities exist, the magnitude of these disparities and why these disparities are occurring. Strategies must be addressed collaboratively with all stakeholders to address disparity within the child welfare continuum.

Tribes

CFS convenes with Tribal representatives, via Tribal operations meetings that are held every other month, to provide information regarding FFPSA and gain input and insight into how the implementation of FFPSA in Nebraska can support the unique cultural needs of Native families. CFS partners with the Tribes in identifying culturally-relevant evidence-based models pertinent for FFPSA. During calendar year 2020, meetings have occurred on January 15, March 18 and May 20, 2020. FFPSA is a standing agenda item for these meetings.

During the external stakeholder meeting in June 2018, all Tribes were included and Winnebago, Omaha and Ponca Tribes were represented at the meeting. This initial meeting outlined the different activities and requirements within the FFPSA and CFS asked external stakeholders to participate in the areas that are of importance to them.

As Tribal resources are limited, many times the Tribes agree that a single representative from one Tribe can represent and bring information back to the other Tribes. This allows participation in multiple subcommittees. The membership roster for various subcommittees indicate Tribal representation on the following subcommittees.

- Model Licensing – Winnebago Tribe and Omaha Tribe
- Prevention of Child Maltreatment Death – Winnebago Tribe and Ponca Tribe
- Prevention of Inappropriate Diagnosis – Ponca Tribe
- Prevention Services and Program Plan – Winnebago Tribe and Santee Sioux Nation

Each committee meets with efforts to be inclusive and reduce the need for travel. Meeting minutes are posted on the DHHS-CFS-FFPSA webpage to ensure members or interested parties who are unable to participate in person are able to remain informed.

CFS continues to facilitate Tribal Operations and Continuous Quality Improvement (CQI) meetings with the four federally recognized Tribes with governmental headquarters within Nebraska's borders—the Omaha Tribe, the Ponca Tribe of Nebraska, the Santee Sioux Nation, and the Winnebago Tribe. The Tribal Operations and CQI meetings will continue to provide opportunities to ask for input, share information, discuss barriers and identify strategies related to FFPSA. CFS meets with Tribal representatives to provide information regarding FFPSA and gain input and insight into how the implementation of FFPSA in Nebraska can support the unique cultural needs of Native families.

CFS met with representatives from each of the four Nebraska Tribes in January 2020 to review the services included in the Nebraska Prevention Plan and discuss opportunities and barriers to the Tribes implementing or contracting for these services through their Tribal CFS programs. The Tribes identified several mental/behavioral health providers they utilized on a regular basis. The Tribes identified two culturally specific services, "Motherhood/Fatherhood is Sacred" and "Positive Indian Parenting", which they use in practice. In further conversations with the Tribes, there was interest voiced in utilizing Healthy Families America (HFA). The Winnebago Tribe has expressed interest in piloting the use of HFA on their reservation. CFS has reached out to the identified HFA provider located in the Northern Service Area of Nebraska, where the Winnebago Tribe is located, to discuss capacity to provide the proposed service.

The purpose of starting this as a pilot is to monitor the frequency of referrals for HFA, the documentation of Foster Care Prevention Plans by Tribal staff, and to identify a smooth process of accessing the Title IV-E prevention dollars for these services, through the Tribal-State agreements for Title IV-E claiming. Through this pilot, it is Nebraska's intention to understand how to streamline this process, so that HFA and/or other FFPSA programs can be utilized by the Tribes across Nebraska. Tribal CFS representatives have also expressed interest in learning more about the process of developing Qualified Residential Treatment Programs.

The opportunity for Tribal CFS and CFS staff members to build relationships and network is one of the most valuable aspects of continuing this collaborative process. CFS ensures that the correct program staff are present at meetings to discuss specific topics and ensure information is shared with Tribal CFS staff. Regular discussion occurs on case practice and protocols and provides opportunities for CFS to involve the Tribes in program discussions. Tribes provide input as to any necessary changes to practice and protocols that impact the work of the case manager and to improve services provided to children and families. The Tribes and CFS share and discuss Disaster Plans and how plans can be improved, and the Tribes have been invited to be involved in the statewide Health Care Oversight Committee, Strengthening Families Act (SFA) Human Trafficking task force, and the multiple FFPSA workgroups developed in the past year.

CFS has incorporated the Foster Care Prevention Plan (FCPP) process into New Worker Training. New tribal workers receive training on prevention planning and the current workforce receives the same training resources as CFS staff regarding implementation of FFPSA. Additionally, CFS and tribal representatives continue to meet to discuss strategies for Tribes to access the Title

IV-E Prevention funds. Current discussions between Tribal CFS Directors, CFS Program Staff, CFS Finance Staff and CFS Contract Staff are exploring necessary modifications to the existing Tribal-State CFS and Title IV-E Claiming agreements, whether Tribes would develop independent contracts with providers for qualifying FFPSA services, and the possibility of Tribes utilizing NFOCUS to refer for FFPSA services through existing CFS-Provider contracts.

CFS has an identified point person (Program Coordinator) to work directly with the Tribes. The Program Coordinator works as a liaison between the Tribes and CFS in obtaining input, sharing information and implementing FFPSA. The Program Coordinator travels to each tribe at least every other month to provide Tribal specific support and technical assistance. This allows for individualized planning time with each of the Tribes.

CFS collaborates with the Society of Care (SOC), as it relates to consultation and collaboration with the Tribes. SOC operates as part of the Santee Sioux Nation and has strong relationships with each of the Nebraska Tribes and Native American communities in urban and rural/frontier areas. SOC aims to assist self-identified Native American young people, their families, caregivers, and communities throughout Nebraska through education, outreach, counseling and system change. SOC is collaborating to increase the use of Native culturally-adapted Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and Parent-Child Interaction Therapy (PCIT) among clinicians serving Native American youth and families.

Family First Prevention Service Coordination with Other IV-B Plan Services

As outlined in Section 4 of the *CFSP: Promoting Safe and Stable Families*, Nebraska utilizes prevention services to assist families experiencing multiple crises to keep families from entering further into the child welfare system. Services currently funded by family support, including Parent-Child Interaction Therapy, Circle of Security Parenting, Lincoln Community Learning Centers, the Families and Schools Together (FAST) program, all outlined in the CFSP Section 4: *Promoting Safe and Stable Families, Title IV-B, Subpart 2*, can be utilized in conjunction with FFPSA services to better support families in improving safety for their children.

Adoption promotion and support services, described in *CFSP Section 4: Promoting Safe and Stable Families*, help adoptive families be more prepared to meet the needs of their children and equipped with resources and tools to prevent disruptions or dissolutions of adoptions and guardianships.

As outlined in the *CFSP Section 4: Stephanie Tubbs Jones Child Welfare Services Program*, CFS utilizes Family Support Services with goals designed to (1) prevent or remedy abuse and neglect; (2) improve basic daily living and coping skills; and/or (3) better manage the home, income and resources. Family Support Service, used in conjunction with FFPSA services, can enhance assistance to families.

Bring Up Nebraska⁵ is a statewide prevention initiative designed to give community partners the ability to develop long-term plans using the latest strategies to prevent life's challenges from becoming a crisis for many Nebraska families and children. The FFPSA and Bring Up Nebraska initiatives align to create a comprehensive approach to supporting the well-being of children and families.

Nebraska has been chosen as a Tier One Thriving Families, Safer Children site with three other jurisdictions: LA County, Colorado and South Carolina. Thriving Families seek to demonstrate that intentional, coordinated investment in a full continuum of prevention and robust community-based networks of support will promote overall child and family well-being, equity and other positive outcomes for children and families. Nebraska has been focused on the knowledge for sometimes that community and family support helps keep children safe and well.

Thriving Families⁶ is rooted in the recognition that all families need help sometimes and that seeking help is a sign of strength and resiliency and that we should strive to keep children safe with their families as opposed to safe from their families. The challenges of the global coronavirus pandemic have underscored the urgency to create such systems.

Thriving Families will focus on diverse stakeholders, particularly developing a community prevention network led by empowered families and persons with lived experience. This work will be key to child and family wellbeing and a broad network focused on prevention.

SERVICE DESCRIPTION AND OVERSIGHT

Nebraska's Landscape

Program and population data during calendar year 2018, from CFS shows:

- 3,364 children were involved in a child abuse/neglect investigation; 1,990 children entered foster care.
- Approximately 65% of the children entered foster care due to a form of neglect and 35% entered due to a form of abuse.
- 40% of all children investigated in 2018, were ages 0-5 years.
- 42% of all children removed from the parental/caregiver home were ages 0-5 years.
 - Of the children ages 0-5 years who entered out-of-home care, 35% were age 1 or younger.

⁵ Bring Up Nebraska: A Community-Based Prevention Strategy; <http://www.bringupnebraska.org/>

⁶ Thriving Families: <https://www.nhchildrenstrust.org/post/thriving-families-safer-children-a-national-commitment-to-well-being>

- Approximately 46% of children who enter out-of-home care ages 0-5 have at least one parent who was previously in the state's custody.
- In July 2018, 40% of all the children involved in an ongoing services case had a parent who was also involved with CFS as a child.
- Parental substance abuse is a contributing factor for approximately 50% or more of children who enter out-of-home care.
- As of July 2018, 61% of all children served are in out-of-home care and 39% were in-home.

Re-entry into foster care after adoption or guardianship dissolution was recently studied by the Nebraska Foster Care Review Office.⁷ This study included analysis of point-in-time data from December 31, 2018. On this date, of the 4,200 children in out-of-home care, 226 were previously state wards who had exited state care to “permanent” homes through either adoption or guardianship. Analysis of this sample showed:

- 4.3% of the child welfare population were previously placed in permanent homes, and many of these homes are no longer a permanent option.
- For youth involved with both CFS and Juvenile Probation, while placed in CFS care, 14.5% were previously adopted or placed in a guardianship, which is substantially higher than the proportion of kids solely involved with child welfare or juvenile justice. Dually-involved youth have both an active child welfare and juvenile justice case.
- Nearly all children who re-entered care did so during the early teenage years.

The report states, “Better preparing adoptive parents and guardians for the teenage years and ensuring families in need have access to behavioral health services outside of the child welfare system may reduce re-entry and assist all families.” Including this population of youth in the Nebraska definition of candidacy will assist with these efforts. The full Nebraska Foster Care Review Office Quarterly Report issued March 1, 2019, is found [here](#).

Definition of Candidacy

Developing a clear scope for Nebraska’s children and families in need of FFPSA prevention services is a critical task for CFS, its partners and stakeholders. Nebraska has been tasked with making the determination of the children and families that are eligible and meet the candidacy definition, to be eligible to receive FFPSA approved services.

⁷ The Nebraska Foster Care Review Office Quarterly Report; March 1, 2019; www.fcro.nebraska.gov

Nebraska's Definition of Candidacy:

Children and youth at imminent risk of entering foster care, as defined by Nebraska Revised Statute 71-1901, but who can remain safely in the child's home or kinship/relative non-foster care home as long as Title IV-E prevention services necessary to prevent entry into the foster care system are provided. This state statute provides clear delineation what foster care means, and the types of foster homes available in Nebraska, including kinship and relative foster homes. This candidacy definition includes, but is not limited to those children and youth who are:

1. *residing in a family home accepted for assessment; or*
2. *within an ongoing services case including non-court and court involved families where the child may be a state ward; or*
3. *reunified with their caregiver following an out-of-home placement; or*
4. *the subject of a case filed in juvenile court and is mentally ill and dangerous, as outlined by Nebraska Revised Statute 43-247 (3)c and defined by Nebraska Revised Statute 71-908. This statute defines that a mentally ill and dangerous person is one that is of substantial risk of serious harm to themselves or others in the recent past or near future; or*
5. *pre- or post-natal infants and/or children of an eligible pregnant/parenting foster youth in foster care; or*
6. *at risk of an adoption or guardianship disruption or dissolution that would result in a foster care placement; or*
7. *presenting with extraordinary needs and whose parents/caretakers are unable to secure assistance for the child to transition between traditional IV-E eligibility and FFPSA IV-E eligibility; or*
8. *involved with juvenile probation and living in the parental/caretaker home.*

Assessing Children and their Parents for Eligibility

CFS uses SDM®, a comprehensive case management system for child welfare, to guide decision making. SDM® is rated as a promising practice per the California Evidence-Based Clearinghouse for Child Welfare (CEBC). SDM® assessments are used to guide decision making, including identification of families at high risk of maltreatment, and ensures interventions meet the needs and strengths of families. Families involved in accepted intakes of abuse or neglect receive this initial assessment. A family with a case that does not close after the initial assessment, receives an ongoing services case. Nebraska will offer FFPSA prevention services to families involved with CFS prior to October 1, 2019, as well as new families, who meet the definition of candidacy and are in need of such services (**Attachment A**).⁸

⁸ Please see Attachment A: Standard Work Instruction for Foster Care Prevention Plan, for regarding the policies and procedures for CFS staff regarding the FFPSA prevention program including determining candidacy and eligibility for FFPSA prevention programs and services.

Nebraska provides post-adoption and post-guardianship support and services to families meeting the criteria of: a) having a current adoption/guardianship assistance agreement with CFS for a child who was a state ward, b) a child whose adoption/guardianship arrangement is at risk of disruption or dissolution and would result in a foster care placement, or c) any family who adopted a child or became a guardian of a child and is currently residing in the State of Nebraska.

CFS provides post-adoption services through an external contractor. Currently CFS has issued a Request for Proposal (RFP) for post-adoption and post-guardianship services. The provider awarded this contract will provide intervention services to candidates at risk of an adoption/guardianship disruption. Referrals for these services can come from families, CFS or other sources. The contractor will provide intervention services such as advocacy, intervention, crisis management, mental health referrals, respite care, training and education, support groups for parents and children, and mentoring based on individualized needs of the family.

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 Service⁹	Outcomes (CEBC and/or Federal Clearinghouse)¹⁰	Federal Clearinghouse Rating	CEBC Rating	Requesting Transitional Payments¹¹
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

⁹ Average length of service obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/> and/or Federal Clearinghouse; <https://preventionservices.abtsites.com/>

¹⁰ Outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/> and/or Federal Clearinghouse; <https://preventionservices.abtsites.com/>

¹¹ ACYF-CB-PI-18-09-06; Transitional Payments for the Title IV-E Prevention and Family Services and Programs; <https://www.cwla.org/wp-content/uploads/2019/07/ACYF-CB-PI-18-09-Attachment-A.pdf>

NEBRASKA'S FIVE-YEAR TITLE IV-E PREVENTION PROGRAM PLAN 2020

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

⁷ Average length of service obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/> and/or Federal Clearinghouse; <https://preventionservices.abtsites.com/>

⁸ Outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/> and/or Federal Clearinghouse; <https://preventionservices.abtsites.com/>

⁹ ACYF-CB-PI-18-09-06; Transitional Payments for the Title IV-E Prevention and Family Services and Programs; <https://www.cwla.org/wp-content/uploads/2019/07/ACYF-CB-PI-18-09-Attachment-A.pdf>

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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.

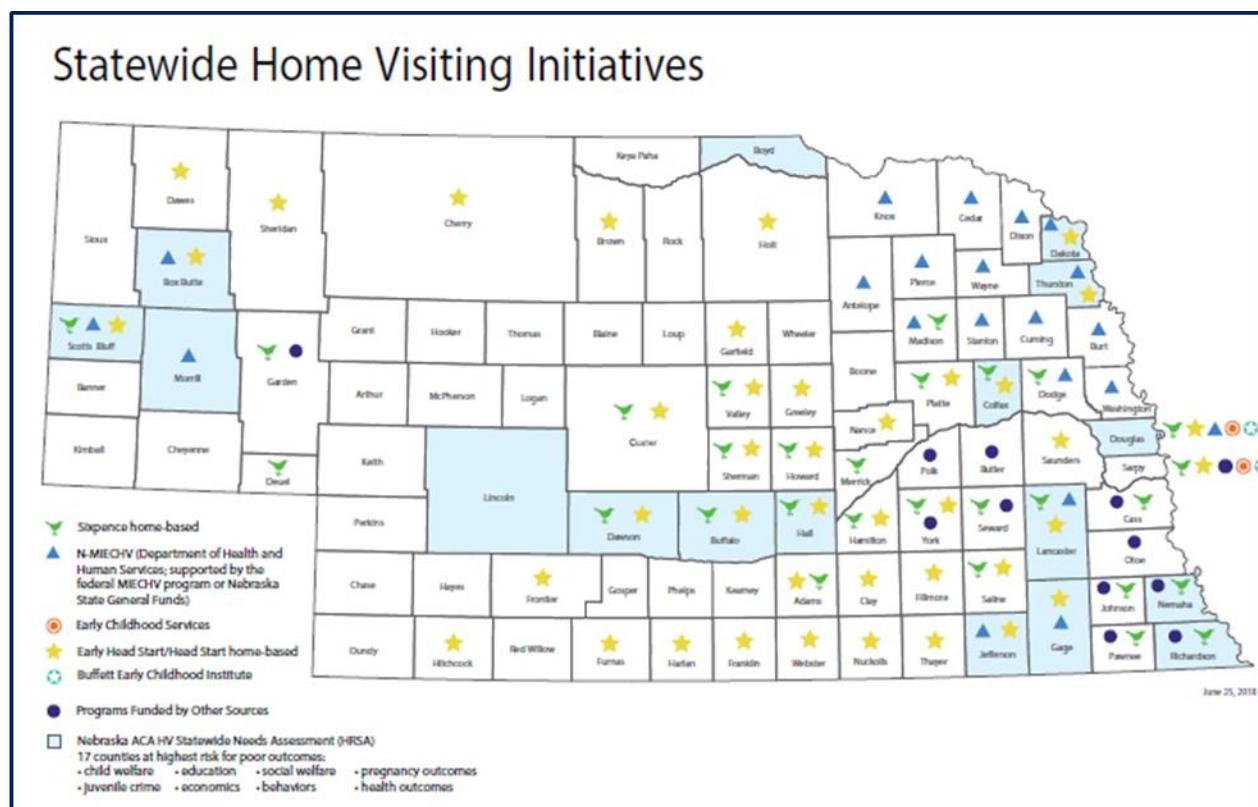
CFS intends to implement the HFA child welfare protocol to allow for the expanded enrollment criteria for children up to 24 months of age. HFA providers are accredited by the national office and will follow the Best Practice Standards that provides specificity in regards to enrollment, eligibility, and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

¹² Health Resources & Services Administration, Maternal & Child Health, Home Visiting; <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>

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.healthyfamiliesamerica.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:

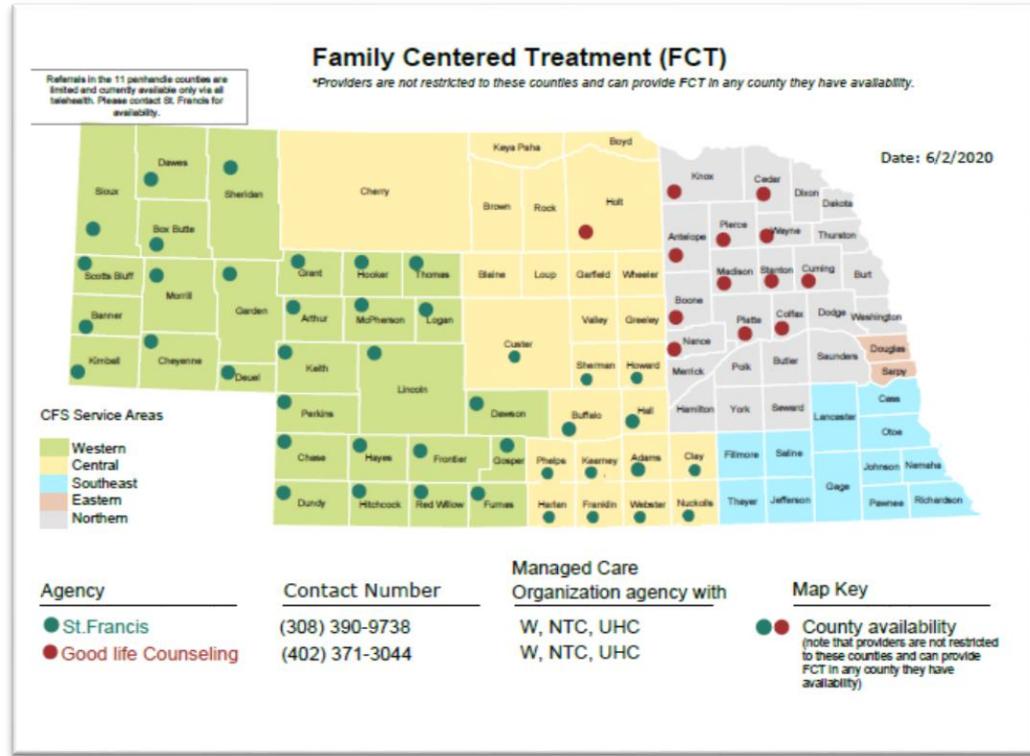
1. Families who have an identified safety threat(s) and/or high/very high risk factors and whose children are at risk of an out of home placement or need intensive services to prevent out of home placement.
2. Families with youth who are transitioning home from a higher level of care.
3. Families with 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's independent systematic review was not reviewed by HHS because FCT had been previously approved for transitional payments.

Book/Manual: 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., & Neub, 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. Nebraska's expectation is that each of the nine evidence based programs proposed, when administered to model fidelity, will meet the individualized outcomes listed on the Nebraska Title IV-E Prevention Services table, located on pages 20-21 of this Plan. Each of these nine programs has individualized outcomes that target the specific needs of the children and families served by CFS. The help determine if these individualized outcomes have been realized, CFS will gather the information located on the **Specific Outcome Measures-Table 1**, which is referenced later in this Plan. CFS will also collaborate with service providers and the purveyor of the specific EBP, to verify if the outcomes being reported, align with the intended outcomes of the program.

To help bolster Nebraska's plan to improve outcomes for youth 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.

Continuous Quality Improvement

The Nebraska CFS Continuous Quality Improvement (CQI) team is currently positioned and ready to begin in earnest the CQI and fidelity evaluation for families who are receiving MST, TF-CBT, PCIT, FFT, PAT, Homebuilders, MI and/or FCT, via the FFPSA pathway. CQI and fidelity monitoring of HFA is conducted through Nebraska MIECHV CQI. Along with internal staff of experts, Nebraska will also be contracting with Chapin Hall, who will be leading the evaluation for the State of Nebraska.

The Nebraska CFS CQI & Fidelity Evaluation process will draw upon internal teams and contracted professionals with expertise from the following areas;

- a) Internal NFocus development for requisite system changes and system generated reporting
- b) Internal child welfare statistical analysis and reporting team
- c) Internal Program Accuracy Specialists for detailed full case reviews
- d) Contract Monitoring staff who assess contracted agency performance to ensure compliance with contractual language and measures designed to assess fidelity of FFPSA evidence based services.
- e) CFS Program Specialists with expertise in each of the FFPSA EBP services include service provisions, target populations, service objectives & candidacy for FFPSA.
- f) Chapin Hall will provide expertise developing and performing a rigorous evaluation design & execution for non-waived services and consulted with for the CQI/Fidelity for all services.

Nebraska's CQI team provides quantitative analysis, qualitative reviews, and clear and concise feedback directly to program and staff statewide via established communication methods. An important first-step in the CQI process is a measurement plan and the existence of accurate data to analyze.

CFS has made the necessary changes to Nebraska's SACWIS system to enable data collection by the case manager for all relevant FFPSA factors, such as identifying families that meet the definition of candidacy for risk of removal, as well as pregnant/parenting youth. Additionally, service provider tables have been modified to include details on the service type, including the level of evidence based practice by service for each particular agency providing the services.

A quantitative analysis includes analyzing measures ranging from basic counts stratified demographically and geographically and measures of central tendencies to assess case durations, family risk/safety and frequencies of service provisions, etc. The quantitative analysis includes an in-depth review of outcomes for families receiving FFPSA services to assess the success of the services measured by traditional types of outcomes such as removal rates, re-entry, and recurrence of substantiated maltreatment. The quantitative reviews will include a corollary analysis to determine the accuracy to which outcomes can be predicted based upon case characteristics as well as service provisions.

An important step in the CQI process are qualitative case reviews derived from targeted area-specific reviews. This will include correct and consistent reviews of determination of: candidacy, accurate safety/risk assessments; court orders for QRTP youth; accurate pregnant and/or parenting status; and appropriateness of the service referral for the youth/family. These items will be encompassed within the comprehensive CFSR Items 1-18 reviews, which address outcomes for safety, permanency and well-being. As with all reviews conducted by the CQI team, aggregated results will be compiled and provided to CFS Program Managers to measure and analyze the quality of the case management actions and service to ensure consistency and compliance with statutes, regulations and best practices.

Capturing and analyzing the qualitative information collected from the FFPSA case review process is just the first step. Nebraska CQI will be creating comprehensive quantitative outcome reports and performance dashboards containing a wide cross-section of measurements, both qualitative and quantitative. The dashboards will present the information in both aggregate and stratified formats to provide the most value and insight into the analysis process. The data will be presented over time to ensure CFS quickly identifies emerging trends, along with areas of progress and needed improvement.

While measurement systems, dashboards, and case review information are essential to an effective CQI program, the information feedback loop is an equally critical component. To further this effort, Nebraska has established CQI meetings across the state attended by various levels of CFS staff and the CQI team that will be used as one of the venues to share the learnings and brainstorm solutions to identified concerns. Meetings will be held quarterly between CFS and EBP providers to identify any gaps in service delivery and review CQI information in an effort to collaborate together. Consistent with all reviews performed by the CQI team, cases reviewed where safety concerns or case management deficiencies are identified will result in immediate notification to administrators to ensure proactive corrective action is taken.

Nebraska is implementing a broad array of the Federal Clearinghouse approved evidence based services in an effort to maximize CAN prevention efforts. Because of the large array of services being offered, CFS anticipates the need to review and validate the utilization of services based on needs of the family and objectives of the service to ensure CFS is accurately matching the service with the need. Accordingly, CFS will be using Table 1 below as a review guide. When reviewing cases and assessing applicability of the service to the youth/family, CFS CQI will identify whether the expected outcomes for the service were realized. There are numerous well-being outcomes that are highly subjective and therefore difficult to quantify. This makes it difficult to understand the high needs and low needs of the youth and/or family. Nebraska will utilize outcome measures to assess effectiveness of the evidence based programs.

Assessing child and family outcomes is a critical component of the CQI process and is an area CFS will approach from multiple ways. As previously indicated, Nebraska has modified the SACWIS system to include a foster care prevention plan, with begin and end dates, which enables CFS to specifically identify all families that meet the candidacy definition criteria as well as eligibility types, both prevention candidacy as well as pregnant & parenting. Accordingly, CFS has the ability to accurately identify all candidates for FFPSA services in SACWIS system. With this information being accurately captured, CFS will be creating a system generated FFPSA performance outcome report that will refresh monthly. This report, as reflected in Table 1 will include all FFPSA youth and will enable CFS to measure key outcomes, such as case duration, services provided and duration, substantiated recurrence of maltreatment, removal in twelve and twenty-four months, and other outcome measures derived from case management data in SACWIS that enables us to assess safety, permanency and well-being. This report will be developed from existing performance accountability reports, ensuring that detailed case information is available and analysis is performed each month to proactively measure outcomes and identify emerging trends.

Specific Outcome Measures-Table 1

EB Interventions: Specific Outcome Measures	TF- CBT	PCIT	MST	FFT	FCT	HFA	PAT	Homebuilders	MI
% of Youth Entering OHC 12-months Post-Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frequency (Rate) of Entry to OHC 12-months Post-Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Time to Reunification	✓	✓	✓	✓	✓	✓	✓	✓	✓
% of Youth Remaining in Home Throughout Involvement with CW System	✓	✓	✓	✓	✓	✓	✓	✓	✓
Verified Maltreatment 6-months Post-Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Verified Maltreatment 12-months Post-Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Verified Maltreatment 6-months Post-Case Closure	✓	✓	✓	✓	✓	✓	✓	✓	✓
Verified Maltreatment 12-months Post-Case Closure	✓	✓	✓	✓	✓	✓	✓	✓	✓

For Healthy Families America (HFA), CFS will meet the continuous monitoring requirements in partnership with the N-MIECHV Program. Based on the federal MIECHV Needs Assessment, N-MIECHV has strategically invested in planning, supporting professional development, and

implementing HFA in Nebraska. This includes plans for CQI (**Attachment I**). The N-MIECHV CQI plan is updated every year and approved by the Health Resources and Services Administration (HRSA). N-MIECHV is in the process of updating and submitting the 2020 CQI Plan. CFS will partner with N-MIECHV to utilize the existing CQI structure for HFA and will tailor the process to meet the additional data analysis requirements of FFPSA.

CQI is an integral component of the N-MIECHV program. Local HFA sites are expected to participate in both state and program level CQI. The N-MIECHV Program Manager guides the sites through program level CQI. Examples of past program level CQI topics are staff retention and home visit completion rates. State level CQI is directly related to the federal performance measures; the N-MIECHV Team helps to guide local sites through this process with a community of practice approach. In the past local sites have worked on a variety of topics in state level CQI, including increasing screening and appropriate referrals for domestic violence, maternal depression, and substance abuse.

Determining if Outcomes Are Achieved

In order to determine if desired outcomes are achieved for HFA, CFS will utilize the benchmark plan developed by N-MIECHV which was last updated in August 2019 (**Attachment J**). The federal MIECHV program requires that Nebraska data reflect positive change in a minimum of 4 out of the 6 benchmarks every 3 years as a determinant of funding.

Local HFA sites use a case management system to manage caseloads and track individual progress. The case management systems are the source of demographic and benchmark data that N-MIECHV collects and reports on families served. For FFPSA, the local HFA sites will add an indicator to track referrals for FFPSA eligible candidates. Program Managers/Supervisors are responsible for monitoring accuracy and timeliness of the data entered by the home visitors, it is analyzed and reviewed by N-MIECHV staff, then reported back to the programs, HRSA, and the Nebraska State Legislature.

All sites use an approved case management system. N-MIECHV maintains a contract with the University of Kansas Centers for Public Partnerships and Research (KU-CPPR) to provide data management, integration, analysis, and report functions in support of benchmark data collection and reporting through a software program specifically designed for the federal MIECHV program, called Data Application and Integration Solutions for the Early Years (DAISEY).

How Information Learned From the Monitoring Will Be Used To Refine and Improve Practices

The N-MIECHV Surveillance Specialist works in partnership with KU staff, by conducting the data cleaning and queuing the administrative data in preparation for analysis. N-MIECHV receives monthly data transfers from each case management system. These data files are cleaned and analyzed on a quarterly basis. The end result is performance reports that the Surveillance Specialist provides and reviews with the local sites. CFS will participate in these discussions to support ongoing refining, improvement of practice, and alignment with FFPSA. In

addition, local sites have access to their data and can run reports to monitor progress in real-time. N-MIECHV team is available at any time to answer questions, offer training or help brainstorm ideas.

Fidelity to the Model

In addition to collecting and reviewing outcome data and case management adherence to policies and procedures, Nebraska CQI also has a team of professionals dedicated to monitoring agency provider performance. Nebraska is cognizant that the quality of the services being provided to youth and families in care is a critical component of CFS' success, and most importantly the family's success. In 2016 and as an intervention for the IV-E Waiver, CFS developed a Continuous Quality Improvement (CQI) program entitled Provider Performance Improvement (PPI). This team of specialists focuses exclusively on monitoring the performance of agencies that CFS has contracted with to provide various services, such as agency based foster care, visitation, in-home family support, Intensive Family Preservation (IFP), etc. This team assesses provider performance from many angles, including data from SACWIS, data loaded by the providers, audits from on-site visits, and through consultation with case managers and the Resource Development teams in each of the service areas.

Nebraska has identified 9 evidence based services the State intends to provide to children and families who meet the FFPSA candidacy definition, over the course of the next 5 years; this is done in an effort to provide in-home parenting services, mental health and substance abuse services to help keep children in their home, when it is safe to do so. Because the successful implementation of FFPSA is highly dependent on in-home service provisions provided by contracted private agencies, many of which will be well-supported evidence based practices, Nebraska is aware of the need to closely monitor the agencies and the execution of these services. Accordingly, Nebraska will expand the reach and design of the CFS PPI program to include performance and process assessments to monitor service fidelity, both directly and indirectly, for the FFPSA service array. CFS expects this to be a highly collaborative process with data being collected both by CFS and by the agencies providing the service.

To adhere with model fidelity standards, Nebraska expects the outcomes of each proposed program to align with the outcomes identified by the Federal Clearinghouse and/or the CEBC as referenced in the table on pages 20-21 of this Plan, with the intended goal to improve the livelihood of the children and families served within Nebraska.

In order to monitor fidelity of implementation, CFS will verify the fidelity monitoring instruments as developed by the model purveyors. This will involve CFS verifying with each purveyor, what the individual fidelity requirements are to implement the program, such as certification, training and identification of the workbook/manual used. CFS will verify with the

provider, if they meet these requirements. Initial and ongoing fidelity with the model will be contingent upon the agency having an initial an ongoing certification process, as required by the purveyor. If the provider is not able to meet these requirements, they will be unable to provide the program as an FFPSA service. Further fidelity monitoring instruments will be utilized by accessing data reports generated by CFS and by information obtained by Contract Monitoring Staff who assess contracted agency performance to ensure compliance with contractual language. This assessment is obtained through file reviews and reported on a central data site kept by CFS. As referenced earlier in the Plan, the use of PPI and Salesforce will assist in identifying fidelity measurements.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) is one of two programs that will have an evaluation completed through Chapin Hall as a result of its current rating not being “well-supported”. The outcomes identified by the Federal Clearinghouse for TF-CBT indicate that PTSD, depression and anxiety symptoms should be improved; behavioral problems reduced; adaptive functioning and parent skills improved; and, parental distress reduced. Chapin Hall will be conducting an outcome evaluation as part of their overall evaluation of this model.

The evaluation will correlate with the aforementioned outcomes identified by the Federal Clearinghouse by reviewing the proximal, intermediate and distal outcomes of TF-CBT. The proximal outcomes will focus on the increased caregiver coping skills; increased caregiver perceptions of parenting support; increased trauma management skills in the children and caregivers; and, improved parenting behaviors. The intermediate outcomes will focus on the families improved relationships between the caregiver and child(ren); and the improved overall household functioning. It will also focus on the TF-CBT’s providers practice being adjusted based on current fidelity to TF-CBT; and the provider’s progress towards treatment goals being consistently documented by the providers. The distal outcomes will focus on the families reduction in child welfare referrals and severity of involvement; reduction in placement in out of home care; reduced duration in out of home care; lower average level of risk identified in case management; fewer prevention needs identified in case management; and, higher family strengths and fewer family needs identified in the Family Strengths and Needs Assessment tool within Structured Decision Making. It will also focus on the provider consistently tracking fidelity and practicing fidelity to the model; and, the provider reporting out aggregate improvements in the families’ outcomes.

Family Centered Treatment (FCT) is the second program that will have an evaluation completed through Chapin Hall as a result of its current rating not being “well-supported”. The outcomes identified by the CEBC for FCT indicate that family stability; increased family functioning in the critical areas of contributing to increased risk of family dissolution; increased effective coping skills; reduced harmful or hurtful behaviors; and the building upon strengths to sustain changes made. Chapin Hall will be conducting an outcome evaluation as part of their overall evaluation of this model.

The evaluation will correlate with the aforementioned outcomes identified by the CEBC by reviewing the proximal, intermediate and distal outcomes of FCT. The proximal outcomes will

focus on the increased caregiver coping skills; increased behavior management skills in children and caregivers; reduced PTSD symptoms in children and caregivers; and, improved parenting behaviors. The intermediate outcomes will focus on the families improved relationships between the caregiver and child(ren); and the improved overall household functioning. It will also focus on the FCT providers practice being adjusted based on current fidelity to FCT; and the provider's progress towards family behavioral goals being consistently documented by the provider. The distal outcomes will focus on the families reduction in child welfare referrals and severity of involvement; reduction in placement in out of home care; reduced duration in out of home care; lower average level of risk identified in case management; fewer prevention needs identified in case management; and, higher family strengths and fewer family needs identified in the Family Strengths and Needs Assessment tool within Structured Decision Making. It will also focus on the provider consistently tracking fidelity and practicing fidelity to the model; and, the provider reporting out aggregate improvements in the families' outcomes.

In an effort to ensure optimum outcomes are realized from each of the FFPSA services, CFS will be implementing a new provider fidelity review and feedback process to monitor fidelity of the service providers, and to ensure feedback is both provided and received from agencies providing FFPSA services. Through this process CFS will be creating a CQI process to monitor, inform and improve FFPSA services and outcomes for families receiving these services. This FFPSA fidelity review process will be less rigorous for the Healthy Families America (HFA) service because these providers currently have a rigorous fidelity verification process monitored by the model developer – however various factors of HFA will still be reviewed.

The first component of the fidelity review process is ensuring all agencies have proper model certification and the clinicians being assigned CFS cases have the required educational/training requirements consistent with the model developer guidelines and terms of the CFS contract. Each calendar quarter a personnel file review is performed by the CFS contract monitoring team to assess a contractor's suitability and conformance with the contract to perform the contracted service. For FFPSA contracted agencies, the personnel file reviews will include validation of current model certification, as well as confirmation of educational/training status for staff providing direct FFPSA services.

The second component of the fidelity process is for the agency to log service information for every instance of a FFPSA service in the Provider Performance Improvement (PPI) system. The data elements were selected in partnership with agencies in an effort to ensure the agency's voice is heard regarding several critical factors that often directly affect outcomes. The PPI system is a cloud-based system available to both agencies and CFS. The following data elements will be entered by the agency for each family receiving a FFPSA service;

- a) Service begin date
- b) Service end date

- c) Target Population – The evidenced based intervention serving the population as identified by the standards developed by the model developer of each evidence-based intervention implemented.
- d) Therapist's Name – This category will allow for the Contract Monitoring Team to ensure that staff providing the evidenced based intervention is trained and certified to provide the evidence based service as set forth by the model developer.
- e) Family Engaged – This data set will allow for Contract Monitoring to look at the participant's responsiveness, (e.g. the extent to which participants are engaged or involved in the activities and content of the program). Was the intervention provided in consideration of the specific logistics necessary for a conducive learning environment?
- f) Youth at Home at Closure – Has the provider of the evidenced based practice been able to implement the service in accordance with the model developer and effect the necessary change requirements to provide the tools needed to keep the youth in the home environment.
- g) Was the referral appropriate – This data will allow for agency feedback to determine if service, outcomes, and objectives are appropriate for the service provided. Targeted reviews can be conducted on a random sample and/or conducted on each service as the needs are identified.
- h) Family agreed to participate – This will allow contract monitoring to work with agencies to help identify family participation and appropriateness of referrals based on the families willingness to actively participate in the service.

The aforementioned data elements provide high-level insight into the appropriateness of the service referral from the clinician's perspective, as well as provide context data for outcome analysis. This data also provides the ability to analyze case durations and outcomes at case closure, as well as the ability to analyze data specifically by agency and clinician. The contract monitors will be reviewing the data throughout the month, looking for responses requiring prompt communication with the CFSS team or the agency, e.g., inappropriate referral. For example, the CFS contract monitors will look for referrals that are marked as not appropriate (item c above). If the agency marks the referral as not appropriate, the contract monitor will discuss the concerns with the agency and develop a plan for the referral to be addressed by CFSS team. Contract monitors will also review PPI information in regard to information being entered by the agency as it relates to family engagement (item g above) and the family's alignment with the target population (item e above) for the service being provided. In the event an agency makes a selection indicating concern with a case, the contract monitors will help facilitate resolution and provide assistance in order to rectify logged concerns.

The third component of the fidelity process is to analyze the PPI data and include this information in existing quarterly conversations between the agencies and the contract monitoring team. These

meetings are currently occurring so adding FFPSA data to the conversation will be very efficient and effective. Listening to FFPSA service provider's comments and suggestions is a key objective of this process, and the one-on-one meetings between the contract monitors and agencies provides an effective venue to accomplish this objective. At these meetings a myriad of data are discussed and FFPSA PPI results will be included. The contract monitors discuss areas of strength and areas needing improvement, as well as actions or activities the agencies are utilizing to achieve positive results. As needed, CFS Policy and Program will be included in these conversations to ensure full exchange of information and resolution to identified areas of question.

The fourth component is to utilize the Quality Assurance (QA) case review information gathered from FFPSA targeted case reviews. These reviews will be both random and case-selected depending on the situation. In the event an agency or CFSS expresses a concern about a family receiving a FFPSA service, that family's case will likely be selected for a QA review. Conversely, each month a random selection of cases receiving FFPSA will also be reviewed. The quality assurance review tool for this read is not yet complete as CFS Program continues to identify the critical components and where they are to be found in the SACWIS system. Given the variance of the services provided, CFS expects the review tools to be unique for each service to ensure the ability to review for specific policy guidelines or best practices associated with each service.

The fifth component is to bring all known data and information together at a quarterly FFPSA CQI meeting. The attendees of this meeting will include CFS Policy, Program, Contract Monitoring, Quality Assurance, Data Analysis, Chapin Hall, as well as a sampling of FFPSA agency service providers. This meeting will focus conversations on outcomes, service challenges, policy changes, and solutions in an effort to continually assess and improve practice. At this meeting all CFS teams will be represented and all areas of strength and areas needing improvement will be discussed. At this point, CFS is planning to have one CQI session which includes a discussion of all FFPSA services. However, should circumstances warrant, facilitating additional sessions will be an option should it be necessary to allocate additional time to a particular service(s).

The HFA programs supported by N-MIECHV and FFPSA are required to be accredited by Prevent Child Abuse America. Prevent Child Abuse America has an intensive accreditation process for the 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. Accredited HFA programs must follow the "HFA Best Practice Standards"¹³ 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 have a section on governance and administration which articulates expectations for effective site management. The governance and administration standards include the requirement for each site to have a quality assurance plan to monitor and track quality of all aspects of implementation:

¹³ Healthy Families America Best Practice Standards, 2018-2021 are a proprietary product that are copyrighted and only available to affiliated partners/programs.

performance measures, screening process, family acceptance, family retention, satisfaction surveys, case file reviews, shadowing, quality assurance phone calls, and reflective supervision.

In addition, N-MIECHV staff will be providing technical assistance and training as needed, annual refreshers on documentation and data, programmatic implementation, and model orientation for new staff. The N-MIECHV

Program Manager and Surveillance Specialist are both trained in the model, and work with the national HFA office closely. In addition, annual site visits by the HFA National Office to each program site, reviews documentation and model requirements.

Nebraska has direct experience monitoring service fidelity and helping CFS to improve service quality and youth outcomes with an existing service, IFP. Since the inception of this service in 2014 under the Title IV-E Waiver, CFS has mandated that service providers track numerous case characteristics, such as weekly hours with the family, contact made in 24 hours, mode of communication with the family, certification levels of agency employees involved with the case, and many more fidelity measures. This fidelity approach has proven to be very effective for CFS. CFS has been able to sustain the outcome levels of IFP to reflect that 85% or higher of the families receiving this service, have remained in home. When outcomes are reduced for any given provider agency, CFS has been able to analyze the parameters and identify the factors that contributed to the decrease. As such, CFS' experience with this fidelity monitoring will yield great dividends for CFS as the FFPSA service array is implemented.

Nebraska is confident to the design will allow effective monitoring of internal performance, agency performance, and most importantly improve the outcomes experienced by the children and families receiving the FFPSA array of services. Nebraska is eagerly looking forward to this service pathway and to providing internal Program teams with continuous quality improvement support for FFPSA youth, families and services.

EVALUATION STRATEGY

Evaluation Intent and Approach

Evidence-based interventions that are determined to be supported, promising by the Federal Clearinghouse or provided a proposed rating via the independent systematic review process, will be evaluated by Chapin Hall. These programs in Nebraska's Plan consist of FCT and Trauma-Focused Cognitive Behavioral Therapy. Consistent with federal legislation and subsequent HHS guidance, the Department is requesting a waiver of evaluations requirements for its well-supported programs.

Ability to Conduct an Evaluation of Prevention Programming

Please refer to **Attachment H** to review Nebraska's rigorous evaluation strategy, as set forth by Chapin Hall.

EVALUATION WAIVER

CFS is requesting a waiver for the following programs rated well-supported on the Federal Clearinghouse and will follow established procedures to monitor, compile, assess and report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions.

- Healthy Families America
- Homebuilders
- Parents as Teachers
- Motivational Interviewing
- Parent-Child Interaction Therapy
- Multisystemic Therapy
- Functional Family Therapy

Evidence of Effectiveness

Healthy Families America

HomVEE¹⁴, Home Visiting Evidence of Effectiveness, a program administered by the United States DHHS ACF, reviews the effectiveness for specific home visiting models. Per this review of HFA last updated in September 2018, HFA meets the criteria set forth by US DHHS. HFA was found to have favorable results in studies rated high or moderate in the following areas: child development and school readiness, child health, family economic self-sufficiency, linkages and referrals, maternal health, positive parenting practices, reductions in child maltreatment, and reductions in juvenile delinquency, family violence, and crime.

Since its inception in 1992, the HFA model has been working with child welfare referred families and has also allowed flexibility with regard to age of child at intake in its manuals [*pg. 63, HFA Best Practice Standard 3-1.B regarding families enrolled with open and active child welfare/CPS involvement*].

¹⁴ U.S. DHHS, ACF, Home Visiting Evidence of Effectiveness;
https://homvee.acf.hhs.gov/effectiveness?model=&hhs=All&sort_by=title&sort_order=ASC&page=1

Over the past several years, HFA has developed an optional child welfare protocol, which maintains the expected rigor and fidelity requirements providers have expected from HFA for almost 30 years. HFA sites that have received national office approval to utilize this adaptation are able to extend enrollment for families with a child up to 24 months of age referred by the child welfare system. All of the Nebraska sites implementing the HFA child welfare protocol have received national office approval.

HFA's best practice standard is to strive for serving at least 80% of families beginning prenatally or while in the newborn period because doing so optimizes the ability to achieve greater maternal and child health outcomes, but there is flexibility so this standard is not absolute [pg. 48, *HFA Best Practice Standard 1-3.B regarding 80% first home visits occurring prenatally or within first three months, and pg. 6-7, HFA BPS Glossary, which indicates threshold for accreditation and demonstration of model fidelity requires adherence to 85% of all HFA Best Practice Standards*].

HFA's best practice standard requires home visiting services are offered for a minimum of three years and through age five, allowing children enrolled up to 24 months of age the full length of service [pg. 80, *HFA Best Practice Standard 4-3*].

Studies have been conducted to prove the efficacy of HFA and its use of the child welfare protocol. Below are four studies and identified outcomes:

Study: DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect*, 32, 295-315. doi:10.1016/j.chabu.2007.07.007.

This study assessed the use of Healthy Families America, by families who were considered "at risk" for child abuse and neglect, during the first two years of life for the child, with approximately 20% of the sample having already had prior involvement with Child Protective Services.

Outcome: Mothers utilizing HFA were found to have a reduction in the use of child abuse and harsh parenting. During year one, mothers participating in HFA reported having drastically fewer acts of physical abuse, physical aggression and/or psychological aggression. Within year two, HFA parents reduced their use of physical abuse by one fourth, as compared to the year prior. This suggests that by prioritizing or enhancing the HFA model to meet the needs of "hard to serve" families, the effectiveness of the model will be realized; abusive and neglectful parenting during the first two years of the child's life will be reduced.

Study: Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. *Child Abuse & Neglect*, 34, 711-723. doi:10.1016/j.chabu.2010.03.004.

This study used observational assessments of the interactions between the mother and child via a random controlled trial study. A focal point of this study was on parenting in the third year of life amongst mothers who were deemed at risk for perpetrating child abuse and/or neglect. The purpose of these assessments was to identify if the mothers who received the home visiting services (HFA) were more likely to utilize positive parenting and less negative parenting behaviors in comparison to the mothers who did not receive home visiting services.

Outcome: Positive parenting for mothers who were identified as being “at risk” for abuse and/or neglect of their child, was promoted and found to be successful. It was suggested that the use of positive parenting such as maternal responsiveness and cognitive engagement, demonstrated the use of harsh parenting to decrease, therefore preventing the initiation of child abuse and neglect. Results indicated during the third year of life, that mothers who received HFA, demonstrated a higher propensity of engaging in positive parenting. These positive parenting behaviors can promote the child to regulate their emotions, demonstrate self-control and decrease the risk of the child having negative outcomes such as delinquency.

Study: Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. *Child Abuse & Neglect*, 86, 55-66. doi:10.1016/j.chabu.2018.09.004.

This study conducted a randomized controlled trial (RCT) of HFA, which included mothers who had at least one substantiated child protective services report within five years prior to enrolling into the HFA program. Through this RCT, the long term maltreatment outcomes were reviewed.

Outcome: During the time between the child’s fourth and seventh birthdays, the rates of additional CPS reports increase more slowly for the parents participating in the HFA program. Over time, the recurrence of maltreatment was found to steadily reduce for the mothers participating in the HFA program. The use of the HFA model was also found to significantly lower the rate of child welfare services related to foster care placement. This study supports the extension of the program to those families that are involved in the child welfare system.

Study in support of the Child Welfare Protocol: Easterbrooks , M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. *American Journal of Public Health*, 109(5), 729-735. doi:10.2105/AJPH.2019.304957.

This study evaluated if HFA for first time young mothers (ages 16-20), reduced the recurrence of child maltreatment in the first seven years of the firstborn child’s life, as evidenced by child protective services reports. This evaluation was conducted through a RCT study with 704 first time mothers assigned to the HFA group or to a control group.

Outcome: It was determined that approximately 50% of the mothers in the HFA group experienced an additional report to CPS. Mothers who received home visits were found to have

reduced risk of receiving a report of recurrence of maltreatment. It was also found that if a second report of maltreatment was made, the report occurred approximately 18 months following the initial report of maltreatment. Therefore, the use of HFA was found to reduce the recurrence of maltreatment and increased the period of time between the initial CPS report and subsequent CPS report, if one was made.

HFA's evidence of effectiveness and the flexibility of enrollment makes HFA a great prevention choice for states and child welfare agencies seeking to strengthen families and reduce the number of children placed in foster care. Almost half of all children who enter foster care in Nebraska are ages 0-5, and 14% of which are age 1 or younger.

The Healthy Families America [website](#)¹⁵ includes specific research on how HFA prevents child abuse and neglect. HFA released a one pager specific to FFPSA and highlights a few of the child welfare areas in which HFA was found to be effective in eight studies including: fewer substantiated child abuse/neglect reports, less neglect and abuse, reduced child welfare involvement and preventing recurrence of child maltreatment by 1/3 among families with prior child welfare involvement.

Homebuilders

According to the Institute for Family Development, report outcomes demonstrated that reduction of risk and increase in community connections. The Washington State Office of Children's Administration Research indicated that at the start of the Homebuilders service, the majority of the families served had a caretaker risk factor. However, at time of case closure, a high percentage of those families demonstrated a reduced risk within that same category. Further, those same families had an increased connection to their communities, especially within mental health and medical services, along with the child's school. Additional resources regarding program effectiveness can be found [here](#).

Per the CEBC, there are three relevant published, peer-reviewed research articles listed regarding Homebuilders. Of those, one was focused on the preservation of the family. This article, by Wood, S., Barton, K., & Schorder, C. (1988), demonstrated the effectiveness of Homebuilders as results indicated that 74% of the families served remained in the home, with a follow up completed 1 year post-intervention.

Motivational Interviewing

According to the official MI website, which can be found [here](#), there is a variety of research articles posted to reflect the effectiveness of MI. Per the CEBC, eight relevant published, peer-

¹⁵Healthy Families America: Preventing Child Abuse and Neglect; https://www.healthyfamiliesamerica.org/wp-content/uploads/2019/10/FFPSA_HFA_one-pager.pdf

review research articles are listed, which reviewed the use of MI in certain target populations and the outcomes of the intervention, up to four years post intervention. In review of each study, a majority reflected behavioral and motivational changes within the clients being provided with MI, in comparison with control group or in random controlled trials.

The Federal Clearinghouse reports that of prioritized studies that were considered to be high or moderate, sixteen favorable outcomes were identified. MI was found to have favorable results within adult well-being: parent/caregiver substance use.

Parents as Teachers

According to the PAT official website, which can be found [here](#), over a dozen outcome studies have been completed on the PAT model. The overall results indicate that use of this model can assist in identifying a child's developmental delays and/or health problems early; children are ready and prepared to enter kindergarten; children achieve school success as they proceed through elementary school; parents own parenting knowledge and skills are improved; parents are more involved in their children's schooling; families are more inclined to promote children's language and literacy, and; child abuse and neglect is prevented. Additional details and information can be found on the PAT website, listed above.

The Federal Clearinghouse provides a number of studies that have been identified and reviewed for PAT. Within these studies, findings indicated a favorable outcome within child safety, child well-being: social functioning, and child well-being: cognitive functions and abilities.

Parent-Child Interaction Therapy

The [CEBC](#) rated PCIT as having well-supported research evidence with medium relevance to child welfare in the following areas: disruptive behavior treatment (child and adolescent) and parent training programs that address behavior problems in child and adolescents¹⁶.

[The U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention \(OJJDP\)](#)¹⁷ identified PCIT as a model with an evidence rating of effective. According to their website, "Program children were more compliant with less behavior problems than the wait list group. The treatment group parents gave more praise and fewer criticisms and improved negative aspects of their parenting. There were fewer reports of physical abuse."

PCIT was also one of the programs included in the [annual evaluations](#) by the Nebraska Child Abuse Prevention Fund Board¹⁸, which was created in 1986 by the State Legislature and is administered by Nebraska DHHS. A few areas where PCIT was found to be effective was in reducing child behaviors, child conduct scores and positive parent interactions.

¹⁶ <https://www.cebc4cw.org/program/parent-child-interaction-therapy/>

¹⁷ <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=122>

¹⁸ <https://www.nebraskachildren.org/what-we-do/prevent-child-abuse-nebraska/child-abuse-prevention-fund-board.html>

Multisystemic Therapy

The [CEBC](#) rated MST as having well-supported research evidence with medium relevance to child welfare in the following areas: alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child & adolescent) and substance abuse treatment (adolescent)¹⁹.

The [OJJDP](#) identified MST as a model with an evidence rating of effective. Per their website, "The treatment group had fewer rearrests and spent fewer days incarcerated than a comparison group that received usual services. The program had a positive impact on family cohesion and social skills for the intervention group."²⁰

Functional Family Therapy

The [CEBC](#) rated FFT as having supported research evidence with medium relevance to child welfare in the following areas: alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child & adolescent) and adolescent substance use treatment²¹.

The OJJDP identified FFT as a model with an evidence rating of effective. According to their website, "Program participants showed a statistically significant reduction in general recidivism and risky behavior, compared with control group participants."

The effectiveness of the HFA, PCIT, MST, and FFT have been demonstrated through multiple research studies and inclusion as evidence-based programs in various clearinghouses. When considered together along with the Federal Clearinghouse's Summary of Findings , Nebraska child welfare-involved families demographics and desired outcomes, Nebraska determined these programs effectiveness is compelling for Nebraska's child welfare populations.

See Attachments Section for **Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice.**

CHILD WELFARE WORKFORCE SUPPORT

CFS has contractors providing the prevention services included in this Plan. The contracted providers are responsible for working with referred families to deliver the evidence-based program to fidelity. CFS staff will complete the Foster Care Prevention Plan (FCPP) as well as be responsible for monitoring safety and risk and documenting the corresponding SDM® Safety and Risk Assessments.

¹⁹ <https://www.cebc4cw.org/program/multisystemic-therapy/>

²⁰ The OJJDP identified FFT as a model with an evidence rating of effective.

²¹ <https://www.cebc4cw.org/program/functional-family-therapy/>

To ensure that contracted providers are qualified to provide one of Nebraska's FFPSA services, DHHS will ensure the provision of services adhere to the standards of being a promising, supported or well-supported service.

For each evidence based intervention included in Nebraska's Plan, the following administrative components will be reviewed as part of the continuous improvement/fidelity process:

- Staff Credentials: Validate the staff providing the evidence-based intervention meet the minimum education, training and certification requirements as required by the model developer, including verification of the workbook/manual being used. This will be conducted quarterly as part of the Contract Monitoring Team's Personnel File Reviews.
- Internal QA/CQI procedures: Validate the provider has implemented and maintains a comprehensive internal quality management review and continuous improvement process (policies and procedure review). This will be conducted annually as part of the Contract Monitoring Team's Personnel File Reviews.
- Contractual requirements: Validate any requirements specific to the evidence-based intervention being provided are complied with, in accordance with the current contractual agreement. This will be conducted annually and will be in collaboration with any Contract Management review efforts conducted by DHHS when appropriate and possible.

CFS partners with the University of Nebraska, Center for Children, Families and the Law (CCFL) to provide training for the CFS workforce. This training helps to ensure staff are competent, skilled, and professional when working within child welfare. CFS worked to ensure CCFL is knowledgeable and equipped to provide new worker training related to FFPSA.

Part of the requirements of being an evidenced based service, is that the service must be trauma informed. It is important that CFS staff receive trauma informed training. All new staff who attend CFS new worker training are provided with several different trauma-informed trainings. A description of these trainings are as follows:

Training: Introduction to Trauma Informed Care

Topic Area: Understanding, recognizing and responding to the effects of all types of trauma; trauma-informed care.

Description: Trainees learn the important concepts and practices related to trauma and trauma-informed care.

Topics include: Types of trauma in children, adolescents, and adults; typical trauma reactions in children; the five core principles of trauma-informed care; and the impact of trauma on the mind, body and behavior.

Training: Secondary Trauma

Topic Area: Understanding, recognizing and responding to the effects of all types of trauma; trauma-informed care.

Description: Trainees learn about secondary trauma and its possible impact on workers.

Topics include: What is secondary trauma, how to recognize it, and protective strategies for self and others.

Training: Trauma Review and Preparation

Topic Area: Trauma-informed care

Description: Trainees review the important concepts and practices related to trauma and trauma-informed care in preparation for application in the classroom.

Topics include: Review of core principles of trauma-informed care, awareness of impacts on traumatic stress, and what therapeutic services should be utilized for trauma.

Training: Trauma Capable

Topic Area: Addressing trauma's consequences and facilitate healing.

Description: Trainees continue to explore the important concepts and practices related to trauma and trauma-informed care.

Topics include: Adverse Childhood Experiences (ACEs); resiliency; how trauma can affect safety, permanency, and well-being; core principles of trauma-informed care and how to respond effectively to traumatic reactions; what therapeutic services should be utilized for trauma; and referring to evidence-based, trauma-focused treatment services.

During both new worker training and continuous trainings each year, CFS will provide training regarding the implementation of FFPSA in the field:

Training: Family First Prevention and Services Act Overview

Topic Area: Understanding the provisions of FFPSA and the Implementation of FFPSA Services in the Field

Description: This course provides an overview of the provisions of the Family First Prevention and Services Act which will directly impact the work of Child and Family Services Specialists and Supervisors.

Topics Include: Information regarding the purpose and philosophy of FFPSA; details on Candidates for Foster Care; the Foster Care Prevention Plan; information on how placements are impacted by FFPSA; and step-by-step instructions for NFOCUS changes that will occur as a result of the implementation of FFPSA.

Training: Family First Prevention and Services Question and Answer Webinar

Topic Area: Additional information on how prevention services for Foster Care Prevention Services are managed and referred as well as to provide an opportunity for staff to gain clarification on the Foster Care Prevention Plan, Prevention Services, QRTP's and placement of youth with their parents in a residential treatment facility.

Description: The purpose of this webinar is to provide information and clarification to Child and Family Services Specialists, Supervisors and Administrators regarding use and implementation of FFPSA services.

Topics Include: How prevention services for Foster Care Prevention Services are managed; how prevention services are referred; and provide an opportunity for staff to gain clarification on the Foster Care Prevention Plan, Prevention Services, QRTPs and Placement of youth with their parent(s) in a residential treatment facility.

Training: Motivational Interviewing

Topic Area: Understanding how to engage, focus, evoke change and plan with others.

Description: Participants learn about Motivational Interviewing as a collaborative conversation style, for strengthening a person's own motivation and commitment to change.

Topics Include: How to help creating change conversations; how to actively listen; how to demonstrate reflective listening; asking open ended questions; how to provide affirmations; how to provide summaries; how to address/handle ambivalence; how to recognize change talk; how to address/handle resistance; how to help sustain change talk, and; how to address/handle discord.

CFS will assess the need for additional trainings each year as part of the required annual in-services training for staff. For additional CFS training details, please see the following section.

CHILD WELFARE WORKFORCE TRAINING

CFS and Center of Children, Families and the Law (CCFL) provide new and current caseworkers with training related to assessing a family's needs for prevention services and accessing identified trauma-informed and evidence-based services. CFS staff are trained in SDM® and SOP®, to enhance family engagement. CFS uses SDM® to help make case management decisions and SOP is a framework used to assist in gathering information. SOP® provides concepts and tools that help provide additional ways to engage and reach understanding with families. SOP® is a model designed to help child welfare staff use critical thinking and build good working relationships with families to improve child safety. The key features of SOP® is that it focuses on teamwork; builds and strengthens the partnership between the agency and family; it involves the family's informal supports and builds on their strengths; it uses strategies and techniques that the child and family as the main focus. Training is provided on an ongoing basis

for specific trauma-informed and evidenced-based services as they become available to each community.

CFS created FFPSA specific on-line training for all staff. Key topics included the purpose and goals of FFPSA, defining candidacy, evidence-based practices, and creating the FCPP on the SACWIS system N-Focus. The goals for CFS are:

1. Ensure children are protected from abuse and neglect through timely contacts and safely maintained in their homes when appropriate with thorough risk and safety assessments throughout the life of the case.
2. Improve engagement with children, youth, parents and foster parents throughout the life of the case to ensure safety, well-being and achieve permanency.
3. Enhance current service array to ensure appropriate and individualized services are accessible
4. Fully implement all provisions of the Family First Prevention Services Act
5. Provide comprehensive, evidence based services to children and families in their homes.
6. Use of family voice/choice in the decision making process.
7. Fully implement Safety Organized Practice.
8. Continue with collaboration with community partners to prevent child abuse/neglect.

CFS has a very comprehensive training program for new Children and Family Services Trainees. Training consultants were utilized to develop a New Worker Training Model which was implemented in May 2017. Training was modified based on feedback of prior trainees, stakeholders, CQI, and needs of the field. Training is offered in an alternating pattern of multiple weeks of local office learning interspersed with single weeks of classroom application training. During the local office learning weeks, trainees acquire new knowledge and skills by completing self-paced online learning activities, participating in webinars, completing field tasks outlined in the Service Area Learning Team (SALT) binder, and by participating in field shadowing or observation opportunities supported by Field Training Specialist (FTS)s. Classroom weeks are face to face instructor led training in Lincoln, Nebraska that focuses on application, role play, and simulated experiences that give trainees an opportunity to apply what is learned during the previous local-office learning weeks. For a full description of New Worker Training refer to the Training Plan submitted for 2020. Changes and modifications are included in the Training Plan submitted for 2020. For the purposes of this systemic factor, Initial Training is defined as all of New Worker Training. CFS Trainees are assigned to work with 4 families and supervisors will assess the CFS Trainees knowledge, skills and abilities utilizing the Competency Development Tool (CDT) between weeks 16 and 20. Upon successfully passing the CDT, the CFS Trainee may be promoted to CFS Specialist on original probation. After promotion to a CFS Specialist, their caseload will gradually increase to a full caseload.

During New Worker Training with CCFL, new staff are provided with a “Case Management Desk Aide” to help guide them in decision making, when they begin to formally manage cases. Additional items added to this guide to assist in understanding FFPSA include the following:

1. Foster Care Prevention Plan SWI
2. QRTP Flowchart
3. QRTP SWI
4. Residential Treatment Facility SWI
5. Example of a documented Foster Care Prevention Plan

Children and Family Services is partnering with CCFL to provide an “In Service” training platform to agency staff on an annual basis to review the Family First Prevention Services Act. Prior to the agency staff participating in this training, they will be required to complete the FFPSA Overview pre-recorded webinar, Residential Substance Use Facilities Overview pre-recorded webinar and the FFPSA Overview-Bridge to Independence pre-recorded webinar. Once this pre-work is completed, the Child and Family Services Specialists, Child and Family Services Supervisors and Child and Family Services Administrators will attend two In Service webinar trainings. These webinars will provide additional training on the following:

1. Foster Care Prevention Plan
 - a. Review of SWI
 - b. Understanding candidacy and eligibility
 - c. Referral process for services
 - d. Documentation on NFOCUS
 - i. How to document a quality FCPP
2. QRTP
 - a. Clarification of what a QRTP is, when to use it, why to consider use of it
 - i. Documentation in NFOCUS (Use of SWI)
 - b. Referral for CAFAS assessment
 - i. Review of flowchart that discusses steps taken after referral is made
 - c. Documentation: where to document this information into N-FOCUS
3. Youth w/parent in residential substance abuse treatment facility
 - a. Clarification of what this type of residential substance use treatment facility is
 - i. Understand what the requirements are for this type of facility under FFPSA
 - b. Documentation in NFOCUS
 - i. Use of the SWI
 - c. Understanding connection to Economic Assistance services (SNAP, Medicaid, etc.).
 - i. Identify what kinds of things/requirements need to be in place that Economic Assistance is looking for to ensure continuity of their benefits

Effective October 1, 2020, CCFL will be contracted to provide "In Service" trainings to the contracted staff providing case management in the Eastern Service Area. CFS will continue to collaborate with St. Francis to have the recorded trainings available on the St. Francis website, for their staff to access and review. Further, St. Francis will train case management and utilization management staff regarding the fidelity and validity of each evidenced-based model utilized in the Eastern Service Area. St. Francis will utilize a referral matrix to track the use of the evidence based programs with families, and evaluate the use of the assigned EBP's to determine continued appropriateness.

In preparing for Family First Prevention Services Act, Saint Francis Ministries staff will receive training designed to educate staff on the evidence-based services available in the Eastern Service Area along with the referral process to each service to ensure families have access to the services outlined in Section 3. Saint Francis Ministries will work with their provider network to support and incorporate the purpose and benefit for utilizing each evidenced based practice intervention through in-services trainings. Saint Francis Ministries continues to move forward with the development of service navigator/locator tools as well as staff use of these tools with children and their families to support the referral process including child and family voice and choice to determine service provision.

CFS has a Professional Development Requirements procedure memo that requires all CFS Specialists, CFS Supervisors, CFS Administrators and CFS Program Specialists to complete 24 hours of in-service professional development per year. The 24 hour annual training requirement is based on a calendar year, January 1 through December 31 following the successful completion of New Worker Training.

Professional development is any training as approved by the employee's supervisor that enhances the employee's knowledge and skills of assessing child or adult safety, initial assessments of children and families, ongoing case management and the provision of services. Data is housed in the Department's Employee Development Center data system and supervisors are to document completion in the employee's Annual Performance Evaluation by reviewing the employee's transcript twice per year. St. Francis Ministries requires all Family Permanency Specialists and Family Permanency Supervisors complete 24 hours of ongoing training each year.

Tribal trainees are invited and recommended to come to New Worker Training however due to workload constraints completion of training by Tribal staff is limited. UNL-CCFL continues to provide one staff member to support field activities to Tribal Trainees and experienced Tribal staff in their local offices. Additionally, CFS holds monthly Tribal Operations and CQI meetings, in which the Tribes are able to voice any concerns or training needs to the CFS Program Specialist. A major support the Tribes requested was continued coordination between UNL-CCFL staff, Quality Assurance (QA) staff, and the Tribes to address missing data within the N-Focus data management system. Tribal workers do not have an ongoing training requirement.

CFS continues to enhance training to focus on the areas of need for case management practices. With the implementation of the Families First Prevention and Services Act (FFPSA), Professional Development training and New Worker Training curriculum and topic areas will be added or modified to meet the needs identified in the Plan.

Training will focus on three primary topics: SOP®, Supervisory Training and Advanced SDM® training.

- CFS has begun implementation of SOP®. Early Adopters began training in January 2019 and training has continued through 2020. CFS continues to utilize partners in San Diego for ongoing coaching and assistance through the implementation. SOP® is being integrated into new worker training to ensure that all CFS staff are trained upon hire. CFS and UNL-CCFL will partner to ensure that ongoing Module training is available to all experienced and new staff.
- CFS and the Department's Learning and Development Unit modified the prior supervisory training to be used by supervisors in all divisions within the Department, therefore training is no longer specialized for CFS Supervisors. Specialized CFS Supervisor training continues to be a need and has been prioritized for the 2019-2020 training plan. UNL-CCFL has provided proposed outline for new supervisor training and curriculum development is in progress.
- Additionally CFS contracted with Burdick Consulting to provide Advanced SDM® Training to Supervisors in the fall of 2019. This training focused on improved assessment for improved outcomes.

Training related to the FFPSA will focus on 1) assessing child and family needs for prevention services; and 2) how to access and deliver the identified trauma informed and evidence-based services. In addition, training is provided on an on-going basis for specific trauma-informed and evidenced-based services as they become available in each community in the form of presentations from service providers, in-service trainings and webinars.

For comprehensive information regarding CFS child welfare workforce training, please see the *Nebraska Training Plan 2020-2024* submitted with the Nebraska CFSP 2020-2024. These plans have been submitted to the Children's Bureau.

MONITORING CHILD SAFETY

As previously noted, CFS utilizes SDM® assessments and is in the process of implementing SOP® to assess and monitor the safety and risk of children and families. SOP® uses a variety of strategies to engage children and families by identifying the concerns that brought the family to the attention of CFS. CFS uses SOP® to identify services that address the safety and risk factors and assess the family's perceptions of where they are in relation to mitigating the safety or risk issues.

SDM® Safety Assessments are required in the initial assessment phase of a case and documented within 24 hours of first contact with the victim or identified child. Additionally, SDM® Safety Assessments are required if there is a change in family conditions, the original safety decision changes, all victims or identified children were not initially interviewed and the original safety decision changes or when a recommendation is made to close an ongoing services case.

SDM® Risk Assessment is completed for families where maltreatment has been alleged in the current intake. A SDM® Prevention Assessment is completed for families when there is not a current maltreatment alleged in the intake. These SDM® Assessments evaluate the family's risk or likelihood of future maltreatment.

The SDM® Family Strengths and Needs Assessment (FSNA) is completed for each family throughout the life of the case. The SDM® FSNA assesses areas of strength and need for the caregiver and child. Such areas include coping skills, mental health, resource management, substance use and parenting skills. Regular assessment allows case managers to identify needs of the family that should be prioritized in the family's case plan, will improve child safety, and will reduce risk of maltreatment by utilizing protective factors already existing in the family.

SDM® Risk Re-Assessments are completed every ninety days for families with children in-home and participating in ongoing case services. The Risk Re-Assessment evaluates a family's progress towards meeting case plan goals and guides decision-making related to case closure. When an ongoing case is considered for case closure based on the Risk Re-Assessment, a new safety assessment is completed. The CFS Standard Work Instructions regarding these assessments can be found within **Attachment L** and **Attachment M**.

In addition to regular SDM® assessments, the CFS staff are required to meet with families and children face-to-face monthly. These visits should occur in the family home or home in which the child resides if they are placed out of the home. The case manager must obtain supervisor approval prior to conducting monthly face-to-face visits with a child outside the home.

Visits with children should be private face-to-face visits. These monthly visits provide information about the child's safety, permanency and well-being and allow the child an opportunity to share information about what is working well, what are they worried about and what needs to happen next²².

CFS staff have monthly face-to-face visits with all parents of all children involved in the case. These visits should occur in the family home at least every other month. During these visits there should be discussion regarding child safety and risk factors, areas of strengths, family needs, and the effectiveness of services being provided to improve the family's safety. A parent is also provided an opportunity to express concerns or input regarding their case. CFS staff will

²² Academy for Professional Excellence; *Safety Organized Practice*; <https://theacademy.sdsu.edu/programs/cwds/sop/>

discuss the SOP danger or harm statements identified by CFS and the family. These statements focus on the areas of concern related to safety and risk. These statements clearly identify what the worry is about, what actions needed to mitigate the worry and how long the action needs to be demonstrated.

The CFS Standard Work Instruction regarding monthly face-to-face contact with families is included as **Attachment K**.

PREVENTION CASELOADS

Caseload sizes for CFS staff with FFPSA eligible families will align with current caseload standards. The Department maintains strict case load standards for all CPS workers. CFS regularly oversees and monitors caseload standards through ongoing CQI practices. The below table contains operational definitions utilized for caseloads in accordance with Neb. Rev. Statute 68-1207. The current caseload ratio for all CPS workers are as follows:

Caseload Type	Caseload Standard
Initial Assessment Cases	1:12 families – urban 1:10 families – rural
Mixed – Initial Assessment Cases & On-Going Cases	1:4 families for Initial Assessment 1:7 children out-of-home 1:3 non-court-involved families <i>Total: 1:14</i>
On-Going – Court-Involved, In-Home Cases	1:17 families
On-Going – Court-Involved, Out-of-Home Cases	1:16 children
On-Going – Court-Involved, Blended In-Home & Out-of-Home	1:10 Out-of-home wards 1:7 In-Home families <i>Total: 1:17</i>

ASSURANCE ON PREVENTION PROGRAM REPORTING

See Attachments Section for **Attachment I: State Title IV-E Prevention Program Reporting Assurance**.

FUTURE PLANNING

Given the many components involved with implementation of FFPSA, Nebraska has focused on short-term implementation goals as well as building a broader service array in the coming months and years. Over the course of the next 5 years, CFS intends to use the information learned from the initial phase of implementation to drive later phases. Some future planning includes the following.

Nebraska decided to begin with a limited definition of candidacy for the initial phase of implementation. However, after transitioning the current system to the changes required within FFPSA and evaluating how the system is functioning, Nebraska intends to **broaden the candidacy definition** further upstream towards primary prevention. This will allow Nebraska to provide additional resources to already strong community prevention efforts focused on supporting families prior to involvement with CFS.

In order to better understand the needs of these families, CFS Program staff review child abuse and neglect intakes that do not meet the standards to be accepted for an assessment. Data was collected beginning in June 2019, identifying potential needs of the family that might be able to be addressed in a less intrusive way and not creating a system.

The complexities of sustaining evidence-based practices are magnified in Nebraska's rural areas. As described in Nebraska's CFSP, effective January 1, 2017, Nebraska Medicaid allowed several services to be delivered through means of Telehealth so families could access the medically necessary services to address physical and behavioral health needs.

Telehealth can be used for assessments and allows clinicians to serve families despite transportation challenges, provider capacity and availability, and access to services in rural areas. This option for service delivery is still fairly new and some youth involved with child welfare are receiving services through telehealth. CFS intends to work with partners in the Division of Medicaid and Long Term Care as well as EBP model developers to expand the use of telehealth for services while still maintaining fidelity to the model.

Additionally, Nebraska has released the [Nebraska Community Opportunity Map](#), launched by Casey Family Programs in 2018. The map is "designed to empower people working in and with communities across the state by providing easily accessible, timely, relevant, and high-quality data." The map provides information relevant to the safety and well-being of children and families. This interactive map is a valuable resource in identifying future services gap and community needs.

FFPSA supports Nebraska's vision for moving the child welfare system to serving families through prevention rather than intervention. The State of Nebraska is proud to be one of the first states to implement FFPSA and looks forward to the renewed vision it offers for the child welfare system.

STATE CONTACT

Jamie Kramer
jamie.kramer@nebraska.gov

ATTACHMENTS

Attachment A: CFS Standard Work Instruction for Foster Care Prevention Plan

Attachment B: Draft Nebraska Evidence-Based Programs

Attachment C: Healthy Families America Protocols for Working with Child Welfare Families

Attachment D: Letter from Family Centered Treatment (FCT) Foundation's Executive Director

Attachment E: Research Publications, Independent Reports and Published Articles Regarding FCT 2004-2019

Attachment F: Independent Review of Family Centered Treatment (ACYF-CB-PI-19-06)

Attachment G.1: Signed Conflict of Interest Statement from The Stephen Group (FCT Independent Review)

Attachment G.2: Signed Conflict of Interest Statement from MEF (FCT Independent Review)

Attachment H: Evaluation Strategy

Attachment I: N-MIECHV 2019 CQI Plan

Attachment J: N-MIECHV User Friendly Benchmark Plan

Attachment K: CFS Standard Work Instruction for Mandatory Monthly Visits

Attachment L: CFS Standard Work Instruction for Initial Assessment

Attachment M: CFS Standard Work Instruction for Ongoing Case Management

Attachment I: State Title IV-E Prevention Program Reporting Assurance

Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Attachment III: State Assurance of Trauma-Informed Service-Delivery

Attachment IV: State Annual Maintenance of Effort (MOE) Report

Purpose: Provides guidance to CFS field staff regarding the process and use of the Foster Care Prevention Plan and Prevention Services

Scope: Division of Children and Family Services Protection and Safety, Bridge to Independence

Responsibilities: Child and Family Services Specialist/Independence Coordinators: Determine whether children are Candidate for Foster Care. Determine eligibility for Pregnant/Parenting Foster Youth. Create Foster Care Prevention Plan (FCPP) with the family. Document progress on goals, strategies and services in the FCPP. Determine whether an extension to the FCPP is necessary and consult with CFS Supervisor for approval.

Child and Family Services Specialist Supervisor: Assist in determining eligibility for Candidates for Foster Care as necessary. Approve FCPP. Consult with CFS Specialist if an extension for a FCPP is necessary and document the Mandatory Consultation Point.

Definitions: AILA: Approved Informal Living Arrangement

Another Planned Permanent Living Arrangement (APPLA): The permanency objective Independent Living will be removed as a Permanency Objective. Another Planned Permanent Living Arrangement (APPLA) will be used for those youth who remain in foster care, who are in a permanent living arrangement with a foster parent, relative or a kinship caregiver and there is a commitment on the part of all parties involved that the youth will remain in the placement until the youth reaches the age of majority or chooses to live independently in a supervised independent living setting.

APPLA goal refers to a situation in which the Department maintains care and placement responsibilities for and supervision of the youth, and places the youth in a setting in which the child is expected to remain until adulthood, such as with:

- Foster parents who made the commitment to care for the child permanently, but not legally.
- Relative caretakers who made the commitment to care for the child permanently, but not legally.
- Supervised Independent Living Setting

CFS: Child and Family Services

CFSS: Child and Family Services Specialist

Evidence-Based Programs (EBP): services that use a defined curriculum or set of services that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence.

Foster Care Prevention Plan (FCPP): a written plan describing the goals, strategies, prevention services and progress, in order to prevent a child from entering foster care.

TLP: Transitional Living Plan

Pregnant or Parenting Foster Youth: a youth or young adult currently placed in foster care, which includes youth placed in APPLA and young adults participating in the Bridge to Independence Program, who are pregnant or parenting. Youth or young adults can be at any stage of pregnancy. Youth or young adults do not have to have their child(ren) in their care or custody to be defined as a “parenting youth”, however, they must have parental rights intact. It is not necessary for paternity to have been established in order for a youth or young adult identified as the father of a child to be defined as “parenting”.

Candidate for Foster Care: a child who is at imminent risk of entering foster care but can remain safely in his or her home or an Approved Informal Living Arrangement as long as Prevention Services are in place to prevent the youth from entering foster care.

This includes:

- A child who is residing in a family home accepted for assessment, with an active, ongoing case, including Court, non-Court, and Alternative Response involved youth;
- A child who was previously in out-of-home care but has been reunified with his/her parent/caregiver.
- A child with a 3c case filed in Juvenile Court; this is a child found to be “mentally ill and dangerous” as defined by Nebraska Revised Statute 43-247 (3)(c)
- A pre-natal infant and/or child(ren) of an otherwise eligible pregnant/parenting foster youth in foster care (including placed in Another Planned Permanent Living Arrangement (APPLA) or participating in the Bridge to Independence program).
- A child whose adoption or guardianship is at risk of disruption or dissolution that would result in foster care placement.
- A child with extraordinary needs and whose parents/caretakers are unable to secure assistance for them; and
- Youth involved with Juvenile Probation and living in the parental/caretaker home

Procedure:

A. Determining a Candidate for Foster Care:

1. A child should be determined to be a Candidate for Foster Care when the following circumstances are met:
Part One-child should meet one of these criteria:

- When an intake is accepted by the Abuse/Neglect Hotline for a family and assigned to a CFS Specialist, Initial Assessment requirements and procedures will remain the same as outlined in Protection and Safety Procedure #2-2018. Once an SDM Safety Assessment has been completed, if a child has been found SAFE or CONDITIONALLY SAFE in their family home and ongoing services are recommended by SDM or otherwise determined to be helpful for the family, this child can be classified as a Candidate for Foster Care.
- When a child's parent(s) is currently placed in foster care, has a permanency plan of an APPLA or participating in the Bridge to Independence Program, this child can be classified as a Candidate for Foster Care.

Part Two: The child can remain safely in his or her home or an Approved Informal Living Arrangement as long as Prevention Services are in place to prevent the youth from entering foster care.

2. If a youth is determined to be a Candidate for Foster Care, the CFS Specialist should discuss with the family the opportunity to participate in Prevention Services. If the family is in agreement with Prevention Services, a FCPP should be developed with the family:
 - i. In conjunction with the Case Plan for Court involved cases and/or cases that involve a pregnant or parenting foster youth;
 - ii. For Alternative Response cases. A permanency objective is not required to be documented.
 - iii. The FCPP and the Case Plan (for court involved cases and/or cases that involve a pregnant or parenting foster youth) must be completed in order to claim IV-E funding.
 - iv. If the youth is determined to be a Candidate for Foster Care, is part of an alternative response or traditional non-court case and their parent is not a pregnant/parenting foster youth, only the FCPP will need to be completed; a case plan is not necessary. A permanency objective is not required to be documented.
3. Structured Decision Making assessments required for traditional Initial Assessment, On-Going Case Management or Alternative Response cases remain the same for cases with families also participating in Prevention Services. Expectations for SDM assessments to be completed is outlined in the following Policies and Standard Work Instructions: PSP #34-2016: Ongoing Case Management; Administrative Memo 2-2018: Initial Assessment; Alternative Response Program Manual.

B. Pregnant/Parenting Foster Youth:

1. If the youth or young adult is pregnant, medical confirmation of the pregnancy is necessary for eligibility. This documentation should be provided by a medical professional and should be scanned into the master case in Document Imaging under Casework. Once this has been provided, a FCPP can be created with the youth or

young adult. It is not necessary for paternity to be established for a father to be eligible for services.

2. If the youth or young adult has qualified for Medicaid services based on a confirmed pregnancy and documentation of the pregnancy confirmation has been provided to Medicaid and displayed on N-FOCUS, a narrative can be entered by the CFS Specialist in the CFS Program Case under Correspondence that a Medicaid narrative confirming the pregnancy; CFS Specialist should provide the date that the narrative was entered.

3. If an eligible youth/young adult is in agreement with participating in prevention services, a FCPP should be created with them. These services are voluntary for the youth or young adult and it should not be required of them to participate.

4. A FCPP should be developed with the eligible youth/young adult *in conjunction* with the Case Plan or Transitional Living Plan in the case of young adults participating in the Bridge to Independence program. The FCPP and the Case Plan/Transitional Living Plan may contain similar information, however, they both need to be completed.

C. Foster Care Prevention Plan

1. The FCPP is a written plan describing the goals, strategies, prevention services and progress, in order to prevent a child from entering foster care. An FCPP shall be created on all traditional non-court cases and alternative response cases, in which the youth meets the FFPSA eligibility and candidacy definition, regardless of whether the service is an FFPSA service. This plan should:

- Include the date a child was identified as a Candidate for Foster Care;
NOTE: this date must be prior to the start of prevention services

Be created *with* the family and must be tied to the family's Case Plan, only when the case is court involved or the caretaker is a pregnant/parenting foster youth. If the parent is involved in the Bridge to Independence program, the FCPP can be tied to the parent's Transitional Living Plan. If a family has an open Alternative Response Case, the FCPP should be created with the family, documented on

- NFOCUS and scanned into Document Imaging, under Casework; the Family Plan is still required.
- The progress narrative shall be updated on a monthly basis, or as circumstances change, whichever comes sooner. The progress narrative shall include the following information:
 - a. Compliance of each caregiver and/or child within the plan for each strategy and service
 - i. Include dates of any missed appointment or services
 - ii. Include conversations had with the family regarding compliance/progress
 - iii. Include next steps and expected outcomes
 - b. Progress of each caregiver and/or child within the plan for each strategy and service
 - i. Include completion dates for specific strategies and services or anticipated completion dates
 - ii. Include overall updates from service providers working with the family on their strategies and goals

iii. Include any barriers the family has experienced regarding their progress

2. Every FCPP should be created with the family. The goals and strategies to address needs within the family should be developed and agreed upon with the parent(s)/caregiver(s) as well as the child(ren) in a developmentally appropriate manner whenever possible. The family should be provided a copy of their FCPP and the CFS Specialist should maintain a copy of the FCPP on N-FOCUS. Any changes to the FCPP should be discussed with the family prior to changes being made and an updated copy should be offered to the family after changes have been made.
3. When identifying Evidence-Based Program(s) and other services to address needs in the family, the CFS Specialist should review the one-page summaries of the EBP services and/or be able to articulate the service array options, that are designed to address the family's specific needs and allow for family voice and choice in deciding which services and provider they feel best fit the needs of their family. The CFS Specialist can make recommendations for services they feel would be the best fit and provide additional information they have on the services based on professional experience with them, however, it is ultimately the family's decision which services are referred for them and are included in their FCPP.
4. The FCPP can remain active for up to the last day of the 12th month from the date it is created (for example: if a FCPP is created 10/2/2019, it can remain active until October 31, 2020). If a need for Prevention Services remains for a family after their FCPP has been active for 12 months, the FCPP can be extended for an additional 12 months. Extending a FCPP is a Mandatory Consultation Point between the CFS Specialist and CFS Supervisor which should be documented under Mandatory Consultation Point on N-FOCUS as well as the in Progress field in the FCPP.
5. If, after closing a FCPP after the initial 12-month time period, additional needs for Prevention Services are identified and the child(ren) continue to meet the criteria to be a Candidate for Foster Care, a new FCPP can be created at any time and can be active a new 12-month time period. For example, if a FCPP is active from 10/2/2019-10/31/2020 and additional needs are identified for the family on 11/3/2020, a new FCPP can be created and can be active until 11/30/2021.

D. Cases open prior to October 1, 2019 with Candidates for Foster Care

Families who are working with CFS prior to the implementation of the FCPP on October 1, 2019, whose child(ren) meet qualifications to be a Candidate for Foster Care are eligible for Prevention Services. The CFS Specialist assigned to work with the family should discuss with the family the opportunity to participate in Prevention Services and, if the family is in agreement with Prevention Services, develop a FCPP for their child(ren). A FCPP should be developed with the family *in conjunction with the Case Plan for Court involved cases and/or cases that involve a pregnant or parenting foster youth or Family Plan for Alternative Response cases. The FCPP and the Case Plan (for court involved cases and/or cases that involve a pregnant or parenting foster youth)/Family Plan may contain similar information, however, they both need to be completed in order to claim IV-E funding. If the youth is determined to be a Candidate for Foster Care, is part of a non-court case and their parent is not a pregnant/parenting foster*

youth, only the FCPP will need to be completed; a case plan is not necessary. As a reminder, the FCPP must be created **prior** to a Prevention Service starting.

E. Creating a Foster Care Prevention Plan on NFOCUS

1. IMPORTANT: FCPP must be in FINAL status for Prevention IV-E eligible services to be reimbursable with Prevention IV-E funds. Additionally, each child must have his/her own FCPP.

2. To document a FCPP, follow these steps:

- Navigate to the Detail Program Case window, highlight a child/youth, and



click the FCPP icon.



- The Detail FCPP window will display.

Attachment A

The screenshot shows the 'N-FOCUS - Detail Foster Care Prevention Plan' application window. At the top, there's a menu bar with 'File', 'Actions', and 'Help'. Below the menu is a toolbar with several icons. The main area has fields for 'Name' and 'Person Number', and an 'ADD' button. A section titled 'Foster Care Prevention Plan' contains 'Begin Date' (07-10-2019), 'Plan ID Nbr' (0), 'End Date' (06-30-2020), 'Completed By' (with a dropdown arrow icon), 'Office' (Status Draft, Status Date 07-10-2019), and 'Eligibility Type' (dropdown list). Below this is a 'Reviewed By' section with 'Reviewed By' and 'On Behalf Of' fields. At the bottom, there's a 'Goto Person Detail' button and a status bar showing '07-10 N-FOCUS - Test Date'.

- **Note:** The Begin Date will be auto-populated with today's date. The End Date will be auto-populated to the last day of the 12th month from the Begin Date.
- Enter the "Completed By" field by selecting the Out Select Arrow.
- The "Search Office Position" window will display. Search for the worker and return to the "Detail Foster Care Prevention Plan" window with the **Blue Select Arrow**.
- Click on the Eligibility Type dropdown list and select the appropriate option.
- Click the Eligibility Questions button and complete the questions.

Attachment A

The screenshot shows the 'N-FOCUS - Detail Foster Care Prevention Plan' application window. In the center, there is a modal dialog box titled 'NFOCUS - Prevention Plan Eligibility Question'. The dialog contains three dropdown menus labeled '01. Is this child at serious risk of entering foster care?', '02. Can this child remain safely in the family home or a kin caregiver's home with services in place?', and '03. Is foster care the planned arrangement for the child if removal from the family home becomes necessary?'. Each dropdown has a red border around it. At the bottom of the dialog are 'Confirm' and 'Cancel' buttons. The main window background shows fields for 'Name', 'Person Number', 'Begin Date' (07-10-2019), 'Plan ID Nbr' (0), 'End Date' (06-30-2020), 'Completed By', 'Office', 'Status' (Draft), 'Status Date' (07-10-2019), 'Eligibility Type' (Candidate for Foster Care), and a 'Plan/Goals' button.

- If any questions are answered “NO”, you will receive a message indicating the child/youth is not eligible. The plan cannot be saved until all questions are answered “YES”. You can click Cancel to close the window without saving the responses and return to the Detail Foster Care Prevention Plan window.
- When all the questions are answered “YES”, click Confirm to return to the Detail Foster Care Prevention Plan window.
- Click Save.
- A Draft version of the FCPP is now saved.
 - **Note:** There will be no permanent record of the FCPP before this step.
- Click the “Plan/Goals” button and go to the “Detail Foster Care Prevention Plan Narratives” window.

Attachment A

N-FOCUS - Detail Foster Care Prevention Plan Narrative

File Actions Help

Household Name: Case Plan ID: ADD

Goals:

Strategy:

Services:

Progress:

Max ABC

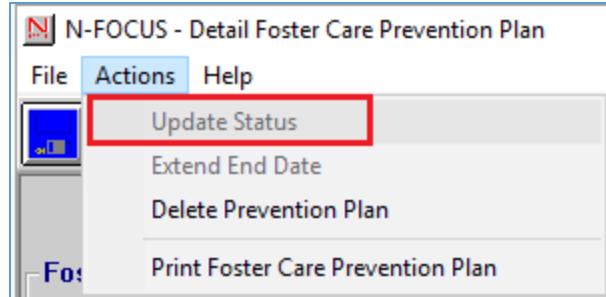
Max ABC

Max ABC

Max ABC

N-FOCUS - Test Date
08-08-05-2014 | 12:57

- Complete the “Goals”, “Strategy”, “Services”, and “Progress” fields
 - **Note:** The Goals, Strategies and Services should be reflect what has been developed with the family. The “Progress” field can be used to provide update notes regarding progress or additional goals or services that have been added.
- If the user wants to add an additional goal, click the Save and Next button.
- If the user wants to return to the Detail screen, click Save and Close.
- When there are multiple Plan/Goals, the user can view these in the List
- Ensure that progress notes are documented on a monthly basis or when circumstances change; whichever occurs sooner. Documentation in this box will satisfy the “compliance” requirement contained within the monthly Child Advocacy Center report, via Neb. Rev. Stat. 43-4407.
- When ready to change the status to Ready for Review, select Action> Update Status.



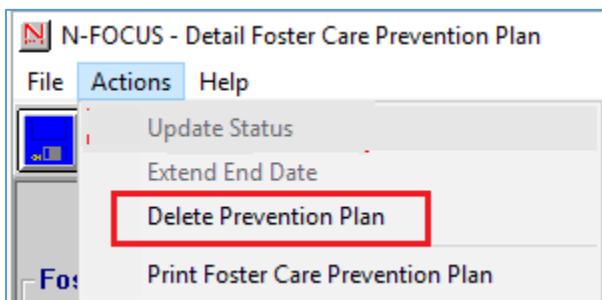
F. Deleting a Foster Care Prevention Plan

1. **IMPORTANT:** This function is only available when the Foster Care Prevention Plan is in Draft or Revisions Required status.

2. To delete a FCPP, follow these steps:

- Navigate to the Detail Program Case window, highlight a child/youth, and click the Foster Care Prevention Plan icon.

- The List Foster Care Prevention Plan window will display.
- Highlight a plan and select Action>Delete Prevention Plan.



G. Foster Care Prevention Plan Copy Narrative

1. When the Copy icon  is selected, the Copy Plan Narrative pop-up window will display.

- Select the individual whose goals you wish to copy.
- Click the Copy Plan Narratives button
- The selected narratives will be created in the current individuals Prevention Plan.

H. Foster Care Prevention Plan Review Narrative

1. The Detail Foster Care Prevention Plan window has a Review Narrative button

Review Narrative

2. When this button is selected, the Search Narrative window will display.

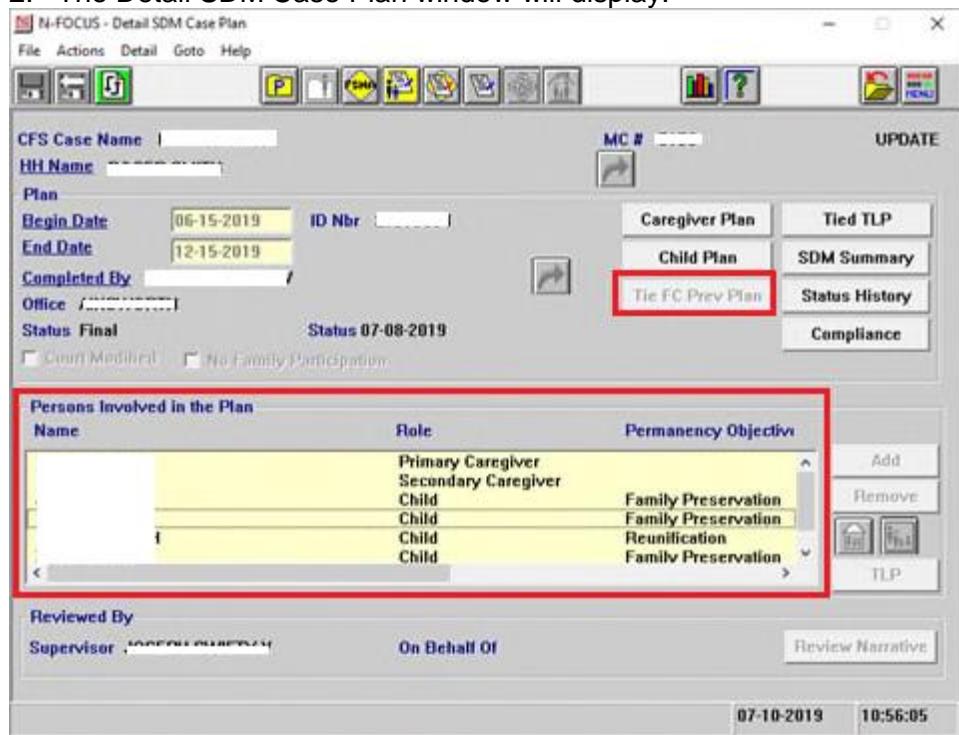
3. From this window, you can either create new or search for existing Foster Care Prevention Plan Review narratives.

I.Tying a FCPP to a Case Plan

1. Navigate to the Detail Program Case window and click the Case Plan button

Case Plan

2. The Detail SDM Case Plan window will display.



3. Highlight the child/youth from the Persons Involved in the Plan list box.

- The Tie Foster Care Prevention Plan push button will become active.

Tie FC Prev Plan

4. Click the Tie FC Prev Plan button

- The List FC Prev Plan window will display.

5. Select the appropriate FCPP from the list.

6. Click the Blue Return Arrow.
 7. Confirm the correct FCPP was selected.
 8. Once tied, the user may view the tied FCPP by clicking on the Foster Care Prevention Plan icon  on the Detail SDM Case Plan window.
9. **Note:** Case Plans cannot be moved from FINAL status to ADMIN REOPEN status when one or more FCPP's are tied. You must untie each FCPP and then change the status of the Case Plan.
- To untie a FCPP, select the child/youth on the Detail SDM Case Plan window, click Actions>Untie Foster Care Prevention Plan.
 - Follow the instructions above to retie the FCPP's prior to returning the Case Plan to FINAL status.

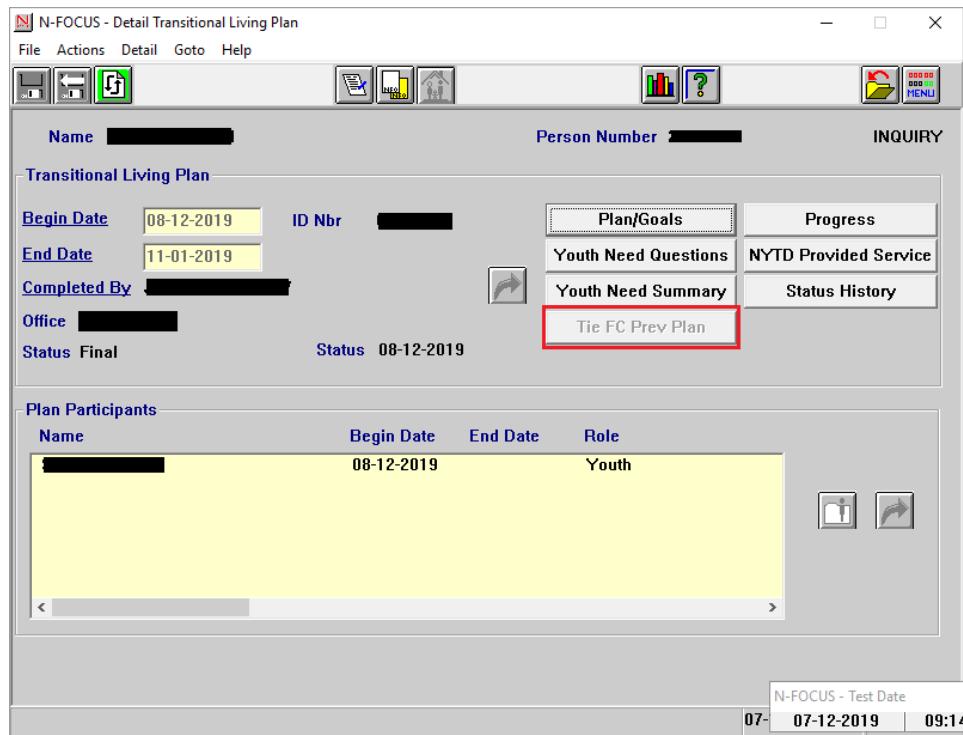
B. Tying a FCPP to a Transitional Living Plan

1. Navigate to the Detail Program Case window and click the TLP button.



TLP

The Detail Transitional Living Plan window will display.



N-FOCUS - Detail Transitional Living Plan

Name [REDACTED] Person Number [REDACTED] INQUIRY

Transitional Living Plan

Begin Date 08-12-2019	ID Nbr [REDACTED]	Plan/Goals	Progress
End Date 11-01-2019		Youth Need Questions	NYTD Provided Service
Completed By [REDACTED]		Youth Need Summary	Status History
Office [REDACTED]		Tie FC Prev Plan	
Status Final	Status 08-12-2019		

Plan Participants

Name	Begin Date	End Date	Role
[REDACTED]	08-12-2019		Youth

N-FOCUS - Test Date 07-07-2019 09:14

2. Highlight the child/youth.
3. The Tie FC Prev Plan button will become active.
4. Click the Tie FC Prev Plan button.



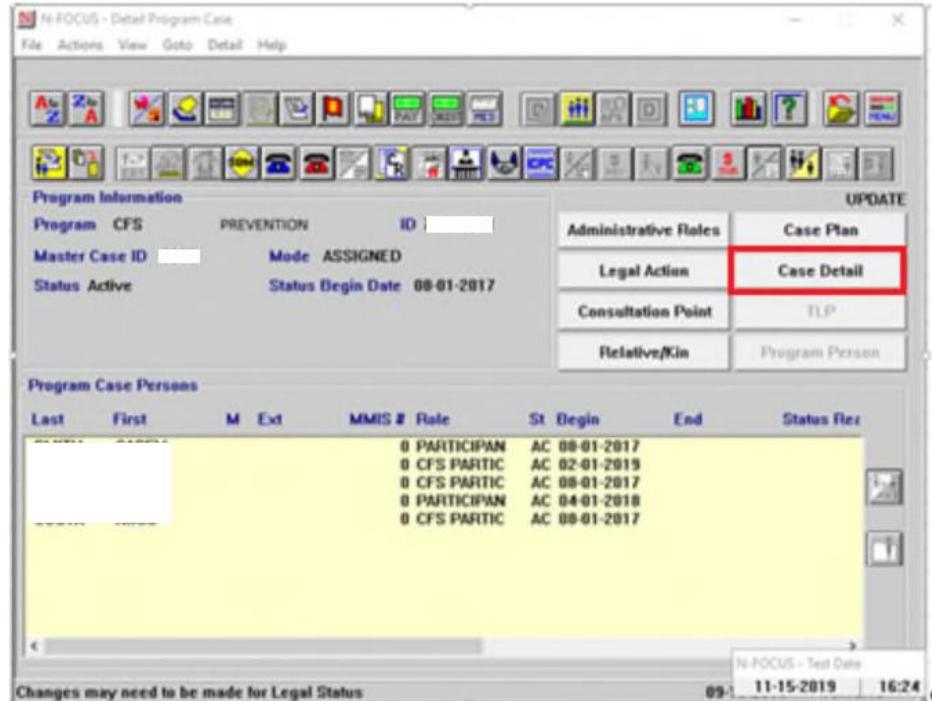
Tie FC Prev Plan

- The List Foster Care Prevention Plan Window displays.
5. Select the appropriate Foster Care Prevention Plan
 6. Click the Blue Return Arrow.
 7. Confirm the correct Foster Care Prevention Plan was selected.
8. Once tied, you may view the tied Foster Care Prevention Plan by clicking the  Foster Care Prevention Plan icon on the Detail Transitional Living Plan window.
9. **Note:** TLPs cannot be moved from FINAL status to ADMIN REOPEN status when one or more Foster Care Prevention Plans are tied. You must untie each Foster Care Prevention Plan and then change the status of the TLP.
10. To untie, highlight the child/youth on the Detail Transitional Living Plan window, click Actions, and click Untie Foster Care Prevention Plan.
 11. Follow the instructions above to retie the Foster Care Prevention Plans prior to returning the TLP to FINAL status.

K. FFPSA Assistance Code

Children/youth in Guardianships and Adoptions and youth who are not directly involved in an open/active CFS case, represent a population that is eligible for FFPSA funds. However, FFPSA requires the IV-E agency to maintain the prevention plan for these children/youth. Some of these children/youth, and some others, are not currently involved with CFS and therefore do not have a CFS Program Case on N-FOCUS, where the formal Foster Care Prevention Plan is maintained.

1. This Assistance Code permits adding individuals to N-FOCUS who otherwise would not have a CFS Program Case.
2. A new CFS Program Case (and Master Case if one does not exist) must be created.
3. The Assistance Code will be set to Traditional Response
4. Add (or create) the applicable individuals as you normally would.
5. Once the CFS Program Case is created, use the following steps to change the assistance code to "Prevention".
 - i. Navigate to the CFS Detail Program Case window
 - ii. Click the Case Detail Button



The Case Detail pop up window will display

- iii. Select Prevention from the Assistance drop down
- iv. Click OK



Expected Results: To provide clear and accurate instruction for CFS Specialists to determine Candidacy Eligibility for Foster Care Prevention Services and for creating a Foster Care Prevention Plan.

Attachment A

References:

PSP #34-2016: Ongoing Case Management
Administrative Memo 2-2018: Initial Assessment
Alternative Response Program Manual
Neb. Rev. Stat. 43-4407

Revision History:

REVISION LEVEL	DESCRIPTION	AUTHOR	APPROVAL DATE	EFFECTIVE DATE
Version 5		Jamie Kramer	7-1-2020	7-1-2020

Approval by: *Jamie Kramer* **Date:** _____ **7-1-2020** _____

Nebraska EBP - DRAFT

**SEE KEY ON LAST PAGE		Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
Type of FFPSA Service	Name of Program								
In Home Parenting Skill Based Program	3 5 7 Model	The 3-5-7 Model® is a copyrighted strengths-based approach that empowers young people and families to engage in the work of grieving their losses and rebuilding relationships towards the goals of well-being, safety, and permanency. The 3-5-7 Model® incorporates the underpinnings from child development, attachment, separation and loss, trauma, family systems, relationship development, and resiliency theories to provide a directional approach to achieving permanency in relationships. The 3-5-7 Model® uses tools (e.g., lifebooks, loss/life lines) to support work around issues of separation and loss, identity formation, attachment, and building relationships, and it also supports deeper therapeutic work around abuse, abandonment, and neglect experiences. Practice applications can be made throughout ongoing case management services, from intake to child protective to placement services. Along with being a standalone program as described in this entry, the three tasks of the 3-5-7 Model® are designed to be able to be used with other child welfare practice models. The 3-5-7 Model® supports kinship, foster, and adoptive family relationships. The 3-5-7 Model® can also be used as an engagement strategy with birth families.	Young people and parents (biological, foster, kinship, and adoptive) receiving services in the child welfare system For children/adolescents ages: 0 – 21 For parents/caregivers of children ages: 0 – 21	NR	High	Yes		http://www.cebc4cw.org/program/3-5-7-model/	
Juvenile Justice	Crossover Youth Practice Model (CYPM)	CYPM is for child welfare agencies with youth receiving any level of services) that are at-risk for or have been referred to or become involved with the juvenile justice system and for juvenile justice departments with youth who are subsequently referred to and become involved in the child welfare system because of suspicions of abuse/neglect. CYPM is designed to create a multisystem approach to identification of youth, assessment of needs, collaborative case planning, and ongoing case management. The model is designed to provide a foundation that helps jurisdictions work collaboratively with the goals of improving system functioning and outcomes for youth. The model implements a process that seeks to reduce the number of youth who crossover between the child welfare and juvenile justice systems, the number of youth entering and reentering out-of-home care, the length of stay in out-of-home care, the use of congregate care, and the disproportionate representation of children of color. The CYPM infuses into this work values and standards; manualized practices, policies; and procedures; and quality assurance processes.	A child welfare agency and juvenile justice department serving the same youth or youth at risk of becoming involved in each other's system For organizations that serve children ages: 11 – 17	3	High	Yes		http://www.cebc4cw.org/program/crossover-youth-practice-model-cypm/	
Mental Health and Substance Abuse Prevention Treatment Service	Aggression Replacement Training (ART):	Aggression Replacement Training® is a cognitive-behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents ages 12–17. The program consists of 10 weeks (30 sessions) of intervention training, and is divided into three components—social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition, and reinforce the lessons in the curriculum	Chronically aggressive children and adolescents ages 12–17 For organizations that serve children ages: 12 – 17	3	Medium	No	Cost: \$1,449 (for youth in state juvenile justice institutions) Savings: \$4,865 B-C: \$4,03	http://www.cebc4cw.org/program/aggression-replacement-training/	
Mental Health and Substance Abuse Prevention Treatment Service	Alternative Response	NE: A comprehensive assessment of (i) child safety, (ii) the risk of future child abuse or neglect, (iii) family strengths and needs, and (iv) the provision of or referral for necessary services and support that does not include an investigation or formal determination as to whether child abuse or neglect has occurred or the entry of the subject of the report into the central registry of child protection cases maintained pursuant to Neb. Rev. Stat. § 28-718. (http://dhss.ne.gov/children_family_services/AlternativeResponse/Pages/Program.aspx)	NE: Intakes of child abuse/neglect that do not meet any exclusionary criteria and dependent on RED Team criteria review - NE's program is being evaluated; Minnesota's AR model called Family Assessment Response is a 3	NR- NE; 3- MN	High (MN)	Yes		http://www.cebc4cw.org/program/family-assessment-response/	
Mental Health and Substance Abuse Prevention Treatment Service	Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	Alternatives for Families: A Cognitive-Behavioral Therapy (originally named Abuse-Focused Cognitive-Behavioral-Therapy) is designed for families who are referred for problems related to the management of anger and/or aggression, which include several behaviors on a continuum reflecting the use of coercion and/or physical force. Specifically, AF-CBT seeks to improve the relationships between children and their parents/caregivers who experience any of the following clinical concerns: anger/emotional abuse, family conflict, child behavior, child physical abuse. AF-CBT is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, developmental victimology, and the psychology of aggression.	Caregivers who are emotionally or physically aggressive or abusive with their children, children who experience behavioral dysfunction, especially aggression, or trauma-related symptoms secondary to their as exposure to physical discipline/abuse, and high conflict families who are at-risk for these problems. For children/adolescents ages: 5 – 17 For parents/caregivers of children ages: 5 – 17	3	High	Yes	N/A (\$1500 per therapist to be trained.)	http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/	
In Home Parenting Skill Based Program	Attachment Biobehavioral Catchup	ABC targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first prevention component helps caregivers to re-interpret children's behavioral signals so that they 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 environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children's lead with delight. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child	Caregivers of infants 6 months to 2 years old who have experienced early adversity	1	High	Yes		http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/	
Mental Health and Substance Abuse Prevention Treatment Service	Celebrating Families	Celebrating Families!™ is a family-inclusive, trauma-informed, skill-building program for families with a parent with a substance addiction that was developed to prevent children's future addiction, mental and physical health problems. The program combines prevention and intervention in order support the healing of families in early recovery, while developing skills to prevent future addiction. The program is available in a Spanish version, ¡Celebrando Familias!, with a minor cultural modifications but the same content.	Adults with a diagnosed substance use disorder, or substance use problems, addiction, dependence, or abuse For children/adolescents ages: 0-17	NR	Medium	No		http://www.cebc4cw.org/program/celebrating-families/	
Mental Health and Substance Abuse Prevention Treatment Service	Child Centered Play Therpay	CCPT is a developmentally responsive, play-based mental health intervention for young children ages 3 to 10 who are experiencing social, emotional, behavioral and relational disorders. CCPT utilizes play, the natural language of children, and therapeutic relationship to provide a safe, consistent therapeutic environment in which a child can experience full acceptance, empathy, and understanding from the counselor and process inner experiences and feelings through play and symbols. In CCPT, a child's experience within the counseling relationship is the factor that is most healing and meaningful in creating lasting, positive change. Based on person-centered principles, overarching goal of CCPT is to unleash the child's potential to move toward integration and self-enhancing ways of being. Child outcomes following CCPT include decreased symptomatic behaviors and improvement in overall functioning.	Children ages 3-10 who are experiencing social, emotional, behavioral and relational problems For children/adolescents ages: 3 – 10	3	Medium	No	N/A	http://www.cebc4cw.org/program/child-centered-play-therpay-ccpt/	

Type of FFPSA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
In Home Parenting Skill Based Program	Child Focused Recruitment (Wendy's Wonderful Kids)	Child-Focused Recruitment is a prescribed model of foster care adoption recruitment that addresses the individual needs, circumstances, and history of children waiting to be adopted and provides the foundation for searching for appropriate families for children, particularly children most at risk of aging out of care (e.g., older youth, youth with mental challenges, sibling groups, children already in care for significant periods of time and in multiple placements). The program is currently managed by the Dave Thomas Foundation for Adoption.	Children 9-18 years of age that have been freed for adoption or with a plan for adoption with an emphasis on older youth waiting to be adopted; also appropriate for younger children with special needs, part of a sibling group, or with mental or physical challenges For children/adolescents ages: 9 – 18	3	High	Yes		http://www.cebc4cw.org/program/child-focused-recruitment-wendy-s-wonderful-kids/	
Mental Health and Substance Abuse Prevention Treatment Service	Child-Parent Psychotherapy	CPP is a treatment for trauma-exposed children aged 0-5. 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 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). 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.	Target Population: Children age 0-5, who have experienced a trauma, and their caregivers For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5	2	High	Yes	N/A Training costs available	http://www.cebc4cw.org/program/child-parent-psychotherapy/	
In Home Parenting Skill Based Program	Circle of Security	The COS-P protocol presents Circle of Security content in eight chapters using a manual for the provider, handouts for the parents, and a DVD that explains and shows examples of all concepts presented. The facilitator stops at designated moments and asks reflective questions to participants. The core concepts of the program are: •The caregiver serves as a secure base from which the child can explore and as a safe haven to which the child can return for connection in times of stress •Some parents feel uncomfortable/threatened by their child's exploration (moving away), whereas others have these negative feelings instead in response to their child's attachment wishes (bids for connection) •Given that a child thrives when the caregiver is relatively responsive to both attachment and exploratory behavior, it is important that the caregiver develop the reflective capacity to consider what may hinder or help her/his capacity to respond.	Families with children younger than 6 years old in high-risk populations such as child enrolled in Early Head Start, teen moms, or parents with irritable babies For parents/caregivers of children ages: 0 – 5	NR	Medium	Yes		http://www.cebc4cw.org/program/circle-of-security-parenting/	
In Home Parenting Skill Based Program	Circle of Security - HV4	COS-HV4 is a version of Circle of Security that includes a mandatory home visiting component consisting of 4 home visits. The overall Circle of Security protocol focuses on: •Teaching caregivers the fundamentals of attachment theory (i.e., children's use of the caregiver as a secure base from which to explore and a safe haven in times of distress) by introducing a user-friendly graphic to the caregivers that they can refer to throughout the program •Exploring not only parenting behaviors but also internal working models •Presenting caregivers with a simple structure for considering the ways in which their internal working models influence their cognitive, affective, and behavioral responses to their children, thus helping caregivers gain awareness and understanding of the nonconscious, problematic responses they sometimes have to their children's needs The Circle of Security approach provides caregivers with the skills to understand their children's behavior, and the skills to understand and regulate their own cognitive, affective, and behavioral responses to their children.	Families with children younger than 6 years old in high-risk populations such as child enrolled in Early Head Start, teen moms, or parents with irritable babies For parents/caregivers of children ages: 0 – 5	3	Medium	Yes	N/A	http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/	
Mental Health and Substance Abuse Prevention Treatment Service	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	CBITS is a school-based, group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems among students exposed to traumatic life events, such as exposure to community and school violence, accidents, physical abuse, and domestic violence. It is designed for students, who have experienced a traumatic event and have current distress related to that event. The goals of the intervention are to reduce symptoms and behavior problems and improve functioning, improve peer and parent support, and enhance coping skills. The program includes 10 student group sessions, 1-3 student individual sessions, 2 parent sessions, and a teacher educational session. Developed for the school setting in close collaboration with school personnel, the program is well suited to the school environment.	3rd through 8th grade students who screened positive for exposure to a traumatic event and symptoms of posttraumatic stress disorder related to that event, largely focusing on community violence exposure; may be used with older students as well For children/adolescents ages: 8 – 15	3	Medium	No		http://www.cebc4cw.org/program/cognitive-behavioral-intervention-for-trauma-in-schools/	
Mental Health and Substance Abuse Prevention Treatment Service	Cognitive Processing Therapy (CPT)	CPT was originally developed for use with rape and crime victims, but it is used with a variety of trauma populations, including both military and civilian samples. CPT focuses on identifying and challenging maladaptive beliefs that develop about, and as a result of, the traumatic event. The therapist helps the client to identify problem areas (i.e., stuck points) in their thinking about the traumatic event, which have impeded their recovery. Therapists then use Socratic dialogue, a form of questioning that encourages clients to examine and evaluate their own beliefs rather than being told in a directive way, to help clients challenge their stuck points. Throughout the treatment, worksheets and Socratic dialogue are used to help clients replace maladaptive beliefs with more balanced alternative statements. CPT can be delivered individually or in a group format.	Adults who have experienced a traumatic event and are currently suffering from the symptoms of posttraumatic stress disorder (PTSD) and/or meet criteria for a diagnosis of PTSD	1	Medium	No	N/A	http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/	
Mental Health and Substance Abuse Prevention Treatment Service	Cognitive-Behavioral Therapy (CBT); (includes CPT and TF)	CBT is a skills-based, present-focused, and goal-oriented treatment approach that targets the thinking styles and behavioral patterns that cause and maintain depression-like behavior and mood. Depression in adults is commonly associated with thinking styles that are unrealistically negative, self-focused and critical, and hopeless in nature. Rumination thinking processes are also typical. Cognitive skills are used to identify the typical "thinking traps" (cognitive distortions) that clients commit and challenge them to consider the evidence more fairly. Depressed adults also demonstrate increased isolation, withdrawal, simultaneous rejection of others and sensitivity to rejection, and decreased activity and enjoyment in activities. They typically experience a number of functional impairments including disrupted sleep cycles, eating and appetite issues, and increased thoughts of death and dying. Behavioral interventions can often help these interpersonal and functional impairments. Behavioral interventions include problem solving, behavioral activation, and graded activation or exposure. Treatment is generally time-limited and can be conducted in individual or group formats.	Adults (18 and over) diagnosed with a mood disorder, including Unipolar Major Depressive Disorder (MDD), Depressive Disorder Not Otherwise Specified, and minor depression.	3	Medium	No	Cost: \$1,436 (2014) Savings: \$12,221 B-C: \$9.39	http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/	
In Home Parenting Skill Based Program	Common Sense Parenting	Common Sense Parenting™ (CSP) is a group-based class for parents comprised of 6 weekly, 2-hour sessions led by a credentialed trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior. Each class is formatted to include a review of the prior session, instruction of the new skill, modeled examples, skill practice/feedback, and a summary.	Parents and other caregivers of children ages 6 - 16 years For parents/caregivers of children ages: 6 – 16	2	Medium	No	N/A	http://www.cebc4cw.org/program/common-sense-parenting/	

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Mental Health and Substance Abuse Prevention Treatment Service	Dialectical Behavior Therapy - DBT	Dialectical behavior therapy (DBT) is an evidence-based[1] psychotherapy designed to help people suffering from borderline personality disorder (BPD). It has also been used to treat mood disorders as well as those who need to change patterns of behavior that are not helpful, such as self-harm, suicidal ideation, and substance abuse.[2] This approach is designed to help people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helping to assess which coping skills to apply in the sequence of events, thoughts, feelings, and behaviors to help avoid undesired reactions	Ages 13–25. Borderline personality disorder (BPD), self-harm, and substance abuse	was on SAMHSA			Cost: \$2,148 (2016) \$150/ individual session + \$60/ group session = for full year intensive, cost could be		
	Domestic Abuse Intervention Project - The Duluth Model (DAIP)	The DAIP was designed in 1981 as a Coordinated Community Response (CCR) and includes law enforcement, the criminal and civil courts, and human service providers working together to make communities safer for victims. The DAIP, located in Duluth, Minnesota, includes a 28-week education program for offenders. This model is commonly referred to as the "Duluth Model." The program uses the curriculum Creating a Process of Change for Men Who Batter, which was developed by the DAIP. Advocates at the DAIP contact the partners of men court-ordered to the program to offer advocacy, community resources, and education groups for women.	Adult males who are both court-ordered (civil or criminal) and voluntary participants	3	Medium	No	Cost: \$1,365 (2011)	http://www.cebc4cw.org/program/domestic-abuse-intervention-project/	
In Home Parenting Skill Based Program	Early Head Start	Early Head Start (EHS) is a federally funded early childhood development program aimed at low-income families. Children and families enrolled in center-based programs receive comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. In home-based settings, children and their families are supported through weekly home visits and bi-monthly group socialization experiences. EHS also serves children through locally designed family child care options, in which certified child care providers care for children in their homes. Services include: early education both in and out of the home; parenting education; comprehensive health and mental health services for mothers and children; nutrition education; and family support services.	0-3 Early Childhood	3	Medium	Yes		http://www.cebc4cw.org/program/early-head-start/	
Mental Health and Substance Abuse Prevention Treatment Service	Ecologically Based Family Therapy	EBFT addresses multiple ecological systems and originated from the therapeutic work with substance-abusing adolescents who have run away from home. The treatment was developed to address immediate needs, to resolve the crisis of running away, and to facilitate emotional re-connection through communication and problem solving skills among family members. Family interaction is a necessary target of the therapeutic techniques. Therapy relies on understanding the individual, interpersonal, and environmental context as well as the unique resources and needs of the family and its members. The intervention includes family systems techniques such as reframes, relabels, and relational interpretations; communication skills training; and conflict resolution, but also therapeutic case management in which systems outside the family are directly targeted. The model includes 12 home-based (or office-based) family therapy sessions and 2-4 individual HIV prevention sessions.	Substance-abusing runaway adolescents (12-17) and their family members who are willing to have the adolescents live in their homes For children/adolescents ages: 12 – 17 For parents/caregivers of children ages: 12 – 17	2	Medium	Yes	N/A	http://www.cebc4cw.org/program/ecologically-based-family-therapy/	
Mental Health and Substance Abuse Prevention Treatment Service	Eye Movement Desensitization and Reprocessing (for Children) (for Adult PTSD)	EMDR therapy is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the EMDR trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used. EMDR is also highlighted on the CEBC website in the Trauma Treatment - Client-Level Interventions (Child & Adolescent) topic area, click here to go to that entry.	Children and adolescents who have experienced trauma; research has been conducted on posttraumatic stress disorder (PTSD), posttraumatic stress, phobias, and other mental health disorders For children/adolescents ages: 2 – 17 Adults who have experienced trauma and may experience posttraumatic stress disorder (PTSD), post-traumatic stress, phobias, and other mental health disorders	1	Medium	No	Children - Cost: \$886 (2009) Savings: \$8,810 B-C: N/A Adults - Cost: \$974 (2014) Savings: \$41,349 B-C: \$598.49	http://www.cebc4cw.org/search/results/?keywword=EMDR	
In Home Parenting Skill Based Program	Families and Schools Together	FAST® - Elementary School Level is a 2-year prevention/early intervention program based on social ecological theory, family systems theory, social mobility theory, child development theory, and family stress theory. FAST® is designed to build relationships within and between families, schools, and communities (particularly in low-income areas) to improve childhood outcomes. The intervention consists of an active outreach phase to engage and recruit families; 8 weeks of multifamily group meetings, each about 2.5 hours long; and continued in 2 years of monthly, parent-led group meetings. The 8 weekly sessions follow a preset schedule and include activities such as family communication and bonding games, parent-directed family meals, parent social support groups, between-family bonding activities, one-on-one child-directed play therapy, and opening and closing routines modeling family rituals. Sessions are led by trained culturally representative teams that include at least one member of the school staff in addition to parents and professionals from local social service agencies.	Children in Pre-Kindergarten through 5th grade and their families	3	Medium	No	Cost: \$1,694 (2009) Savings: \$439 B-C: \$1.23	http://www.cebc4cw.org/program/kids-families-and-schools-together-kids-fast/	
Mental Health and Substance Abuse Prevention Treatment Service	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. 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. A foundational belief influencing the development of FCT is that the recipients of service are great people with tremendous internal strengths and resources. This core value is demonstrated via the use of individual family goals that are developed from strengths as opposed to deficits. Obtaining highly successful engagement rates is a primary goal of FCT. The program is provided with families of specialty populations of all ages involved with agencies that specialize in child welfare, mental health, substance abuse, developmental disabilities, juvenile justice and crossover youth. Critical components of FCT are derivatives of Eco-Structural Family Therapy and Emotionally Focused Therapy which were enhanced with components added based on experience with clients.	Families with 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; ages: 0-17	3	High	Yes	N/A	http://www.cebc4cw.org/program/family-centered-treatment/	
In Home Parenting Skill Based Program	Family Finding	The Family Finding model establishes a lifetime network of support for children and youth who are disconnected or at risk of disconnection through placement outside of their home and community. The process identifies family members and other supportive adults, estranged from or unknown to the child, especially those who are willing to become permanent connections for him/her. The program also keeps contact with the youth on a weekly basis who are provided with an update on progress, assessed for support and safety needs, and consulted about key decisions where appropriate. Upon completion of the process, youth have a range of commitments from adults who are able to provide permanency, sustainable relationships within a kinship system, and support in the transition to adulthood and beyond. Keeping safety at the forefront and using a family-driven process, families are empowered to formulate highly realistic and sustainable plans to meet the long-term needs of children and youth. Child outcomes may include increased reunification rates, improved well-being, greater placement stability, transition out of the child welfare system, decreased re-entry rates, and stronger sense of belonging for children.	Children and youth (birth through young adulthood), who have been disconnected from their families by virtue of placement outside of their home, community, and kinship network. For children/adolescents ages: 0 – 21 For parents/caregivers of children ages: 0 – 21	NR	High			http://www.cebc4cw.org/program/family-finding/	

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Mental Health and Substance Abuse Prevention Treatment Service	Functional Family Therapy	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 11-18, younger siblings of referred adolescents often become part of the intervention 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 an outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases which organizes 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.	11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse	2	Medium	Yes	Cost: \$3,134 Savings and B-C: N/A	http://www.cebc4cw.org/program/functional-family-therapy/	YES
Mental Health and Substance Abuse Prevention Treatment Service	GenerationPMTO (GROUP delivery format)	Same at Generation PMTO except GROUP delivery format. 10-14 weeks duration	Parents of children 2-18 years of age with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors						
Mental Health and Substance Abuse Prevention Treatment Service	GenerationPMTO (INDIVIDUAL delivery format)	GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). GenerationPMTO (Individual Delivery Format) is a parent training intervention that can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, adoptive parents, and other primary caregivers. This behavioral family systems intervention can be used as a preventative program and a treatment program. It can be delivered through individual family treatment in agencies or home-based and via telephone/video conference delivery, books, audiotapes and video recordings. GenerationPMTO interventions have been tailored for specific child/youth clinical problems, such as externalizing and internalizing problems, school problems, antisocial behavior, conduct problems, deviant peer association, theft, delinquency, substance abuse, and child neglect and abuse. For the group version of GenerationPMTO, please see Parenting Through Change (PTC; GenerationPMTO Group).	Parents of children 2-18 years of age with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors	1	High	Yes	Cost: \$619 Savings: \$5,587 B-C: \$9.50	http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/	
In Home Parenting Skill Based Program	Healthy Families America Home Visiting Program (HFA)	Healthy Families America (HFA) has been rated by the CEBC in both Home Visiting topic areas. Please click here to see the HFA entry and rating in the Home Visiting for Prevention of Child Abuse and Neglect topic area. HFA is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby). HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; strengths-based; family-centered; culturally sensitive; and reflective. The HFA model is based upon 12 Critical Elements. These Critical Elements are operationalized through a series of standards that provide a solid structure for quality, yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities. HFA's Vision: All children receive nurturing care from their family essential to leading a healthy and productive life. HFA's Mission: To promote child well-being and prevent the abuse and neglect of our nation's children through home visiting services.	Overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences; families are determined eligible for services once they are screened and/or assessed for the presence of factors that could contribute to increased risk for child maltreatment or other poor childhood outcomes, (e.g., social isolation, substance abuse, mental illness, parental history of abuse in childhood, etc.); home visiting services must be initiated either prenatally or within three months after the birth of the baby For parents/caregivers of children ages: 0 – 5	1	Medium	Yes	Cost: \$5,071 (2016) Loss: (\$1,840) B-C: \$0.64	https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/	YES
Mental Health and Substance Abuse Prevention Treatment Service	Helping Men Recover	HMR is a gender-responsive, trauma-informed treatment program for men. The materials include a facilitator's guide and a participant's workbook. This is the men's version of the women's curriculum, Helping Women Recover, which is highlighted on the CEBC as part of a combined Helping Women Recover & Beyond Trauma (HWR/BT) intervention. HMR addresses what is often missing in prevailing treatment modes: a clear understanding of the impact of male socialization on the recovery process, a consideration of the relational needs of men, and a focus on the issues of abuse and trauma (both experienced and perpetrated). The Helping Men Recover Facilitator's Guide for the 18-session program is a step-by-step manual containing the theory, structure, and content needed for running groups. The participant's workbook allows men to process and record the therapeutic experience. The program model is organized into four modules that emphasize the core areas of men's recovery: Self, Relationships, Sexuality, and Spirituality. The materials are designed to be user-friendly and self-instructive.	Men with addictive disorders	NR	Medium	No		http://www.cebc4cw.org/program/helping-men-recover-a-program-for-treating-addiction-hmr/	
Mental Health and Substance Abuse Prevention Treatment Service	Helping Women Recover & Beyond Trauma	HWR/BT is a combination of two manualized curricula: Helping Women Recover (HWR): A Program for Treating Addiction and Beyond Trauma (BT): A Healing Journey for Women, that in order to replicate the research protocol and outcomes, they both need to be used, as this entry details. When used individually, there is not enough research evidence to be able to rate either curricula on the CEBC Scientific Rating Scale. HWR/BT is a combined intervention of 29 sessions that integrates three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma; and then adds a psychoeducational component that teaches women what trauma is, its process, and its impact. The program model is organized into seven modules. The first four: Self, Relationships, Sexuality, and Spirituality are areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The last three: Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma; focus on the trauma with a major emphasis on coping skills, with specific exercises for developing emotional wellness. The program comes with facilitator's manuals, two participant workbooks (A Women's Journal and A Healing Journey), and 3 DVDs. The materials are designed to be user-friendly and self-instructive. A special edition for criminal justice settings has also been developed. Note: The Beyond Trauma materials were expanded and revised in 2017. The changes include an additional session, expanded sessions, inclusion of information from neuroscience, updated statistics, and resources. These changes have not been reviewed by the CEBC and are not included in the program's Scientific Rating.	Adult women with addictive disorders and a trauma history (e.g., abuse, domestic violence, community violence, etc.)	2	Medium	No	N/A	https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/	

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In Home Parenting Skill Based Program	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.	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 justice facilities For children/adolescents ages: 0 – 17 For parents/caregivers of children ages: 0 – 17	2	High	Yes	Cost: \$3,547 (2008) Savings: \$13,005 B-C: \$4.73	http://www.cebc4cw.org/program/homebuilders/	
In Home Parenting Skill Based Program	Love & Logic	The Love and Logic Institute, Inc., developed training materials designed to teach educators and parents how to experience less stress while helping young people learn the skills required for success in today's world. This approach is called Love and Logic and is based on the following two assumptions: •That children learn the best lessons when they're given a task and allowed to make their own choices (and fail) when the cost of failure is still small; and •That the children's failures must be coupled with love and empathy from their parents and teachers. This model has been used by parents and teachers and has been applied to a wide range of situations.	Parents, grandparents, teachers, and other caretakers working with children, children 0-18	NR	Medium	No		http://www.cebc4cw.org/program/love-and-logic/	
Mental Health and Substance Abuse Prevention Treatment Service	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.	Caregivers of children referred to the child welfare system, has been used with adolescents	1	Medium	No	Cost: \$263 (2014) Savings: \$5,572 B-C: \$21.95	http://www.cebc4cw.org/program/motivational-interviewing/	YES
Mental Health and Substance Abuse Prevention Treatment Service	Multisystemic 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; (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.	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, see the Essential Components section for more details)	1	Medium	Yes	Cost: \$7,076 Savings: \$4,824 B-C: \$1.62	http://www.cebc4cw.org/program/multisystemic-therapy/	YES
Mental Health and Substance Abuse Prevention Treatment Service	Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	MST-N63:N66CAN is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. MST-CAN clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of 4 families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between CPS and the family. Empirically-based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, Cognitive Behavioral Therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and Reinforcement Based Therapy for adult substance abuse.	Families who have come to the attention of Child Protective Services within the past 180 days due to the physical abuse and/or neglect of a child in the family between the ages of 6 and 17; where the child is still living with them or is in foster care with the intent of reunifying with the parent(s); other criteria may apply For children/adolescents ages: 6 – 17 For parents/caregivers of children ages: 6 – 17	2	High			http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/	
Pregnant Parenting Youth	Nurse-Family Partnership (NFP)	The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.	First-time, low-income mothers (no previous live births) For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5	1	Medium	Yes	Cost: \$5,944 (2015) B-C: \$0.81	http://www.cebc4cw.org/program/nurse-family-partnership/	YES
In Home Parenting Skill Based Program	Nurturing Parenting (for Parents and their school-aged children 5-12 years)	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. Parents and their children attend separate groups that meet concurrently. Each session is scheduled for 2.5 hours with a 20-minute break in which parents and children get together and have fun. The lessons in the program are based on the known parenting behaviors that contribute 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, Oppressing children's power and independence Assessment (pre, process, and post) of parent's parenting and child rearing beliefs, knowledge, and skills allows the program facilitators to measure the attainment of lesson competencies.	Families who have been reported to the child welfare system for child maltreatment including physical and emotional maltreatment in addition to child neglect; may be used as a court-ordered parenting program	3	High	No	B-C: .87	http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/	
In Home Parenting Skill Based Program	On the Way Home Program	OTWH is a 12-month reunification program developed to address the transition needs of middle and high school youths with, or at-risk of, emotional and behavioral disorders who are reintegrating into the home and community school settings following a stay in residential care. The program modifies and integrates three interventions: Check & Connect, Common Sense Parenting, and homework support to address the educational and family-based transition challenges most common for school-aged youths. Services are provided by a trained Family Consultant in the family home, school, and community, and primary objectives are to promote youth home stability and prevent school dropout. On average, families engage in 2 hours of direct service hours per week and consultants carry caseloads of up to 15 families. Training is manualized, service decisions are guided by weekly data analysis, and consultants are supervised by a licensed mental health practitioner (e.g., professional counselor, social worker).	Middle and high school students (12-18) with, or at-risk for, emotional and behavioral disorders transitioning from residential placements back into the home and community school settings and their caregivers For children/adolescents ages: 12 – 18 For parents/caregivers of children ages: 12 – 18	3	High	Yes		http://www.cebc4cw.org/program/on-the-way-home-otwh/	

Type of FFPSA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
Mental Health and Substance Abuse Prevention Treatment Service	Parent and Child Interaction Therapy - PCIT	Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. PCIT is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions.	Children ages 2-7 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers	1	Medium	No	Cost: \$2,240 (2007) Savings: \$22,994 B-C: \$15	http://www.cebc4cw.org/program/parent-child-interaction-therapy/	YES
In Home Parenting Skill Based Program	Parents As Teachers	Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." Based on theories of human ecology, empowerment, self-efficacy, attribution, and developmental parenting. Parents as Teachers involves the training and certification of parent educators who work with families using a comprehensive curriculum. Parent educators work with parents to strengthen protective factors and ensure that young children are healthy, safe, and ready to learn. An agency may choose to use the Parents as Teachers model to focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten.	Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years) For parents/caregivers of children ages: 0 – 5	3	Medium	Yes		http://www.cebc4cw.org/program/parents-as-teachers/	YES
Mental Health and Substance Abuse Prevention Treatment Service	Prolonged Exposure Therapy for Adolescents (PE-A)	PE-A is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories through imaginal and in vivo exposure. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they are capable of tolerating this distress.	Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma. For children/adolescents ages: 12 – 18	1			N/A (4-day on-site training costs \$1500 per participant for PE Therapy for PTSD)	http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adolescents/	
In Home Parenting Skill Based Program	Promoting First Relationships	Promoting First Relationships (PFR) is a manualized home visiting intervention/prevention program which includes parent training components based on strengths-based practice, practical, and in-depth strategies for promoting secure and healthy relationships between caregivers and young children (birth to 3 years). Features of PFR include: •Videotaping caregiver-child interactions to provide insight into real-life situations and help the caregiver reflect on the underlying needs of the child and how those needs impact behavior •Giving positive and instructive feedback that builds caregivers' competence with and commitment to their children •Focusing on the deeper emotional feelings and needs underlying children's distress and behaviors •Using handouts and homework to enhance parent insight and learning about child social and emotional development, needs, and concerns	Caregivers of children birth to three years For children/adolescents ages: 0 – 3 For parents/caregivers of children ages: 0 – 3	3	High	Yes	N/A	http://www.cebc4cw.org/program/promoting-first-relationships/	
Mental Health and Substance Abuse Prevention Treatment Service	Psychological First Aid (PFA)	PFA is a modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress and to foster short- and long-term adaptive functioning. It is for use by first responders, incident command systems, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, Community Emergency Response Teams, Medical Reserve Corps, and the Citizens Corps in diverse settings.	Children and adolescents in the immediate aftermath of a disaster or terrorism	NR	Medium			http://www.cebc4cw.org/program/psychological-first-aid/	
Mental Health and Substance Abuse Prevention Treatment Service	Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)	The SMART Model is an innovative, structured, phase-based, abuse-focused treatment approach to address the emotional and behavioral needs of young children with a history of child sexual abuse (CSA) exhibiting problematic sexual behavior (PSB). A major premise of the model is that the PSB stems from emotional responses to the prior CSA causing the child to form cognitive distortions about themselves, others, and the world around them. The family unit is a major target of treatment. Important aspects of family values and beliefs are integrated into the model including examining the family power structure, perceptions regarding sexuality, gender roles and identity, stigmatization of mental health, and spirituality. Unique to the model is the formation of parallel narratives of the child's experiences as a victim and as one who victimizes others and the development of a family narrative that addresses the impact and difficulties associated with caring for a child with a history of CSA and PSB.	Children ages 4-11 who have a history of child sexual abuse (CSA) and are exhibiting problematic sexual behavior (PSB) For children/adolescents ages: 4 – 11 For parents/caregivers of children ages: 4 – 11	NR	Medium	No		http://www.cebc4cw.org/program/safety-mentoring-advocacy-recovery-and-treatment/	
Mental Health and Substance Abuse Prevention Treatment Service	Seeking Safety (Adult version)	Seeking Safety is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format; with females and males; and in various settings (e.g., outpatient, inpatient, residential, home care, schools). Seeking Safety consists of 25 topics that can be conducted in as many sessions as time allows, and in any order. Examples of topics are Safety, Asking for Help, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Coping with Triggers, Self-Nurturing, Red and Green Flags, and Life Choices. Seeking Safety is also rated on the CEBC in the Substance Abuse Treatment (Child & Adolescent) and Trauma Treatment - Client-Level Interventions (Child & Adolescent) topic areas, click here to go to this entry.	Adults who have a history of trauma and/or substance abuse	2	Medium	No	Cost: \$526 (2013)	http://www.cebc4cw.org/program/seeking-safety-for-adults/	
Mental Health and Substance Abuse Prevention Treatment Service	Strengthening Families Program (SFP) *CFP has Strengthening Families for Parents and Youth 10-14 as Promising	The Strengthening Families Program (SFP) is a 10- to 14-week parenting and family skills training program for high-risk and general population families. It is unique because the whole family attends and practice new relationship skills together in family groups. SFP is designed to significantly improve parenting skills and family relationships, reduce child maltreatment, children's problem behaviors, delinquency and alcohol and drug abuse; and to improve social competencies and school performance. The program is designed to work with many different ethnicities and races. In addition, it is available as a Home-use DVD for school, behavioral health, and family services to use alone or with case managers. It can also be given to families to view at home.	Parents and their children ages 0-17 who need skills to reduce family conflict and the risk of abuse or neglect, including substance abusing parents, those already reported for child maltreatment, and those who need skills to deal with a disruptive child For children/adolescents ages: 0 – 17 For parents/caregivers of children ages: 0 – 17	NR	High	Yes		http://www.cebc4cw.org/program/strengthening-families-program-sfp/	

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In Home Parenting Skill Based Program	Structured Decision Making	SDM is a comprehensive case management system for Child Protective Services (CPS). CPS workers employ objective assessment procedures at major case decision points from intake to reunification to improve child welfare decision-making. SDM targets agency services to children and families at high risk of maltreatment and helps ensure that service plans reflect the strengths and needs of families. When effectively implemented, it increases the consistency and validity of case decisions, reduces subsequent child maltreatment, and expedites permanency. The assessments from the model also provide data that help agency managers monitor, plan, and evaluate service delivery operations.	Families referred to and assessed by child protective service (CPS) agencies For parents/caregivers of children ages: 0 – 17	3	High	Yes		http://www.cebc4cw.org/program/structured-decision-making/	
In Home Parenting Skill Based Program	Teaching-Family Model (TFM)	TFM is a unique approach to human services characterized by clearly defined goals, integrated support systems, and a set of essential elements. TFM has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. The model uses a married couple or other "teaching parents" to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers, and other support network to help maintain progress.	Youth who are at-risk, juvenile delinquents, in foster care, mentally retarded/developmentally disabled, or severely emotionally disturbed; families at risk of having children removed 0-17	3	High			http://www.cebc4cw.org/program/teaching-family-model/	
In Home Parenting Skill Based Program	The Incredible Years	The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.	Parents, teachers, and children For children/adolescents ages: 4 – 8 For parents/caregivers of children ages: 4 – 8	1	Medium	Yes	Cost: \$2,215 (2013) Savings: \$1,039 B-C: 1.79	http://www.cebc4cw.org/program/the-incredible-years/	
Mental Health and Substance Abuse Prevention Treatment Service	The MANDT System	The Mandt System® is a relationally based program that uses a continuous learning and development approach to prevent, de-escalate, and if necessary, intervene in behavioral interactions that could become aggressive. The context of all behavior is relational.	Child welfare organizations and other human service programs concerned with the physical, psychological, and emotional safety of service recipients and service users	NR	High	Yes		http://www.cebc4cw.org/program/the-mandt-system/	
Mental Health and Substance Abuse Prevention Treatment Service	Therapeutic Crisis Intervention	At TCI's core lies the principle that successful resolution of a child's crisis depends on the environment's (the care organization) and the individual's (the care worker) therapeutic and developmentally appropriate response. The TCI system teaches and supports strategies for care workers at all levels of the organization to: •Assess children's aggressive behaviors as expressions of needs. •Monitor their own levels of arousal. •Use non-coercive, non-aggressive environmental and behavioral strategies and interventions that de-escalate the crisis and that lead to the child's own emotional self-regulation and growth. •Use physical interventions only as a safety intervention that contains a child's acute aggression and violence.	Staff working in residential child care organizations	NR	High	No		http://www.cebc4cw.org/program/therapeutic-crisis-intervention/	
Mental Health and Substance Abuse Prevention Treatment Service	TheraPlay	Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used for many years with foster and adoptive families.	Children ages 0-18 who exhibit behavioral problems and their caregiver (biological, adoptive, or foster) For children/adolescents ages: 0 – 18 For parents/caregivers of children ages: 0 – 18	3	Medium	Yes		http://www.cebc4cw.org/program/theraplay/	
Mental Health and Substance Abuse Prevention Treatment Service	Trauma Systems Therapy (TST)	Trauma Systems Therapy (TST) is a comprehensive, phase-based treatment program for children and adolescents who have experienced traumatic events and/or who live in environments with ongoing stress and/or traumatic reminders. TST is designed to address the complicated needs of a trauma system, which is defined as the combination of a traumatized child/adolescent who, when exposed to trauma reminders, has difficulty regulating his/her emotions and behavior and his/her caregiver/system of care who is not able to adequately protect the youth or help him/her to manage this dysregulation. The most common setting in which TST is implemented is for youth involved with the child welfare system who may be in birth homes, foster care, residential treatment centers, community-based prevention programs, juvenile justice settings, school-based programs, and programs for unaccompanied alien minors. TST aims to stabilize the child's environment while simultaneously enhancing his/her ability to regulate emotions and behaviors. TST begins by assessing each child and his/her environment. Based on this assessment, the child is placed into one of three treatment phases. A TST priority problem is established, and a TST treatment team is assembled to address this priority problem from multiple perspectives. Different interventions and therapies are indicated within each phase, designed to both help the youth to better regulate survival states, and to help caregivers and providers to become better able to meet the child's needs.	The combination of a traumatized child/adolescent who, when exposed to trauma reminders, has difficulty regulating their emotions and behavior and their caregiver/system of care who is not able to adequately protect the youth or help them to manage these survival in the moment states For children/adolescents ages: 4 – 21 For parents/caregivers of children ages: 4 – 21	NR	High	Yes		http://www.cebc4cw.org/program/trauma-systems-therapy-tst/	
Mental Health and Substance Abuse Prevention Treatment Service	Trauma-Focused Cognitive- Behavioral Therapy (TF-CBT)	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. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.	Target Population: Children with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment. For children/adolescents ages: 3 – 18 For parents/caregivers of children ages: 3 – 18	1	High	Yes	\$1,037 (CBT based models for child trauma)	http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/	YES

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Mental Health and Substance Abuse Prevention Treatment Service	Trauma-Focused Coping (Multimodality Trauma Treatment)	TFC targets the internalizing effects of exposure to trauma in children and adolescents, with an emphasis on treating posttraumatic stress disorder (PTSD) and the collateral symptoms of depression, anxiety, anger, and an external locus of control [i.e., tendency to attribute one's experiences to fate, chance, or luck]. The intervention utilizes social learning theory and a skills-oriented cognitive-behavioral approach that is carried out in 14-week sessions of gradual exposure, moving from psycho-education, anxiety management skill building, and cognitive coping training to finally trauma narrative and cognitive restructuring activities.	Children and adolescents in schools who have suffered a traumatic exposure (e.g., disaster, violence, murder, suicide, fire, accidents) For children/adolescents ages: 9 – 18	3	Medium	No		http://www.cebc4cw.org/program/trauma-focused-coping/	
Mental Health and Substance Abuse Prevention Treatment Service	Triple P - Positive Parenting Program (only Level 4 is on CFP list)	Level 4 Triple P is one of the five levels of the Triple P - Positive Parenting Program® System which is also highlighted on the CEBC. Level 4 Triple P helps parents learn strategies that promote social competence and self-regulation in children as well as decrease problem behavior. Parents are encouraged to develop a parenting plan that makes use of a variety of Level 4 Triple P strategies and tools. Parents are then asked to practice their parenting plan with their children. During the course of the program, parents are encouraged to keep track of their children's behavior, as well as their own behavior, and to reflect on what is working with their parenting plan and what is not working so well. They then work with their practitioner to fine tune their plan. Level 4 Triple P practitioners are trained to work with parents' strengths and to provide a supportive, non-judgmental environment where a parent can continually improve their parenting skills. Level 4 Triple P is offered in several different formats (e.g., individual, group, self-directed, and online). The CEBC evaluated the standard version of Level 4 Triple P as described above and not any other variations (including early teen versions or those for children with developmental delays).	Target Population: For parents and caregivers of children and adolescents from birth to 12 years old with moderate to severe behavioral and/or emotional difficulties or for parents that are motivated to gain a more in-depth understanding of positive parenting For parents/caregivers of children ages: 0 – 12	1	Medium	Yes		http://www.cebc4cw.org/program/triple-p-level-3-discussion-group/	
In Home Parenting Skill Based Program	Trust-Based Relational Intervention (TBCI)	TBCI Online Caregiver Training is a program available via 18 modules on a website that can be accessed in the home or any other location with Internet availability. The training presents the Trust-Based Relational Intervention, a holistic approach that is multidisciplinary, flexible, and attachment-centered. It is a trauma-informed intervention that is specifically designed for children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence, but can be used with all children. TBCI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting Principles. These principles have been used in homes, schools, orphanages, residential treatment centers and other environments. They are designed for use with children and youth of all ages and risk levels. By helping caregivers understand what should have happened in early development, TBCI principles guide children and youth back to their natural developmental trajectory.	Parents (e.g., birth parents, foster parents, kinship parents, adoptive parents, etc.) and caregivers of children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence For parents/caregivers of children ages: 0 – 17	3	High	Yes		http://www.cebc4cw.org/program/trust-based-relational-intervention-tbci-online-caregiver-training/	
In Home Parenting Skill Based Program	Visit Coaching	Visit Coaching (developed by Marty Beyer, PhD) is fundamentally different from supervised visits because the focus is on the strengths of the family and the needs of the children. Visit Coaching supports families to meet the unique needs of each child during their family time in the community, family homes, visit centers, or offices. Visit Coaching includes: •Helping parents understand the unique developmental needs of their child and demonstrate that understanding during visits with their child •Preparing parents for their children's trauma-related needs and reactions during visits •Helping parents give their children their full attention at each visit •Building on the parent's strengths in meeting each child's needs •Helping parents visit consistently and keep their sadness, anger, and other issues out of the visit	Parents whose child(ren) are living in foster care and see them only during visits	NR	High	Yes		http://www.cebc4cw.org/program/visit-coaching/	
In Home Parenting Skill Based Program	Wraparound	Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed. The values associated with Wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community-based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, Wraparound should be "strengths-based", helping the child and family recognize, utilize, and build talents, assets, and positive capacities.	Designed for children and youth with severe emotional, behavioral, or mental health difficulties and their families where the child/youth is in, or at risk for, out-of-home, institutional, or restrictive placements, and involved in multiple child and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education, etc.)	3	High	Yes	Varies by the study	http://www.cebc4cw.org/program/wraparound/	
In Home Parenting Skill Based Program	Wyman's Teen Outreach Program (TOP)	The Wyman's Teen Outreach Program® (TOP®) promotes the positive development of adolescents through curriculum-guided, interactive group discussions; positive adult guidance and support; and community service learning. TOP® is focused on key topics related to adolescent health and development, including building social, emotional, and life skills; developing a positive sense of self; and connecting with others. Specific curriculum lesson topics include health and wellness (including sexuality), emotion management, and self-understanding among many others. In addition, the development of supportive relationships with adult facilitators is a crucial part of the model, as are relationships with other peers in the program. TOP® has been adapted to fit the needs of special populations, including youth in foster care, justice involved youth, and LGBTQ youth. Any adaptations need Wyman's prior approval which can be requested through the program representative whose contact information is located at the end of this entry. Please note, the adapted versions have not been reviewed or rated by the CEBC.	Male and female adolescents in grades 6-12 who may come from disadvantaged circumstances For children/adolescents ages: 11 – 19	3	Medium	No		http://www.cebc4cw.org/program/wymans-teen-outreach-program/	
Casey Family List (11.10.18)	1	Well Supported	*Rows that are mostly yellow or red but Name of Program is green: Casey Family Program list indicates these programs could be classified as well-supported under FFPSA but listed at a lower level on CEBC						

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	2	Supported	currently						
	3	Promising							

**Casey Family Programs notes that their catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA

Cost & Cost Savings (See KEY tab for description)

Casey Family Programs List (dated 11.10.18)	
Rating	
1	Well Supported
2	Supported
3	Promising

*Rows that are mostly yellow or red but Name of Program is green: CFP list indicates these programs could be classified as well-supported under FFPSA but listed at a lower level on CEBC currently

**Casey Family Programs notes that their catalog offers a rough estimate as to what interventions are likely to be covered under FFPSA

Intervention Cost and Cost Savings (from Pages 7-9 of CFP Interventions with Special Relevance for the FFPSA, Second Edition)

We draw heavily from the Washington State Institute for Public Policy (WSIPP) for cost estimates around program costs, monetary benefits, and cost-benefit ratios, when available.^[1] These costs are estimated and adjusted to be specific to Washington State, based on state wage, child welfare, and other state-specific data. Nonetheless, we believe these Washington State cost estimates provide a helpful guide to a program's effectiveness. The user of this information will need to determine how these costs and benefits may, or may not, apply in another state. Details on the three cost figures, as reported from WSIPP, can be found from WSIPP's technical documentation:^[2]

When we cite the WSIPP cost figures we present them in this manner:

- Cost: \$267
- Savings: \$6,787
- B-C: \$26.46

The program **costs**, if derived from the WSIPP Cost-Benefit analyses, were calculated using a variety of methods. If available, average program costs were collected directly from the operating agency. If not, and program resource needs were available from the published evaluations, these were converted to unit costs with available data, such as relevant personnel salaries. Otherwise, when available, we obtained program costs directly from program Web sites or through personal communication. These costs are the direct costs of implementing the program per participant, family, or child.

Cost savings or loss, if reported from WSIPP, are the life cycle benefits (direct and indirect) minus net program costs (program costs compared to the alternative) in present value. These are the expected returns over time per participant. If cost savings were derived from a source other than WSIPP, we recommend going to the original source document to see how the cost savings were calculated as there are different definitions and methodologies used. If reported as a loss (in red with accounting parentheses), it is because the costs, compared to the alternative, exceed any observed or anticipated benefits.

The **benefit-to-cost ratio** is the life cycle program benefits divided by the net program cost of producing the outcomes. This ratio is another way of presenting the same information and represents the monetary gain (or loss) for every dollar spent over the life cycle. Occasionally the costs for an intervention compared to the alternative will exceed the savings it generates, and those figures are presented in red font and in parentheses:

- Cost: \$1,979
- Loss: (\$4,046)
- B-C: (\$0.17)

Note that in the example above, the B-C ratio is a negative \$.17 cents. That means for every dollar spent, society will lose an additional .17 cents from the program investment. If, for example, the benefit cost ratio is not in red, as below, the B-C ratio would be interpreted as recouping \$.16 cents for every dollar spent, because there were positive societal benefits, just not enough in relationship to the program costs relative to the alternative.

- Cost: \$1,979
- Loss: \$1,703
- B-C: \$0.16

Please note, that the B-C ratio uses cost estimates NOT reported in our tables below to calculate the B-C ratio. That is, rather than using the per participant program cost, the B-C ratio uses the program cost, as compared to the alternative, which we do not report in these tables. We report the per participant program cost instead, because we believe this is more useful information to jurisdictions who want to know how much a program might cost to implement on a per person basis, regardless of the alternative. (To locate the per participant annual program cost in the WSIPP materials, after clicking on the program name in their benefit-cost results tables, scroll to the table titled, "Detailed Annual Cost Estimates Per Participant" and find the "Program costs" under the "Annual Cost" column. Please note the year for which the program cost is valid for.)

For some interventions, the developer websites were consulted and additional cost per client and cost-savings information is provided. If cost savings or benefit-to-cost ratios are reported from a source other than WSIPP, we recommend going to the original source document to see how the ratio was calculated as definitions and methodologies may vary. An important task for each jurisdiction is to distinguish which interventions could be paid for by Medicaid or behavioral health systems versus federal or state child welfare funds. In a few areas, we included what services or other supports might be needed to help a youth "step down" into a less restrictive form of care. For example, in juvenile probation in Los Angeles, Functional Family Therapy (FFT) is an important intervention while the youth is placed but also for helping the entire family when the youth returns home.

HFA PROTOCOLS FOR WORKING WITH CHILD WELFARE FAMILIES

The HFA model, since its inception, has been focused on the prevention of child abuse and neglect. In communities throughout the country, child welfare providers have always served as a source of referral to HFA for families who could benefit from home visiting. This has resulted in improved parent-child relationships, improved child health and safety, and many families averting further child welfare involvement. HFNY's randomized control study found that mothers with prior CPS reports experienced a reduced rate of confirmed abuse, as well as reduced rate of child welfare services cases opened.

The HFA model seeks to engage families as early as possible, during pregnancy or at the birth of a baby to optimize health and child wellbeing outcomes. However, the model has always allowed for families to be engaged beyond newborn period. The HFA Best Practice Standards allow up to 20% of the service population to be older than three months at the time of the first home visit. For child welfare providers who work on the front lines each day and who recognize the value of connecting families in distress to long-term, intensive home visiting services like HFA, these existing model protocols allow affiliated sites to accept child welfare referred families up to the age of twenty-four months. This is in keeping with the model's original design to offer services for a minimum of three years and up to the time the child is five years of age.

HFA affiliates (new or existing) who work with local child welfare providers and who choose to implement HFA's protocols for working with child welfare referred families, will submit an implementation plan to indicate how HFA's required protocols will be implemented at the site. Those who implement HFA's child welfare protocols may utilize an extended enrollment window from pregnancy to age 24 months, offering services for a minimum of three years from birth or enrollment, whichever is longer, such that families enrolled at 24 months will be offered services until the child is 60 months.

HFA provides upon request additional guidance and sample resources including MOU for use with local child welfare providers.



Family Centered Treatment Foundation, Inc.

10140 Thomas Payne Cir. • Charlotte, NC 28277

(703) 757-6243 • www.familycenteredtreatment.org

July 20, 2018

Attn: Deputy Assistant Secretary for Planning, Research, and Evaluation
Subject: Federal Register/Vol.83, No.121

Dear Deputy Assistant Secretary Goldstein,

We are submitting comments and recommendations for the **Family Centered Treatment®** (FCT) in-home family therapy model as a **Candidate Program and Service for prioritized review** by HHS. Specifically, these comments and recommendations address recommended programs and services as requested in sections 2.1 through 2.5 of the Administration for Children and Families, HHS request for public comment.

FCT is a listed California Evidence-Based Clearinghouse (CEBC [Family Stabilization Programs]) and SAMSHA's NREPP Legacy model.

FCT maintains a Child Welfare Relevance rating of **High** under its listing on CEBC.

<http://www.cebc4cw.org/program/family-centered-treatment/>

<https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=363>

Brief Description: 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, or circumstances, or forced removal of children from the home due to the youth's delinquent behavior or parent's harmful behaviors. A core belief influencing the development of FCT is that the recipients of service are great people with tremendous internal strengths and resources. This core value is demonstrated via the use of individual family goals that are developed from strengths as opposed to deficits. Obtaining highly successful engagement rates is a primary goal of FCT. The program is provided with families of specialty populations of all ages involved with agencies that specialize in child welfare, mental health, substance abuse, developmental disabilities, juvenile justice and crossover youth. Critical components of FCT are derivatives of Eco-Structural Family Therapy and Emotionally Focused Therapy, which were enhanced and expanded upon based on more than 20 years of practice-based experience with children and families.

Section 2.1

(Section 2.1.1) FCT historically and presently serves families with members at *imminent risk of* placement into, or needing intensive services to *return from*, treatment facilities, foster care, group or



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10140 Thomas Payne Cir. • Charlotte, NC 28277

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residential treatment, psychiatric hospitals, or juvenile justice facilities. FCT is a treatment model designed to address mental health and in-home parent-based skills program (inclusive of parent skill training, education, individual and family counseling). Additionally, FCT is utilized to address substance abuse in a family systems context and works to restore baseline functioning by reducing or eliminating maladaptive behaviors associated with substance abuse within the family system.

(Section 2.1.2) FCT utilizes a comprehensive manualized digital training curriculum. The manualized training curriculum for licensed FCT organizations is known as Wheels of Change: The Family Centered Specialist's Handbook and Training Manual©. Licensed FCT sites are required to have all FCT personnel (Supervisors, Trainers, Clinicians) complete (and achieve Certification in) the manualized training. Additional requirements to implement FCT include adherence to protocols documented in manuals that outline Implementation of FCT, monitoring of Clinical Performance & Fidelity, as well as a multitude of additional documents that demonstrate practice protocol and describe how to administer the program with fidelity. All manuals and documents are housed in a digital library that may be accessed by FCT practitioners.

Section 2.2

(Section 2.2.1) We are recommending FCT receive prioritized review as a Well-supported Practice that meets all eligibility criteria for this request. FCT is rated *High* in Child Welfare Relevance by CEBC, is manualized with a successful track record of replication across multiple states in the US, has demonstrated no empirical risk of harm or case data indicating risk or harm, and the weight of researched evidence supports benefits with reliable and valid peer reviewed outcome measures. Additionally, by definition of its services, FCT is a mental health service, which includes and in-home parent-based skills program (inclusive of parent skill training, education, individual and family counseling) and has been modified to work effectively with a substance abuse population.

(Section 2.2.2) Annually, FCT provides treatment service to thousands of children and families involved in child welfare systems. Additionally, FCT serves youth and families involved in other systems of care including mental health, managed care, and court involved or juvenile justice. Frequently children, youth and families do not fall into a singular system of care. Multiple studies utilizing the FCT model have researched the population known as “Crossover Youth.” Crossover Youth are defined as youth involved in both the child welfare system and juvenile justice system (frequently simultaneously). Likewise, many families find themselves involved in Mental Health or managed care systems while simultaneously being involved in Child Welfare Systems.

Per request of HHS, we would recommend that Crossover Youth be identified as a priority target population of interest.

(Section 2.2.3) As peer review and practice-based evidence (annual outcome reporting measures) have demonstrated, FCT addresses and demonstrates favorable results towards HHS ‘target outcomes.’ Peer reviewed journal publications and government report findings for FCT support significant and favorable outcomes in the domains of safety (target outcomes: maintained in-home, repeat maltreatment

[abuse/neglect]), permanency (target outcomes: reunification, time involved in child welfare services, time to family reunification), well-being (target outcomes: safety rating, well-being assessment scoring) as well as reducing the likelihood of out of home placement (in foster care, residential, hospitalization, youth detention) and reducing the length of stay in out of home placement.

The FCT model has over 15 years of practice based data (outcome reporting) that demonstrates the models ability to address reoccurrence of child abuse and neglect, reduce the likelihood of foster care placements (or higher intensity levels of care such as hospitalization, youth detention centers, or closed door congregate care facilities), reduction in length of stay in foster care with return to family of origin or permanency placement, reunification to family of origin or permanency of birth parents/kinship care.

(Section 2.2.4) The FCT model has participated in 2 non-overlapping, rigorous, independent, and peer review published quasi-experimental studies: (Attached for review)

- Family Centered Treatment—An alternative to residential placements for adjudicated youth: Outcomes and cost effectiveness. - OJJDP Journal of Juvenile Justice
- Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration. – Research on Social Work Practice

Additionally, FCT has been published in a matched case control sub-study in the government report:

- Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project PREPARED BY: The Indiana University Evaluation Team & The Department of Child Services (Attached for review)

Other non-published studies of note:

- Youth outcomes following Family Centered Treatment® in Maryland. - University of Maryland School of Social Work
- Final Summary Report for “Building the Evidence Base: Family Centered Treatment for Crossover Youth” -Funded by the Annie E. Casey Foundation, University of Maryland School of Social Work and MENTOR
- Adapting Juvenile Justice Interventions to Serve Youth with Trauma Histories - University of Maryland School of Social Work

Current studies in progress

- Randomized Controlled Trial of Family Centered Treatment in North Carolina (Working Title) -Duke University Center for Child and Family Policy, Funded by The Duke Endowment

(Section 2.2.5) FCT is actively utilized as a treatment modality in 10 states and more than 70 ‘sites’ nationally. The model is being implemented by 18 distinct human service organizations.

(Section 2.2.6) FCT has a well-documented and manualized implementation process inclusive of fidelity and adherence components. Replication of the model is monitored continuously by the FCT Foundation

(purveyor nonprofit licensing organization). Implementation and Fidelity support is provided continuously by the FCT Foundation as a requirement to be a licensed FCT provider organization.

Additionally, there are a multitude of FCT Implementation Documents and Guides to support the implementation process of FCT for organizations. Implementation protocols, documents and guides were designed, by the FCT Foundation, in collaboration with the National Implementation Research Network (NIRN).

Pre-implementation materials to measure organizational or provider readiness for *Family Centered Treatment (FCT)* are listed below:

The Readiness Assessment is designed to evaluate applicant agency capacity to implement the components necessary for the provision of FCT. In that FCT is both a management and clinical model, this process will include:

- Completion of the FCT Readiness Assessment Matrix®, a 100-component tool designed to assess the scope and readiness of prospective organizations across nine different implementation domains.
- A review of submitted materials such as philosophy or organizational design of management, to include the mission statement and other policy and procedures that demonstrate the support necessary to fulfill the Family Centered Treatment agency licensing process
- Interview of the top management system
- Willingness to enter contract for board/funding commitment and support to enable Family Centered Treatment Certification for all FCT therapists
- Willingness to enter contract for board/funding commitment and support to ensure sustainability of adherence (fidelity) to the FCT model after the rollout of the training and certification of therapists, (oversight and management contract with Family Centered Treatment Foundation)
- Willingness to enter contract for board/funding commitment and support to ensure a system to provide data collection and research as required to ensure fidelity to the FCT model during the course of treatment for each client and outcome data provided upon discharge
- Interview with key clinical staff and Executive Director regarding applicant agency's rationale for the selection of FCT as the model of choice for the agency
- Review of applicant agency's accreditation, endorsement, and CABHA assignment records and responses
- The process includes the agency's provision of required materials and documents prior to the onsite visit. During the onsite evaluation, the applicant agency is expected to provide or make available specifically requested clinical and management staff and materials that prove capacity to implement specific components of the model as part of the FCT Readiness Assessment Matrix®.
- Review and willingness of external stakeholders and funders to support FCT implementation.

There is formal support available for implementation of FCT as listed below:

Family Centered Treatment Foundation (FCTF) provides onsite and web-based direction, technical assistance, formal coaching, consultation, oversight, and monitoring for implementation. It also provides adherence verification for provider agencies. Upon FCT licensure, the FCTF consults with organizations

as necessary on the effective use and assessment of implementation tools. Various assessments and tracking mechanisms are incorporated to ensure that organizational development around the model is nearly as important as the clinical approach itself. Tools and trackers are utilized at varying intervals depending on their use and need.

Stage of implementation specific tools include:

- FCT Readiness Assessment Matrix®
- Fidelity Adherence Compliance Tracker (FACT)
- Implementation Driver Assessment® (IDA)
- FCT Implementation-strategy Tool (FIT)
- Licensing and Implementation Report (LIR)

(Section 2.2.7) FCT is considered a Trauma Informed and Trauma Treatment modality. FCT certified practitioners are required to complete a trauma training curriculum as part of their certification. This training was designed in collaboration with personnel from the National Childhood Traumatic Stress Network (NCTSN) and the FCT Foundation. Detailed description of how FCT utilizes a trauma informed approach and addresses trauma as part of treatment is attached for reference.

Attached:

Taking Trauma Treatment out of the office and into the home for multi-generational usage; Family Centered Treatment® trauma components for the whole family

Components of FCT Trauma Treatment

- Systemic assessments
 - Determination of primary area of Family Functioning that led to trauma or impedes healing
- Family Life Cycle
 - Connection of caregiver's past to their present parenting
- Treatment of the functions or needs rather than behaviors alone
 - Incidents as functions of behaviors and an area of family functioning need
- Parenting techniques to step out of the trauma bond and/or triangle
- Apology from caregiver or relevant person frame work – 4-part process
 - Permission for all feelings
 - Expression of feelings that work
- Sensory based scrapbooking
 - Re-authored narrative

(Section 2.2.8) FCT is a comprehensive intensive in-home family therapy model. The primary place of treatment is provided in the home of parents and/or caregivers, foster care homes, as well as in the community as required. Parent skill-based services are inclusive as part of FCT.

2.3

(Section 2.3.1) As noted in section 2.2.4, FCT has participated in 2 rigorous peer reviewed, published, quasi-experimental studies. Additionally, FCT has participated in the state of Indiana IV-e waiver study that reports to the Administration for Child Services (government report).

These studies address a number of target outcomes including child and family safety, well-being and reducing the likelihood of foster care placement (or higher levels of care such as group home, hospitalization or incarceration).

These studies are attached to this email correspondence.

(Section 2.3.2) Per request for comment from HHS, we suggest that target outcomes should consider child welfare or court system recidivism and repeat placement in foster care settings by youth (or higher levels of care). Additionally, we suggest that HHS should consider expanding the ‘level of care’ language to include outcomes that look to prevent youth from entering levels of care that are considered residential facilities, youth detention or incarceration and/or mental health hospitalizations. Likewise, we suggest that a treatment programs capacity to reduce length of stay in foster care settings (or group home settings) as it relates to reunification with birth families should be considered a target outcome.

(Sections 2.3.3, 2.3.4, 2.3.5, 2.3.6) All eligible FCT studies and government reports were conducted in the United States, are published in English, and were prepared and published after 1990. Additionally, all FCT studies were carried out in the usual care or practice setting.

2.4

Per request of HHS, the FCT Foundation suggests that priority eligible studies should include those models that have been determined to achieve a Child Welfare Rating of *High* by the CEBC and include those studies that, at minimum, involved a study population of children and families involved with child welfare systems.

(Section 2.4.1) FCT service delivery (Clinical services directly provided to youth and families) averages nationally 180 days or 6 months. The national aggregate data for 2017 highlighted that the average days in treatment for families receiving FCT was 143 days.

The following comment addresses length of implementation for startup programs to begin providing the FCT treatment model to families (training and launch).

FCT has been implemented (whereby children and families begin receiving the treatment model with fidelity) in as little as 2 months from ‘inquiry’ of a prospective organization to ‘implementation launch’.

As a founding member of the Global Implementation Society, the FCT Foundation understands, via reliable and valid research that ‘full implementation’ (defined below) can take many years before fully independent organizational sustainability can be achieved. This does not preclude initial implementation of FCT whereby children and families can begin receiving the treatment model with fidelity.

Per request, the FCT Foundation suggests that HHS further define or quantify its intention to pay a State to implement an EBP based on ‘stages of implementation’ and based on provider organizations ability to properly implement a model based on objective metrics inclusive of ‘time’ or ‘months’ of treatment. Program models that offer a Readiness Assessment and a defined Implementation Process have a superior capacity to deliver programs with fidelity while considering numerous internal and external variables that strengthen and sustain, or threaten, proper replication of target outcomes.

National Implementation Research Network Definition of Full Implementation: In the Full Implementation Stage the new ways of providing services are now the standard ways of work where practitioners and staff routinely provide high quality services and the implementation supports are part of the way the provider organization carries out its work. Implementation Teams remain essential contributors to the ongoing success of using the evidence-based program. Practitioners, staff, administrators, and leaders come and go and each new person needs to develop the competencies to effectively carry out the innovation and its implementation supports. Managers and administrators come and go and need to continually adjust organizational supports to facilitate the work of practitioners. Systems continue to change and impact organizations and practitioners. Evidence-based programs continue to be developed and programs already in place continue to be improved. The number of variables and complexity of issues probably qualify as “wicked problems” as described by Rittel and Webber (1973). The work of Implementation Teams is to ensure that the gains in the use of effective practices are maintained and improved over time and through transitions of leaders and staff.

(Section 2.4.2) As previously noted in section 2.2.2 we request that FCT receive priority review based on its research and study findings with target population children and families involved in child welfare systems.

Per HHS request, we again suggest that HHS should strongly consider utilizing studies that involve ‘Crossover Youth’ (those involved in multiple systems simultaneously) as a target population.

2.5

(Sections 2.5.1, 2.5.2) FCT attached studies for review have demonstrated multiple positive significant and favorable effects on target populations. This includes favorable and positive significant effects on target outcomes such as safety, well-being, and reduction of likelihood of foster care placement (or higher levels of care or incarceration) for youth, adults and families.

Unfavorable effects (negative significant effects) have not been found for any targeted outcomes in any FCT involved study or report.

Summary conclusions for 2 published, peer-review quasi-experimental studies:

Conclusion: “In this long-term follow-up study of adjudicated youth in the state of Maryland, FCT is shown to be a promising and cost-effective alternative to residential placements. In the first year following treatment, we found that youth receiving FCT significantly reduced the frequency of their

offenses and adjudications, and that the proportion of youth with offenses and adjudications was also significantly reduced. These findings were sustained 2 years post-treatment. The results were consistent across groups in the first year following treatment. In the second year following treatment, however, FCT youth exhibited a much greater decline than the Placed group in both the average frequency of adjudications and the proportion of youth with adjudicated offenses. Moreover, in the first year following treatment, we found that the effect of FCT reduced the average frequency of residential placements, days in pending placements, and days in community detentions relative to those of the comparison group. These outcomes were achieved at substantial cost savings: every \$1.00 spent on the FCT program saved the state of Maryland between \$2.03 and \$2.29, for a total estimated savings of \$10.9 million to \$12.3 million over 4½ years.”

-Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter, W. E., & Wood, T. J. (2012). Family Centered Treatment—An alternative to residential placements for adjudicated youth: Outcomes and cost effectiveness. *OJJDP Journal of Juvenile Justice*, 2, 25–40.

Conclusion: “Juvenile services have an important role to play in the grand challenge of promoting smart decarceration. If social workers advocate reduced reliance on institutions to treat offenders, full-scale implementation of community-based alternatives to incarceration will be required. Further, as the juvenile justice system serves a greater proportion of its youth in the community, research on effectiveness of a broad array of services is necessary (Lipsey, 2012). The results of this study suggest that FCT is effective at reducing adult criminal justice involvement. These findings support the use of FCT as an alternative to GC for high-risk and/or high-need offenders. This research contributes to the literature on juvenile services and effectiveness and provides a basis for ongoing study of comprehensive, community-based treatment. This study is one piece of a comprehensive research agenda on social work’s grand challenge of promoting smart decarceration.

-Charlotte Lyn Bright, Jill Farrell, Andrew M. Winters, Sara Betsinger, and Bethany R. Lee. (2017) Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration. *Research on Social Work Practice*, Vol.28, Issue 5.

Summary: “Findings from this study replicate and extend an earlier evaluation of FCT (Sullivan et al., 2012). With a longer study period and larger sample, results continue to show an effect of FCT on juvenile justice commitment following discharge from treatment. In a multivariate survival analysis, the adjudication rates for FCT youth and group care youth are not significantly different. However, FCT youth show non-significantly lower rates of adjudication. Moreover, given the findings in the cost analysis, FCT appears to be substantially more economical than group home use.”

Of particular interest is the potential FCT may have to decrease adult criminal justice system involvement. In these analyses, youth in the FCT group show more favorable outcomes than group care recipients following the propensity score match that creates statistical equivalence between the two groups. FCT is associated with a decreased risk of adult arrest leading to conviction, as well as a sentence of incarceration in the criminal justice system (this outcome includes suspended sentences). A subsample of FCT participants ages 16 and older also show significantly lower rates of these two adult criminal justice outcomes relative to group care recipients, suggesting that FCT may be effective at disrupting chronic offending trajectories.”

- Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2017). Youth outcomes following Family Centered Treatment® in Maryland. Baltimore: University of Maryland School of Social Work. Retrieved August 11, 2017, from [https://theinstitute.umaryland.edu/topics/ebpp/docs/FCT/Maryland%20FCT%20Outcome%20Study%20FINAL\(revised%20and%20updated2\).pdf](https://theinstitute.umaryland.edu/topics/ebpp/docs/FCT/Maryland%20FCT%20Outcome%20Study%20FINAL(revised%20and%20updated2).pdf)

Summary of FCT Comparison Findings: “Overall, children, and families, who participated in FCT appear to fare better than children who do not participate in FCT. While the cost of administering the program is higher for children who participate in FCT than those that do not, children who participated in FCT have better outcomes associated with their safety, permanency goals, and well-being. Children who participated in FCT were more likely to remain in-home during their involvement with DCS, as well as be reunited with their family in shorter timeframe and more likely to be ranked as conditionally safe and safe.”

-Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project FINAL REPORT PREPARED BY: THE INDIANA UNIVERSITY EVALUATION TEAM & THE DEPARTMENT OF CHILD SERVICES

(Section 2.5.3) FCT research has multiple studies demonstrating sustained favorable effect including ‘reducing the likelihood of foster care placement by supporting birth families’ (or higher levels of care or incarceration including penetration into adult correctional systems for youth involved in child welfare).

In the Research on Social Work Practice publication (Bright, et al 2017) the study follows youth for up to 6 years post treatment, depending on date of discharge. "We find that FCT could support efforts to promote smart decarceration. As an alternative to Group Care (GC), FCT provides an opportunity to serve youth in their homes and communities. FCT results in reduced adult convictions and sentences of incarceration, relative to GC. Average time between treatment discharge to arrest is 58 months for those receiving FCT and 53.4 months for those receiving GC. Evidence of sustained positive outcomes within the adult criminal justice system supports the potential of FCT to decrease mass incarceration."

In the Journal of Juvenile Justice publication (Sullivan, et al 2012) follows youth for up to 2 years post-treatment and examines out of home placements during the first and second year following treatment. In the first year, youth receiving FCT were less likely to be placed than those receiving GC (effect size 24%). During the second year post-tx there was no difference between the groups, but the frequency of placements was lower for both groups.

In 2017, the Indiana Department of Child Services Family Centered Treatment Calendar Year 2016 and 2017' outcomes report examining youth and families receiving FCT through Title IV-E Waiver funding found:

- 86% of FCT Youth and Families had Absence of Repeat Maltreatment for All Participants with Closed Cases. Absence of repeat maltreatment constitutes any substantiated allegation made to DCS within 365 days of the case close date.
- 87% of FCT Youth and Families had Absence of Repeat Maltreatment for Successful Program Completers with Closed Cases. Absence of repeat maltreatment constitutes any substantiated allegation made to DCS within 365 days of the case close date.



Family Centered Treatment Foundation, Inc.

10140 Thomas Payne Cir. • Charlotte, NC 28277

(703) 757-6243 • www.familycenteredtreatment.org

Thank you for your consideration of recommendations and for consideration of prioritizing review of Family Centered Treatment as a Well-supported Practice.

Sincerely,

Timothy J Wood, LPC

Timothy Wood, LPC
Executive Director-Family Centered Treatment Foundation, Inc.



Attachments incorporated for review:

- The Definitive Report for Family Centered Treatment v2.0
- FCT Trauma Treatment v.18
- Program Design and Implementation Guide v.16
- Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration. Research on Social Work Practice
- OJJDP Journal of Juvenile Justice Vol 2. Issue 1 Fall 2012 p.25-40
- Indiana DCS Title IV E Waiver Demonstration Report Sub Study
- Youth Outcomes Following FCT in MD UM SOSW 2015.pdf
- FCT Outcomes (Crossover) Building the Evidence
- Indiana Department of Child Services Family Centered Treatment Calendar Year 2016 and 2017' outcomes report

Cc. Family Centered Treatment Foundation, Inc. Board of Directors

Research Publications, Independent Reports and Published Articles Regarding Family Centered Treatment 2004-2019



Contents

Research Publications.....	2
National evaluation of Safe Start Promising Approaches Assessing Program Implementation (2010).....	2
Family Centered Treatment®—An Alternative to Residential Placements for Adjudicated Youth: Outcomes and Cost-Effectiveness (2012).....	2
Youth Outcomes Following Family Centered Treatment® in Maryland (2017)	3
Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration (2017).....	4
Independent Reports	4
Final Summary Report for “Building the Evidence Base: Family Centered Treatment for Crossover Youth” (2017)	4
Adapting juvenile justice interventions to serve youth with trauma histories (2017).....	5
Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project. Final Report. (2018)	5
Published Articles	7
Strengthening Community-Based Programming for Juvenile Sexual Offenders: Key Concepts and Paradigm Shifts (2004).....	7
Family Centered Treatment: A unique alternative. (2006)	7
Team Primacy Concept (TPC) Based Employee Evaluation and Job Performance (2006).	7
A strategic approach to reunification for juveniles with placements out-of-home. (2012).	8
Henderson County: Putting families back Together (2017).....	8

Research Publications, Independent Reports and Published Articles Regarding Family Centered Treatment 2004 to Present

2019

RESEARCH PUBLICATIONS

Schultz, D., Jaycox, L. H., Hickman, L. J., Chandra, A., Barnes-Proby, D., Acosta, J., Honess-Morreale, L. (2010). *National evaluation of Safe Start Promising Approaches Assessing Program Implementation*. Retrieved from the Rand Corporation's website:

http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR750.pdf

RAND Corporation researchers evaluated the SSPA phase of the initiative in collaboration with the national evaluation team: OJJDP, the Safe Start Center, the Association for the Study and Development of Communities (ASDC), and the 15 program sites. The evaluation design involved three components: a process evaluation, including a cost analysis; an evaluation of Summary xi training; and an outcomes evaluation. This report presents the results of our implementation process evaluation as well as the cost and training evaluation results.

Broward County's Family-Centered Treatment® is evaluated in this study. In Broward County, the lead agency developed Family-Centered Treatment® more than 20 years ago. This intensive family-centered service model was designed to foster strong healthy attachment to parents and a sense of belonging, competence, independence, and value in children (Institute for Family-Centered Services, Inc., 2004). Family-Centered Treatment® involves five procedures, including safety assessment, crisis intervention, individual and family counseling, education about child development and appropriate expectations, and wraparound services 24 hours a day, seven days a week, for the duration of the service period. All services were provided in the family's own home and environment.

The intervention was conducted in the context of a rigorous outcome evaluation as required by OJJDP (see the box titled "Broward County Safe Start Evaluation" for a description). The Safe Start program built a local reputation for working with "difficult" families, and thus appeared to be a resource to some of the agencies working with families who had experienced domestic violence. This resulted in the program implementing the full model with most families, offering the full four to six-month program that combined stabilization, psychoeducation, and skill building, as well as their intensive services that attempt to improve family functioning. However, the approach, which includes the abuse perpetrator in the therapy at some points, was controversial with some agency partners and made some agencies wary about referring families into the program.

Successes of the program included steady referrals into the project and a positive reputation in the community overall. Challenges related to tracking these highly mobile families and establishing trust with community partners who were concerned about their work with perpetrators. As a program that has promise, the successful implementation of the program in this environment would allow the outcomes to be evaluated, to show whether this approach can be successful, and to what degree.

Sullivan, Melonie B. Department of Research, FamiliFirst, Inc.; Bennear, Lori Snyder Department of Environmental Economics and Policy, Nicholas School of the Environment and Earth Sciences, Duke University; Honess, Karen Independent Contractor, FamiliFirst, Inc.; Painter, Jr., William E., Department of Organizational Development, Institute for Family Centered Services; Wood, Timothy J. Department of Research, FamiliFirst, Inc. *Family Centered Treatment®—An Alternative to Residential Placements for Adjudicated Youth: Outcomes and Cost-Effectiveness*. OJJDP Journal of Juvenile Justice, Volume 2, Issue 1, Fall 2012, Pages 25-37.

In this long-term follow-up study of adjudicated youth in the state of Maryland, FCT is shown to be a promising and cost-effective alternative to residential placements. In the first year following treatment, we found that youth receiving FCT

significantly reduced the frequency of their offenses and adjudications, and that the proportion of youth with offenses and adjudications was also significantly reduced. These findings were sustained 2 years post-treatment. The results were consistent across groups in the first year following treatment. In the second year following treatment, however, FCT youth exhibited a much greater decline than the Placed group in both the average frequency of adjudications and the proportion of youth with adjudicated offenses. Moreover, in the first year following treatment, we found that the effect of FCT reduced the average frequency of residential placements, days in pending placements, and days in community detentions relative to those of the comparison group. These outcomes were achieved at substantial cost savings: every \$1.00 spent on the FCT program saved the state of Maryland between \$2.03 and \$2.29, for a total estimated savings of \$10.9 million to \$12.3 million over 4½ years.

Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. (2017). *Youth Outcomes Following Family Centered Treatment® in Maryland*. Baltimore, MD: University of Maryland School of Social Work. April, 2017

Family Centered Treatment is designed to reduce out-of-home placements for youth involved with the juvenile justice system. FCT provides services in youths' home communities, within their families. Previous research has supported the effectiveness of FCT, and it appears in three registries of promising or effective programs for youth and families. The current project represents a larger, independently led study of the intervention in Maryland. The following report summarizes findings from an external evaluation of FCT, with a focus on outcomes, cost, and program implementation.

Highlights from Findings:

FCT Utilization and Fidelity; The study includes a total of 1,246 youth who started FCT between fiscal years 2009 and 2013. Most youth admitted to FCT during the study period were between the ages of 15 and 17 years old (75%), and the average age at admission was just over 16 years old. The majority of youth were male (79%) and African American/Black (67%). Fidelity to the FCT practice model was high, with average fidelity to specified treatment activities exceeding 75% in fiscal years 2011-2013 (the years in which fidelity data was consistently captured in client records). Over 85% of the sample met FCT's definition of engaged in treatment (11 or more direct contacts). Fidelity and engagement in treatment were not significantly related to justice system outcomes, but dosage as measured by length of treatment was significant in most models of later outcomes. Longer FCT treatment periods were associated with decreased odds of juvenile adjudication, adult conviction, and adult incarceration.

Outcomes; Relative to a statistically equivalent comparison group of youth who received group care, youth participating in FCT were significantly less likely to experience arrest resulting in conviction or sentences of incarceration in the criminal justice system. No significant difference was found between youth receiving FCT and group care on readjudication or commitment in the juvenile justice system. Re-adjudication rates were relatively low and juvenile justice commitment rates were very low in both groups. Analysis of a matched female subsample showed non-significant differences between FCT participants and group care participants; relatively few female youth experienced the outcomes evaluated in the current research. Analysis of a matched subsample of youth 16 and older at initiation of FCT services also showed non-significant differences in adult criminal justice system involvement.

Costs; With shorter lengths of stay and a lower daily cost, the initial intervention cost for FCT was \$30,170 less per youth than group home placement for a statistically equivalent comparison group, on average. Accounting for initial intervention costs and any additional residential placement costs during the first 12 months after the start of each intervention, costs were an estimated \$41,729 less per youth, on average, for the FCT group as compared with the control group, who were placed in group homes. During the period 12 to 24 months post-admission, costs were \$20,339 lower on average for FCT youth.

Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B. R., & Afkinich, J. University of Maryland School of Social Work. *Family Centered Treatment, Juvenile Justice, and the Grand Challenge of Smart Decarceration Research on Social Work Practice 1-8* ^a The Author(s) 2017 Reprints and permission: sagepub.com/journals Permissions.nav DOI: 10.1177/1049731517730127 journals.sagepub.com/home/rsw

Responding to social work's grand challenge of smart decarceration, this study investigated whether Family Centered Treatment (FCT), a home-based service for juvenile court-involved youth, is more effective than group care (GC) in reducing recidivism. Outcomes are juvenile readjudication and commitment to placement, and adult conviction and sentence of incarceration.

Method: Data were drawn from service provider and state administrative databases. Propensity score matching was used to create a sample of 1,246 FCT youth and 693 GC youth. Cox proportional hazard models estimated time to the four outcomes.

Results: FCT participants had a significantly lower risk of adult conviction and adult incarceration relative to youth who received GC. The findings for juvenile outcomes were nonsignificant.

Discussion: FCT shows more favorable adult criminal justice outcomes than GC, making it a potentially effective community-based service to support smart decarceration for juvenile court-involved youth. Juvenile services have an important role to play in the grand challenge of promoting smart decarceration. If social workers advocate reduced reliance on institutions to treat offenders, full-scale implementation of community-based alternatives to incarceration will be required. Further, as the juvenile justice system serves a greater proportion of its youth in the community, research on effectiveness of a broad array of services is necessary (Lipsey, 2012). The results of this study suggest that FCT is effective at reducing adult criminal justice involvement. These findings support the use of FCT as an alternative to GC for high-risk and/or high-need offenders. This research contributes to the literature on juvenile services and effectiveness and provides a basis for ongoing study of comprehensive, community-based treatment. This study is one piece of a comprehensive research agenda on social work's grand challenge of promoting smart decarceration.

INDEPENDENT REPORTS

Final Summary Report for “Building the Evidence Base: Family Centered Treatment for Crossover Youth”; Project period: 1/1/16-12/31/16. Funded by the Annie E. Casey Foundation, with matching funds supplied by the University of Maryland School of Social Work and MENTOR (The Mentor Network).

This project, “Building the Evidence Base: Family Centered Treatment for Crossover Youth,” sought to determine the effectiveness of a promising practice, Family Centered Treatment® (FCT), in a sample of juvenile court-involved youth with child welfare histories (hereafter “crossover youth”; Herz, Ryan & Bilchik, 2010). Crossover youth constitute a high-need population, as described below. In order to better serve this population, the research project addressed rates of recidivism and commitment in the juvenile and criminal justice systems for FCT recipients with child welfare histories, relative to those who have no child welfare history; child welfare and maltreatment experiences associated with outcomes following FCT; and effectiveness of FCT relative to group care for African American youth.

Due to FCT’s focus on trauma and experience treating youth with both child welfare and juvenile justice histories, we expected to find significant differences in justice outcomes between FCT and group care youth. We also explored the question of whether FCT had the potential to reduce disproportionate minority contact by effectively serving African American youth, relative to group care. We were surprised to find most analyses were non-significant, and particularly

surprised that the multivariate models did not fit the data in most cases. Our interpretation of these findings is that treatment of crossover youth, and criminogenic risk factors among crossover youth, are more complex and multi-faceted than we captured in our data, despite inclusion of several relevant matching covariates, child welfare and maltreatment history variables, and treatment features. In two cases, however, FCT did outperform group care in the multivariate survival analyses. It appears that FCT may be more effective than group care in preventing adult conviction and adult arrest resulting in sentence of incarceration (including suspended sentences). This is promising evidence in support of FCT and should be explored further. Additional research is clearly needed to better understand the needs, risks, and outcomes of crossover youth. For the next stage of our research agenda, we plan to undertake a qualitative study of FCT practitioners and trauma-informed care. The information practitioners share may have relevant implications for service provision, service administration, and policy in juvenile justice treatment.

Bright, C. L. (2017, July). *Adapting juvenile justice interventions to serve youth with trauma histories.*

Presented at the International Academy of Law and Mental Health's 35th International Congress on Law and Mental Health, Prague, Czech Republic.

The study is designed to understand the experiences and perceptions of service providers who provide Family Centered Treatment to juvenile court-involved families. The study will explore the experiences about the level of comfort and skill in working with traumatized youth, the procedures they use to assess for trauma, the adaptations they make to existing services in the cause of trauma, and their perceptions of the success of these efforts.

Preliminary Findings:

Theme 1 – trauma awareness

In every interview – trauma is described as serious concern with court-involved youth. “Almost 100%”. View of trauma as behind, or causing, behavioral issues.

Theme 2 – FCT Alignment; Assessment, practices, ACES questionnaire, Additional structured assessment items about trauma, On-going engagement with families are all indicators of alignment.

Theme 3 – Use of Trauma Informed Elements Discussions of safety, making families feel in control is a sentiment expressed repeatedly. Belief that specialized trauma treatment takes longer than the time available; short-term options needed.

Theme 4 – Systemic Barriers Placement decisions outside provider control, short-term treatment and competing demands and high-need families come up frequently.

Next Steps - Conduct additional data collection (target sample 30-40), More rigorous data analysis (multiple coders, more iterative process – constant comparison, examining possible differences by site or role) and discussing results with agency staff prior to final dissemination products.

Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project. Final Report.
Prepared by: The Indiana University Evaluation Team & The Department of Child Services, 2018. US Government submitted and republished in Profiles of the Active Title IV-E Child Welfare Waiver Demonstrations, Prepared for: Children’s Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services Prepared by: James Bell Associates Arlington, VA July 2018.- Pending Journal Publication 2019

As part of the original Terms and Conditions of the Indiana 2012 IV-e Waiver, the Indiana University (IU) *project team* developed a sub-study which focused on the implementation and effectiveness of a specific treatment program. After considering options, IU developed a research design that evaluated the impact and effectiveness of Family Centered Treatment (FCT) which was implemented due to Waiver funds.

The effectiveness of the Family Centered Treatment (FCT) intervention was studied from January 1, 2015-December 31, 2015. All children referred for FCT received services as indicated via the model. Fidelity was established using a manualized training and certification of home-based workers, supervision, consultation with national FCT Foundation clinicians, and monthly compliance checks on dosage of the intervention. Children (and families) in the FCT treatment group were matched with children (and families) who received usual and customary care using propensity score matching. Matching characteristics were age, gender, race, region, county, number of focus children, involvement status, permanency goal, CANS score, and risk score. Overall, 20,779 children were within DCS between January 1, 2015 and December 31, 2015 and 230 of those children not involved with the justice system received FCT. Matching characteristics were too restrictive, and we were unable to obtain sufficient number of pairs to conduct and analysis. Therefore, region and permanency were removed as they were the characteristics restricting matching. The final data set then included 187 children who received FCT and 187 children who did not. The sample set demonstrated similar demographic characteristics with no significant differences.

Safety: First we analyzed the difference in remaining home throughout DCS involvement. Children who had FCT were significantly more likely to remain in the home throughout (55.61% vs. 39.04%, $p < .001$). Next, we analyzed repeat maltreatment during and 6 months post-DCS involvement. Children in FCT had higher rates of repeat maltreatment (10.61% vs. 5.98%), however, this was not statistically significant. Children in FCT did have a lower rate of repeat maltreatment 6 months after their involvement with DCS ended but again this was not statistically significant (1.68% vs. 4.35%). Finally, we assessed re-entry into DCS following involvement. Although FCT children had higher rates of re-entry than non-FCT children, this difference was not statistically significant (56.42% vs. 50%). These findings indicate that FCT was only partially effective in addressing safety concerns.

Permanency: First we analyzed total days of DCS involvement and number of days elapsed to reunification for each group. Children in FCT had fewer days on average than children who did not have FCT, but this was not statistically significant (331 vs. 344). Children in FCT did have statistically significantly fewer days on average until reunification than non-FCT children (341 vs. 417, $p < .05$). These findings indicate some success using FCT to increase time to permanency.

Well-being: To analyze well-being we analyzed risk level for children in both groups. Children who participated in FCT had a lower rate of being classified as “very high risk” as compared to children who did not (50.8% vs. 51.87%) and a higher rate of being classified as “low risk” (1.6% vs. 0.53%). Neither was statistically significant. We analyzed Child Abuse and Neglect (CANS) scores for each group and found that FCT children had a slightly higher average CANS score but it was not a statistically significant difference (1.27 vs. 1.22). To clarify the well-being assessment, we assessed changes in child’s safety rating. Children who had FCT had a statistically significantly higher rate of being rated as safe (35.71% vs. 28.49%, $p < .001$) and conditionally safe (39.56% vs. 27.93%, $p < .001$), and a significantly lower rate of being rated as unsafe (24.73% vs. 43.58%, $p < .001$) than children who did not participate in FCT.

Cost: We analyzed total case cost and cost per child for each group. The average total cost of the case was statistically significantly higher for children in FCT (\$19,673 vs. \$17,719, $p < .05$). However, the cost per child was not statistically significant (\$10,277 vs. \$6,481) between groups. This finding is not surprising since FCT was an additional cost to the DCS system.

Summary of FCT Comparison Findings: Overall, children, and families, who participated in FCT appear to fare better than children who do not participate in FCT. While the cost of administering the program is higher for children who participate in FCT than those that do not, children who participated in FCT have better outcomes associated with their

safety, permanency goals, and well-being. Children who participated in FCT were more likely to remain in-home during their involvement with DCS, as well as be reunited with their family in shorter timeframe and more likely to be ranked as conditionally safe and safe.

PUBLISHED ARTICLES

Hunter, John A.; University of Virginia, Gilbertson, Stephen; Wraparound Milwaukee, Vedros, Dani; The Institute for Family Centered Services, Morton, Micheal; Norfolk Court Services Unit. *Strengthening Community-Based Programming for Juvenile Sexual Offenders: Key Concepts and Paradigm Shifts*; CHILD MALTREATMENT, Vol. 9, No. 2, May 2004 177-189, DOI: 10.1177/1077559504264261 © 2004 Sage Publications

This article describes the use of the community based programming of FCT in one of the programs evaluated. It is believed that clinically and legally integrated programming, using newer social-ecological methodologies and supports, offers promise of reducing the number of youth who require residential placement, shortening residential lengths of stay and improving the transition of residentially treated youth back into community settings. Key concepts relevant to bolstering community-based programming for juvenile sexual offenders are identified and discussed.

Two programs are described, and program evaluation data reviewed, in support of the viability of innovative community-based approaches to the management of this population. The success of community-based programming for juvenile sexual offenders is also dependent on broad interagency planning in the delivery of integrated clinical, legal, and social services to these youths and their families. Key stakeholders must be trained and actively engaged in program planning and resource development, and strong community infrastructures must be developed to meet the varied and complex service needs of the described clientele. Program evaluation data suggest that programs based on the described model are clinically and cost effective and are enthusiastically supported by participating courts and public agencies.

Sullivan, J. P. (2006). *Family Centered Treatment: A unique alternative*. Corrections Today, 68(3).

This article describes a project with the Virginia Department of Juvenile Services treated juveniles who were at imminent risk of out-of-home placement; 89 percent had committed at least one felony, and all had a history of out-of-home placements and/or secure detention. Despite their high risk status, 84 percent of these youths successfully completed the program and either remained with their families or were reunited with them, 77 percent incurred no new charges while in treatment, 74 percent incurred no new charges in the first six months following discharge, and none incurred new charges in the second six months following discharge. Considering the placement rate, prevailing costs and expected length of stay for out of home placements, this program saved approximately \$100,000 per youth. An individual case study is described in this article defining via an example the FCT process.

Eivina I. Muniute; Florida International University and Mary V. Alfred Texas A&M University. *Team Primacy Concept (TPC) Based Employee Evaluation and Job Performance*. International Journal of Training and Development 2006

This qualitative study explored how Family Centered Treatment model staffs employed in the provider agency learn from Team Primacy Concept (TPC) based employee evaluation and how they use the feedback in performing their jobs. TPC based evaluation is a form of multirater evaluation, during which the employee's performance is discussed by one's peers

in a face-to-face team setting. The study used Kolb's learning model to describe employees' learning from evaluation. The findings suggest that such evaluation plays a positive role in facilitating employees' performance.

Painter, W. E. (2012). *A strategic approach to reunification for juveniles with placements out-of-home*. FOCUS, 18(2), 11-13.

This article summarizes the specialty reunification components utilized within Family Centered Treatment®. A successful and expedited reunion can occur when critical parenting and trust issues have been resolved or at least addressed prior to reunification. An effective reunification program identifies and treats both the expressed and unexpressed needs of the child placed out of the home. As these needs are met, the potential for a successful reunification is increased.

Hensley, Jennifer (2017) *Putting families back together*. BlueRidgeNow.com
<https://www.blueridgenow.com/news/20170420/henderson-county-putting-families-back-together>

This article highlights Family Centered Treatment® and briefly discusses the need for implementation of the model in Henderson County, North Carolina. The article, written by Henderson County DSS personnel, outlines some of the challenges seen with families in care and pushes the reader to examine the need for intensive home-based family therapy as an alternative to removing children from their homes.



A SYSTEMATIC REVIEW OF FAMILY CENTERED TREATMENT

Title IV-E Transitional Payment Assessment for the
Nebraska Department of Health and Human Services

Abstract

This document provides a summary of the process used by the Stephen Group to review Family Centered Treatment (FCT) for the purpose of claiming Title IV-E evidence-based prevention services Transitional Payments. Using a systematic approach to the review of multiple studies, FCT was found to have at least two contrasts with non-overlapping samples in studies carried out in usual care or practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome. As a result, the intervention has been determined to be well-supported.

The Stephen Group, LLC
814 Elm Street
Suite 309
Manchester, NH 03101
(603) 419-9592
www.stephengroupinc.com

A Systematic Review of Family Centered Treatment

Title IV-E Transitional Payment Assessment for the Nebraska Department of Health and Human Services

Table of Contents

Overview	2
Review Team and Conflict of Interest Statement	2
Family Centered Treatment	3
Program or Service Area(s)	3
Handbook, Manual and Program Documentation	3
Eligible Studies	4
Study Reviews	4
Summary	12
Appendix A: Calculation Methods	13
Appendix B: Completed PI-19-06 Attachment.....	14

A Systematic Review of Family Centered Treatment

Title IV-E Transitional Payment Assessment for the Nebraska Department of Health and Human Services

Overview

Under contract to the State of Nebraska Department of Health and Human Services, The Stephen Group (TSG) has completed a review of the evidence base for Family Centered Treatment (FCT) in accordance with the standards articulated in the *Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures* (“the Handbook”). In collaboration with our subcontracted partner, MEF Associates, a systematic review of three published studies was completed and we have arrived at a rating of **WELL-SUPPORTED** for FCT. According to the Handbook, a well-supported program:

“Has at least two contrasts with non-overlapping samples in studies carried out in *usual care or practice settings* that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts must demonstrate a sustained favorable effect of at least 12 months *beyond the end of treatment* on at least one target outcome (p. 43).”

We find these standards to have been met. This memo summarizes our review of the three FCT studies examined, providing supporting evidence for the well-supported rating we have assigned. In the course of this review, there were several occasions where the Handbook’s guidance was unclear or left room for interpretation. In these instances, we made decisions based on our understanding of the guidance and our best judgment; we have detailed our choices and justifications for them here.

Review Team and Conflict of Interest Statement

Review Team

This evaluation consisted of an experienced team of researchers and evaluation professionals from TSG and MEF Associates. TSG was pleased to partner with MEF Associates who provided expert technical guidance and assistance in the validation of study designs and statistical outcomes. Project staff included:

David DeStefano, MA – Senior TSG Consultant and Project Manager: Mr. DeStefano has more than 17 years of experience designing, implementing and conducting outcome evaluation for various federally-funded projects including a National Resource Center, Quality Improvement Center and numerous Administration on Children, Youth and Families funded demonstration grants and collaborative agreements. His experience includes quasi-experimental research design, focus group studies, survey research and data analysis. He earned a Master of Public Policy from New England College and a BA from Purdue University.

Kate Stepleton, PhD – MEF Associates Senior Research Associate: Ms. Stepleton has expertise in child and family research and policy, particularly in the areas of child welfare, maltreatment prevention, early childhood, and child well-being. She is skilled in qualitative and quantitative methods, design of experimental and quasi-experimental studies, survey research, and data analysis. She has managed research projects at Rutgers University School of Social Work, served in the Administration on Children, Youth and Families in the U.S. Department of Health and Human Services, and was an Associate with the Center for the Study of Social Policy in Washington, D.C. She has a Ph.D. in social work from Rutgers, an MSW from the University of Chicago’s School of Social Service Administration, and a BA in Sociology from Barnard College.

Marissa Putnam, PhD – MEF Associates Research Associate: Ms. Putnam has conducted random assignment experimental research projects at Georgetown University, funded by the National Science Foundation and has also worked as a Research Assistant and Programmer at Mathematica Policy Research where she contributed to federal and state program implementation and evaluation, as well as measure development, in early childhood and health areas. Marisa earned her Master of Public Policy from the McCourt School of Public Policy at Georgetown University and her PhD in Developmental Psychology at Georgetown University.

Conflict of Interest Statement

TSG is committed to integrity and fairness in the conduct of all of its activities. As such, we certify neither TSG, our subcontracted partner, MEF Associates, or staff of either organization have a relationship with the developer of FCT or study authors through employment, consultancies, stock ownership, honoraria, or other relationship, either directly or through immediate family, which may be considered a conflict of interest. As such, the resulting opinion presented in this document is impartial and independent of external influence which may bias our determination.

Family Centered Treatment

Family Centered Treatment (FCT) is a behavioral intervention for youth who are in need of intensive services to prevent placement or to be reunified. The treatment model was developed by practitioners and has been refined by provider wisdom and experience over thirty years. FCT engages members of youths' family systems, targeting multiple dimensions of family functioning. Services are delivered at home or in the community over approximately six months. FCT is a listed treatment intervention on the National Child Trauma Stress Network website and is a SAMHSA trauma grant awardee. Additional information about FCT's treatment model can be found at www.familycenteredtreatment.org.

Program or Service Area(s)

Family Centered Treatment was reviewed in the area(s) of:

- In-Home Parenting Skills Based Program
- Mental Health

Handbook, Manual and Program Documentation

Program implementation materials including an online manual, implementation guide and other documentation were made available to reviewers in digital copies. The implementation manual, Wheels of Change © is accessible as a digital training manual through the e-learning platform *Mindflash*. Access to this platform was provided to the reviewers by the model developer for the purpose of verification. In addition to access to the online training materials, the model developer provided the following documents for review:

- Program Design and Implementation Guide
- Path of Implementation for Providers
- FCT Readiness Assessment Interview Plan
- Implementation Driver Assessment – closed copy
- Fidelity Adherence Compliance Tracker (FACT) – copy
- Fidelity Implementation-strategy Tool
- Readiness Assessment Report – Example Redact

- Readiness Assessment Matrix (RAM)
- Definitive Report on FCT – 1 of 6 required readings for FCT to achieve Certification

Program materials have been archived by The Stephen Group and are available for review, upon request.

Eligible Studies

Based on a comprehensive literature review of bibliographic databases and public websites maintained by state and local governments, three studies were identified and deemed eligible for review. Table 1 lists these three studies:

Table 1. Studies and Publications Reviewed

Indiana Waiver Substudy:	<ul style="list-style-type: none"> • 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.
Sullivan, et al.	<ul style="list-style-type: none"> • Sullivan, M.B., Bennear, L.S., & Honess, K. (revised 2011). A quasi-experimental evaluation of Family Centered Treatment in the Maryland Department of Juvenile Services Community Based Non-residential Program: A report to Maryland Department of Juvenile Services and Institute for Family Centered Services. Great Falls, VA: FamiliFirst. • Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter Jr, W. E., & Wood, T. J. (2012). Family Centered Treatment®--an alternative to residential placements for adjudicated youth: outcomes and cost-effectiveness. <i>Journal of Juvenile Justice</i>, 2(1), 25-40.
Bright, et al.	<ul style="list-style-type: none"> • Bright, C. L., Betsinger, S., Farrell, J., Winters, A., Dutrow, D., Lee, B.R. & Afkinich, J. (2017). Youth Outcomes Following Family Centered Treatment In Maryland. Baltimore, MD: University of Maryland School of Social Work. • Bright, C.L., Farrell, J., Winters, A.M., Betsinger, S., & Lee, B. (2017). Family Centered Treatment, juvenile justice, and the Grand Challenge of Smart Decarceration. <i>Research on Social Work Practice</i>, 28(5), 638-645.

Copies of these studies have been maintained by The Stephen Group and are available for review, upon request.

Steps undertaken in the review of each study are described, below. Documentation detailing communication with study authors or the developer of FCT has been maintained by TSG and is available upon request.

Study Reviews

The Indiana Waiver Substudy employs a quasi-experimental design (QED) to evaluate the impact of FCT in a sample of child welfare-involved youth in Indiana.

- **Population:** The intervention group contained all youth who received FCT in Indiana from January 1, 2015 to December 31, 2015. The authors use propensity score matching to construct a comparison group of youth receiving child welfare services during the same period who did not receive FCT. As a result of the matching, the comparison group is similar on demographic and risk factors to the treatment group.
- **Data:** Administrative child welfare data

Study Design and Execution Rating

We have assigned the Indiana Waiver Study a design and execution rating of **Moderate** for all contrasts.

- **Statistical Models:** The statistical modeling measures are, according to the information provided, appropriate for the analysis task (section 5.9.1). The authors' propensity scoring model includes appropriate covariates, and matching procedures eliminated any statistically significant differences in groups. The baseline equivalence standard was met for all contrasts, and no adjustment to the impact model was needed. Matching was done without replacement.
- **Measurement Standards:** All outcome and pre-test measures meet the Handbook's measurement standards (section 5.9.2). All have face validity. Because the measures are drawn from administrative child welfare data, all are assumed reliable and to have been consistently measured across intervention and comparison groups.
- **Design Confounds:** No design confounds were identified (section 5.9.3). Intervention and comparison groups were successfully matched on demographics and child welfare case characteristics. Post-match comparisons demonstrated nonsignificant differences between groups. It is possible that the groups differed on unobserved characteristics, but we are satisfied that the groups are comparable based on what the authors present. The intervention was delivered statewide, so we assume no n=1 person-provider confound exists.
- **Missing Data:** There does not appear to be any missing data.
- **Baseline Equivalence:** The child welfare outcomes assessed in the study do not have direct pre-tests. As such, we needed to identify a suitable pre-test alternative for each outcome. We selected safety ranking as a plausible pre-test, seeing it as a "common precursor" (Handbook, p. 30) to all outcomes examined. Safety risk itself is a multi-level categorical variable, so we selected a single level of the variable, high risk, to use as the pre-test. We believe this to be an appropriate selection because (a) it is likely to be associated with the study's outcomes, and (b) approximately half of the study population were assessed as high risk (whereas fewer than two percent of the population were assessed as low risk). The baseline equivalence standard (section 5.7) across intervention and treatment groups was met (Table 2) and no adjustment was needed in the impact model.

Table 2. Indiana Waiver Substudy: Baseline Equivalence

Contrasts: Outcome Measures	Pre-Test or Pre- Test Alternative	Intervention Group		Matched Comparison Group		Effect Size	Equivalence Standard Met
		n	Proportion	n	Proportion		
Remaining in-home throughout involvement with DCS	Safety ranking: Very High Risk"	187	.51	187	.52	-0.03	Yes
No repeat maltreatment during case	Safety ranking: Very High Risk"	187	.51	187	.52	-0.03	Yes
No repeat maltreatment within 6 months of case closure	Safety ranking: Very High Risk"	187	.51	187	.52	-0.03	Yes
No re-entry after case closure	Safety ranking: Very High Risk"	187	.51	187	.52	-0.03	Yes
Days of DCS involvement	Safety ranking: Very High Risk"	187	.51	187	.52	-0.03	Yes

Days until reunification	Safety ranking: Very High Risk”	187	.51	187	.52	-0.03	Yes
Safety ranking: safe	Safety ranking: Very High Risk”	187	.51	187	.52	-0.03	Yes
Safety ranking: conditionally safe	Safety ranking: Very High Risk”	187	.51	187	.52	-0.03	Yes
Safety ranking: unsafe	Safety ranking: Very High Risk”	187	.51	187	.52	-0.03	Yes

Impact Estimates

The study had two significant contrasts, both of which were favorable (Table 3).

Table 3. Indiana Waiver Substudy: Impact Estimates for Favorable Contrasts

Contrasts: Outcome Measure	Intervention Group			Matched Comparison Group			p value	Effect Size
	n	m	sd	n	m	sd		
Remaining in-home throughout involvement with DCS	187	.56	N/A	187	.39	N/A	.001	.41
Days until reunification	69	341	238.42	83	417	229.81	.02	-.32

Sullivan, et al.

The Sullivan, et al. study employs a quasi-experimental design QED to evaluate the impact of FCT in a sample of child welfare-involved youth in Maryland.

- **Population:** The intervention group contained youth who received FCT between July 1, 2003 and December 31, 2007 in Maryland. A propensity score-matched comparison group was constructed from youth who were discharged from group homes, therapeutic group homes, and committed residential placements during the same time.
- **Data:** All data are drawn from administrative records from the state Department of Juvenile Services.

Study Design and Execution Rating

We have assigned the Sullivan, et al. study a design and execution rating of **Moderate** for some but not all contrasts. While the authors present findings both one and two years post-treatment, the Handbook requires only one contrast with a sustained favorable effect for at least twelve months for an intervention to receive a rating of well-supported. Having identified favorable 12-month effects, we did not review year-two findings.

- **Statistical Models:** The statistical modeling measures are, according to the information provided, appropriate for the analysis task. The authors' propensity scoring model includes appropriate covariates, and matching procedures eliminated any statistically significant differences in groups. It is possible that the groups differed on unobserved characteristics, but we are satisfied that the groups are comparable based on what the authors present. However, as demonstrated below, the baseline equivalence standard was not met for several of the study's contrasts, and the authors do not appear to control for these post-matching group differences in their impact models. Therefore, in presenting impact estimates, we have only shown those statistically significant contrasts for which the baseline equivalence standard was met.

- **Measurement Standards:** All outcome and pre-test measures meet the Handbook's measurement standards. All have face validity. Because the measures are drawn from administrative juvenile justice data, all are assumed reliable and to have been consistently measured across intervention and comparison groups.
- **Design Confounds:** We have not identified any design confounds. The authors describe how selection into FCT takes place: judges make decisions informed by a structured assessment tool and the recommendations of case managers and probation officers. While this potentially introduces selection bias, the authors make two arguments about how they address this: first, they include an approximation of the measures from the structured assessment tool in the propensity score model. Assessments were not available for all youth in the sample, so the authors identified proxies for the measures drawn from pre-treatment juvenile justice data for youth. Sufficient detail is given to demonstrate that these proxy measures are suitable alternatives to the assessment's indicators. Second, the authors specify the matching model such that region is fixed. Intervention group youth may only be matched with comparison group youth in their region in an effort to hold constant the effect of geographic variation in how the child welfare system operates. We find these measures to be adequate for controlling for potential selection bias. Youth who are assigned to FCT are considered "at imminent risk for out of home placement (Sullivan, Bonnear, & Honess, p. 4)," suggesting that youth who did not receive FCT would otherwise have been placed in group or residential placements. As such, we find that the comparison group is conceptually suitable to the study. There is no n=1 person-provider confound.
- **Missing Data.** The authors appear to have complete data on all baseline and outcome variables. We did note that there is a slight discrepancy in the size of the matched comparison group used to calculate pre-treatment characteristics (n=1,785) and the size of the matched comparison group used to estimate treatment effects at one year (n=1,788). The authors note that they omitted some cases from the descriptive analysis because "they skewed the means of the matched groups on important characteristics" (p. 13). They go on to explain that this is "an artifact of using 4 matches for each treatment observation, with replacement, and an aggregation of matching characteristics via the propensity score" (p. 13). The skewed means in the matched comparison group were observed for measures relating to youth placements in secure confinement and special placements; these measures were not skewed in the unmatched comparison sample. When presenting descriptive statistics for the matched comparison group, the authors note that the observations responsible for skewing the noted means were dropped and assure the reader that differences between the full matched comparison sample (n=1,788) and the slightly smaller group (n=1,785) on other measures are "minuscule." We did not use measures related to secure confinement or special placements to establish baseline equivalence for any of the contrasts, so we are satisfied that this difference in reported comparison sample sizes does not threaten the validity of the study.
- **Baseline Equivalence:** We were able to find direct pre-tests for many of the outcomes examined in the study; for others, we identified pre-test alternatives that were conceptually similar or could be plausibly considered precursors to the outcomes in question. The baseline equivalence standard was met for some but not all contrasts (Table 4). Where baseline equivalence was not established, the effect sizes fell into the range requiring the researchers to adjust for the pre-tests or pre-test alternatives in the impact model; however, as noted below, the impact model did not appear to include any adjustment.

Table 24. Sullivan et. al: Baseline Equivalence

Contrasts: Outcome Measures (one year post- treatment)	Pre-Test or Pre-Test Alternative	Intervention Group			Matched Comparison Group			Effect Size	Equivalence Standard Met
		n	m	sd	n	m	sd		
Proportion of youth with residential placements	Proportion of youth with placements: community based residential	446	0.17	0.38	1785	0.17	0.37	0.00	Yes
Frequency residential placements	Placement frequency: community based residential	446	0.23	0.56	1785	0.21	0.51	0.04	Yes
Duration residential placements	Placement duration: community based residential	446	37.16	131.30	1785	25.16	83.93	0.13	Adjustment needed
Conditional duration residential placements	Placement duration: community based residential	446	37.16	131.30	1785	25.16	83.93	0.13	Adjustment needed
Proportion of youth with pending placements	Proportion of youth with placements: community based residential	446	0.17	0.38	1785	0.17	0.37	0.00	Yes
Frequency pending placements	Placement frequency: community based residential	446	0.23	0.56	1785	0.21	0.51	0.04	Yes
Duration pending placements	Placement duration: community based residential	446	37.16	131.30	1785	25.16	83.93	0.13	Adjustment needed
Conditional duration pending placements	Placement duration: community based residential	446	37.16	131.30	1785	25.16	83.93	0.13	Adjustment needed
Proportion of youth with community detention	Proportion of youth with placements: community detention	446	0.62	0.49	1785	0.65	0.48	-0.06	Adjustment needed
Frequency of community detentions	Placement frequency: community detention	446	1.11	1.19	1785	1.23	1.23	-0.10	Adjustment needed

Duration of community detentions	Placement duration: community detention	446	45.09	53.92	1785	48.46	59.58	-0.06	Adjustment needed
Conditional duration community detentions	Placement duration: community detention	446	45.09	53.92	1785	48.46	59.58	-0.06	Adjustment needed
Proportion of youth with secure detentions	Proportion of youth with placement: secure detention	446	0.63	0.48	1785	0.65	0.48	-0.04	Yes
Frequency of secure detentions	Placement frequency: secure detention	446	1.23	1.36	1785	1.23	1.29	0.00	Yes
Duration of secure detentions	Placement duration: secure detention	446	22.82	32.03	1785	20.27	28.21	0.09	Adjustment needed
Conditional duration secure detentions	Placement duration: secure detention	446	22.82	32.03	1785	20.27	28.21	0.09	Adjustment needed
Proportion of youth offending	Proportion of youth with offenses: category 1	446	0.28	0.45	1785	0.26	0.44	0.05	Yes
Frequency of offenses	Frequency of offenses: All categories	446	8.19	6.30	1785	7.96	6.34	0.04	Yes
Proportion of offending in category 1 and 2	Proportion of youth with offenses: category 1	446	0.28	0.45	1785	0.26	0.44	0.05	Yes
Frequency of category 1 and 2 offenses	Frequency of offenses: category 1	446	0.43	0.89	1785	0.37	0.76	0.08	Adjustment needed
Proportion of youth with adjudications	Proportion of youth with adjudications: all categories	446	1.70	1.76	1785	0.12	0.45	0.04	Yes
Frequency of adjudications	Frequency of adjudicated offenses: all categories	446	2.70	2.42	1785	2.67	2.30	0.01	Yes
Proportion adjudications category 1 and 2	Proportion of youth with adjudications: category 1	446	0.11	0.31	1785	0.09	0.28	0.07	Adjustment needed
Frequency of category 1 and 2 adjudications	Frequency of adjudications: category 1	446	0.14	0.47	1785	0.12	0.45	0.04	Yes

Impact Estimates

The impact model for all contrasts did not include any adjustment for variables that did not meet the baseline equivalence standard. For contrasts that met the baseline equivalence standard, we calculated *p* values according to the procedures described in Appendix A. However, the authors

conducted propensity score matching with replacement, meaning that once a youth in the comparison group was matched, they were returned to the sample and could be matched with additional treatment youth. As such, youth in the comparison group may be counted multiple times. The resultant downward biasing of standard errors yields potentially inflated p values in traditional t -tests unless a statistical correction is applied. The authors have corrected for this duplication in comparison observations in their reported findings; however, short of replicating their analyses with their raw data, we cannot do the same. The p values reported in Tables 5 and 6, which were calculated based on traditional t -tests, may therefore be artificially low. However, our review and the authors' findings agree that the contrasts listed in these tables are significant.

Among those contrasts for which pre-tests and pre-test alternatives met the baseline equivalence standard, four were significant.¹ Two significant contrasts were favorable (Table 5) and two were unfavorable (Table 6) when considered in isolation. Importantly, however, the unfavorable contrasts, when considered in the context of the other significant findings, tell a story about FCT's overall positive impact. This distinction is explained in greater detail below. All contrasts pertain to outcomes measured at 12 months post-treatment.

Table 5. Sullivan, et al.: Impact Estimates for Favorable Contrasts

Contrasts: Outcome Measure	Intervention Group			Matched Comparison Group			p value	Effect Size
	n	m	sd	n	m	sd		
Proportion of youth with residential placements at 12 months post-treatment	446	.38	0.49	1788	0.50	0.50	<.001	-.30
Frequency of residential placements at 12 months post-treatment	446	0.50	0.74	1788	0.63	0.70	<.001	-.18

Table 6. Sullivan, et al.: Impact Estimates for Unfavorable Contrasts

Contrasts: Outcome Measure	Intervention Group			Matched Comparison Group			p value	Effect Size
	n	m	sd	n	m	sd		
Proportion of youth with adjudications at 12 months post-treatment	446	.32	0.47	1788	.23	.44	<.001	.28
Frequency of adjudications at 12 months post-treatment	446	0.70	1.52	1788	0.45	1.04	<.001	.18

Results indicate that, compared to youth in the comparison group, more youth who received FCT had adjudications in the year following treatment. Youth in the treatment group also had a higher frequency of adjudications in the post-treatment year. However, considering these findings alongside the study's other results, the authors argue that higher adjudication rates among FCT, at minimum,

¹ One additional case requires special explanation. In our review, the contrast for the proportion of youth with secure detentions, for which the baseline equivalence standard was met, was significant at $p<.001$. However, in the report, the contrast does not meet even a minimum threshold for statistical significance. While our p value may be inflated due to duplication in the comparison sample, we suspect there may be a typo in the report and the article, as the average effect of treatment on the treated (SATT) reported does not seem appropriate given the treatment and comparison means presented. We have asked the authors to verify the values in the publications, but as of November 25, 2019, we have not received a response. As the Clearinghouse only requires one sustained favorable outcome for an intervention to be rated as well-supported, and as our review and the authors' analysis agree on the significance of two sustained favorable outcomes, we did not feel it necessary to pursue the issue further.

do not suggest unfavorable effects of FCT. Rather, they might be evidence of the program's capacity to change family system values. The authors write:

[Higher adjudication rates] must be reflective of court decisions as applied to youth receiving FCT. This outcome may be interpreted as a manifestation of the emphasis on accountability in Family Centered Treatment; the model attempts to instill accountability by accepting responsibility for one's actions as a family system value. This may be exhibited in the family's interactions with the courts as an increase in the likelihood of an offense being adjudicated. Overall, however, the fact that residential placements and days in detention are significantly lower suggests that the average youth receiving FCT committed fewer offenses of a nature that would warrant a consideration of removal from the community (Sullivan, Bonnear, & Honess, pp. 12-13).

We agree with the authors that the adjudication findings must be considered in the context of the study as a whole and that they do not undermine the evidence for the program's effectiveness.

Bright, et al.

Similar to Sullivan, et al., the Bright, et al. study employs a quasi-experimental design to evaluate the impact of FCT in a sample of child welfare-involved youth in Maryland. The Bright et al. study covers a later, non-overlapping time period.

- **Population:** The study population consisted of youth who had been adjudicated delinquent in Maryland. The intervention group consisted of 1,246 youth who received FCT, initiating treatment between July 1, 2008 and June 30, 2013. The comparison group was drawn from the population of youth who were served in group homes or treatment group homes during the same period.
- **Data:** Data are drawn from the administrative records of the service provider and the state Department of Juvenile Services.

Study Design and Execution Rating

We have assigned the Bright, et al. study a design and execution rating of **LOW** for all contrasts.

- **Statistical Models:** The authors' propensity scoring model includes appropriate covariates, and matching resulted in nonsignificant differences between intervention and comparison groups. However, as demonstrated below, even after matching, none of the pre-test alternatives met the Handbook's standard for baseline equivalence; all fell into the adjustment range. In these instances, the Handbook requires that the impact model control for the group differences in the pre-test alternatives. However, the study's impact models do not include any such controls.
- **Measurement Standards:** All outcome and pre-test measures meet the Handbook's measurement standards. All have face validity. Because the measures are drawn from administrative juvenile justice data, all are assumed reliable and to have been consistently measured across intervention and comparison groups.
- **Design Confounds:** We have not identified any design confounds.
- **Missing Data:** There does not appear to be any missing data.
- **Baseline Equivalence:** The juvenile justice outcomes identified in this study do not have direct pre-tests. As such, we have identified pre-test alternatives, that, according to our judgment, are conceptually similar or could be plausibly considered precursors to the study's outcomes. None of the pre-test alternatives we identified met the baseline equivalence

standard (Table 7). Where baseline equivalence was not established, the effect sizes fell into the range requiring the researchers to adjust for the pre-tests or pre-test alternatives in the impact model; however, as noted below, the impact model did not appear to include any adjustment.

Table 7. Bright, et al: Baseline Equivalence

Contrasts: Outcome Measures	Pre-Test or Pre-Test Alternative	Intervention Group			Matched Comparison Group			Effect Size	Equivalence Standard Met
		n	m	sd	n	m	sd		
Re-adjudication	Number of prior delinquency complaints	1246	5.29	3.80	693	5.73	4.00	-.11	Adjustment needed
Commitment	Any prior committed placement	1246	.124	N/A	693	.144	N/A	-.10	Adjustment needed
Conviction	Any prior adjudication for a violent offense	1246	.167	N/A	693	.190	N/A	-.10	Adjustment needed
Incarceration	Any prior committed placement	1246	.124	N/A	693	.144	N/A	-.10	Adjustment needed

Summary

Based on our thorough review of the Indiana Waiver Substudy, Sullivan et al., and Bright et al., we find that FCT meets the Title IV-E Prevention Services Clearinghouse's standards for a rating of **WELL-SUPPORTED**. As all of the contrasts in the Bright et al. study were rated as low, we draw exclusively on the Indiana Waiver Substudy and Sullivan et al. in making this determination. These studies examine two non-overlapping samples in usual care or practice settings. Each had contrasts that were rated as moderate and were statistically significant. In addition to the favorable outcomes reported in the Indiana Substudy, the favorable outcomes presented in Sullivan et al. were sustained for at least 12 months after treatment.

According to these two studies, it appears FCT decreases out-of-home placement for youth. Compared to youth who did not receive FCT, those who did were less likely to be in residential placements during their involvement with child welfare (Indiana Waiver Substudy) and in the year after FCT ended (Sullivan et al.). Those who were in residential placements had fewer residential placements in the year after FCT ended (Sullivan et al.). Youth in out-of-home placement who received FCT also had shorter time to reunification than those who did not receive FCT (Indiana Waiver Substudy)

Appendix A: Calculation Methods

The Title IV-E Prevention Services Clearinghouse standards are substantially based on the standards created for the What Works Clearinghouse (WWC). We therefore used the formulas found in the [WWC procedures handbook](#) for calculating effect sizes and p values.

Calculating Effect Sizes: The Handbook specifies preferred statistics for effect sizes: Hedges' g for continuous outcomes and the Cox index for dichotomous outcomes. These are also the preferred effect size statistics for the WWC; formulas are presented on pages 13 and 14 of the WWC procedures handbook.

Calculating p values: The Handbook instructs reviewers to calculate p values for contrasts for which the baseline equivalence standard has been met. For continuous outcomes, we conducted t -tests using the means, standard deviations, and sample sizes reported. We also conducted t -tests for binary outcomes presented in the Sullivan, et al. study, as standard deviations were provided. To calculate the p value for dichotomous outcomes when standard deviations were not provided, as in the Indiana Waiver Substudy, we used the formula found on page 16 of the WWC Procedures Handbook.

Appendix B: Completed PI-19-06 Attachment

Attachment B: Checklist for Program or Service Designation for HHS Consideration

Instructions:

Section I: The state must complete Section I (Table 1) once to summarize all of the programs and services that the state reviewed and submitted and the designations for HHS consideration.

Section II: The state must complete Section II (Tables 2 and 3) once to describe the independent systematic review methodology used to determine a program or service (listed in Table 1) designation for HHS consideration. Section II outlines the criteria for an independent systematic review. To demonstrate that the state conducted an independent systematic review consistent with sections 471(e)(4)(C)(iii)(I), (iv)(I)(aa) and (v)(I)(aa) of the Act, the state must answer each question in the affirmative. If the independent systematic review used the Prevention Services Clearinghouse Handbook of Standards and Procedures, the relevant sections must be indicated in the “Handbook Section” column. If other systematic standards and procedures were used, states must submit documentation of the standards and procedures used to review programs and services. States should determine the standards and procedures to be used prior to beginning the independent systematic review process. If the state cannot answer each question in Table 2 and Table 3 in the affirmative, ACF will not make transition payments for the program or service reviewed by the state using those standards and procedures.

Section III: The state must complete Section III (Tables 4 and 5) for each program or service listed in Table 1, and provide all required documentation. Section III outlines the requirements for the review of the program or service. States should complete Table 4 prior to conducting an independent systematic review to determine if a program or service is eligible for review. For a program or service to be eligible for review, the answer to both questions in Table 4 must be affirmative and the state must provide the required documentation. If a program or service is eligible for review, the state must conduct the review and identify each study reviewed in Table 5, regardless of whether a study was determined to be eligible to be included in the review.

Section IV: The state must complete Section IV (Tables 6-10) for each program or service (listed in Table 1) reviewed and submitted and provide all required documentation. Section IV lists studies the state determined to be “well-designed” and “well-executed” and outlines characteristics of those studies. Do not include eligible studies that were not determined to be “well-designed” and “well-executed” in Tables 6 -10. States should complete Table 6 with a list of all eligible studies determined to be “well-designed” and “well-executed.” States should complete Table 7 to describe the design and execution of each eligible “well-designed” and “well-executed” study. States should complete Table 8 to describe the practice setting and study sample. States must answer in the affirmative that the program or service included in each study was not substantially modified or adapted from the version under review. States must detail favorable effects on target outcomes present in eligible studies determined to be “well-designed” and “well-executed.” States must detail unfavorable effects on target and non-target outcomes present in eligible studies determined to be “well-designed” and “well-executed.”

Section V: The state must complete Section V (Table 11) for each program or service reviewed and submitted. Section V lists the program or service designation for HHS consideration and verification questions relevant to that designation. The state must answer the questions applicable to the relevant designation in the affirmative.

Section I: Summary of Programs and Services Reviewed and their Designations for HHS Consideration

Section I. Summary of Programs and Services Reviewed

Table 1. Summary of Programs and Services Reviewed

To be considered for transitional payments, list programs and services reviewed and provide designations for HHS consideration.

Program or Service Name <i>(if there are multiple versions, specify the specific version reviewed)</i>	Proposed Designations for HHS consideration <i>(Promising, Supported, or Well-Supported)</i>
Family Centered Treatment	Well-Supported

Section II: Standards and Procedures for an Independent Systematic Review

Section II. Standards and Procedures for a Systematic Review

(Complete Table 2 and Table 3 to provide the requested information on the independent systematic review. The same standards and procedures should be used to review all programs and services.)

Table 2. Systematic Review

Sections 471(e)(4)(C)(iii)(I), (iv)(I)(aa) and (v)(I)(aa) of the Act require that systematic standards and procedures must be used for all phases of the review process. In the table below, verify that systematic (i.e., explicit and reproducible) standards and procedures were used and submit documentation of reviewer qualifications. If the systematic review used the Prevention Services Clearinghouse Handbook of Standards and Procedures, indicate the relevant sections in the "Handbook Section" column. If other systematic standards and procedures were used, submit documentation of the standards and procedures.

Table 2. Systematic Review	<input checked="" type="checkbox"/> to Verify	Handbook Section
Were the same systematic standards and procedures used to review all programs and services?	✓	--
Were qualified reviewers trained on systematic standards and procedures used to review all programs and services?	✓	--
Were standards and procedures in accordance with section 471(e) of the Social Security Act?	✓	--
Were standards and procedures in accordance with the Initial Practice Criteria published in Attachment C of ACYF-CB-PI-18-09 ?	✓	--
<i>Program or Service Eligibility:</i> Were systematic standards and procedures used to determine if programs or services were eligible for review? At a minimum, this includes standards and procedures to:	✓	
• Determine if a program or service is a mental health, substance abuse, in-home parent-skill based, or kinship navigator program; and	✓	2.1
• Determine if there was a book/manual or writing available that specifies the components of the practice protocol and describes how to administer the practice.	✓	2.1.2
<i>Literature Review:</i> Were systematic standards and procedures used to conduct a comprehensive literature review for studies of programs and services under review? At a minimum, this includes standards and procedures to:	✓	
• Search bibliographic databases; and Search other sources of publicly available	✓	3.2
• Studies (e.g., websites of federal, state, and local governments, foundations, or other organizations).	✓	3.2
<i>Study Eligibility:</i> Were systematic standards and procedures used to determine if studies found through the comprehensive literature review were eligible for review? At a minimum, this includes standards and procedures to:	✓	
• Determine if each study examined the program or service under review (as described in the book/manual or writing) or if it examined an adaptation;	✓	4.1
• Determine if each study was published or prepared in or after 1990;	✓	4.1.1
• Determine if each study was publicly available in English;	✓	4.1.2, 4.1.3
• Determine if each study had an eligible design (i.e., randomized control trial or quasi-experimental design);	✓	4.1.4
• Determine if each study had an intervention <i>and</i> appropriate comparison condition;	✓	4.1.4
• Determine if each study examined impacts of program or service on at least one 'target' outcome that falls broadly under the domains of child safety, child permanency, child well-being, or adult (parent or kin-caregiver) well-being. Target outcomes for kinship navigator programs can instead or also include access to, referral to, and satisfaction with services; and	✓	4.1.5

Table 2. Systematic Review	<input checked="" type="checkbox"/> to Verify	Handbook Section
<ul style="list-style-type: none"> Identify studies that meet the above criteria and are eligible for review. 	✓	4.1
<i>Study Design and Execution:</i> Were systematic standards and procedures used to determine if eligible studies were well-designed and well-executed? At a minimum, this includes standards and procedures to:	✓	
<ul style="list-style-type: none"> Assess overall and differential sample attrition; Assess the equivalence of intervention and comparison groups at baseline and whether the study statistically controlled for baseline differences; Assess whether the study has design confounds; Assess, if applicable, whether the study accounted for clustering (e.g., assessed risk of joiner bias¹); Assess whether the study accounted for missing data; and Determine if studies meet the above criteria and can be designated as well-designed and well-executed. 	N/A ✓ ✓ N/A ✓ ✓	5.7 5.9.3 5.9.4 5.1 – 5.9
<i>Defining Studies:</i> Sometimes study results are reported in more than one document, or a single document reports results from multiple studies. Were systematic standards and procedures used to determine if eligible, well-designed and well-executed studies of a program and service have non-overlapping samples?	✓	
<i>Study Effects:</i> Were systematic standards and procedures used to examine favorable and unfavorable effects in eligible, well-designed and well-executed studies? At a minimum, this includes standards and procedures to:	✓	
<ul style="list-style-type: none"> Determine if eligible, well-designed and well-executed studies found a favorable effect (using conventional standards of statistical significance) on each target outcome; and Determine if eligible, well-designed and well-executed studies found an unfavorable effect (using conventional standards of statistical significance) on each target or non-target outcome. 	✓ ✓	5.10 5.10
<i>Beyond the End of Treatment:</i> Were systematic standards and procedures used to determine the length of sustained favorable effects beyond the end of treatment in eligible, well-defined and well-executed studies? At a minimum, this includes standards and procedures to:	✓	
<ul style="list-style-type: none"> Identify (and if needed, define) the end of treatment; and Calculate the length of a favorable effect beyond the end of treatment. 	✓ ✓	
<i>Usual Care or Practice Setting:</i> Were systematic standards and procedures used to determine if a study was conducted in a usual care or practice setting?	✓	6.2.2
<i>Risk of Harm:</i> Were systematic standards and procedures used to determine if there is evidence of risk of harm?	✓	6.2.1
<i>Designation:</i> Were systematic standards and procedures used to designate programs and services for HHS consideration (as promising, supported, well-supported, or does not currently meet the criteria)? At a minimum, this includes standards and procedures to:	✓	
<ul style="list-style-type: none"> Determine if a program or service has one eligible, well-designed and well-executed study that demonstrates a favorable effect on a target outcome and should be considered for a designation of promising; Determine if a program or service has at least one eligible, well-designed and well-executed study carried out in a usual care or practice setting that demonstrates a favorable effect on a target outcome at least 6 months beyond the end of treatment and should be considered for a designation of supported; and Determine if a program or service has at least two eligible, well-designed and well-executed studies with non-overlapping samples carried out in usual care or practice 	✓ ✓ ✓	6 6 6

¹If a cluster randomized study permits individuals to join clusters after randomization, the estimate of the effect of the intervention on individual outcomes may be biased if individuals who join the intervention clusters are systematically different from those who join the comparison clusters.

Table 2. Systematic Review	<input checked="" type="checkbox"/> to Verify	Handbook Section
settings that demonstrate favorable effects on a target outcome; at least one of the studies must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on a target outcome; and should be considered for a designation of well-supported.		
<i>Reconciliation of Discrepancies:</i> Were systematic standards and procedures used to reconcile discrepancies across reviewers? (applicable if more than one reviewer per study)	✓	
<i>Author or Developer Queries:</i> Were systematic standards and procedures used to query study authors or program or service developers? (applicable if author or developer queries made)	✓	

Table 3. Independent Review

The systematic review must be independent (i.e., objective and unbiased). In the table below, verify that an independent review was conducted using systematic standards and procedures by providing the names of each state agency and external partner that reviewed the program or service. States must answer all applicable questions in the affirmative. Submit MOUs, Conflict of Interest Policies, and other relevant documentation.

List all state agencies and external partners that reviewed programs and services.

The Stephen Group, Inc. in collaboration with MEF Associates

Table 3. Independent Review	<input checked="" type="checkbox"/> to Verify
Was the review independent (conducted by reviewers without conflicts of interest including those that authored studies, evaluated, or developed the program or service under review)?	✓
Was a Conflict of Interest Statement signed by reviewers attesting to their independence? If so, attach the statement.	✓
Was a Memorandum of Understanding (MOU) signed by external partners (if applicable)? If so, attach MOU(s).	✓

Sections III-V: Describe and Document Findings from Each Program and Service Reviewed and Submitted

Section III. Review of Programs and Services

(Complete Tables 4-5 for each program or service reviewed.)

Table 4. Determination of Program or Service Eligibility

Fill in the table below for each program or service reviewed.

<i>Table 4. Determination of Program or Service Eligibility:</i>	<input checked="" type="checkbox"/> to Verify
<p>Does the program or service have a book, manual, or other available documentation specifying the components of the practice protocol and describing how to administer the practice?</p> <p>Provide information about how the book/manual/other documentation can be accessed OR provide other information supporting availability of book/manual/other documentation.</p> <p>Program implementation materials were made available to reviewers in digital copies. The implementation manual, <i>Wheels of Change</i> © was made available as a digital training manual through the e-learning platform <i>Mindflash</i>. Access to this platform was provided to the reviewers by the model developer for the purpose of verification. In addition to access to the online training materials, the model developer provided the following documents for review:</p> <ul style="list-style-type: none"> • Program Design and Implementation Guide • Path of Implementation for Providers • FCT Readiness Assessment Interview Plan • Implementation Driver Assessment – closed copy • Fidelity Adherence Compliance Tracker (FACT) – copy • Fidelity Implementation-strategy Tool • Readiness Assessment Report – Example Redact • Readiness Assessment Matrix (RAM) • Definitive Report on FCT – 1 of 6 required readings for FCT to achieve Certification 	Yes.
<p>Is the program or service a mental health, substance abuse, in-home parent-skill based, or kinship navigator program or service?</p> <p>Identify the program or service area(s).</p>	In-Home Parent Skill-Based Mental Health

Table 5. Determination of Study Eligibility

Fill in the table below for each study of the program or service reviewed. Provide a response in every column; N/A or unknown are not acceptable responses. The response in columns iii, v, vi, vii, and ix must be “yes” or “no.” The response in column ix is “yes” only when the responses in columns iii, v, vi, and vii are “yes.”

i. Study Title/Authors	ii. Publicly Available Location	iii. Is the study in English? (Yes/No)	iv. Design (RCT, QED, or other). If other, specify design.	v. Did the intervention condition receive the program or service under review in accordance with the book/manual/documentation? (Yes/No)	vi. Did the comparison condition receive no or minimal intervention or treatment as usual? (Yes/No)	vii. Did the study examine at least one target outcome? (Yes/No)	viii. Year Published	ix. Eligible for Review? (Yes/No)
Indiana Waiver Substudy: 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.	https://www.in.gov/dcs/files/20180102FinalReportfromDCSandIU.pdf	Yes	QED	Yes	Yes	Yes	2018	Yes
Sullivan, et al.: Sullivan, M.B., Bennear, L.S., & Honess, K. (revised 2011). A quasi-experimental evaluation of Family Centered Treatment in the Maryland Department of Juvenile Services Community Based Non-residential Program: A report to Maryland	http://www.bscc.ca.gov/wp-content/uploads/JOJJVol2_Iss1.pdf ; full report available upon request from authors	Yes	QED	Yes	Yes	Yes	Report revised 2011; article published in 2012	Yes

i. Study Title/Authors	ii. Publicly Available Location	iii. Is the study in English? (Yes/No)	iv. Design (RCT, QED, or other). If other, specify design.	v. Did the intervention condition receive the program or service under review in accordance with the book/manual/documentation? (Yes/No)	vi. Did the comparison condition receive no or minimal intervention or treatment as usual? (Yes/No)	vii. Did the study examine at least one target outcome? (Yes/No)	viii. Year Published	ix. Eligible for Review? (Yes/No)
Department of Juvenile Services and Institute for Family Centered Services. Great Falls, VA: FamiliFirst. Abridged results reported in Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter Jr, W. E., & Wood, T. J. (2012). Family Centered Treatment®--an alternative to residential placements for adjudicated youth: outcomes and cost-effectiveness. <i>Journal of juvenile justice</i> , 2(1), 25-40.								

Section IV. Review of “Well-designed” and “Well-executed” Studies (Complete Tables 6-10 for each program or service reviewed.)

Table 6. Studies that are “Well-Designed” and “Well-Executed”²

Provide an electronic copy of each of the studies determined to be eligible for review and determined to be “well-designed” and “well-executed.”

<i>List all eligible studies that are “well-designed” and “well-executed” (Study Title/Author)</i>
Indiana Waiver Substudy: <ul style="list-style-type: none">• 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.
Sullivan, et al. <ul style="list-style-type: none">• Sullivan, M.B., Bennear, L.S., & Honess, K. (revised 2011). A quasi-experimental evaluation of Family Centered Treatment in the Maryland Department of Juvenile Services Community Based Non-residential Program: A report to Maryland Department of Juvenile Services and Institute for Family Centered Services. Great Falls, VA: FamiliFirst.• Sullivan, M. B., Bennear, L. S., Honess, K. F., Painter Jr, W. E., & Wood, T. J. (2012). Family Centered Treatment®--an alternative to residential placements for adjudicated youth: outcomes and cost-effectiveness. <i>Journal of juvenile justice</i>, 2(1), 25-40.

² For reference, the Prevention Services Clearinghouse Handbook Chapter 5 defines “well-designed” and “well-executed” studies as those that meet design and execution standards for high or moderate support of causal evidence. Prevention Services Clearinghouse ratings apply to contrasts reported in a study. A single study may have multiple design and execution ratings corresponding to each of its reported contrasts.

Table 7. Study Design and Execution

For each study eligible for review and determined to be “well-designed” and “well-executed,” fill out the table below. Provide a response in every column; N/A or unknown are not acceptable responses for columns i, ii, iii, v, vi, and vii. The response in column ii must be “yes.”

i. Study Title/Authors	ii. Verify the Absence of all Confounds? (Yes/No)	iii. List Measures that Achieved Baseline Equivalence	iv. List Measures that did NOT Achieve Baseline Equivalence but were Statistically Controlled for in Analyses	v. Overall Attrition ³ (for RCTs only)	vi. Differential Attrition ⁴ (for RCTs only)	vii. Does Study Meet Attrition Standards?	viii. Notes, as needed
Indiana Waiver Substudy	Yes	Risk classification: very high risk	Treatment and comparison groups were satisfactorily equalized on baseline characteristics using propensity score matching. The impact model did not include any adjustment for pre-treatment characteristics.	The study is a QED.	The study is a QED.	The study is a QED.	A risk classification of “very high risk” was identified by the reviewer as a suitable pretest alternative for all outcome variables.
Sullivan, et al.	Yes	<ul style="list-style-type: none">• Proportion of youth with placements: community based residential• Placement frequency: community based residential• Placement duration in days: community based residential• Proportion of youth with placements: secure detention	Treatment and comparison groups were satisfactorily equalized on baseline characteristics using propensity score matching. The impact model did not include any	The study is a QED.	The study is a QED.	The study is a QED.	

³ For reference, the Prevention Services Clearinghouse Handbook section 5.6 defines *overall attrition* as the number of individuals without post-test outcome data as a percentage of the total number of members in the sample at the time that they learned the condition to which they were randomly assigned.

⁴ For reference, the Prevention Services Clearinghouse Handbook section 5.6 defines *differential attrition* as the absolute value of the percentage point difference between the attrition rates for the intervention group and the comparison group.

i. Study Title/Authors	ii. Verify the Absence of all Confounds? (Yes/No)	iii. List Measures that Achieved Baseline Equivalence	iv. List Measures that did NOT Achieve Baseline Equivalence but were Statistically Controlled for in Analyses	v. Overall Attrition ³ (for RCTs only)	vi. Differential Attrition ⁴ (for RCTs only)	vii. Does Study Meet Attrition Standards?	viii. Notes, as needed
		<ul style="list-style-type: none"> • Placement frequency: secure detention • Proportion of youth with offenses: category 1 • Frequency of offenses: all categories • Frequency of adjudicated offenses: category 1 • Proportion of adjudicated offenses: all categories • Frequency of adjudicated offenses: all categories 	adjustment for pre-treatment characteristics.				

Table 8. Study Description

For each study eligible for review and determined to be “well-designed” and “well-executed,” fill out the table below to describe the practice setting and study sample as well as affirm that the program or service evaluated was not substantially modified or adapted from the version under review. Provide a response in every column; N/A or unknown are not acceptable responses. The response in column v must be “yes.”

i. Study Title/Authors	ii. Was the study conducted in a usual care or practice setting? (Yes/No)	iii. What is the study sample size?	iv. Describe the sample demographics and characteristics of the intervention group	v. Describe the sample demographics and characteristics of the comparison group	vi. Verify that the program or service evaluated in the study was NOT substantially modified or adapted from the manual or version of the program or service selected for review (Yes/No)
Indiana Waiver Substudy	Yes	N = 374 Intervention: 187 Matched Comparison: 187	<ul style="list-style-type: none">• 49.2% male, 50.8% female• 89.3% white, 6.42% black, 0.00% American Indian• 75.4% designated CHINS (child in need of services)• 99.1% with reunification as permanency goal• 32.1% classified as very high risk	<ul style="list-style-type: none">• 50.2% male, 49.7% female• 86.6% white, 13.4% black, 4.28% American Indian• 69.5% designated CHINS• 95.8% with reunification as permanency goal• 33.2% classified as very high risk	Yes
Sullivan, et al.	Yes	N = 2,234 Intervention: 446 Matched Comparison: 1,788	<ul style="list-style-type: none">• Age at first offense: 12.85• Age at intake: 15.20• Proportion of males: .75• Proportion African American: .31• Proportion Caucasian: .31• Proportion Hispanic: .08	<ul style="list-style-type: none">• Age at first offense: 12.86• Age at intake: 15.19• Proportion of males: .73• Proportion African American: .59• Proportion Caucasian: .33• Proportion Hispanic: .077	Yes

Table 9. Favorable Effects

For each study eligible for review and determined to be “well-designed” and “well-executed,” fill out the table below listing only target outcomes with **favorable effects**. Provide a response in every column; N/A or unknown are **not acceptable** responses.

i. Study Title/Authors	ii. List the Target Outcome(s)	iii. List the Outcome Measures	iv. List the Reliability Coefficients for Each	v. Are Each of the Outcome Measures Valid?	vi. Are Each of the Outcome Measures Systematically Administered?	vii. List the P-Values for Each of the Outcome Measures	viii. List the Size of Effect for Each of the Outcome Measures	ix. Indicate the Length of Effect Beyond the End of Treatment (in months)
Indiana Waiver Substudy	Permanency	Remaining in home throughout involvement with child welfare	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	< .001	.41	Minimum 0 months; the time between end of treatment and case closure would differ for each child. Treatment did not continue after case closure.
Indiana Waiver Substudy	Permanency	Days to reunification	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	< .001	-.32	Minimum 0 months; the time between end of treatment and reunification would differ for each child.
Sullivan, et al.	Permanency	Proportion of youth with residential placements	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	<.001	-.30	12 months post-treatment

i. Study Title/Authors	ii. List the Target Outcome(s)	iii. List the Outcome Measures	iv. List the Reliability Coefficients for Each	v. Are Each of the Outcome Measures Valid?	vi. Are Each of the Outcome Measures Systematically Administered?	vii. List the P-Values for Each of the Outcome Measures	viii. List the Size of Effect for Each of the Outcome Measures	ix. Indicate the Length of Effect Beyond the End of Treatment (in months)
Sullivan, et al.	Permanency	Frequency of residential placements	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	<.001	-.18	12 months post-treatment

^a Of those youth who were pending placement, days spent pending placement.

Table 10. Unfavorable Effects

For each study eligible for review and determined to be “well-designed” and “well-executed,” fill out the table below listing only target outcomes with **unfavorable effects**. Provide a response in every column; N/A or unknown are not acceptable responses.

i. Study Title/Authors	ii. List the Target or Non-Target Outcome(s)	iii. List the Outcome Measures	iv. List the Reliability Coefficients for Each	v. Are Each of the Outcome Measures Valid?	vi. Are Each of the Outcome Measures Systematically Administered?	vii. List the P-Values for Each of the Outcome Measures	viii. List the Size of Effect for Each of the Outcome Measures	ix. Indicate the Length of Effect Beyond the End of Treatment (in months)
Sullivan, et al.	Child Well-Being	Proportion of youth with adjudications	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	<.001	.20	12 months post-treatment
Sullivan, et al.	Child Well-Being	Frequency of adjudications	Measure is drawn from administrative data and presumed reliable per section 5.9.2 of the Handbook.	Yes	Yes	<.001	>22	12 months post-treatment

NOTE: The study authors argue that the increase in adjudications is evidence of FCT’s emphasis on accountability, given that the number of offenses is the same across groups.

“Post-treatment offenses committed by the youth in this treatment sample are more likely to be adjudicated, however, and the [SATT] effect size is curiously large. The number of offenses committed over the follow-up period that were adjudicated were measured and the frequency of offenses is the same across groups. This must be reflective of court decisions as applied to the youth receiving FCT. This outcome may be interpreted as a manifestation of the emphasis on accountability in Family Centered Treatment; the model attempts to instill accountability by accepting responsibility for one’s actions as a family system value. This may be exhibited in the family’s interactions with the courts as an increase in the likelihood of an offense being adjudicated. Overall, however, the fact that residential placements and days in detention are substantially lower suggests that the average youth receiving FCT committed fewer offenses of a nature that would warrant a consideration of removal from the community.”

Section V. Program or Service Designation for HHS Consideration

Table 11. Program or Service Designation for HHS Consideration

Fill out the table below for the program or service reviewed. Only select one designation. Answer questions relevant to the selected designation; relevant questions must be answered in the affirmative.

<i>Table 11. Program or Service Designation for HHS Consideration</i>		<input checked="" type="checkbox"/> to Verify
There is NOT sufficient evidence of risk of harm such that the overall weight of evidence does not support the benefits of the program or service.		Yes
		<input checked="" type="checkbox"/> the Designation and Provide a Response to the Questions Relevant to that Designation
Well-Supported		
<ul style="list-style-type: none">• Does the program or service have at least two eligible, well-designed and well-executed studies with non-overlapping samples⁵ that were carried out in a usual care or practice setting?		Yes
<ul style="list-style-type: none">• Does one of the studies demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome		Yes
Supported		
<ul style="list-style-type: none">• Does the program or service have at least one eligible, well-designed and well-executed study that was carried out in a usual care or practice setting and demonstrate a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome?		Yes
Promising		
<ul style="list-style-type: none">• Does the program or service have at least one eligible, well-designed and well-executed study and demonstrate a favorable effect on at least one ‘target outcome’?		Yes

⁵Samples across multiple sources of a study are considered overlapping if the samples are the same or have a large degree of overlap. Findings from an eligible study determined to be “well-executed” and “well-designed” may be reported across multiple sources including peer-reviewed journal articles and publicly available government and foundation reports. In such instances, the multiple sources would have overlapping samples. The findings across multiple sources with these overlapping samples should be considered one study when designating a program or service as “well-supported,” “supported,” and “promising.”

A Systematic Review of Family Centered Treatment

Title IV-E Transitional Payment Assessment for the Nebraska Department of Health and Human Services

Conflict of Interest Statement

The Stephen Group (TSG) and MEF Associates are committed to integrity and fairness in the conduct of all activities. As such, we certify neither organization, or staff of either organization have a relationship with the developer of FCT or study authors through employment, consultancies, stock ownership, honoraria, or other relationship, either directly or through immediate family, which may be considered a conflict of interest. As such, the resulting opinion generated as a result of TSG's participation in the review of Family Centered Treatment is impartial and independent of external influence which may bias the determination and rating of the program.

The undersigned staff participated in the completion of this review and provide assurance no such conflict of interest exists at the time of its completion.

Organization: The Stephen Group

Date: December 6, 2019

Name: David DeStefano, MA Project Manager

Signature: 

A Systematic Review of Family Centered Treatment

Title IV-E Transitional Payment Assessment for the Nebraska Department of Health and Human Services

Conflict of Interest Statement

MEF Associates (MEF) participated in a review of the evidence base for Family Centered Treatment as a subcontractor to The Stephen Group (TSG).

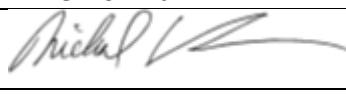
The Stephen Group and MEF Associates are committed to integrity and fairness in the conduct of all activities. As such, we certify that the undersigned organization and its staff do not have a relationship with the developer of Family Centered Treatment or study authors through employment, consultancies, stock ownership, honoraria, or other relationship, either directly or through immediate family, which may be considered a conflict of interest. As such, the resulting opinion generated as a result of MEF's review of Family Centered Treatment is impartial and independent of external influence which may bias our determination and rating of the program.

The undersigned staff participated in the completion of this review and provide assurance no such conflict of interest exists at the time of its completion.

Organization: MEF Associates

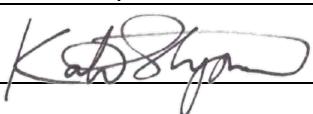
Date: December 6, 2019

Name: Mike Fishman



Signature:

Name: Kate Stepleton



Signature:

Name: Marisa Putnam



Signature:



Chapin Hall at the University of Chicago

Nebraska FFPSA Evaluation Plan Proposal

Submitted to:

Nebraska Department of Health and Human Services (DHHS)

Division of Children and Family Services (CFS)

March 2020; Revised June 2020



Chapin Hall at the University of Chicago

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Contact:

Julie S. McCrae, Ph.D.

Senior Researcher

Chapin Hall at the University of Chicago

jmccrae@chapinhall.org

Anne F. Farrell, Ph.D.

Director of Research

Chapin Hall at the University of Chicago

afarrell@chapinhall.org

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Table of Contents

Background.....	4
FCT Evaluation Plan	8
Introduction	8
Initial Evaluation Plan FCT	9
Process Evaluation - FCT.....	10
Outcome Evaluation - FCT	15
Strategies to Mitigate Limitations in Evaluation Design	21
TF-CBT Evaluation Plan	22
Introduction	22
Initial Evaluation Plan TF-CBT	22
Process Evaluation – TF-CBT	24
Outcome Evaluation – TF-CBT	28
Strategies to Mitigate Limitations in Evaluation Design	33
Quality Control and Human Subjects Protection.....	35
Data Security and Privacy	35
Informed Consent Procedures.....	35
IRB Approval	36
Evaluation Roles and Responsibilities Staffing.....	37
Statement of Conflict of Interest.....	41
References.....	42
Appendix A. Evaluation Work Plan	43
Appendix B. FCT Provider Locations in Nebraska.....	45
Appendix C. Nebraska's Prevention Plan: Interventions, Descriptions, and Related Feature.....	46

Background

The *Family First Prevention Services Act* is intended to promote the application of research evidence to child welfare interventions, thereby increasing the likelihood that children and families participate in services that are effective and promote improved outcomes. The Act supports evidence building by requiring states to employ continuous quality improvement methods (at minimum) or rigorous experimental or quasi-experimental designs to the evaluation of selected interventions.

Nebraska Department of Health and Human Services (DHHS), Division of Children and Family Services (CFS) proposes to provide two interventions to families who meet their definition of candidacy for prevention services: Family Centered Treatment (FCT) and Trauma-Focused Cognitive Behavior Therapy (TF-CBT). Chapin Hall at the University of Chicago has prepared initial evaluation plans at the request of and in partnership with the Nebraska DHHS, CFS to be submitted to the Children's Bureau for consideration. Of note, we based these plans on a current understanding of the plan and conditions in the field; they will be modified according to input from FCT and TF-CBT providers and NE CFS as adjustments are made to the state's Family First Prevention Plan and its implementation.

Under its FFPSA Prevention Plan, CFS proposes to provide FCT to families with children at risk of entering foster care¹, or transitioning home and in need of an intensive level of care. CFS will provide TF-CBT to families with children at risk of entering foster care and who have been verified as exhibiting trauma symptoms. FCT is currently not rated by the Title IV-E Prevention Services Clearinghouse ("The Clearinghouse"), and TF-CBT has been rated *promising*. For interventions to be well supported, the Clearinghouse requires randomized controlled trials (RCTs) or highly rigorous quasi-experimental designs (QEDs) such as regression discontinuity and propensity score matching. Well-conducted QEDs enable estimation of treatment effects similar to the "gold standard" RCT. These approaches have as their primary advantage the ability to estimate the causal effects of interventions, thereby providing a high level of confidence that the treatment itself is responsible for observed outcomes rather than other factors (e.g., participant characteristics, referral biases). Rigorous experimental and QE designs also include careful observation and measurement of implementation. A full understanding of how participants are selected and recruited into intervention studies is necessary if the evaluations are to inform the field. That is, our ability to make accurate inferences about effective treatments (and to scale them) is limited without a corresponding understanding of the characteristics of families participating in treatments; and the systems, contexts, and personnel who connect them to those services. As such, finalizing and adjusting the evaluation research plan for Nebraska will involve a full partnership between Nebraska DHHS and Chapin Hall, one that enables us to ensure a rigorous evaluation plan, incorporating feedback by the Children's Bureau.

¹ Foster care and out-of-home (OOH) care are used interchangeably in this evaluation plan. For the purpose of this evaluation, these terms refer to formal out-of-home care such as placement with a non-relative or residential care.

The Nebraska Context

Nebraska's child welfare system is geographically diverse, and child welfare professionals serve both rural and urban areas. In 2018, 3,364 families were involved in an investigation, and 1,990 (59%) children entered foster care. Of those entering foster care, 65% of the children entered due to neglect and 35% entered due to abuse. Forty percent of children investigated were 0-5 years old, and approximately 46% of those 0-5 year olds entering care had at least one parent who was previously in the state's custody. Notably, parental substance abuse was a contributing factor for approximately 50% of children entering out-of-home care. These descriptive statistics indicate that a significant proportion of the families that come to the attention of the child welfare system in Nebraska ultimately experience separation. As such, the Nebraska child welfare population is well suited for prevention services, and the potential to positively influence child welfare outcomes is substantial.

FFPSA prevention plans include definitions of candidacy for prevention services. Nebraska's definition includes demonstrated risk of entering OOH care through one or more of seven criteria:

Nebraska Candidacy Definition, FFPSA

1. Residing in a family home accepted for assessment, or with an ongoing services case including non-court and court involved families;
2. Reunified with their caregiver following an out-of-home placement;
3. The subject of a case filed in juvenile court and is mentally ill and dangerous, as outlined by Nebraska Revised Statute 43-247 (3) and defined by Revised Statute 71-908;
4. Pre- or post-natal infants and/or children of an eligible pregnant/parenting foster youth in foster care;
5. At risk of an adoption or guardianship disruption or dissolution that would result in foster care placement;
6. Presenting with extraordinary needs and whose parents/caretakers are unable to secure assistance for them;
7. Involved with juvenile probation and living in the parental/caretaker home.

The subsequent sections of this document provide overviews of the FCT and TF-CBT evaluation plans developed collaboratively by the State of Nebraska and Chapin Hall. DHHS is contracting with Mainspring Consulting to conduct a cost study; Chapin Hall will coordinate its efforts accordingly. The proposed plans for both interventions include process and outcome evaluations. In the sections below, we discuss the evaluation plans for FCT and TF-CBT sequentially; we start with the process evaluation and turn to the outcome evaluation. For each intervention, we propose to conduct a high quality, quasi-experimental evaluation; this choice was informed by discussions between Chapin Hall and Nebraska DHHS; the Clearinghouse evidence standards; information available on the priorities and processes for selection, referral, and implementation; DHHS's existing plan and priorities for "rolling out" additional capacity for FCT and TF-CBT; and other

contextual factors. Whereas we lay out an initial plan, it is important to note that additional design work is necessary later in the process, once provider capacity over time becomes clearer (clinician caseloads “turn over” across time), enabling us to better explicate the means by which families are referred for these treatments, and to observe and project other treatments available and taken up in community (counterfactual conditions). An overview of the evaluation work plan can be found in Appendix A.

Specifically, the process evaluation for both interventions includes fidelity appraisal, monitoring of service utilization, and collecting data on implementation strengths and challenges. The outcome evaluation we propose is modeled after Huhr & Wulcyn’s (2019) examination of the YV Intercept Model. The current proposal includes a quasi-experimental method with an exact-matching analysis to create a comparison group, and discrete time hazard modeling with county-level random effects. Nebraska projects that FCT and TF-CBT FFPSA service use will expand across the years covered in this proposal, and with these expected projections, outcome analyses should include a sufficient number of treatment participants to detect effects (see *Outcome Evaluation*). Chapin Hall will use SACWIS data to more fully understand the subset of prevention “candidates” and the referral/acceptance process into the interventions as the evaluation is initiated, including who might be referred to these interventions (including number by county and region); CFS staffing patterns by office, county and region; screening procedures and inclusion/exclusion criteria; and the existence of potentially “rival” or comparison treatments within regions/counties and their penetrance (e.g., proportion of families who might be exposed to other high quality interventions, which could “mask” treatment effects for FCT and TF-CBT). These and related details are important elements of planning that will be taken up and articulated ahead of study initiation.

As such, Chapin Hall and Nebraska teams will work together to design and conduct a gap analysis to inform the roll-out of FFPSA prevention services and the evaluation plan. Specifically, CFS would like a detailed analysis of the prevention service capacity and needs across the state, e.g., what are the prevention services that families need, how are they determined, the extent to which services are currently (and projected to be) available, and where there are gaps between services needed and services available. The gap analysis will be informed by planning meetings between Chapin Hall and Nebraska, with the aim to further define goals and work plans, develop more specific questions, explore and plan data collection procedures, and build investment from the provider network to participate in surveys and provide invaluable insight into the prevention array in Nebraska. We plan to use administrative data, existing reports and documents, provider survey tools, interviews with child welfare professionals, and focus groups with families to describe the prevention service array across the state and identify service gaps. Focus groups with families will help us identify any needs they feel are unmet through child welfare services and referrals, and interviews with child welfare professionals will allow us to understand the processes and decision-making that occur when matching families’ needs to a prevention service. We will use mapping tools to illustrate the geographic distribution of services and identified gaps. Finally, we will work closely with CFS project leadership and the Chapin Hall implementation team to interpret and apply findings, ultimately

identifying recommendations for Family First implementation readiness and prevention service needs.

Running partially simultaneously to the gap analysis, we will have an intensive project start-up period prior to commencing the evaluation plan. Following submission and in receipt of approval from the Children's Bureau, the Chapin Hall and Nebraska teams will confer regularly to further "build out" the gap analysis and evaluation plans, in light of a full understanding of the details and plans for roll-out of these interventions across the state, and with deep consideration of the inclusion (targeting/candidacy) criteria and how they interface with front line case worker practices. The gap analysis will be crucial for identifying where prevention services are available across the state, where families and child welfare professionals may be managing severe shortages in services, and how child welfare professionals are identifying the most salient family needs and matching them to services. These processes are crucial for identifying the correct comparison groups in the outcome evaluation as well as understanding the implementation process.

FCT Evaluation Plan

Introduction

Family Centered Treatment (FCT) is an evidence-based model for treatment of trauma. It is home-based family therapy that aims to reduce maltreatment, increase caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and improve child well-being. FCT contains elements of Eco-Structural Family Therapy (Lindblad-Goldberg & Northey, 2013) and Emotionally Focused Therapy (Johnson, 2004). These guide the focus of FCT to changing emotional and behavioral patterns among family members. Services are delivered in the home or in the community and include counseling, skills training, and resource coordination. Clinicians carry small caseloads to ensure sufficient time for interaction and relationship-building with families. FCT is unique among home-based treatment models in its focus on ensuring that families value the changes in their behavior and recognize the importance of sustaining those changes. The average length of service is 180 days, and treatment intensity calls for multiple face-to-face contacts per week. FCT providers are certified as such and are required to provide and participate in implementation fidelity monitoring; this appears to be an important strength of the intervention that will serve as an asset in the evaluation process.

The California Evidence Based Clearinghouse (CEBC) identifies two studies of FCT that demonstrated positive effects (Bright et al., 2018; Sullivan et al., 2012). Bright et al. (2018) studied the effects of FCT on juvenile justice involvement. The average age of the sample was 13.6 years, and three-quarters of the sample indicated racial identity other than White. Findings demonstrated FCT participants had significantly lower risk of adult conviction and incarceration when compared to youth receiving care in group homes. Sullivan et al. (2012) also studied the outcomes of adjudicated youth receiving FCT compared to adjudicated youth placed in residential treatment. The average age of the sample was 15 years, and about 70% of the sample indicated racial identity other than White. Findings showed that youth participating in FCT experienced improved behavioral outcomes and reduced posttreatment placements compared to youth receiving residential treatment. Given the positive effects found in these studies, FCT is rated *promising* by the CEBC and is pending review by the Prevention Services Clearinghouse. Additionally, Nebraska hired The Stephen Group, LLC to conduct an independent review of FCT and is requesting Title IV-E evidence-based prevention services transitional payments. Their systematic review of published studies resulted in assigning a rating of *well-supported* to FCT because they found the following standard from the Clearinghouse Handbook to have been met:

"Has at least two contrasts with non-overlapping samples in studies carried out in usual care or practice settings that achieve a rating of moderate or high on design and execution and demonstrate favorable effects in a target outcome domain. At least one of the contrasts must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome (p. 43; Wilson et al., 2019)."

Given the value of FCT and the services it provides, as well as the positive findings from previous reviews, the current evaluation will contribute to building the evidence base for FCT as an effective child welfare prevention service.

Nebraska has numerous certified (individual) FCT providers currently serving families referred by the child welfare system. There are currently two provider agencies in Nebraska that are licensed to offer FCT, and additional agencies have expressed interest in becoming FCT providers. CFS implemented a pilot FCT program in the North Platte-Lexington area and surrounding communities which started offering services in January 2019 and utilizes a blended funding model to enhance sustainability. After considering positive initial outcomes from the pilot, and since CFS's initial Prevention Plan submission in October 2019, CFS has expanded the service reach of FCT programs to over 50% of NE counties. Collectively, these providers serve multiple counties in primarily rural, Western areas of the state (see Appendix B), and there are plans to continue expansion to other regions. Specifically, the Eastern service area is currently in the process of training staff to provide FCT to families through privatized case management. New providers will onboard at different times throughout the project period; they will initiate the process of training and credentialing clinicians. The FCT National Foundation has an extensive on-boarding process to equip providers with the tools necessary to implement the program effectively and faithfully. A *Readiness Assessment Matrix* is administered at the stage of pre-implementation to assess a wide range of organizational readiness factors. Additionally, the FCT Foundation collects data from providers across the country and standardizes those data into consistent outcome and fidelity measures. Chapin Hall will access these data to use in the evaluation.

Initial Evaluation Plan | FCT

After meeting the earlier definition of candidacy (see pg. 2), the target population for FCT includes families that have a minority-aged child, which Nebraska defines as an individual who has not yet reached the age of 19, and meet one or more of the following criteria:

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; or
2. Families with youth who are transitioning home from a high level of care; or
3. Families with youth who have been placed out of home, have a permanency plan of reunification and are transitioning home.

These families are at a sensitive point in their case management and extra supports are often needed to prevent removal or aid in a successful reunification. According to analysis done by Mainspring Consulting, the projected caseloads for FCT – considering current capacity and plans for expansion – are 99 families in 2021, 359 families in 2022, and 639 families in 2023. Thus, we are confident there will be enough treatment recipients to adequately power a treatment effects analysis.

If a case worker believes a family may benefit from FCT, the case worker first asks families if they are willing to participate in FCT. If the family agrees, a referral is made to a FCT provider. A referral can be made at any point in the life of a case if the services seem appropriate. Once a referral

is made to a provider, families may be placed on waiting lists until a provider has capacity to serve them. According to conversations with case workers who have experience referring families to FCT, families typically wait no more than a few months. The precise average time spent on the waitlist will be determined during the project start-up phase of this project, and Chapin Hall will work with CFS to obtain data on other services that are received by the family during this time. Once a family is receiving FCT, there is ongoing contact between the FCT provider and child welfare case workers. FCT providers are invited to monthly family meetings, and providers forward monthly notes on family progress to case workers. In this way, case workers and FCT providers are working together to provide integrated services.

Figure 1 presents a logic model for the FCT intervention. The inputs and activities will lead to a series of outputs and outcomes, and the outcomes that are identified guide the sources of data and methods of data collection and analysis. The following sections detail the design and analysis plans for the process and outcome evaluations of FCT.

Process Evaluation - FCT

The goal of the process evaluation is to assess FCT implementation, ensuring that it consistently meets required standards for fidelity. Without appraisal of the extent to which a treatment is implemented as intended, it is not possible to attribute intervention outcomes with any confidence. This component includes objectives in the areas of fidelity to eligibility and referral processes between CFS and FCT providers, child and family service utilization, clinician fidelity to the FCT treatment model, and observation of implementation strengths and challenges. The process evaluation will use qualitative methods to conduct structured interviews or focus groups (depending on the number of staff per location) with case workers. These will obtain the perspective of a modest sample of NE CFS staff on selection and referral, implementation facilitators, challenges, potential solutions, and support and resources that are needed to ensure that intended protocols are met. The process evaluation will monitor intended activities and Chapin Hall will collaborate with NE CFS to reflect on processes as they are occurring in order to strengthen implementation and contribute to quality improvement. The process evaluation for FCT will assess service utilization (e.g. dosage, completion, gaps in treatment), fidelity that includes both practitioner adherence to the FCT clinical model, and CFS staff adherence to the protocol for determining eligibility and referral between the child welfare system and FCT providers.

Adherence to eligibility and referral protocol will be assessed using NE CFS's SACWIS data (the database is called FACTS) and Provider Performance Improvement (PPI) data provided to Chapin Hall. The PPI used by CFS will track all families served by FCT with a FFPSA service contract and include family-level elements such as whether CFS properly referred the family to FCT and the extent of families' engagement in the service. Adherence to the FCT clinical model will be measured using the fidelity and implementation tracking tools FCT providers use to maintain their status as a credentialed FCT provider. Table 1 details the objectives, research questions and rationale for the process evaluation.

Figure 1. Logic Model for Nebraska Family Centered Treatment

Inputs	Activities	Outputs	Proximal Outcomes	Distal Outcomes
<p>Target population</p> <ul style="list-style-type: none"> Minority-aged children (0 through age of 18) and caregivers Children/youth with significant mental health or behavioral difficulties <p>Target Intervention: FCT</p> <p>Concurrent Interventions</p> <ul style="list-style-type: none"> Trauma Focused CBT Healthy Families America Functional Family Therapy Multisystemic Therapy Parent and Child Interaction Therapy <p>Comparison NE CW business as usual practice</p>	<p>Child Welfare Professional</p> <ul style="list-style-type: none"> Assess and refer families to services Monitor prevention plan Monitor safety plan <p>FCT Provider</p> <ul style="list-style-type: none"> Provide service through trained and credentialed clinicians supported by supervision and FCT Foundation Multiple, weekly treatment sessions with the family as a unit in their home Collect data on family outcomes and fidelity Track progress of families Report process and evaluation outcomes Work closely with child welfare case manager on case planning and goals <p>Families</p> <ul style="list-style-type: none"> Participating in FCT treatment sessions Participating in case management activities 	<p>Families</p> <p>O1. # of families referred to FCT</p> <p>O2. # of families enrolled in FCT</p> <p>O3. # of families who complete FCT</p> <p>O4. Average dose of FCT per family</p> <p>FCT Provider</p> <p>O5. Fidelity to eligibility and referral pathway</p> <p>O6. FCT fidelity monitoring</p> <p>O7. FCT outcome monitoring procedures</p> <p>O8. # of certified FCT providers in NE, completion of implementation and fidelity tracking requirements</p>	<p>Families</p> <p>PO1. Increased caregiver coping skills</p> <p>PO2. Increased behavior management skills in children and caregivers</p> <p>PO3. Reduced PTSD symptoms in children and caregivers</p> <p>PO4. Improved parenting behaviors</p>	<p>Families</p> <p>DO1. Reduction in child welfare referrals and severity of involvement</p> <p>DO2. Reduction in placement in OOH</p> <p>DO3. Reduced duration in OOH</p> <p>DO4. Lower average level of risk identified in case management</p> <p>DO5. Fewer prevention needs identified in case management</p> <p>DO6. Higher family strengths and fewer family needs identified in the FSNA tool in the SDM</p>

Inputs	Activities	Outputs	Proximal Outcomes	Distal Outcomes
			<p>Intermediate Outcomes</p> <p>Families</p> <p>IO1. Improved relationships between caregivers and children</p> <p>IO2. Improved overall household functioning</p> <p>FCT Provider</p> <p>IO3. Practice adjusted by providers based on current fidelity to FCT</p> <p>IO4. Progress towards family behavioral goals is consistently documented by providers</p>	<p>FCT Provider</p> <p>DO7. Fidelity is consistently tracked by providers, and providers practice with fidelity to the model</p> <p>DO8. Aggregate improvements in families' outcomes are reported by providers</p>

Table 1. Nebraska FFPSA FCT Process Evaluation Objectives, Research Questions, and Rationale

Process Study Objectives	Research Questions	Rationale
1. Assess fidelity to the eligibility and referral pathway for families between CFS and FCT service provision.	<p>How consistent and effective is the process to identify and link eligible families to FCT services?</p> <p>Are all families screened for eligibility? Referred as indicated?</p>	Local factors and decision-making may contribute variations to the intended protocol, influencing the extent to which the program reaches the intended population and potentially biasing the study. Monitoring allows for course correction.
2. Assess FCT service utilization.	<p>Among families referred, what is the % uptake? Does it vary systematically? What are rates of retention in FCT among enrolled families?</p>	Consistent referral, enrollment, uptake and retention of families in FCT is important to valid assessment of treatment and outcomes.
3. Monitor and evaluate practitioner fidelity to the FCT model.	To what degree is there fidelity to the FCT model?	Understanding FCT effectiveness in NE requires observing the extent of fidelity to the model; without this, positive and negative outcomes may be erroneously attributed.

Process Study Objectives	Research Questions	Rationale
4. Identify strengths and challenges to implementing FCT as a FFPSA prevention service.	What factors influence implementation, service utilization, and outcomes of FCT as a FFPSA prevention service in NE?	CFS will be better equipped to provide FCT when informed by an understanding of strengths and challenges perceived by case workers.

Process Evaluation Design

The process evaluation is informed by implementation science (Proctor et al., 2011) and centers on three functions: (1) fidelity appraisal, (2) monitoring of service utilization, and (3) collecting data on implementation strengths and challenges. Our assessment of fidelity will include fidelity to the eligibility and referral pathway between CFS and FCT; FCT clinical fidelity that includes the evaluation of training, credentialing, and supervision of clinicians; and implementation of treatment model components. Fidelity will be assessed through data maintained by CFS, FCT providers, and the FCT Foundation and will require data sharing agreements among the parties.

In the process evaluation, we draw on tools used regularly in FCT practice and in prior evaluations of FCT. These include the *Family Centered Treatment® Program Design and Implementation Guide* (Wood, 2014 Revised 2018) and *Instructions for the Family Centered Treatment Fidelity-Adherence Compliance Tracker* (FACT; Family Centered Treatment® Foundation, available at <http://www.familycenteredtreatment.org/>). Further, we will assess implementation by conducting a modest number of implementation interviews with CFS case workers, assessing structures and supports for model fidelity and the evaluation, and using ongoing results to inform changes in the design and execution of implementation protocols and practices.

(1) Fidelity

Eligibility and Referral Pathway. We will use NE CFS administrative data (SACWIS/FACTS) to describe the total number and proportion of children/youth involved with NE child welfare who are eligible, according to candidacy definitions and FCT eligibility requirements, including children/youth whose family ultimately receives a referral to FCT. We will use FCT provider data to examine the number and proportion of families referred to FCT who are assessed, accepted for services, enrolled in FCT, and completed FCT treatment. We will describe the characteristics of families at each referral stage and identify patterns. Finally, we will analyze dates of each contact in the pathway (e.g. determination of candidacy by CFS, date of referral to FCT, start date of services) to assess responsibility, capacity, and timeliness of service.

FCT Clinical Model. CFS will collect information about FCT clinician training and credentialing for each individual clinician providing FCT for a family, and CFS will share these data with Chapin Hall for analysis. We will follow FCT model developer guidance and use their fidelity monitoring system data to evaluate whether clinical (treatment components) fidelity standards are being met. The FCT National Foundation monitors fidelity to model components using the FACT database. FACT is the FCT National Foundation database into which providers submit information on adherence to model

components each month, resulting in summary statistics. Chapin Hall will use these data from FACT, in collaboration with the foundation and local providers, for assessing fidelity.

(2) Service Utilization

Using the FACT database, Chapin Hall will obtain the dates of FCT services and model components completed for each child and family. This includes details about participants in each session and dates each FCT component was initiated and completed. We will create variables to describe service dosage, completion, total treatment time (start to finish or withdrawal), and treatment gaps for each child and family, as data are available. These data will also be used in outcome evaluation for FCT.

(3) Implementation Strengths and Challenges

Throughout implementation, the Chapin Hall team will engage in two forms of regular contact with CFS staff: (1) participation in statewide CQI meetings (these are held monthly; Chapin Hall will participate quarterly); and (2) monthly meetings centered on the evaluation. In years 2 and beyond, we will conduct structured interviews with CFS case workers that will center on inter- and intra-organizational processes that support FCT implementation and those that need additional support, resources, or adaptations to ensure the success of the model. Chapin Hall will summarize interview results and integrate the findings with service utilization and fidelity results to share and discuss with CFS for quality monitoring through CQI.

Sampling Strategy

We will use fidelity data from all engaged FCT providers, so a sampling strategy per se is not necessary for that component of the process evaluation (examination of fidelity and service utilization data). With respect to qualitative data, we will identify a small subset (sample) of CFS locations to conduct qualitative CFS interviews in Years 2 and 3. Currently, FCT is provided in 55 NE counties and served in three of CFS's five local service areas (Western, Central and Northern). We will work with NE DHHS to identify a subset of case workers in locations that are geographically representative and include both early and later adopters of FCT for FFSPA. Depending on the number of case workers per CFS location included, we will collect data either through a focus group or individual interviews. Depending on the modality of data collection, we anticipate interviews with approximately 10-30 case workers in each of Years 2 and 3. At the time of this writing, we do not know the exact number of case workers per office and region. As such, a more detailed sampling approach will be determined during the project start-up phase and will depend on the implementation timeframe.

Measures & Data Collection

Table 2 shows the indicators, measures, data sources, and timeline for data collection for each of the FCT process evaluation's research questions. Chapin Hall will enter into Data Sharing Agreements with NE CFS, the FCT National Foundation, and participating FCT providers (as necessary) to obtain data for the evaluation; we have had preliminary discussions with the National Foundation which has expressed a willingness to collaborate. Chapin Hall will participate in NE CFS

CQI meetings quarterly in order to observe and participate in project updates, with adjustments made to strengthen the model, in keeping with a plan-do-study-act cycle.

Data Analysis

Data analysis for the process evaluation will include quantitative and qualitative methods. We will use quantitative analysis to describe fidelity and service utilization using descriptive means and proportions, and bivariate and non-parametric tests (chi-square, t-tests) will be used to understand patterns of family characteristics related to enrollment and service utilization. We will use qualitative thematic analysis to describe implementation strengths, challenges and potential solutions from case worker perspectives. As available, we will use document review to understand intended protocols and processes. The evaluation team will collaborate with CFS to understand the process evaluation findings in real-time and provide consultation to contribute to quality improvement strategies.

Table 2. Process Evaluation Questions, Indicators, Measures, Data Sources, and Timing of Data Collection, FCT

Research Question	Area	Indicators	Measures	Data Source(s) and Timing of Data Collection
How consistent and effective is the process to identify eligible children/families and refer them to FCT?	<i>Fidelity-Eligibility and Referral Pathway</i>	<ul style="list-style-type: none"> - Existence of an articulated eligibility, referral and enrollment protocol - N and % children screened who meet eligibility criteria - N and % of eligible children whose family is offered and accepts referral - N and % of referred families who are assessed, accepted, enrolled - Family characteristics - Contact dates 	<ul style="list-style-type: none"> - Document review tool - Completed eligibility and referral forms - Completed FCT clinician assessments and enrollments - 	<ul style="list-style-type: none"> - CFS policies and procedures documentation, Annual - CFS administrative data (SACWIS) and PPI system, Monthly - FACT database, Bi-annual
What are rates of retention in FCT?	<i>Service Utilization</i>	<ul style="list-style-type: none"> - N and % of enrolled families that complete FCT treatment sessions - Service dosage - Total treatment time - Treatment gaps - Family characteristics 	<ul style="list-style-type: none"> - Completed FCT clinician fidelity tools 	<ul style="list-style-type: none"> - FACT database, Bi-annual - CFS discharge summaries, Bi-annual
To what degree is there fidelity to the FCT model?	<i>Fidelity-FCT Clinical Model</i>	<ul style="list-style-type: none"> - Number of certified staff - Number of model training and coaching requirements met - Number and types of FCT model components completed - FCT participants (child and family) 	<ul style="list-style-type: none"> - FCT provider and CFS training and certification tracking tools - Completed trauma screenings and assessments - Completed FCT clinician fidelity tools 	<ul style="list-style-type: none"> - CFS records, Bi-annual - FACT database, Bi-annual - FCT Clinical records, Bi-annual

Research Question	Area	Indicators	Measures	Data Source(s) and Timing of Data Collection
What factors influence implementation, service utilization, and fidelity?	<i>Implementation Strengths and Challenges</i>	- Contextual factors influencing implementation reported by CFS case workers	- Project-developed interview and focus group protocol	- CFS staff, Annual Years 2, 3

Outcome Evaluation - FCT

The goal of the outcome evaluation is to determine whether FCT results in positive individual and familial behavioral change after treatment participation (treatment effects), and child placement prevention (child welfare outcomes), having the potential to build evidence to establish FCT as an effective prevention model for child welfare-involved families. Thus, the main outcomes to be assessed include (1) treatment effects: child and caregiver behavioral outcomes and trauma symptomatology; and (2) child welfare outcomes: OOH placement. The outcome evaluation uses quasi-experimental design to assess the effect of FCT on these primary outcomes. We will further examine family functioning as a measure of risk for out-of-home (OOH) placement; OOH placement duration; and child safety. Table 3 details the objectives, research questions, and hypotheses of the outcome evaluation for FCT with emphasis on treatment effects and child welfare outcomes.

Table 3. Nebraska FFPSA FCT Outcome Evaluation Objectives, Research Questions, and Hypotheses

Outcome Study Objectives	Research Questions	Hypotheses
<i>Primary outcome of interest:</i>		
1. Examine the relationship between FCT receipt and likelihood of out of home (OOH) placement (child welfare outcomes).	Are children less likely to be placed in OOH care if their families receive FCT as compared to families receiving services as usual?	Children will be less likely to experience an OOH care placement if their families receive FCT than if their families receive services as usual.
<i>Treatment effects:</i>		
2. Examine the relationship between trauma symptomology and service receipt among children and caregivers.	Do children and caregivers whose families receive FCT report improved behavioral outcomes and trauma symptomology at the end as compared to at the beginning of treatment?	Children and caregivers who receive FCT will report fewer symptoms of PTSD and significant improvement on behavioral goals at the end as compared to at the beginning of treatment.
3. Examine how family functioning changes in relation to service provision.	Do children whose families receive FCT exhibit fewer risks and more strengths than children whose families receive services as usual?	Children whose families receive FCT will demonstrate lower SDM risk assessment scores and higher FSNA scores, indicating better functioning, than children whose families receive services as usual.*
<i>Supplementary questions:</i>		
4. Examine the relationship between FCT receipt and placement duration.	Do children who enter OOH care exit care sooner if their families received FCT	Children will exit care sooner if their families receive FCT than if their families receive services as usual.

Outcome Study Objectives	Research Questions	Hypotheses
5. Examine the relationship between FCT receipt and contact with the child welfare system (referrals and substantiations).	than if their families received services as usual? Are children whose families receive FCT less likely to have contact with the child welfare system after case closure than children whose families receive services as usual?	Children whose families receive FCT will be less likely to experience referrals and substantiated allegations after case closure than children whose families receive services as usual.

*SDM=Structured Decision Making; FSNA=Family Strengths and Needs Assessment

Outcome Evaluation Design

As indicated above, we will evaluate the impact of FCT using a quasi-experimental research design, an exact-matching analysis to create a comparison group, and discrete time hazard modeling with county-level random effects. While we recognize that randomized-controlled trials (RCTs) are the gold standard for evaluation, and particularly useful for discerning treatment effects, randomizing families in this context would require modifications to front line child welfare practice that would significantly complicate the rollout of the interventions. At this writing, CFS indicates that additions to staff workload at multiple sites and decision points is untenable and would be particularly difficult due to the multiple points in the life of a case that a family can be referred to FCT. Moreover, even if families were randomized to a treatment or control group, measuring the effects of FCT would be very difficult because of the wide range of other preventive services that would be provided to families in a control condition (see Appendix C). Thus, a quasi-experimental method is proposed for identifying a control group within NE that is exactly similar to the treatment group in demographic characteristics and likelihood of entry into FCT. Nevertheless, in order to understand with confidence the effects of FCT over any other particular service or array of services, it will be necessary to understand how those other service arrays are comprised.

An alternative service available to families who do not receive FCT is Intensive Family Preservation (IFP). IFP is an in-home service model that provides skill building and therapeutic services, typically for six weeks. Thus, while the IFP model is not as intensive or as long as FCT, it does offer significant in-home supports to families at-risk of OOH placement. This program will be important for creating a comparison group that is similar to FCT families in terms of demographics, service engagement, and child welfare history, but different in their receipt of IFP rather than FCT. One concern is that having a comparison group that also receives an in-home, therapeutic service may make the effects of FCT difficult to identify. However, FCT is a longer service with multiple visits per week, so; it seems logical that FCT could be more effective at improving child welfare outcomes. IFP will be important to consider when creating a comparison group for the quasi-experimental design, and the exact criteria for creating the comparison group will be further developed during the project start-up phase as we learn more about the service array in Nebraska. Additionally, analyses will account for the other prevention services both groups of families are referred to and receive over the course of the study period, as collected in the newly enhanced CFS foster care prevention plan data.

One concern when selecting a quasi-experimental design is selection bias. Selection bias refers to bias that is introduced to a study when individuals are not randomly selected for an intervention, resulting in families with certain characteristics being more likely to participate in or complete a given intervention. This non-random selection introduces biases into the analyses that could reduce the reliability of findings. As such, we have identified strategies to account for some of this bias. These strategies, as well as other components of our evaluation strategy, are guided by an approach previously used by Chapin Hall to evaluate the effects of a foster care intervention in Tennessee (Huhr & Wulczyn, 2019).

(1) Exact-match comparison group

In lieu of randomization, statistical methods of matching can be used to create two groups that are largely similar, except; one group received the treatment under study (FCT) and the other did not. There are numerous ways to approach the matching process, including propensity score 1:1 matching, multiple matching, and exact matching. We will use exact matching because it matches individuals who share the exact same set of covariates (e.g., characteristics that are relevant to the intervention), and it matches an individual from the treatment group to multiple matching individuals in the comparison group (1 to many matching). All individuals with a matched score (similar profile) who did not receive the treatment are retained in the sample. By matching treatment group participants to multiple comparison group participants with matching covariates, we retain a large sample without sacrificing precision or validity (e.g. making valid comparisons across groups). This method can be problematic in smaller samples, but the size of the “business as usual” comparison group (not receiving FCT) in NE is projected to be large; it is likely that multiple exact matches will be found for treatment group families. Because FCT treats the family as a unit, it is important that both children and their caregivers are matched to create comparable groups and establish baseline equivalence. Thus, a set of covariates that describe the child and the caregiver (e.g., age, race, and ethnicity of child and caregiver, number of children in the home, relationship status) will be used for matching purposes. With this strategy, matching will occur at the family level rather than the individual level.

(2) County-level random effects

Nebraska has both rural and urban areas, and counties in different geographic regions likely exhibit variations in child welfare practice and placement rates, as well as variation in service availability. When aiming to understand how a program works across a state, it is important to account for these county-level differences in service delivery, service availability, and county child welfare practices. One way of doing this is to use a multi-level model that includes county-level effects. For this evaluation, we will include county-level random effects in our models to ensure county variation is controlled for in all analyses.

(3) Case worker referral and placement practices

An aspect of child welfare practice that can have large impacts on treatment effects is case worker referral and placement practices. Case workers may refer families for different reasons at

different times, and this variation in practice is difficult to capture without adding more effort and tools to their work. However, we can account for variation in case worker decision-making in statistical models by first estimating a case worker-specific residual statistic that indicates the extent to which a case worker's referral and placement rates differ from an adjusted average (e.g., the "normative" practice in the county). This residual statistic will be calculated using two random effects logistic regression models: one predicting referrals to FCT and one predicting placement of children in OOH care. Each case worker will have two residual statistics based on their history of case practice, and those residual statistics will be linked to children based on the case worker assigned to their case at the relevant decision points. We are confident that, if we use the strategies described above, the effects of FCT we find will be robust to case worker selection bias.

Sampling Strategy

Ideally, we will include in the study all families eligible for and referred to FCT providers. In that case, we will not need a sampling strategy per se because we aim to access data on all families that meet the eligibility criteria and are participating in FCT over the course of the two-year study inclusion period (July 1, 2021 to June 30, 2023). The comparison group will be constructed from a sample of families in the child welfare system during the same period of time. We will follow both groups of families for eighteen months post-enrollment in FCT. Because FCT typically lasts six months, data collection will be complete on June 30, 2025. This will allow us to observe families that enrolled in FCT on the last day of the study inclusion period (June 30, 2023) for eighteen months after their FCT discharge (December 31, 2023). We will avoid problems with sampling bias by using administrative and program data to obtain information on all families who meet eligibility criteria and participate in FCT. However, depending on the geographic representation of FCT service providers after the expansion of FCT services (see Appendix B for current service locations), we may use sample weights to correct for over-representation from a certain geographic area. At time of writing, we do not know the exact number of families served by FCT in each provider location; we cannot determine the current distribution of geographic representation. This will be addressed in the project start-up phase.

Chapin Hall will pursue data-sharing agreements (DSAs) with all FCT providers to access outcome measures for families participating in the intervention. We will also pursue a DSA with the Family Centered Treatment Foundation; the foundation collects data from providers across the country and standardizes those data into consistent outcome and fidelity measures. This program data will mostly be used in the process evaluation, but the outcome evaluation will use some program data regarding service utilization and to assess for improvements in outcomes by comparing pre- and post- trauma and behavioral measures, as collected by FCT providers. Additionally, we will receive Nebraska administrative child welfare data for all families over the course of the study period. These data will allow us to identify all families who were referred to and participated in FCT over the two-year study inclusion period and to measure their child welfare involvement in the eighteen months following treatment.

Measures & Data Collection

The outcome evaluation is summative and designed to discern the treatment effects of FCT and child welfare outcomes. CFS will provide us with child welfare data for three years of historical data, the two-year study inclusion period and eighteen months after treatment end, or until the target child reaches the age of 19. Table 4 provides details about the outcomes, measures, variable type, sources of data, and period and procedures for data collection. Outcomes are identified in two categories: (1) treatment effects (e.g., the immediate behavioral and family functioning changes as a result of FCT); and (2) child welfare outcomes (e.g., administrative child welfare indicators of improvement, such as OOH placement). The outcomes correspond to outcomes identified in the logic model (see Figure 1). Our primary research question is the extent to which participation in FCT is related to positive child welfare outcomes (families remain united, no OOH placement).

Data Analysis

Our analyses will proceed in three steps. First, we will conduct descriptive analysis of the families receiving FCT over the course of the study period including service enrollment, service duration, and service referrals (implementation variables). Next, for analyzing treatment effects of FCT, we will collect FCT program data from FCT providers. Data on traumatic symptoms (PTSD) are collected at various points during treatment, and families and clinicians are asked to rate family improvement in certain behavioral areas. The program data will also include information on the FCT clinician and location of services. This will allow us to control for provider and geographic variation and discern where and for whom FCT may work best by comparing pre- and post- FCT treatment outcomes. Because we will not have data on PTSD and behavioral outcomes for the comparison group, this analysis will only involve families who received FCT.

For child welfare outcome analyses, we will use exact matching to identify a comparison group and conduct analyses to establish baseline equivalence with respect to demographic characteristics, service engagement, and child welfare histories between the treatment and comparison groups. We will also use child welfare administrative data to examine the prevention services each group receives over time; controls will be added into the final statistical models to account for additional services that families receive outside of FCT. All analyses will be conducted in Stata: a statistical software package capable of manipulating large, administrative data sets and conducting complex analyses.

Next, we will estimate a series of discrete time hazard models predicting the key child welfare outcome of interest (e.g., OOH placement) in addition to related variables (referrals, length of placement, etc.). As described earlier, a separate set of regression models will be estimated to determine each case worker's likelihood of referring a family to FCT or placing a child in OOH care. These residual statistics will be included in the hazard models to control for case worker variation. The discrete-time hazard models will include county-level random effects to account for county-level differences in child welfare practice. The effects of each covariate on the outcomes of interest will be expressed as odds ratios, which express the degree of relationship between an experience or exposure and an outcome; that is, the odds that an outcome (placement) will occur given exposure

to treatment (FCT). Odds ratios greater than one indicate increased risk for the outcome of interest, and odds ratios less than one indicate decreased risk. Models will include independent variables of treatment/service dosage, other services received, demographic characteristics, case worker decision-making, and baseline risk. Decisions will be made about the level of each variable (e.g. continuous, dichotomous) as more is understood about NE's data.

Whereas we will measure attrition from the intervention, we can obtain requisite treatment information because we are relying heavily on administrative data. However, the administrative data may be missing some demographic information. Given that this information is most likely to be missing for families that do not receive significant attention from the child welfare system (Huhr & Wulczyn, 2019), a variable capturing missingness can provide important information about family risk. Systematic missingness can signify patterns or characteristics that can affect outcomes. Thus, rather than trying to impute missing values, we will include indicators of missingness in our models to control for similarities among families whose missing data may contribute to spurious findings. Provider data are also likely to be missing for families who leave FCT treatment. To address this, we will develop measures of program dosage to identify any differences in FCT effects by duration of service receipt.

Table 4. Outcome Evaluation Outcomes, Measures, and Sources

Treatment Effects			
Outcome*	Measure	Variable Type	Data source, Process, Timeframe
PTSD symptoms	Child and caregiver measure of PTSD symptoms	Continuous	FCT provider data: Practitioners data to CH 2.5 year data collection period (2-year study inclusion + 6 mos. for treatment completion)
Family behavior	Family behavioral goal/s are met	Dichotomous	
Family treatment outcomes (coded)	Progress and outcomes of families as recorded in the discharge summary	Qualitative	
Child Welfare Outcomes			
Outcome	Measure	Variable Type	Data source, Process, Timeframe
<i>Primary outcome of interest:</i> Placement in OOH care	Indicator of a placement into OOH based on placement date	Dichotomous	
Referral to child welfare system	Future referral involving target child	Dichotomous	SACWIS: NE administrative data:
Referral screening decision	Screening decision of any future referral involving target child	Dichotomous	3 years of historical data plus the 3.5 year data collection period (2-year study inclusion period + 1.5 years follow-up)
Alleged maltreatment type	Type of maltreatment allegation, future referral (i.e., neglect, physical abuse, sexual abuse, and emotional neglect)	Categorical	
Substantiated allegation	Any future substantiated allegation	Dichotomous	
Substantiated allegation type	Type of substantiated maltreatment allegation of any future	Categorical	

substantiation (i.e., neglect, physical abuse, sexual abuse, and emotional neglect)

Note. All data will be collected at the case or child level. Aggregate data may be used to describe the child welfare landscape over the course of the study period. *Treatment outcomes are defined based on preliminary conversations with FCT providers about data collection and documentation processes. These are subject to change if additional information obtained necessitates revisions.

Strategies to Mitigate Limitations in Evaluation Design

As with all evaluations, this design has threats to validity. Some of the most prominent have already been discussed (e.g., county and case worker variation, selection bias). We have identified strategies to address biases that may result from these confounding factors, but other threats to validity remain. The possibility that families may receive prevention services in addition to FCT makes teasing out the effects of FCT challenging. Therefore, as described earlier, we will include indicators of other service receipt in our models. We will also conduct multiple sensitivity tests to assess the robustness of our results and be diligent in testing alternative explanations for any effects that are observed. Finally, researchers can introduce personal bias into their work: particularly if working in isolation. Using a team of researchers and outside reviewers with expertise in the field helps mitigate bias and promote objectivity. It also allows for collaboration that drives creativity and nuance in methods, interpretation, and reporting of findings.

TF-CBT Evaluation Plan

Introduction

Trauma-focused Cognitive Behavioral Treatment (TF-CBT) is a joint child and parent psychotherapy model for children experiencing significant emotional and behavioral difficulties due to traumatic life experiences. Treatment includes trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Stated program goals include: improving post-traumatic stress disorder (PTSD), depressive and anxiety symptoms; improving child externalizing behavior problems; improving parenting skills and parental support of the child; enhancing parent-child communication, attachment, and ability to maintain safety; improving child adaptive functioning; and reducing shame and embarrassment related to the trauma event(s).

The Title IV-E Prevention Services Clearinghouse identified 35 studies that involved TF-CBT, and 11 were eligible for review. Three were rated high, three were rated moderate, and five were rated low. No studies showed any evidence there was risk of harm in TF-CBT. Thirty-eight favorable effects and 41 null effects were identified, resulting in a rating of *promising* (Title IV-E Prevention Services Clearinghouse, n.d.). According to the Prevention Services Clearinghouse standards, a rating of promising means at least one study was found that demonstrates a favorable effect on a target outcome and involves a moderately or highly rigorous study design.

The California Evidence-Based Clearinghouse's (CEBC) review of the literature identified TF-CBT as *well-supported* by research evidence (California Evidence-Based Clearinghouse, n.d.). By CEBC standards, this means there are at least two randomized controlled trials that show a sustained effect of at least one year, and the overall weight of the published literature supports the benefit of TF-CBT. Given the different conclusions reached by these evidence-based clearinghouses, it is crucial to understand how this intervention impacts family and child welfare outcomes, including understanding the mechanisms that could influence effectiveness (implementation and fidelity to the model) in the state of NE.

There are currently six TF-CBT providers requesting to contract with CFS to provide TF-CBT services to families. Collectively, these providers serve 29 counties in a mix of urban, suburban and rural locations. Providers will also on-board at different times throughout the project period, initiating the process of training and credentialing clinicians; specifically, the Eastern service area is currently in the beginning stages of implementing TF-CBT to serve families through privatized case management. The subsequent sections of this document provide an overview of the TF-CBT evaluation plan collaboratively developed by the State of Nebraska and Chapin Hall.

Initial Evaluation Plan | TF-CBT

In addition to meeting the earlier definition for candidacy (see pg. 2), the target population for TF-CBT includes children and adolescents aged 3-18 who have experienced trauma. According to analysis conducted by Mainspring Consulting, the projected caseloads for TF-CBT – considering current capacity and plans for expansion – are 610 children in 2021, 840 children in 2022, and 1086

children in 2023. Thus, we are confident there will be enough treatment recipients to adequately power a treatment effects analysis.

If a case worker believes a family will benefit from TF-CBT (the screening and triage methods are under discussion), then a referral will be made to a TF-CBT provider. Next, a mental health professional assesses the child for trauma experiences and trauma symptoms using a chosen trauma symptom tool. After this initial assessment, the mental health professional determines if the family is appropriate for TF-CBT. At time of writing, we do not have detailed information from providers about the percentage of families referred to TF-CBT who ultimately receive services, and we do not have information on the length of time a family may have to wait for services, if any. These are details that will be determined during the project start-up phase and will help further define the analysis plan.

Children/youth at-risk of entering OOH care and exhibiting significant trauma symptoms are targeted for the current evaluation because these families are best suited for participating in and benefitting from TF-CBT. These are also families at a sensitive point in their case management where extra supports are often needed to prevent removal or aid in a successful reunification.

Figure 2 presents a logic model for the proposed evaluation. The inputs and activities will lead to a series of outputs and outcomes, and the outcomes that are identified guide the sources of data and methods of data collection and analysis. The following sections detail the design and analysis plans for the process and outcome evaluations of TF-CBT.

Figure 2. Logic Model for the Nebraska TF-CBT Evaluation Plan

Inputs	Activities	Outputs	Proximal Outcomes	Distal Outcomes
<p>Target population</p> <ul style="list-style-type: none"> • Children 0-18 and caregivers • Children/youth with experiences of trauma <p>Target Intervention: TF-CBT</p> <p>Concurrent Interventions</p> <ul style="list-style-type: none"> • Family Centered Treatment • Healthy Families America • Functional Family Therapy • Multisystemic Therapy • Parent and Child Interaction Therapy <p>Comparison NE CW business as usual practice</p>	<p>Child Welfare Professional</p> <ul style="list-style-type: none"> • Assess and refer families to services • Monitor prevention plan • Monitor safety plan <p>TF-CBT Provider</p> <ul style="list-style-type: none"> • Provide service through trained and credentialed clinicians supported by training, supervision, and CQI • 8-6 treatment sessions per family, including child, parent, and joint sessions • Collect data on family outcomes and fidelity • Track progress of families • Report process and evaluation outcomes <p>Families</p> <ul style="list-style-type: none"> • Participating in TF-CBT treatment sessions • Participating in case management activities 	<p>Families</p> <p>O1. # of families referred to TF-CBT</p> <p>O2. # of families enrolled in TF-CBT</p> <p>O3. # of families who complete TF-CBT</p> <p>O4. Average dose of TF-CBT per family</p> <p>TF-CBT Provider</p> <p>O5. Fidelity to eligibility and referral pathway</p> <p>O6. TF-CBT fidelity monitoring</p> <p>O7. TF-CBT outcome monitoring procedures</p> <p>O8. # of certified TF-CBT providers in NE, completion of model coaching, supervision, and training requirements</p>	<p>Families</p> <p>PO1. Increased caregiver coping skills</p> <p>PO2. Increased caregiver perceptions of parenting support</p> <p>PO3. Increased trauma management skills in children and caregivers</p> <p>PO4. Reduced PTSD symptoms in children and caregivers</p> <p>PO5. Improved parenting behaviors</p> <p>Intermediate Outcomes</p> <p>Families</p> <p>IO1. Improved relationships between caregivers and children</p> <p>IO2. Improved overall household functioning</p> <p>FCT Provider</p> <p>IO3. Practice adjusted by providers based on current fidelity to TF-CBT</p> <p>IO4. Progress towards treatment goals consistently documented by providers</p>	<p>Families</p> <p>DO1. Reduction in child welfare referrals and severity of involvement</p> <p>DO2. Reduction in placement in OOH</p> <p>DO3. Reduced duration in OOH</p> <p>DO4. Lower average level of risk identified in case management</p> <p>DO5. Fewer prevention needs identified in case management</p> <p>DO6. Higher family strengths and fewer family needs identified in the FSNA tool in the SDM</p> <p>FCT Provider</p> <p>DO7. Fidelity is consistently tracked by providers, and providers practice with fidelity to the model</p> <p>DO8. Aggregate improvements in families' outcomes are reported by providers</p>

Process Evaluation – TF-CBT

The goal of the process evaluation is to assess TF-CBT implementation and to ensure that it continuously meets required standards for fidelity. Without appraisal of the extent to which a treatment is implemented as intended, it is not possible to attribute intervention outcomes with confidence. This component includes objectives in the areas of fidelity to eligibility and referral processes between CFS and TF-CBT providers, child and family service utilization, clinician fidelity to the TF-CBT treatment model, and observation of implementation strengths and challenges. The process evaluation will use qualitative methods, conducting structured interviews or focus groups to obtain the perspective of NE CFS staff on selection and referral, implementation facilitators, challenges, potential solutions, and support and resources needed. The process evaluation will monitor intended activities and collaborate with NE CFS to reflect on processes as they are occurring in order to strengthen implementation and contribute to quality improvement. The process evaluation will describe service utilization (e.g. dosage, completion, gaps in treatment), and fidelity, which includes (to the extent possible) practitioner adherence to the TF-CBT clinical model, and adherence to protocol in the eligibility and referral pathway between the child welfare system and TF-CBT providers. Adherence to the TF-CBT clinical model will be measured using fidelity and implementation tracking tools. Session-level fidelity for TF-CBT is measured using the Brief Practice Checklist; however, we will learn more about the way in which TF-CBT providers in NE track this fidelity and implementation during the project start-up phase. Of note, given the qualitative and nested nature of the practitioner checklist, it may not be suitable for quantitative, study-wide appraisal of fidelity. That is, the checklist is a multiple page table that requires a clinician to "check" what therapeutic strategies they used in a given session. The strategies are listed by therapeutic phase, which is reflective of the client's current status and progress in treatment. Whereas this is a useful guide when provided in full context, it would not be possible to glean the appropriateness of any particular strategy in a given session. That said, the evaluation team will work to locate and incorporate available data to report with some confidence about general adherence. Table 5 details the objectives, research questions and theory for the process evaluation.

Table 5. Nebraska FFPSA TF-CBT Process Evaluation Objectives, Research Questions and Rationale

Process Study Objectives	Research Questions	Rationale
1. Assess fidelity to the eligibility and referral pathway for families between CFS and TF-CBT service provision.	How consistent and effective is the process to identify and link eligible families to TF-CBT services? Are all families screened for eligibility? Referred as indicated?	Local factors and decision-making may contribute to variations to the intended protocol, influencing the extent to which the program reaches the intended population and potentially biasing the study. Monitoring allows for course correction.
2. Assess TF-CBT service utilization.	Among families referred, what is the % uptake? Does it vary systematically? What are rates of retention in TF-CBT among enrolled families?	Consistent referral, enrollment, uptake and retention of families in TF-CBT is important to valid assessment of treatment and outcomes.
3. To the extent possible, monitor and evaluate	To what degree is there fidelity to the TF-CBT model?	Understanding TF-CBT effectiveness in NE requires observing the extent of

Process Study Objectives	Research Questions	Rationale
practitioner fidelity to the TF-CBT model.		fideliy to the model; without this, positive and negative outcomes may be erroneously attributed.
4. Identify strengths and challenges to implementing TF-CBT as a FFPSA prevention service.	What factors influence implementation, service utilization, and outcomes of TF-CBT as a FFPSA prevention service in NE?	CFS will be better equipped to provide TF-CBT when informed by an understanding of strengths and challenges perceived by case workers.

Process Evaluation Design

The process evaluation is informed by implementation science (Proctor et al., 2011) and centers on three functions: (1) fidelity appraisal, (2) monitoring of service utilization, and (3) collecting data on implementation strengths and challenges. Our assessment of fidelity will include fidelity to the eligibility and referral pathway between CFS and TF-CBT, and TF-CBT clinical fidelity that includes the evaluation of training and credentialing of clinicians and implementation of treatment model components, to the extent feasible and practicable. Fidelity will be assessed through data maintained by CFS and TF-CBT providers and will require data sharing agreements among the parties.

In the process evaluation, we draw on tools used regularly in practice and in prior evaluations of TF-CBT. This includes the *TF-CBT: Implementation Manual* (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004) and *Treating Trauma and Traumatic Grief in Children and Adolescents* (J.A. Cohen, A.P. Mannarino, and E. Deblinger; NY: Guilford Press, 2006/17). Further, we will assess implementation by conducting implementation interviews with CFS case workers, assessing structures and supports for model fidelity and the evaluation, and using ongoing results to inform changes in the design and execution of implementation protocols and practices.

(1) Fidelity

Eligibility and Referral Pathway. We will use NE CFS administrative data (SACWIS/FACTS) to describe the total number and proportion of children/youth involved with NE child welfare who are eligible, according to candidacy definitions and TF-CBT eligibility requirements, and whose family ultimately receives a referral to TF-CBT. We will use TF-CBT provider data to examine the number and proportion of families referred to TF-CBT who are assessed, accepted for services, enroll in TF-CBT, and complete TF-CBT treatment. We will describe the characteristics of families at each referral stage and identify patterns. Finally, we will analyze dates of each contact in the pathway to assess responsibility, capacity, and timeliness of service. Importantly, because there is no centralized TF-CBT database similar to FCT, it will be necessary to obtain treatment details from the NE providers. At the time of writing, we do not know how much of this is tracked by each individual provider; this will be assessed during project start-up and Chapin Hall will work with providers and CFS on a plan to contribute to the evaluation.

TF-CBT Clinical Model. CFS will collect information about training and credentialing for each individual clinician providing TF-CBT for a family, and share these data with Chapin Hall for analysis. We will follow TF-CBT model developer guidance and anticipate using their fidelity monitoring tool, the *Brief Practice Checklist*, to evaluate whether clinical fidelity standards are being met. We do not currently know the extent to which NE TF-CBT clinicians use this tool and how it is recorded. This will be learned during the start-up phase; evaluation plans will be adjusted accordingly.

(2) Service Utilization

Using TF-CBT provider data, Chapin Hall will aim to obtain the dates of TF-CBT services for each child and family. This includes details about participants in each session and dates each TF-CBT component was initiated and completed. We will create variables to describe service dosage, completion, total treatment time (start to finish or withdrawal), and treatment gaps for each child and family. If dates are untenable in terms of NE provider capacity to collect, we will aim to collect, or use CFS PPI data on total treatment sessions, time and completion for each child and family.

(3) Implementation Strengths and Challenges

Throughout implementation, the Chapin Hall team will engage in two forms of regular contact with CFS staff: (1) participation in statewide CQI meetings (these are held monthly; Chapin Hall will participate quarterly); and (2) monthly evaluation meetings. In years 2 and beyond, we will conduct structured interviews with CFS case workers in Years 2 and 3 that will center on inter- and intra-organizational processes that support TF-CBT implementation and those that need additional support, resources, or adaptations to ensure success of the model. Chapin Hall will summarize interview results and integrate the findings with service utilization and fidelity results to share with CFS for quality monitoring through CQI.

Sampling Strategy

We plan to use quantitative data from all TF-CBT providers, so a sampling strategy is not necessary for the process evaluation of TF-CBT. This includes analysis of fidelity and service utilization data. We will identify a small subset of CFS locations to conduct the qualitative CFS interviews in Years 2 and 3. Currently, TF-CBT is provided in 29 NE counties; however, current providers are clustered in the Northern, Eastern, and Southeast service areas. We will work with NE DHHS to identify a subset of case workers in locations that are geographically representative and include both early and later adopters of TF-CBT for FFSPA. Depending on the number of case workers per CFS location included, we will collect data either through a focus group or individual interviews. We anticipate collecting the qualitative data from approximately 10-30 case workers in each of Years 2 and 3. At time of writing, we do not know the exact number of case workers per office and region. As such, a more detailed sampling strategy will be determined during the project start-up phase.

Measures & Data Collection

Table 6 shows the indicators, measures, data sources, and timeline for data collection for each of the TF-CBT process evaluation's research questions. Chapin Hall will enter into Data Sharing Agreements with NE CFS and participating TF-CBT organizations to obtain data for the evaluation.

Chapin Hall will participate in NE CFS CQI meetings quarterly so that adjustments can be made to strengthen the model. The process evaluation is designed to assess the extent to which the intended model to use TF-CBT as a NE FFPSA prevention service is implemented. Table 6 describes the research questions, indicators, measures, data sources, and timeline for data collection for the process evaluation. (The outputs are described in Figure 2 Logic Model).

Data Analysis

Given that the process evaluation will include quantitative and qualitative data, we will use multiple approaches to data analysis: (1) quantitative analysis to describe fidelity and service utilization, e.g. descriptive means and proportions and bivariate tests (chi-square, t-tests), to identify patterns of family characteristics related to enrollment and service utilization; and (2) qualitative thematic analysis to describe implementation strengths, challenges and potential solutions from case worker perspectives. We will use document review to understand intended protocols and processes. The evaluation team will collaborate with CFS to understand the process evaluation findings in real-time and provide consultation to contribute to quality improvement strategies.

Table 6. TF-CBT Process Evaluation Questions, Indicators, Measures, Data Sources and Timing

Research Question	Area	Indicators	Measures	Data Source(s) and Timing of Data Collection
How consistent and effective is the process to identify eligible children and families and refer them to TF-CBT?	<i>Fidelity- Eligibility and Referral Pathway</i>	<ul style="list-style-type: none"> - Existence of an articulated eligibility, referral and enrollment protocol - N and % children screened for and meet eligibility criteria - N and % of eligible children whose family is offered and accepts referral - N and % of referred families assessed, accepted, enrolled - Family characteristics - Contact dates 	<ul style="list-style-type: none"> - Document review tool - Completed eligibility and referral forms - Completed TF-CBT clinician assessments and enrollments 	<ul style="list-style-type: none"> - CFS policies and procedures documentation, Annual - CFS administrative data (SACWIS) and PPI system, Monthly - Provider data, Bi-annual
What are rates of Service retention in TF-CBT?	<i>Utilization</i>	<ul style="list-style-type: none"> - N and % of enrolled families that complete treatment - Service dosage, gaps - Total treatment time - Family characteristics 	<ul style="list-style-type: none"> - Completed TF-CBT clinician fidelity tools, Brief Practice Checklist 	<ul style="list-style-type: none"> - Provider data, Bi-annual - CFS discharge summaries, Bi-annual
To what degree is fidelity to the TF-CBT model?	<i>Clinical Model</i>	<ul style="list-style-type: none"> - Number of certified staff - Number of model training and coaching requirements met - Number and types of TF-CBT components completed with fidelity - TF-CBT participants (child and family) 	<ul style="list-style-type: none"> - TF-CBT provider and CFS training and certification tracking tools - Trauma screenings and assessments - Completed clinician fidelity tools 	<ul style="list-style-type: none"> - CFS records, Bi-annual - Provider data, Bi-annual

Research Question	Area	Indicators	Measures	Data Source(s) and Timing of Data Collection
What factors influence implementation, service utilization, and model fidelity?	<i>Implementation Strengths and Challenges</i>	- Contextual factors influencing implementation reported by CFS and TF-CBT staff	- Project-developed interview and focus group protocol	- CFS and TF-CBT staff, Annual Years 2, 3

Outcome Evaluation – TF-CBT

The goal of the outcome evaluation is to determine whether TF-CBT results in positive individual and familial change after treatment participation (treatment effects), and child placement prevention (child welfare outcomes), having the potential to build evidence to establish TF-CBT as an effective prevention model for child welfare-involved families. Primary outcomes that will be assessed are the relation between exposure to the intervention and symptom reduction and child welfare outcomes, principally OOH placement. Specifically, we will examine: (1) child and caregiver trauma symptomatology; (2) OOH placement; (3) family functioning/risk of out-of-home (OOH) placement; (4) placement duration; and (5) child safety. The outcome evaluation uses quasi-experimental design to assess the effect of TF-CBT on these outcomes. Table 7 details the objectives, research questions, and hypotheses of the outcome evaluation for TF-CBT.

Table 7. Nebraska FFPSA TF-CBT Outcome Evaluation Objectives, Research Questions, and Hypotheses

Objectives	Research Questions	Hypotheses
<i>Primary outcome of interest:</i> 1. Examine the relationship between TF-CBT receipt and the likelihood of OOH care placement.	Are children less likely to be placed in OOH care if their families receive TF-CBT than if their families receive services as usual?	Children will be less likely to experience an OOH care placement if their families receive TF-CBT than if their families receive services as usual.
<i>Treatment effects:</i> 2. Examine the relationship between trauma symptoms and service receipt among children and caregivers.	Do children and caregivers whose families receive TF-CBT report improved trauma symptomatology as compared to at the beginning of treatment?	Children and caregivers who receive TF-CBT will report fewer symptoms of PTSD at the end as compared to at the beginning of treatment.
3. Examine how family functioning changes in relation to service provision.	Do children whose families receive TF-CBT exhibit fewer risks and more strengths than children whose families receive services as usual?	Children whose families receive TF-CBT will demonstrate lower SDM risk assessment scores and higher FSNA scores, indicating better functioning, than children whose families receive services as usual.
<i>Supplementary questions:</i> 4. Examine the relationship between TF-CBT receipt and placement duration.	Do children who enter OOH care exit care sooner if their families received TF-CBT than if their families received services as usual?	Children will exit care sooner if their families received TF-CBT than if their families received services as usual.

Objectives	Research Questions	Hypotheses
5. Examine the relationship between TF-CBT receipt and contact with the child welfare system (referrals and substantiations).	Are children whose families receive TF-CBT less likely to have contact with the child welfare system after case closure than children whose families receive services as usual?	Children whose families receive TF-CBT will be less likely to experience referrals and substantiated allegations after case closure than children whose families receive services as usual.

Outcome Evaluation Design

We will evaluate the impact of TF-CBT using a quasi-experimental research design, an exact-matching analysis to create a comparison group, and discrete time hazard modeling with county-level random effects. While we recognize that randomized-controlled trials (RCTs) are the gold standard for evaluation, and particularly useful for discerning treatment effects, randomizing families in this context would require modifications to front line child welfare practice that would significantly complicate the rollout of the interventions. At this writing, CFS indicates that significant additions to staff workload at multiple sites and decision points is untenable and would be particularly difficult due to the multiple points in the life of a case that a family can be referred to TF-CBT. Moreover, even if families were randomized to a treatment or control group, measuring the effects of TF-CBT would be very difficult because of the wide range of other preventive services that would be provided to families in a control condition (see Appendix B). Thus, a quasi-experimental method is proposed for identifying a control group within NE that is exactly similar to the treatment group in demographic characteristics and likelihood of entry into TF-CBT. Additionally, as collected in the newly enhanced CFS foster care prevention plan data, analyses will account for the other prevention services both groups of families are referred to and receive over the course of the study period. Our evaluation strategy is guided by an approach previously used by Chapin Hall to evaluate the effects of a foster care intervention in Tennessee (Huhr & Wulczyn, 2019).

One concern when selecting a quasi-experimental design is selection bias. Selection bias refers to bias that is introduced to a study when individuals are not randomly selected for an intervention; this results in families with certain characteristics being more likely to participate in or complete a given intervention. This non-random selection introduces biases into the analyses that could reduce the reliability of findings. As such, we have identified strategies to account for this bias.

(1) Exact-match comparison group

In lieu of randomization, statistical methods of matching can be used to create two groups that are largely similar, except; one group received the treatment under study (TF-CBT) and the other did not. There are numerous ways to approach the matching process, including propensity score 1:1 matching, multiple matching, and exact matching. We will use exact matching because it matches individuals who share the exact same set of covariates (e.g., characteristics that are relevant to the intervention), and it matches an individual from the treatment group to multiple matching individuals in the comparison group (1 to many matching). All individuals with a matched score (similar profile) who did not receive the treatment are retained in the sample. By matching treatment

group participants to multiple comparison group participants with matching covariates, we retain a large sample without sacrificing precision or validity (e.g. making valid comparisons across groups). This method can be problematic in smaller samples, but the size of the “business as usual” comparison group (not receiving TF-CBT) in NE is projected to be large; it is likely that multiple exact matches will be found for treatment group families. Because TF-CBT treats the family as a unit, it is important that both children and their caregivers are matched to create comparable groups and establish baseline equivalence. Thus, a set of covariates that describe the child and the caregiver (e.g., age, race, and ethnicity of child and caregiver, number of children in the home, relationship status) will be used for matching purposes. With this strategy, matching will occur at the family level rather than the individual level.

(2) County-level random effects

Nebraska has both rural and urban areas, and counties in different geographic regions likely exhibit variations in child welfare practice and placement rates, as well as variation in service availability. When aiming to understand how a program works across a state, it is important to account for these county-level differences in service delivery, service availability, and child welfare practices. One way of doing this is to use a multi-level model that includes county-level effects. For this evaluation, we will include county-level random effects in our models to ensure county variation is controlled for in all analyses.

(3) Case worker referral and placement practices

An aspect of child welfare practice that can have large impacts on treatment effects is case worker referral and placement practices. Case workers may refer families for different reasons at different times, and this variation in practice is difficult to capture without adding more effort and tools to their work. However, we can account for variation in case worker decision-making in statistical models by first estimating a case worker-specific residual statistic that indicates the extent to which a case worker’s referral and placement rates differ from an adjusted average (e.g., the “normative” practice in the county). This residual statistic will be calculated using two random effects logistic regression models: one predicting referrals to TF-CBT and one predicting placement of children in OOH care. Each case worker will have two residual statistics based on their history of case practice, and those residual statistics will be linked to children based on the case worker assigned to their case at the relevant decision points. We are confident that, if we use the strategies described above, the effects we find will be robust to case worker selection bias.

Sampling Strategy

Ideally, we will include in the study all families eligible for and referred to TF-CBT providers. In that case, we will not need a sampling strategy per se because we aim to access data on all families that meet the eligibility criteria and are participating over the course of the two-year study inclusion period (July 1, 2021 to June 30, 2023). The comparison sample will be constructed from families in the child welfare system during the same period of time. We will then follow these families for eighteen months post-enrollment in TF-CBT. Because TF-CBT typically lasts six months, data

collection will be complete on June 30, 2025. This will allow us to observe families that enrolled in TF-CBT on the last day of the study inclusion period (June 30, 2023) for eighteen months after their TF-CBT discharge (December 31, 2023). We will avoid problems with sampling bias by using administrative and program data to obtain information on all families who meet eligibility criteria and participate in TF-CBT. However, the geographic dispersion of TF-CBT providers may vary. Currently, TF-CBT is provided largely in urban areas of the state. As such, once we begin analyzing the data, we may need sample weights to correct for over-representation from urban areas. At time of writing, we do not know the exact number of families served by TF-CBT in each provider location; we cannot determine the current distribution of geographic representation. This will be addressed in the project start-up phase.

Chapin Hall will pursue data-sharing agreements (DSA) with all TF-CBT providers to access treatment outcome measures and service utilization for families participating in TF-CBT. The program data will be mostly used in the process evaluation, but the outcome evaluation will use some program data to assess service utilization and improvements in outcomes by comparing pre- and post-trauma measures, as collected by TF-CBT providers. Additionally, we will receive Nebraska administrative child welfare data for all families over the course of the study period. This will allow us to identify all families who were referred to and participated in TF-CBT over the five-year study period and identify their child welfare involvement in the eighteen months following treatment.

Measures & Data Collection

The outcome evaluation is summative and designed to discern the effects of TF-CBT on child welfare and family outcomes. CFS will provide us with child welfare data for three years of historical child data, the two-year study inclusion period, and eighteen months after treatment end, or until the target child reaches the age of 19. Table 8 provides details about the outcomes, measures, variable type, sources of data, and period and procedures for data collection. Outcomes are identified in two categories: (1) treatment effects (e.g., the immediate behavioral and family functioning changes as a result of TF-CBT); and (2) child welfare outcomes (e.g., administrative child welfare indicators of improvement, such as OOH placement). The outcomes correspond to outcomes identified in the logic model (see Figure 2).

Data Analysis

Our analyses will proceed in three steps. First, we will conduct descriptive analysis of the families receiving TF-CBT over the course of the study period, as well as a description of service enrollment, service duration, and service referrals (implementation variables). Next, for investigating the treatment effects of TF-CBT, TF-CBT program data will be gathered from providers for families participating in TF-CBT and the child welfare system. Identifying a comparison group for these outcomes is difficult because similar families involved in the child welfare system but not participating in TF-CBT will not have the same information on PTSD experiences. However, trauma symptoms are identified at the beginning of TF-CBT treatment; we will use pre- and post-treatment data to identify the effects of TF-CBT on key PTSD outcomes for families receiving the service.

For child welfare outcome analyses, we will use exact matching to identify a comparison group and conduct analyses to establish baseline equivalence with respect to demographic characteristics, service engagement, and child welfare histories between the treatment and comparison groups. We will also use child welfare administrative data to examine prevention services each group receives over time; controls will be added into the final statistical models to account for additional services that families receive outside of TF-CBT, to the extent available in CFS's SACWIS/FACTS. All analyses will be conducted in Stata: a statistical software package capable of manipulating large, administrative data sets and conducting complex analyses.

Next, we will estimate a series of discrete time hazard models predicting the key child welfare outcomes of interest (e.g., placement, referral). As described earlier, a separate set of regression models will be estimated to determine each case worker's likelihood of referring a family to TF-CBT or placing a child in OOH care. These residual statistics will be included in the hazard models to control for case worker variation. The discrete-time hazard models will include county-level random effects to account for county-level differences in child welfare practice. The effects of each covariate on the outcomes of interest will be expressed as odds ratios. Odds ratios greater than one indicate increased risk for the outcome of interest, and odds ratios less than one indicate decreased risk. Models will include independent variables of treatment/service dosage, other services received, demographic characteristics, case worker decision-making, and baseline risk. Decisions will be made about the level of each variable (e.g. continuous, dichotomous) as more is understood about NE's data.

Table 8. Outcome Evaluation Outcomes, Measures, and Sources, TF-CBT

Treatment Effects			
Outcome*	Measure	Variable Type	Data source, Process, Timeframe
PTSD symptoms	Child and caregiver measure of PTSD symptoms	Continuous	TF-CBT provider data Providers provide data to CH
Treatment outcomes of families	Progress and outcomes of families as recorded in the discharge summary	Qualitative	2.5 year data collection period (2-year study inclusion + six months for treatment completion)
Family functioning	Overall assessment of family functioning based on SDM FSNA results in visits during and three months after treatment	Continuous	SDM/FSNA/SACWIS Nebraska provides CH administrative data 2.75 year data collection period (2-year study inclusion + six months for treatment completion + 3 month follow-up)

Child Welfare Outcomes			
Outcome	Measure	Variable Type	Data source, Process, Timeframe
<i>Primary outcome of interest:</i> Placement in OOH care	Indicator of a placement into OOH based on placement date	Dichotomous	SACWIS NE provides administrative data to CH
Length of stay in OOH care	Number of months in placement	Continuous	3 years of historical data plus the 3.5 year data collection period (2-year study inclusion period + 1.5 years follow-up)
Referral to child welfare system	Any future referral involving the target child	Dichotomous	
Referral screening decision	Screening decision of any future referral involving target child	Dichotomous	
Alleged maltreatment type	Type of maltreatment allegation of any future referral (i.e., neglect, physical abuse, sexual abuse, and emotional neglect)	Categorical	
Substantiated allegation	Any future substantiated allegation	Dichotomous	
Substantiated allegation type	Type of substantiated maltreatment allegation of any future substantiation (i.e., neglect, physical abuse, sexual abuse, and emotional neglect)	Categorical	

Note. All data will be collected at the case or child level. Aggregate data may be used only to describe the child welfare landscape over the course of the study period.

*Treatment outcomes are defined based on preliminary conversations with TF-CBT providers about data collection and documentation processes. These are subject to change if additional information obtained during the Project Startup necessities revisions.

We do not expect attrition to be a significant problem because we are relying heavily on administrative data. However, the administrative data may be missing some demographic information. Given that this information is most likely to be missing for families that do not receive significant attention from the child welfare system (Huhr & Wulczyn, 2019), a variable capturing missingness can provide important information about risk for those families. Thus, we will include indicators of missingness in our models to control for any similarities among families missing data that may contribute to spurious effects rather than trying to impute missing values. Data are also likely to be missing from TF-CBT providers for families that do not complete the full TF-CBT treatment. To address this, we will use program data to ensure measures of program dosage to identify any differences in TF-CBT effects by duration of service receipt.

Strategies to Mitigate Limitations in Evaluation Design

As with all evaluations, there are threats to validity. Some of the most prominent are discussed above (e.g., county and case worker variation, selection bias). We have identified strategies to address biases that may result from these confounding factors, but the possibility for variance remains. The possibility that families may receive preventive services in addition to TF-CBT makes

teasing out the effects of TF-CBT challenging. Therefore, as described earlier, we will include indicators of other service receipt in our models. We will also conduct multiple sensitivity tests to assess the robustness of our results and be diligent in testing alternative explanations for any effects that are observed. Finally, researchers can introduce personal bias into their work: particularly if working in isolation. Using a team of researchers and outside reviewers with expertise in the field helps mitigate bias and promote objectivity. It also allows for collaboration that drives creativity and nuance in methods, interpretation, and reporting of findings.

Quality Control and Human Subjects Protection

Data Security and Privacy

Chapin Hall's research data are stored on HITRUST Certified Red Hat Enterprise Linux servers. The servers are protected by a network firewall. Patches are regularly applied to and maintained on the servers. Access is limited to users with IRB approval and stated need. The principle of least privilege is followed—providing a user account only for those privileges that are essential to perform its intended function. Authentication is handled over the cryptographic network protocol Secure Shell (SSH), with password complexity and 90-day age technically enforced. Security controls are regularly reviewed following NIST SP 800-53r4 guidelines to ensure that appropriate physical, administrative and technical controls are in place to guarantee confidentiality, integrity and availability of all data.

Informed Consent Procedures

As discussed below, the Chapin Hall-School of Social Service Administration (SSA) Institutional Review Board (SSA-CH IRB) is the cognizant IRB for Chapin Hall at the University of Chicago. The SSA-CH IRB reviews all Chapin Hall research projects to ensure the protection of human research participants and the confidentiality and security of administrative and other data. It is empowered to approve, require modifications in (to secure approval), or disapprove research. All research protocols for this evaluation will address the process by which the informed consent will be sought where appropriate and (if applicable) authorization for use of protected health information. Additionally, Chapin Hall will seek the review of the cognizant IRB for the Nebraska DHHS, if applicable. We anticipate that some aspects of the proposed research may require individual informed consents and others will be eligible for a waiver of consent. Permission will be sought through the requisite written materials, (a) informed consent (b) waiver of consent or (c) waiver of some or all of the requirements, for consent. Accordingly, consent will include one of the following:

- a written consent/authorization form and a description of the informed consent process;
- a written summary and oral script for the short form consent process and a description of this process;
- a written script to be used in an oral consent process, as well as a description of consent process details and justification for alteration or waiver of documentation of consent;
- a written script to be used for an alteration of consent process (such as an email script) as well as a justification for alteration of the consent process; or
- a request for a non-emergency waiver of consent

AND

- a written authorization form (can be combined with the written consent form);
- justification for waiver of authorization;
- documentation that research data meet requirements for a limited data set; or
- explanation as to why HIPAA does not apply to the research.

Note that the University of Chicago Social Service Administration IRB requires all elements in consent forms as defined in 21 CFR 50.25(a) and 45 CFR 46.116(a-b) as well as required elements of a HIPAA authorization as defined in 45 CFR 164.508.

IRB Approval

Chapin Hall has a fundamental commitment to ensure appropriate protections for human research participants and to uphold individual and organizational responsibilities as good stewards of data: including adherence to ethical principles and federal, state, and local regulations. All projects at Chapin Hall are submitted for review to the Institutional Review Board before work begins. The SSA/CH IRB is comprised of members from both SSA and Chapin Hall who are jointly responsible for reviewing and approving all research conducted with human participants, data generated from human subjects, and data received by SSA and Chapin Hall researchers.

The IRB ensures that all research is consistent with the University's Federal wide Assurance (FWA) and convenes monthly to review IRB protocol applications to ongoing research. The IRB reviews, approves, disapproves, or defers all research protocols; provides assistance with IRB applications; and provides NIH-mandated educational sessions on the fundamentals of the protection of human research participants. In addition, Chapin Hall has additional mandated annual training in data security and the responsible conduct of research.

The SSA/CH IRB procedures and policies abide by the federal regulations for the Protection of Human Subjects (Title 45 CFR Part 46), the principles outlined in the Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research of the National Commission, and the State of Illinois statutes related to vulnerable populations and private records. The SSA/CHC IRB also applies University of Chicago and Chapin Hall policies related to research operations. The Chapin Hall team will submit an application seeking approval to the SSA/CH IRB by the end of the third quarter (Sept 2021).

Evaluation Roles and Responsibilities | Staffing

We will leverage Chapin Hall's substantive child welfare research expertise in design, execution, monitoring, and reporting. Senior Researcher Dr. Julie McCrae will lead Chapin Hall's Family First project engagement in collaboration with Dr. Emma Monahan and a Research Associate TBD, in close consultation with Patrick Fowler, Ph.D. (Washington University of St. Louis) and a set of senior advisors: including Dr. Anne Farrell (Director of Research, Chapin Hall) and Dr. Amy Dworsky (Research Fellow, Chapin Hall).

Principal Investigator | Julie McCrae, PhD

Julie McCrae, PhD, is a Senior Researcher at Chapin Hall. Dr. McCrae's research and expertise are in the development and health of children who are at risk for maltreatment or otherwise exposed to family stress and adversity. Dr. McCrae has substantive expertise in the design of quantitative, qualitative, and mixed methods research that leverages administrative/secondary datasets and original data collection. McCrae has led experimental and quasi-experimental study designs in child welfare, child development, and mental health. McCrae has extensive research methodology and data analysis experience, particularly in longitudinal analysis of child welfare services, child development, and mental health outcomes through her 10+ years work on the National Survey of Child and Adolescent Well-being (NSCAW).

McCrae has been an invited speaker on implementation science, resiliency, mixed methods research, and Adverse Childhood Experiences (ACEs) and in 2019 was one of 25 selected participants in the week-long Arthur M. Blank Foundation Innovation Lab: The State of Well-being in America. McCrae earned a PhD and Master of Social Work from the University of North Carolina at Chapel Hill.

Roles and responsibilities:

- As principal investigator, maintain overall responsibility for the integrity of the project design.
- Maintain responsibility for all aspects of project: including strategy, supervision, implementation, and products.
- Oversee project communication and reporting.

Co-Principal Investigator | Emma Monahan, PhD

Emma Monahan, PhD, is a Researcher at Chapin Hall. Her research interests include child welfare and improving child and family well-being, through prevention and intervention efforts, with a particular focus on economically disadvantaged families.

Previously, Monahan was a program and policy analyst at the Department of Children and Families in Wisconsin. Her work focused on evaluating policies and program initiatives in the Wisconsin child welfare system, as well as guiding implementation and continuous quality improvement efforts. Prior research projects included the evaluation of a randomized-controlled trial in Milwaukee County, Wisconsin, qualitative data collection and analysis, and administrative data

analyses to investigate the relationship of economic resources, specifically income instability and welfare benefit instability, with child welfare outcomes.

Monahan received her Ph.D. and MSW from the University of Wisconsin – Madison, with a specialization in social policy and child welfare research.

Roles and responsibilities:

- As co-principal investigator, help maintain overall responsibility of study activities and implementation of study design.
- Communicate with Nebraska child welfare staff.
- Lead outcome evaluation data collection, design, and analysis.
- Lead role in writing and disseminating findings.

Researcher | Emily Rhodes

Emily Rhodes, MPP, is a Researcher at Chapin Hall. Chapin Hall at the University of Chicago. Her work currently focuses on helping public and private child welfare agencies use administrative data to assess and improve child welfare systems. Rhodes also has experience with quantitative and qualitative program evaluation of child welfare, youth violence prevention, and early education programs. She is currently studying a federally funded demonstration of supportive housing for families involved in the child welfare system, and conducting a cost study of a Title IV-E waiver for alternative child welfare services.

Prior to joining Chapin Hall, Rhodes contributed to internal evaluation and quality assurance of human services and criminal justice programs for state government. She also has previous experience analyzing federal policy, and has staffed policy workgroups for state and local government.

Rhodes holds a Master of Public Policy and a Bachelor of Arts in Public Policy Studies from the University of Chicago and is a PhD candidate at the University of Illinois.

Roles and responsibilities:

- As a member of the research team, contribute to study activities, including protocol design, IRB, analytics, articulation and integration of findings.
- Communicate with Nebraska child welfare staff and participate in remote and on-site consultation.
- Co-design and conduct analysis using administrative data.
- Contribute to writing and disseminating findings.

Senior Research Consultant | Patrick Fowler

Patrick J. Fowler, PhD, serves as Associate Professor in the Brown School and the Division of Computational and Data Sciences at Washington University in St. Louis. Trained in child clinical-community psychology, his research focuses on preventing family homelessness and child maltreatment. Dr. Fowler integrates participatory and computational methods to design and evaluate

system-level interventions. He works with communities to build qualitative models of complex service systems to be tested in computer simulations of policy interventions. He also designs rigorous experimental and quasi-experimental studies. In particular, Dr. Fowler has extensive experience using observational and administrative data to assess child welfare and other social services using an array of counterfactual approaches, such as matching and classification, instrumental variables, differences-in-differences, directed acyclical graphs, etc. He has recently published randomized controlled trials and propensity score matched studies of child welfare interventions. Fowler's transdisciplinary team receives support from the National Institutes of Health, the National Science Foundation, Administration for Children and Families, and the Department of Housing and Urban Development. Dr. Fowler currently services as co-PI in the National Institute of Child Health and Human Development Center for Innovation in Child Maltreatment Policy, Research, and Training.

- Roles and responsibilities: Design consultation, data analysis, and system development.

Senior Advisor | Amy Dworsky, PhD

Amy Dworsky, PhD, is a Research Fellow at Chapin Hall. Her research focuses on vulnerable youth populations—including youth aging out of foster care, youth experiencing homelessness, and youth in foster care who are pregnant or parenting—and the systems in which those youth are involved. Dworsky has experience in several mixed-methods studies using both quantitative and qualitative research methods, analyzing administrative data, and partnering with public and nonprofit agencies to conduct policy and practice relevant research. Dworsky is a nationally recognized expert on pregnant and parenting youth in foster care and the children of those youth. She recently completed an evaluation of a pilot that connected pregnant and parenting youth in foster care with home visiting services. She conducted the first study of child welfare services involvement among children born to youth in foster care and has led several other studies involving youth in foster care who are pregnant or parenting. Dworsky has been working with the Illinois Department of Children and Family Services on its plan to expand home visiting services to pregnant and parenting youth in foster care and to families receiving services to prevent out-of-home care placement throughout Illinois.

Dworsky received her PhD from the University of Wisconsin-Madison's School of Social Work, and her MSW from Syracuse University.

Roles and responsibilities:

- Provide feedback on study design, processes, and methods.
- Advise on implementation and analytic strategies.
- Offer child welfare expertise to key areas of evaluation.

Senior Project Advisor | Anne Farrell, PhD

Anne Farrell, PhD, Director of Research, leads Chapin Hall's research agenda, is responsible for recruiting and mentoring talent, and contributes to the overall strategic direction of the

organization. She conducts research and policy analysis on housing and child welfare, cross-systems collaborations, family-centered services, and family and community resilience. Farrell's work as a scholar focuses on producing, disseminating, and adopting actionable findings to improve the lives of marginalized children, youth, and families. She has published numerous scholarly articles, technical reports, books, and book chapters, and leads systems change initiatives in partnership with public agencies, nonprofits, and educational institutions. Farrell's research leadership includes the design and conduct of numerous field studies of child welfare, housing, education, afterschool programs, juvenile justice initiatives, clinical interventions, and family-professional partnerships. She recently completed a five year randomized controlled trial of housing and child welfare in the state of Connecticut.

Farrell has served on the editorial board of several scholarly journals, and she is the Co-Editor-in-Chief of the *Journal of Child and Family Studies*. She frequently serves as peer reviewer and expert technical advisor for translational research projects. A Clinical and School Psychologist by training, Dr. Farrell received her MA and PhD from Hofstra University and completed internships both in Great Neck, NY Public Schools and the Institute for Rational-Emotive Behavior Therapy in New York, NY.

Roles and responsibilities:

- Provide consultation on the project around design, staffing, data analysis, system development, reporting and dissemination.

Statement of Conflict of Interest

Chapin Hall has reviewed its records to identify any actual or potential apparent conflicts of interest and has identified no such conflicts — whether personal or financial or organizational that could affect the independence or integrity of the research: including the design, conduct, and reporting of the research.

If awarded, this project will also be subject to disclosure through Chapin Hall's annual Conflict of Interest-Conflict of Commitment (COI-COC) process to disclose financial interests of the staff person or those of immediate family members that could reasonably appear to affect the design, conduct or reporting of any current research. The annual process aligns to both the University of Chicago and Federal requirements for disclosure of conflict of interest.

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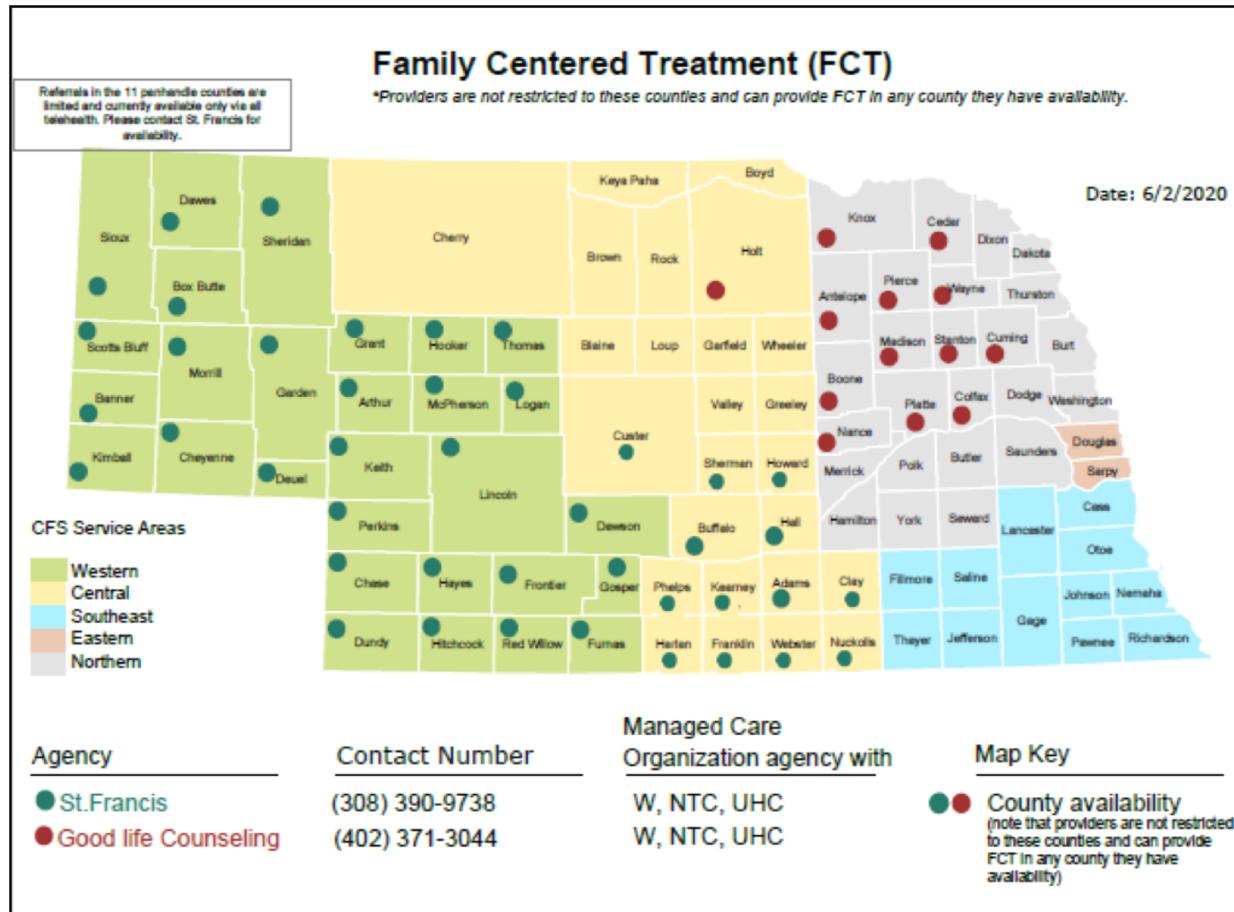
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Appendix A. Evaluation Work Plan

	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Y6 Q1
	Jan 2021	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2022	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2023	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2024	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2025	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2026
Project Start-up (6 months; 1/1/21-6/30/21)																					
Chapin Hall Project Kickoff																					
Administration																					
Refine evaluation plan																					
NE CFS review Final evaluation plan																					
Prepare and submit IRB																					
Implementation (42 months; 7/1/21-12/31/25)																					
Data Collection																					
DHHS SACWIS data download (monthly)																					
Obtain policies and procedures documentation (annual)																					
FCT - FACT and TF-CBT data downloads (bi-annual)																					
CFS Discharge summaries download/sharing (bi-annual)																					

	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Y6 Q1
	Jan 2021	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2022	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2023	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2024	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2025	Apr- Jun	Jul- Sept	Oct- Dec	Jan 2026
Interview CFS case workers																					
Data Analysis																					
Clean SACWIS data, create variables, and analyze -Year 2-4																					
Clean and analyze FCT - FACT and TF-CBT data - Year 2-4																					
Review and analyze DHHS Discharge summaries - Year 2-4																					
Code and analyze qualitative data Year 2-4																					
Bi-annual reports to NE DHHS																					
Annual report to Children's Bureau																					
Final summative analysis & draft report																					
Finalize report and submit to DHHS and CB (10/1/25-12/31/25)																					

Appendix B. FCT Provider Locations in Nebraska



Appendix C. Nebraska's Prevention Plan: Interventions, Descriptions, and Related Feature

Intervention and Description	Age/Indicators	Service Length and Dosage	Outcomes (CEBC)	Clearinghouse Rating	Fidelity
Healthy Families America (HFA): home visiting program model for families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues.	Parents of children 0-5 (must be under 2 at time of referral) I: Families who are at-risk for child abuse and neglect and other adverse childhood experiences (risk assessed by the Parent Survey)	Until child is 3, can be offered until 5 (Weekly, hour-long sessions for min. of 6 months after birth of baby)	Increased nurturing parent-child relationships, healthy child development, enhanced family functioning, increased protective factors, reduced risk	Title IV: Well-supported CEBC: Well-supported	The Parent Survey (formerly the Kempe Family Stress Checklist) or other HFA-approved tool to assess child maltreatment risk. HFA requires implementing sites to utilize the <i>HFA Best Practice Standards</i> and to demonstrate fidelity to the 153 standards through periodic accreditation site visits.
Homebuilders ®: intensive home and community-based family preservation service that enlists families in assessing, goal setting, and treatment planning to avoid unnecessary placement in foster care, group care, psychiatric facilities, or JJ facilities.	Children 0-17 and parents/caregivers I: Families with children at imminent risk of placement into, or return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice	4-6 weeks of 3 to 5 sessions per week, each lasting approx. 2 hrs (for a weekly avg. of 8-10 hrs of face-to-face contact, plus telephone contact between sessions); 2 aftercare 'booster sessions' totaling up to 5 hrs available in the 6 months following referral	Reduce child abuse and neglect; reduce family conflict; reduce child behavior problems; Teach families skills they need to prevent placement or successfully reunify with children	Title IV: Well-supported CEBC: Supported	Use of a quality enhancement system (QUEST) to provide training and maintain an internal management system of evaluation and feedback; includes review of fidelity to 20 standards at institutefamily.org/pdf/HOMEBUILDERS-Fidelity-Measures-Abridged-3.0.pdf
Functional Family Therapy (FFT): for youth who have been referred for behavioral or emotional problems by the JJ, mental health, school or child welfare systems. Address risk and protective factors within and outside of the family that impact the adolescent and their	Children 11-18 (should include caregivers/family) I: typically youth are justice-involved or at risk for delinquency, violence, substance use, or other behavioral problems such as Conduct Disorder or Oppositional Defiant Disorder	3-5 months (approx. 12-14 one-hour sessions, min. 8 and up to 30 sessions; conducted in clinical session as outpatient therapy and/or home-based setting)	Eliminated youth referral problems (e.g., delinquency, oppositional behaviors, violence, substance use), improved prosocial behaviors (e.g., school attendance), improved family	Title IV: Well-supported CEBC: Supported	<i>Weekly Supervision Checklist:</i> A clinical supervisor provides a fidelity rating on therapist adherence and competence for a particular session, up to 50 ratings per year. <i>Global Therapist Ratings:</i> Three times a year the clinical supervisor rates each therapist's overall

Intervention and Description	Age/Indicators	Service Length and Dosage	Outcomes (CEBC)	Clearinghouse Rating	Fidelity
adaptive development.			and individual skills		adherence and competence in FFT.
Motivational Interviewing (MI): sessions that enhance motivation for behavioral change in caregivers with substance abuse, dependence, or behavioral issues affecting their child's welfare. MI utilizes open-ended questions and reflections of listening statements in caregiver's own language of change to evoke confidence that change can take place (incl. potentially supporting other interventions).	Caregivers of children in the child welfare system (but has also been used on adolescents) I: Caregivers who have a specific health behavior, dependence, and/or substance abuse disorder that is leading to negative child welfare outcomes and is ambivalent about change, while choices are available that could benefit the child and/or caregiver.	1-3 individual sessions of 30-50 minutes; 2-3 sessions preferred; can be combined with other interventions, or as pretreatment	Enhance internal motivation to change; reinforce this motivation to change; develop a plan to achieve this change	Title IV: Well-supported CEBC: Well-supported	Use of <i>Motivational Interviewing Treatment Integrity (MITI)</i> instrument to provide feedback about practitioner's use of MI; the <i>MITI</i> is available at casaa.unm.edu/download/miti.pdf
Multisystemic Therapy (MST): intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues, and their families. MST reduces juvenile delinquency and antisocial behavior by addressing the core causes of such conduct—and views the client as a network of systems including family, peers, school, and neighborhood.	Children 12-17 and their caregivers I: Youth 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	3-5 months (intensive services, could be daily or weekly; therapists have small caseloads and on-call 24/7) MST-CAN lasts 6-9 months with intensive therapy addressing child abuse and neglect	Youth: Reduced behavior problems Caregiver: increased ability to address parenting difficulties and empower youth	Title IV: Well-supported CEBC: Well-supported	MST Institute (MSTI) collects and manages database of natl and intl records as specified by MSTI to ensure fidelity. These include <i>The Therapist Adherence Measure Revised (TAM-R)</i> , a 28-item measure reported by the primary caregiver of the family about the therapist, and <i>The Supervisor Adherence Measure (SAM)</i> , a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as

Intervention and Description	Age/Indicators	Service Length and Dosage	Outcomes (CEBC)	Clearinghouse Rating	Fidelity
Parent and Child Interaction Therapy (PCIT): treatment for young children with behavioral problems; treatment includes "coaching sessions" where children and parent are together in playroom while therapist is watching via one-way mirror or live footage and provides in-ear coaching to parent to improve relationship with child	Children 2-7 and their caregivers I: verbally/physically aggressive behavior at a level of intensity that is higher relative to children of the same age; behavior interferes with child's/parent's life; perhaps recent change in child's life leads to manifesting stressors in externalizing behavior; reports from teachers or supervisors of extracurricular activities that behavior is intense rel. to peers	4-5 months (approx. 12-20 sessions until parent has mastered skill sets and rates child's behavior as normal on rating scale)	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	Title IV: Well-supported CEBC: Well-supported	reported by MST therapists. Progress tracked using DPICS and ECBI, other standardized tools. The <i>Dyadic Parent-Child Interaction Coding System (DPICS-IV)</i> uses a behavioral coding system to measure the quality of parent-child social interactions, monitor progress in parenting skills and child compliance. The <i>Eyberg Child Behavior Inventory (ECBI)</i> is a 36-item parent report instrument used to assess common child behavior problems and serves as a weekly indicator of progress. The <i>Therapy Attitude Inventory (TAI)</i> is a 10-item parent-report scale of satisfaction.
Parents as Teachers (PAT): early childhood parent education and family support program providing services to improve child development and academic achievement of children in families who have one or more designated risk characteristics. Program services are characterized by four components: personal visits,	Parents/caregivers of children aged 0-5 I: Parents of a prenatal child or child yet to reach kindergarten age, and have one or more of the following characteristics: are teenage parents; are low-income; have a family history of substance abuse; have low educational attainment; have chronic health	2+ yrs of 60-min sessions at least once per month, incl. 12+ annual sessions for families with 0-1 high needs characteristics; 24+ annual visits for families with 2+ high needs characteristics; 12+ annual group connections/meetings; Annual child screening for health, hearing, vision,	Increase parent knowledge of early childhood development, improve parenting practices; provide early detection of developmental delays/health issues; prevent child abuse and neglect; increase children's school	Title IV: Well-supported CEBC: Promising	Submit annual data on fidelity in Affiliate Performance Report to PAT National Center. Participate in affiliate quality endorsement and improvement process in 4 th year of implementation and every fifth year thereafter.

Intervention and Description	Age/Indicators	Service Length and Dosage	Outcomes (CEBC)	Clearinghouse Rating	Fidelity
group connections, resource network, and child screening.	conditions which affect parents and/or child	developmental health issues.	readiness and success		
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): structured, short-term treatment that effectively improves a range of trauma-related outcomes. Also addresses affective (depressive/anxiety) cognitive, and behavioral probs and improves caregiver distress related to the child's traumatic experience, parenting skills, and supportive interactions with the child. Treatment addresses distorted or upsetting beliefs/attributions related to trauma and provides a supportive environment where children are encouraged to talk about traumatic experiences and learn skills to help cope with ordinary life stressors.	Children 3-18 + caregivers I: Youth with significant emotional or behavioral difficulties related to 1+ traumatic life events (incl complex trauma); youth do not have to meet PTSD criteria. Shown to improve PTSD symptoms, depression, anxiety symptoms, externalizing behavioral problems, sexualized behavior problems, shame, trauma-related cognitions, interpersonal trust, and social competence.	3-5 months (typically 12-16 weekly sessions, but up to 25 for complex trauma; 30-45 min separately for parent and child with weekly conjoint sessions later)	Improved PTSD, depression, anxiety symptoms; reduced behavior problems; improved adaptive functioning; improved parent skills; reduced parent distress	Title IV: Promising CEBC: Well-supported	8 steps as part of extensive training, including completion of TFCBTWeb Certification program and passing a program Knowledge-Based Test. Weekly Sessions are tracked using the <i>TF-CBT Brief Practice Checklist</i> .

FY 2019 CQI Plan Resource

Date: 2/27/2019

State/Territory Awardee: Nebraska DHHS

Part 1. Updates on Prior CQI Activities since Last Update

Awardees should discuss key CQI activities, accomplishments, challenges, and lessons learned from implementing their CQI project from September 2017 through January 2019. To complete this section of the update, consider the following questions:

1. What was your CQI Topic(s)?

Nebraska MIECHV CQI involves surveying and gaining the input of the Local Implementation Agencies (LIA), whose contribution and buy-in determines the effectiveness of the CQI approach with families. During this time period, two main topics were addressed:

- A. Percent of infants among mothers who enrolled in home visiting prenatally, who were breastfed any amount at 6 months of age; and
- B. Percent of children with a family member who reported that during a typical week s/he read, told stories and/or sang songs with their child daily.

In the CQI plan submitted for FY 2017, N-MIECHV intended to address the percent of children who received the last recommended well child visit based on the American Academy of Pediatrics schedule. What was discovered was:

- N-MIECHV was not capturing this construct appropriately. When changes were made to the process and how it was measured, the significance of the number was much less than previously thought. It was no longer a priority.
- The data recognized by the LIAs as having the most significance to their own programs did not include well child visits, and N-MIECHV chose to approach CQI in a manner that focused on the needs of the LIAs.

It is still our intention to address the percentage of well child visits in the future.

In 2016, the CQI state topic was adjustments to the new benchmark plan, and included the ongoing topics of breastfeeding and well child visits among others. During this time, development and implementation of the *Home Safety Checklist* and other educational materials occurred, in collaboration with the Nebraska Safe Kids Program.

In 2017, the state CQI project revolved around smoking cessation referrals. Referral rates increased after education and training in the utilization of the FamilyWise case management system referral categories. Also development and implementation of the *Safe Sleep* materials was completed in collaboration with the Maternal-Infant Health Program.

In 2018, Nebraska MIECHV customized the methodology of Continuous Quality Improvement by implementing a Community of Practice and including the input and education pieces by involving the LIAs directly and establishing a network of resources among them. Topics included:

- A. Continuing education to increase breastfeeding rates among parents;

- B. Education and the increase of literacy skills among parents;
- C. Education and reduction of screen time/media for target children and siblings;
- D. Improve the consistent and correct use of the CHEERS Parent/Child Interaction tool;
- E. Prevention of Abusive Head Trauma (development and implementation of: *1, 2, 3 Don't Shake Me* and *The Crying Plan* in collaboration with the Maternal-Infant Health Program and both the Infant Mortality and Child Safety COIINs); and
- F. Increasing the number and appropriate documentation of individual family referrals based on their needs.

2. What was your SMART Aim(s)?

The SMART Aim's listed below were taken directly from the LIA's documentation of CQI efforts submitted to the N-MIECHV program. **Note: During FY 2018, one of the LIAs was going through a significant challenging time with transition in management and complications in staff performance, so was excused from actively participating in state CQI projects. HRSA was made aware of the challenges, improvement processes and the outcomes.

Performance Measure Related CQI Projects:

Breastfeeding: By November 30, 2018, the *increase of women initiating breastfeeding in the current cohort reflecting FY 2017 to FY 2018, will be greater than the 6% gain from 2015 to 2016.*

In a CQI project started in 2015, the percentage of women initiating breast feeding increased from 79% to 85% in 2016. In the 2017 – 2018 cohort, greater education to both the home visitor in support, and to the new mothers will reflect an even greater gain.

The LIA is utilizing a long-range plan, over a period of 15 months (allowing 9 months for pregnancy then looking at (any amount of) breastfeeding when the baby is 6 months old) that includes the creation of a “dashboard” in order to track progress. This will include documentation of several strategies to improve the rates: to provide staff with education and training in breastfeeding support; to normalize breastfeeding with new mothers by not mentioning bottle-feeding unless initiated by the parent; to utilize pamphlets and videos with mothers during every home visit; to take advantage of help and support from Certified Lactation Consultants on staff; and to track all efforts on the dashboard and review with supervisor regularly. . .

Literacy: *By 12/31/17, at least 75% of active families who have a home visit during the quarter will report (at least once during the quarter) that they read, sang, or told stories to the target child at least “5”, “6”, or “7” times within the previous 7 days. This began in FY 2017 and was carried into FY 2018. . .*

Programming Related CQI Projects:

Screen time/media and children:

By March 31, 2018, 85% of all active families who receive a home visit will have received education (at least 1x) regarding screen time/media and children. Education will include, but is not limited to, healthy media use with infants & toddlers and the effects of extended screen time on infant/toddler development. . .

CHEERS Parent/Child Interaction tool:

The percentage of completed CHEERS documentation will be in accordance with the 2018-2022 HFA standards as of November 2018. EHS data indicating current percentage of completed CHEERS documentation will be used as a baseline with an expected increase to 100% once new process is in

place. Over a 15 month period (October 2016-December 2017), average documentation opportunities per month was 278.13. Of those opportunities, all six domains of CHEERS were documented 6% of the time. .

CHEERS- 2nd program site:

By December 31, 2018, 75% of all visits completed for the selected families will be planned using the previous visit's Cheers. .

Prevention of Abusive Head Trauma:

By September 30, 2018, 85% of all families pregnant or with a child under 1 year of age will receive education about the Period of Purple Crying or The CRYing Plan (documented on The Crying Plan Evaluation Survey) to improve awareness of Abusive Head Trauma/Shaken Baby Syndrome and to be prepared in times of high stress. .

Referrals:

By June 30, 2018, 75% of all active families will get at minimum one referral each month (documented in Family Wise on Tab 3 of the home visit narrative, on the referral drop down, and on monthly IFSPs) to improve connection to the community and meet some of the needs of families.

3. Did you meet your SMART Aim(s)?

Performance Measure Related CQI Projects:

- A. Literacy: There were 87% of active families who have a home visit during the quarter will report (at least once during the quarter) that they read, sang, or told stories to the target child at least "5", "6", or "7" times within the previous 7 days. This *exceeded* the goal of 75% and was a great success. Methods reported as successful: asking consistently at each or every other home visit, bringing in board books and modelling appropriate behavior, teaching simple rhymes and songs, and using HFA reflective strategies to encourage reading and singing daily.
- B. Breastfeeding: The dashboard was created and implemented to track breastfeeding initiation and continuation rates, as well as house educational material and breastfeeding conversation checklists. Home visitors were surveyed in June, 2018 on the use and ease of the dashboard. Most of those who answered felt that the dashboard was useful and some gave suggestions of things to add. Analysis of the November 30, 2018 data has not yet been reported.
- C. Well Child Visits: There was no progress made in this area because this CQI project was deferred until FY 2019. After reviewing our data process for this topic we concluded that we were not capturing this construct appropriately. When we changed how it was captured the number of well child visits increased significantly so it was decided to defer this CQI topic until FY 2019.

Programming Related CQI Projects:

- D. Screen time/media and children: Low-to-moderate success, as 68% of active families received screen time education. However there was progress made within families: one

family actually moved the TV out of the living room for a few weeks to be able to interact with the child better without the TV as a distraction.

E. CHEERS Parent/Child Interaction tool:

- a. 1st site: Survey results showed an increase in all aspects of comfort level and confidence in using the new charting system. Supervisors then pulled samples of all home visitor CHEERS using the new system and reported 100% compliance with the new HFA standards.
- b. 2nd site: Low-to-moderate success; LIA will modify and restart in order to get the home visitors to form good habits of planning based on CHEERS.

F. Prevention of Abusive Head Trauma: The SMART goal was exceeded- 95% of families received *The CRYing Plan* education.

G. Referrals: The SMART goal was met and by June 2018 100% of families got a minimum of 1 referral each month.

4. What progress can you report from the CQI project? Examples of progress that you might describe include:

a. Organizational systems and supports for CQI – e.g., expanding staff time to support local teams, providing ongoing training and coaching in advanced CQI methods, providing opportunities for peer-to-peer learning, etc.

The Community of Practice on CQI held on monthly Open Mic calls has shown success. Each of the LIAs are assigned a date where they prepare two topics: CQI projects and progress and an innovation, guest speaker, or example of exemplary implementation of the Best Practice Standards. N-MIECHV has seen an increase in participation at the direct service level—more home visitors in the programs are involved with CQI projects. On-going training is provided during the calls, on annual site visits, and included in on-boarding of new home visitors.

b. Engagement of families in CQI efforts

CQI for the LIAs has always involved families when trying new methods and in implementation. The advisory committees have low participation from invited families, but they are always invited. At this time, there is no direct engagement of families in CQI projects, however the LIAs are open to the idea for the future.

c. Successful changes or interventions that were tested using CQI methods, such as Plan-Do-Study-Act cycles – e.g., a policy to support maternal depression screening, home visitor training modules for infant feeding and lactation, etc.

d. Methods and tools to support CQI work – e.g., process mapping to assist teams with prioritizing areas for improvement, Plan-Do-Study-Act template to help teams formulate efficient and well-planned tests of change, etc.

The LIAs primarily use an N-MIECHV-developed PDSA tool for reporting CQI projects. Please see Attachment 1.

e. Measurement and data collection processes – e.g., development of short-term measures to assist teams with tracking 90-day goals, tracking forms to capture data on improvement, local data systems to collect variables in an appropriately frequent manner, etc.

Supervisors/Program managers have access to many different reports within their case management system to be help to track data for CQI efforts. If the project they are engaging in requires additional information they reach out to the N-MIECHV data team members and are given appropriate timely data, as well as technical assistance.

f. Monitoring and assessing progress – e.g., regular reviews of data reports to monitor change by local teams, using lessons learned from CQI work to guide decision-making, etc.

The LIA's receive quarterly performance reports which are reviewed regularly with the N-MIECHV staff and are used for programming decisions.

5. Did you encounter challenges in the implementation of your CQI project (e.g., provision of organizational systems and support, engagement of families in CQI work, testing changes or interventions, using methods and tools, developing and implementing measurement and data collection, monitoring and assessing progress, etc.)?

The best-laid CQI plans do not always pan out the way it was intended. Families may not be open to change, or may not see the relevance of going over something again and again. For example:

- although the plan with increasing literacy rates with families did very well overall, challenges identified included: families didn't like the potential "mess" the activity book bags left behind; families would tell the home visitor what they thought she wanted to hear, and may not have been entirely truthful; some parents were not comfortable reading to their child, and did not seem open to change, even after six months; and staff reporting that they and their families were getting "burned out" on the literacy/reading/singing topic.
- In the project surrounding the reduction of screen time, the project went much as the LIA expected: they predicted that "families would be open to hearing about screen time, but may not be ready or willing to change. Many families didn't see the time spent in front of a screen as an issue." In those cases, the home visitors were able to "focus on the content of what they were watching."
- LIAs have encountered times when the plan did not go as predicted, or that had to be re-evaluated at the conclusion, such as with the prevention of Abusive Head Trauma and implementation of The CRYing Plan: "Doing the education, the first time- parents were responsive. However, families lost interest the second and third time the material was discussed. We noticed families did not post their CRY plans. If the parents already saw the video at the hospital, they did not want to see it again." This LIA determined that the best time to educate and introduce The CRYing Plan was prenatally or right after birth. They re-evaluated their plans and decided that they would introduce it with prenatal families, and follow up once after birth.
- The breastfeeding project required a greater length of time to collect data and see any kind of progress. The dashboard developed and the data collected must be shared deliberately with the N-MIECHV team (the State does not have access to the case management system as with the other LIAs) and after so much time goes by, staff doesn't always remember to share or to ask.

An unexpected challenge for the N-MIECHV team was the administrative and programmatic "road blocks" in the 3rd LIA that prevented them from formal CQI projects in FY 2018. A serious issue was brought forward within the staffing component that required intervention, an improvement plan, and the return of federal MIECHV funds. The hire of a new program manager, the "healing" of the home visiting team, the resolution of legal matters, and the hire of new home visitors to fill the positions, all with making sure the families were being personally attended to minimize disruptions, took precedence over formal CQI reports. The LIA was gathering and using all available data to make informed decisions and programmatic changes, but were given the time and space needed to attend to more pressing matters. The HRSA Project Officer was informed and kept up to date on all

activities, and it has now been successfully resolved. N-MIECHV has communicated with the program manager and supervisor about re-starting projects in FY 2019.

6. Did you engage support from technical assistance providers (e.g., specialized coaching, training or sharing of resources) or participate in quality improvement learning opportunities or special initiatives (e.g., HV COIN or CQI Practicum) for the purposes of improving practices and methods related to CQI?

The Nebraska CQI team participated in the second round of the CQI Practicum. Due to unforeseen circumstances LIA participation was not possible during this practicum. The Nebraska team still participated for the learning experience. During the practicum many different CQI tools were utilized and explained in depth. The team was able to bring back this knowledge and share it with the LIA's.

N-MIECHV also worked with the Maternal-Infant Health and Nebraska Safe Kids programs to develop and pilot new tools that are shared across the State home visiting network as well as the greater national MIECHV network. That work also served as Nebraska projects in the Infant Mortality COIN and the Child Safety COIN.

7. What are you doing to sustain the gains from your CQI project (e.g., integrating new processes into staff training, updating agency protocols, ongoing monitoring of data, etc.)?

As described, many of the CQI projects span over a longer period of time than just a quarter. The Healthy Families America Best Practice Standards are always being reviewed and updated. As Re-Accreditation of the model occurs every three years, the LIAs are constantly reviewing their own processes, policy and procedures to ensure fidelity to an evolving landscape. In order to sustain gains from the projects, N-MIECHV and the LIAs will continue to monitor the data on a regular basis, and touch base often and consistently. LIA Supervisors/Managers have access to their data and can run reports to monitor progress in real-time. N-MIECHV is taking on a greater role in analysis of the raw data and will be aware of swings in performance. All performance data is discussed with LIA program managers/supervisors on a quarterly basis, and the N-MIECHV team is available at any time to answer questions, offer training or help brainstorm ideas.

8. To what extent, if any, did you spread the lessons learned from your CQI project? What opportunities did you have to spread successful CQI activities beyond the original sites? Please share any resources electronically that were used to disseminate results.

CQI processes, projects and results are shared within the N-MIECHV network, including not only the MIECHV-funded sites, but the state-funded sites as well. Tools developed, such as with the *Home Safety Checklist*, and the Prevention of Abusive Head Trauma materials including *The CRYing Plan*, are being put into a "toolkit" being developed for dissemination to all the Nebraska home visiting partners/programs at the state level, such as Head Start, the Buffet Early Childhood Institute, Project

Harmony, and Sixpence. (The toolkit is still being developed.) Those tools will be shared within the MIECHV federal network of states and territories as well.

9 What lessons learned will you apply to your FY 2019 CQI plan?

The Nebraska MIECHV team has been focusing on creating a network of well-trained, thoughtful and innovative home visiting sites. When the program has the support it needs, the training, and the experience, families are served well. N-MIECHV receives this support from HRSA and in turn guides the LIAs to improved outcomes.

Each LIA has unique CQI needs, some sites are more seasoned than others in the CQI process. The role of the N-MIECHV team is to help guide the LIA's in the right direction during the whole CQI process. Open communication is encouraged between the LIA's, the program manager and the health surveillance specialist. This communication can take place in phone calls, email or in person. The Program Manager and Health Surveillance Specialist are available to travel to sites to do a refresher on CQI at annual site visits and as requested. By creating a *network* of experts, there is reliance on themselves and the other sites for support, answers, ideas, and innovation. Just as relationships are key in the work of home visiting, by creating this interconnected web of professionals, the relationships between sites across the state create sustainability and spread of best practices. N-MIECHV ensures guidance, support in training and professional development opportunities as well as providing opportunities for the network to meet face to face at least annually. It is a process improvement of the N-MIECHV program overall.

The Community of Practice within the N-MIECHV network has worked very well. N-MIECHV has seen gains in confidence in CQI processes, sharing of ideas and the use of tools such as the fishbone diagrams or "5 Whys," seeing that each site has the same expectations and reporting requirements, utilizing and reaching out to each other for different expertise within the network, plus the advantage of each site being responsible for content and discussion topics on a rotating basis. N-MIECHV is moving forward by adding a webinar format to the Open Mic calls to increase engagement.

In FY 2019 N-MIECHV will be adding a CQI educational component to the Open Mic calls at least twice a year. These webinars would be presented to the LIA's on an Open Mic call in an online format. The webinar content will be based off the modules that were created by James Bell Associates in the new CQI toolkit. . These webinars will be interactive and allow the sites to ask questions and provide feedback to better tailor upcoming webinar's that are presented.

10 What successful innovations, tested during the course of your project, could be shared with other awardees?

Statewide innovations include , utilization of the Community of Practice within the network. Other innovations include the *Home Safety Checklist*, the prevention of Abusive Head Trauma materials, including *The CRYing Plan* and the *1-2-3 Don't Shake Me* video and training modules could be shared within the network.

Successful innovations related to increasing literacy include home visitors teaching parent's simple rhymes and songs they can sing and tell to their children. Home Visitors also, use HFA reflective strategies to encourage reading and singing daily to children. The combination of these innovations helped this particular LIA to exceed their SMART AIM by 16%.

11. The following continuum¹¹Adapted from Design Options for Home Visiting Evaluation, *Suggested Guidelines for Continuous Quality Improvement for MIECHV Grantees*, (June 2011) can help you assess your organization's current CQI capacity, with higher stages indicating greater CQI capacity. For each stage listed below, check all elements that apply, and rate your organization on a scale of 1 to 3 with:

- 1- no or few elements currently in place;
- 2- most elements currently in place; or
- 3- all elements currently in place.

Stage 1: Basic Data Collection and Report Usage

- ✓ A culture of quality exists in the organization whereby data are valued and striving for process improvement and optimal outcomes is a shared vision of all members including both front-line staff and management.
- ✓ Data collection is sufficient to document benchmarks and facilitate CQI.
- ✓ Management Information Systems (MIS) are sufficient to allow for collection and storage of required performance measures.
Reports are produced on a regular basis and reflect important aspects of service provision (processes) and outcomes.
- ✓ Reports are used by key stakeholders to track performance and outcomes.
- ✓ Staff are trained in the basic concepts of quality improvement.

Stage 1 Assessment (1 – 3): 3

Stage 2: More Advanced Reporting and Systematic Improvement Efforts

- ✓ Data collection is expanded to cover a wider range of outcomes and service delivery elements.
MIS are larger, more flexible, and serve multiple purposes.
Reports are produced on a regular basis and are used to inform decisions at all levels of the organization.

- ✓ Deep understanding of processes and outcomes is achieved through systematic inquiry.
- ✓ New strategies and approaches are systematically tested and evaluated.
- Effective strategies and approaches are disseminated throughout the organization and monitored.
- ✓ Staff receive ongoing training and coaching.

Stage 2 Assessment (1-3): 2

Stage 3: Additional elements of quality improvement are integral to day to day work, such as critical incident monitoring

- Dedicated professional CQI staff are part of the team.
- Experimental tests of change are implemented.
- ✓ Constant efforts to accelerate improvement.
- Home visiting families are engaged in CQI efforts.
- ✓ Regular opportunities exist for peer-to-peer learning.

Stage 3 Assessment (1-3): 2

Part 2. CQI Plan Updates for FY 2019

Organizational System and Support

Awardee or Recipient Level

1. *Will modifications to state/territory level personnel assigned to CQI teams be made for FY 2019?*
No we do not anticipate any changes to CQI teams.
2. *In FY 2019, will you make modifications to the method and/or frequency of CQI trainings you provide to local teams? This may include training to strengthen CQI competencies or to understand and interpret data collected for CQI projects.*
N-MIECHV anticipates the same level of frequency in the continuation of the Community of Practice on a monthly basis. As more of the data quality and “cleaning” is put to the LIAs’ responsibility, there will be frequent follow-up or additional training as identified.

One of the goals of the FY 2019 CQI plan will focus on developing a refresher training in CQI in collaboration with HRSA, James Bell Associates and HV-IMPACT. The hope is to deliver this training at the upcoming Recharge for Resilience Conference in October. The target audience has not 100% been decided. Most likely this refresher will be targeted to program managers and supervisors although inviting home visitors may also be considered. This refresher will address the overall CQI process and also focus on showing the LIA’s how to do CQI on a much smaller scale than they currently do. Examples of CQI projects on small scale will be shared with the group so they can get a better understanding. After this refresher training is delivered the N-MIECHV team will follow-up with individual LIA training as appropriate.

3. *Will you make changes in the level of financial support (e.g. allocation of resources and staff time at the state/territory level and allocation of state time) for CQI in FY 2019?*
There is no plans to do so.

4. *Describe how you will engage with technical assistance providers for the purpose of improving agency level practices and methods in FY 2019 (e.g. HV-PM, HV CollN 2.0, HV-Impact, etc).*
N-MIECHV will continue to maintain a productive and valuable working relationship with our TA providers. The technical assistance plan has been submitted and approved by our HRSA Project Officer, and in collaboration with HV ImpACT, we are moving forward on those projects.

Local Level

Consider the items below to address the following FY 2018 FOA requirements:

1. *Describe the extent to which home visiting clients will be involved in CQI teams.*
CQI for the LIAs has always involved families when trying new methods and in implementation. The advisory committees have low participation from invited families, but they are always invited. At this time, there is no direct engagement of families in CQI projects, however the LIAs are open to the idea for the future.
2. *Describe the extent to which local implementing agency (LIA) management will support direct involvement in CQI activities and allocation of staff time (for those LIA's participating in CQI efforts).*
All of the LIAs are directly involved in CQI efforts. As part of the model and the MIECHV program requirements, staff time is allowable and allocable.
3. *Have modifications been made to financial support for CQI, including allocation of resources and staff time at the LIA level?*
CQI expectations of quarterly projects are a regular part of the N-MIECHV program, regardless of federal or state funding. There are no modifications expected.
4. *Will topic(s) of focus for each LIA participating in CQI change from your FY18 CQI plan?*
All of the LIAs will continue to decide on CQI projects that are most relevant for them and submit quarterly reports to N-MIECHV. In addition, each LIA will participate in state CQI projects.
 - A. Well Child Visits
After reviewing performance measurement data, it was discovered that although well child visits for FY 2018 were approximately 81%, there is still room for improvement. For FY 2019 the first quarter (10/1/2018-12/31/2018) data for well child visits is at 80%. Strategies and brainstorming with the LIAs is scheduled.

Goals and Objectives

5. *Will LIA's modify current SMART Aim(s) for the CQI projects underway for FY 2019?*
It is unlikely that modifications to AIM statements in projects already underway will be made beyond timing of measurement. A more accurate assessment will be made toward the end of each project.

Changes to Be Tested

6. *What changes will teams test out to achieve the goals and objectives of the CQI projects? If your changes need further input and development, describe how you will accomplish that.*

Specific changes that will be tested have not been identified yet. How these might be identified:

- A. In the CQI practicum that Nebraska participated in, it was discovered that Hawaii completed a CQI project on the increase of well child visits. Partners in the Hawaii MIECHV program have agreed to a discussion of methodology and results.
- B. HV ImpACT (the TA providers for the MIECHV programs) has approved an annual technical assistance request update from N-MIECHV. TA is provided in several different ways: identifying research articles of interest, identifying conference presentation materials that are relevant, identifying other states that have worked within the same parameters and making the connection with them, providing web-based education, and regular conference calls to monitor progress.
- C. N-MIECHV team members' work on other program advisory boards, meeting schedules, work groups, etc. that is brought back to the team for discussion. Innovations and lessons learned, as well as resources can identify areas of change that is possible.

Methods and Tools

7. *Identify the CQI tools below that will be utilized by LIA teams in FY 2019 in the optional table format on page 8 or in a discussion in the text.*

- Charter that outlines the scope of the CQI project
- Key driver diagram that displays the theory of change underlying the improvement efforts
- Fishbone diagrams
- Root-cause analysis
- Process mapping or flow charts
- Data graphs such as frequency plots, run charts, and Pareto charts.
- Other, please describe:

8. *Identify the methods below that will be utilized by LIA teams in FY 2019 in the optional table format on page 8 or in a discussion in the text.*

- Plan-Do-Study-Act: the sites have a PDSA template that they fill out and submit to N-MIECHV staff at a minimum of quarterly. Please see Attachment 1 for the template.
- Six Sigma
- FADE
- Model for Improvement
- Other, please describe:

Measurement and Data Collection

9. *Will you make changes in CQI data systems at the local level, including plans for how CQI data will be collected in an appropriately frequent manner (e.g. monthly) in FY 2019*

There is no plan to do so.

- 10. Will you make changes in the mechanisms available to QI teams and home visitors at the local level to track progress, determine if change ideas tested result in improvement, identify the need for course corrections, and use data to drive decision making in FY 2019?*
- There is no plan to do so.

Modified SMART Aim	Method(s) Tool(s)	Data Collection	Data Review and Interpretation
By June 30, 2019, there will be a 6% increase from 81% to 86% in the number of enrolled children who have their most recent well child visit following AAP guidelines.	<p>Methods: LIA's will use PDSA cycles to test changes. A flow chart of data collection will be included in the PDSA. Please see Attachment 1: PDSA worksheet that each LIA will complete unique to their agency and data.</p> <p>Tools: Brainstorming , problem solving and process maps</p>	All the sites will receive data from the N-MIECHV data team at least quarterly on their progress made towards Well Child Visits in the form of a benchmark report. The sites also have the ability to pull reports in FamilyWise on a regular basis to look at Well-child visit data.	<p>The data team will review the performance data with the LIA's and identify strengths and areas of potential improvement.</p> <p>At a minimum of monthly the supervisors and home visitors at the LIA's should have a meeting about data. During these meetings the staff should talk about areas and methods they can use to show improvement. This could include data collection practices or documentation of the data.</p>

Sustaining the Gains

- 11. Describe strategies to be used at the awardee and local levels to sustain the gains after the CQI project has ended (e.g., integrating new processes into staff training, updating agency protocols, ongoing monitoring of data, etc.)*

When a CQI project has a successful outcome, or produces the desired result, in one or more small application, implementation and training across the program site is the next step. Policy and procedures are either updated or developed to ensure the strategies remain in place for purposes of on-boarding, review training, or meeting HFA Accreditation standards. The LIA will report on the project to N-MIECHV and the shared network; the processes they used and the outcomes, as well as be open to discussion on how others might implement the same changes.

Communication

12. *Describe plans to work with LIA's to identify lessons learned and spread successful CQI activities beyond the original LIA's.*

As described above, sharing topics, methods, outcomes and duplication assistance in the network Open Mic calls is now common practice.

ATTACHMENT 1: PDSA Worksheet

PDSA WORKSHEET

Aim Statement:

By _____, _____ of _____ will _____
(when) (#, % or % change) (who or what) (what result, change, benefit)

(Example: By December 31st 2015, 94% of post-partum mothers will be screened with the CES-D Screening, which will improve referrals for mental health services)

Plan: Identify who, what and why, and changes

1. Please document the work flow for this project; attach if possible (Process Map).
2. Brainstorm Ideas (Please provide a short list of potential changes/improvements that were brainstormed by your team).
3. List potential barriers.

Do: Try change.

1. The project chosen is _____
2. Who will try to do the change/improvement?
3. How will the project be carried out?
4. When will it happen?
Start Date:
Finish Date:

Study: Results: What happened?

1. Did the project turn out the way you thought? Please explain briefly.
2. What change did you see?

3. How can you tell if a change happened (measurement)?

Act:

- Implement Plan
- Modify Plan & Start Again
- Create and Start New Project

1. If you choose to implement this plan. How will you implement program wide?
2. If you do not implement the plan what are your next steps.

Nebraska MIECHV- Constructs and Measures

Benchmark I. Maternal and Newborn Health

Construct	Measurement Tool	Indicator	Population Assessed	Numerator	Denominator	Timing of Data Collection
1. Preterm Birth	N/A	(Systems Outcome) Percent of infants (among mothers who enrolled prenatally before the 37 th week) who are born preterm following program enrollment.	Target women enrolled prenatally before the 37 th week of gestation.	Number of live births among mothers who enrolled prenatally before the 37 th week) born before 37 completed weeks of gestation and after enrollment	Number of live births after enrollment who were born to mothers enrolled in home visiting prenatally before the 37 th week.	At Birth
2. Breastfeeding	N/A	(Systems Outcome) Percent of infants (among mothers who enrolled in HV prenatally) who were breastfed any amount at 6 months of age	All target children enrolled prenatally	Number of infants aged 6-12 months whose mother enrolled prenatally who were breastfed any amount at 6 months of age.	Number of infants aged 6-12 months whose mothers enrolled prenatally and have been enrolled for at least 6 months	Home Visit after baby turns 6 months
3. Depression Screening	Center for Epidemiological Studies Depression scale (CES-D)	Percent of primary caregivers who are screened for depression using a validated tool within 3 months of enrollment (for those enrolled prenatally) or within 3 months of delivery (for those enrolled postpartum)	All Primary Caregivers	For those enrolled <u>postpartum</u> , number of primary caregivers enrolled who are screened for depression within the first three months since enrollment ; for those enrolled <u>prenatally</u> , the number of primary caregivers screened for depression within 3 months of delivery.	For those enrolled <u>postpartum</u> the number of primary caregivers enrolled for at least 3 months; for those enrolled <u>prenatally</u> , the number of primary caregivers enrolled for at least three months post-delivery.	3 months postpartum for those enrolled <u>prenatally</u> 3 months post enrollment for those enrolled <u>postpartum</u>
4. Well Child Visit	N/A	Percent of children who received the last recommended well child visit based on the American Academy of Pediatrics (AAP) schedule.	All target children	Number of children who received the last recommended well child visit based on the following AAP schedule. 3-7 Days, 2-4 Weeks 2-3 Months, 4-5 Months 6-7 Months, 9-10 Months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5 years	Number of children enrolled.	Point in time 3-7 Days, 2-4 Weeks 2-3 Months, 4-5 Months 6-7 Months, 9-10 Months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5 years
5. Postpartum Care	N/A	Percent of mothers enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.	All target women	Number of mothers enrolled prenatally or within 30 after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery.	Number of mothers who enrolled prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery	8 weeks post-partum
6. Tobacco Cessation Referrals	N/A	Percent of primary caregivers who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months of enrollment.	All Primary Caregivers	Number of primary caregivers who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within 3 months.	Number of primary caregivers who reported using tobacco or cigarettes at enrollment and were enrolled for at least 3 months.	3 months post-enrollment
7. Safe Sleep	N/A	Percent of infants that are always placed to sleep on their backs, without bed-sharing or soft-bedding	All target children up to a year.	Number of infants aged less than 1 year whose primary caregiver report that they are always placed to sleep on their backs, without bed-sharing or soft-bedding	Number of infants who were aged less than 1 year during the reporting period.	Annually between birth and 12 months.

Benchmark II. Child Injuries, Abuse, Neglect, and Maltreatment and Emergency Department Visits

8. Child Injury	N/A	(Systems Outcome) Rate of injury-related visits to the Emergency Department (ED) among children.	All target children	Number of parent-reported nonfatal injury-related visits to the ED.	Number of children enrolled.	Ongoing
9. Child Maltreatment	N/A	(Systems Outcome) Percent of children with at least 1 investigated case of maltreatment within the reporting period.	All target children	Number of children with at least 1 investigated case of maltreatment.	Number of children enrolled	Ongoing

Benchmark III. School Readiness and Achievement

10. Parent-Child Interaction	CHEERS Check in Tool (CCI)	Percent of primary caregivers who receive an observation of caregiver child interaction by the home visitor using a validated tool.	All Primary Caregivers	Number of primary caregivers who receive an observation of caregiver-child interaction by the home visitor using a validated tool.	Number of primary caregivers with children reaching the target age range.	(child reaches) 4-12 months (child reaches) 13-24 months (child reaches) 25-36 months
11. Early Language and Literacy Activities	N/A	Percent of children with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily every day.	All target children	Number of children with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily every day.	Number of children enrolled	Monthly after birth.
12 Developmental Screening	Ages & Stages 3 (ASQ-3)	Percent of children with a timely screen for developmental delays using a validated parent-completed tool.	Target children aged 9-30 months.	Number of children with at least one screening within the AAP-defined age groups during the reporting period.	Number of children reaching the specified time frame during the reporting period.	9 months, 18 months, and 24 or 30 months
13 Behavioral Concerns	N/A	Percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning.	All target children	Number of postnatal Home Visits primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning	Total number of postnatal home visits during the reporting period.	Every postnatal home visit

Benchmark IV. Crime or Domestic Violence

14. IPV Screening	3 question tool	Percent of primary caregivers enrolled who are screened for IPV within 3 months of enrollment using a validated tool.	All primary caregivers	Number of primary caregivers who are screened for IPV using a validated tool within 3 months of enrollment	Number of primary caregivers enrolled for at least 6 months	3 months post-enrollment
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Benchmark V. Family Economic Self Sufficiency

15. Primary Caregiver Education	N/A	(Systems Outcome) Percent of primary caregivers who enrolled without a high school (HS) degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed HS or equivalent during their participation	All primary caregivers	Number of primary caregivers who enrolled in, maintained continuous enrollment in, or completed a high school degree or equivalent after enrollment into HV (and met the conditions specified in the denominator)	Number of primary caregivers without a high school degree or equivalent at enrollment	At enrollment and annually.
16. Continuity of Insurance Coverage	N/A	(Systems Outcome) Percent of primary caregivers who had continuous health insurance coverage for at least 6 consecutive months	All primary caregivers	Number of primary caregivers who reported having continuous health insurance coverage for at least 6 consecutive months during the reporting period.	Number of primary caregivers enrolled for at least 6-months	Monthly

Benchmark VI Coordination and Referrals for other community resources and supports

17. Completed Depression Referrals	N/A	Percent of primary caregivers referred to services for a positive screen for depression measure 3 who receive one or more service contacts.	All primary caregivers	Number of primary caregivers who screened positive for depression in measure 3 who received a referral.	Number of primary caregivers who screened positive for depression in measure 3.	90 Days after screening positive
18. Completed Developmental Referrals	N/A	Percent of children with positive screens for developmental delays measure 12.	All target children	Number of children who screened positive for developmental delay in measure 12 who received a referral.	Number of children who screened positive for developmental delay in measure 12.	30 Days-Community Services
						45 Days-Early Intervention Services
19. Intimate Partner Violence Referrals	N/A	Percent of primary caregivers with positive screens for IPV measure 14 who receive referral information to IPV resources	All primary caregivers	Number of primary caregivers who screened positive for IPV in measure 14 who received a referral.	Number of primary caregivers who screened positive for IPV in measure 14.	90 Days after screening positive

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 1 of 7

Purpose: Provide instructions for DCFS case managers regarding requirements for mandatory monthly contacts with children, parents and out of home care providers.

Scope: Division of Children and Family Services Protection and Safety

Responsibilities: Child and Family Services Specialists

Definitions:

Out of Home Care Provider: Any adult providing care for a child other than the parent(s). This can include relatives, kinship placement, foster parents, group home staff, PRTF staff, adult caregiver(s) in an informal living arrangement, etc. If a youth is placed in Independent Living or with a legal parent, they do not have an out of home care provider.

Procedure:

1. Who will Conduct the Visit?

- A. The assigned CFS Specialist or DCFS contractor for case management (hereafter CFS Specialist) will conduct the visit. On rare occasions, a different CFS Specialist, the CFS Supervisor, DCFS contractor for case management or Resource Development worker may conduct the visit.
- B. When multiple children are placed in a facility such as a group home or residential treatment facility, DCFS can designate one or more CFS Specialists to make the monthly visit to a number of children and report individually to each child's CFS Specialist. In all situations, it remains the responsibility of the assigned CFS Specialist to ensure that the visits are made and appropriately documented on N-FOCUS in the Required Contacts narrative.
- C. Wards placed out-of-state may have a person designated in the other state to conduct the visit. Such individuals may be staff of a private agency with a contract with Nebraska for the service or a courtesy case manager assigned by the other state under Interstate Compact for the Placement of Children (ICPC) or Interstate Compact for Juveniles (ICJ).
 - 1. The CFS Specialist will not visit a child in another state without first notifying the Nebraska ICPC Office in DCFS Central Office to determine if the other state allows Nebraska staff to conduct visits in the other state.

2. Visitation with Children:

- A. Placed In-Home: The CFS Specialist will have face-to-face contact with all children in the home, regardless of whether the child is a DHHS ward or Non-ward.
- B. Placed Out-of-Home: The CFS Specialist will have face-to-face contact with all children placed out of the home as well as any other children remaining in the family home, regardless of whether or not the other children in the family home are DHHS wards or Non-wards.
- C. All children placed in Nebraska under the auspices of the Interstate Compact on Placement of Children (ICPC) or Interstate Compact on Juveniles (ICJ) in non-facility placements.
- D. When a parent chooses to prohibit the CFS Specialist from having contact with the non-ward minor siblings of state wards, the CFS Specialist will document and discuss this with their

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 2 of 7

supervisor. The CFS Specialist and supervisor will discuss alternative ways to engage the parent to allow access.

- E. For a child living outside the Service Area or local office area, a courtesy case manager in the area where the child resides can, upon request, be assigned to conduct the monthly visit.
- F. All visits with children must occur in the home where they reside. When a visit cannot occur in the home, the CFS Specialist must obtain approval from their supervisor and document the approval in Consultation Point narrative.
- G. If the child cannot be located at his or her residence, the CFS Specialist will notify his or her supervisor immediately in writing, by phone or other electronic means. For youth missing from placement, the CFS Specialist will follow the procedure for reporting a youth that is missing from care, as outlined in the program guidance on "Youth Who Cannot Be Located" #29-2017.
- H. The frequency of face-to-face contact is based on the SDM risk levels.
 - 1. In Home Cases
 - a. Low or Moderate Risk – One face-to-face contact per month.
 - b. High or Very High Risk – Two face-to-face contacts per month.
 - 2. Out-of home Cases
 - a. Low or Moderate Risk – One face-to-face contact per month.
 - b. High or Very High Risk – Two face-to-face contacts per month. One of the two contacts may be made by the agency supported foster care worker or Resource Development worker assigned to the specific child.
- I. With supervisory approval, when more than one contact per month is required, one contact can be via SKYPE, phone call, text or other electronic means if an in-person contact cannot occur. CFSS will document in the Required Contact narrative why a face to face contact could not occur and what efforts were made to have face to face contact with the youth.
- J. All visits with children age 18 months and older must be private. Others may be present with children who are less than 18 months old, non-verbal (involving little or no use of words) or have a disability limiting their ability to communicate. This will be considered and documented as a private contact.
- K. All children in out-of-home care will have contact with the CFS Specialist within the first 7 calendar days of any out-of-home placement. This does not apply to youth placed in another state through the Interstate Compact for the Protection of Children (ICPC).
- L. Children placed out-of-state through ICPC, will have contact with their case manager based on the ICPC regulations and laws.

M. Topics to be Covered/Focus of the Visit:

- 1. Visits should address the following:
 - a. The strengths and needs of the child;
 - b. Evaluation of current services;
 - c. Permanency, establishment and evaluation of goals;
 - d. Assessment of the child's safety in the residence and safety of the community;
 - e. School; and
 - f. Visits with parents and siblings.
- 2. The following information should be provided and discussed with the child when appropriate, taking into account age, development, mental health concerns, etc.:

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 3 of 7

- a. Dates for court hearings and discussion on the child attending and participating;
 - b. Court ordered expectations;
 - c. Requirements of probation or parole;
 - d. Explanation of the Youth Bill of Right and discussion monthly regarding whether those rights have been respected for the youth. If the youth feels their rights have been violated in anyway, CFSS will work with the youth as well as their parents and out of home caregiver when applicable to address those issues.
 - e. Opportunity to ask questions or express concerns.
3. Discussion about Transitional Living plans for state wards age 14 or older and discussions on Independent Living should occur with every child age 14 or older. This discussion should center on: assessment of the youth's knowledge, skills and abilities; areas needing more education, training, and mentoring; and plans for the future. Discussion should include asking the child for his or her input and hopes for the future as well as how he or she is doing in school; medical issues or concerns. If applicable, discussion of mental health and substance use issues or concerns including discussion of how psychotropic medications are working and any side effects the youth may be experiencing.
4. For children who are non-verbal due to age or disability, the CFS Specialist must observe and document the child's general growth, progress in meeting developmental milestones, behavior, and any concerns and progress shared by the caregiver. Refer to Program Guidance on "Health Care Coordination and Psychotropic Medication Guidelines".

3. Visitation with Parents

- A. The CFS Specialist will have a private face-to-face visit with:
1. Legal parents and non-custodial parents of all children who are HHS-Wards whose parental rights are not terminated, regardless of the permanency objective
 2. Legal parents and non-custodial parents providing care to a child placed under the auspices of ICPC or ICI
- B. Visits with custodial and non-custodial parents must be confidential. The parents must be in agreement with any additional individuals being present during the visit. At least every other month the visit must occur in the parent's residence unless otherwise instructed below.
1. For a parent receiving treatment in a residential facility, monthly face-to-face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face-to-face visit. The barriers identified must be documented in the Required Contact narrative
 2. For a parent who is incarcerated, monthly face-to-face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face-to-face visit. The barriers identified must be documented in the Required Contact narrative
 3. For a parent living outside the Service Area or local office area, a courtesy case manager in the area where the parent resides may be assigned to conduct the monthly visit
 4. For a parent living out-of-state, monthly contact can be made via phone or other avenues such as letter, e-mail, texting or other forms of communication at the request of the parent

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 4 of 7

5. Refusal to meet or appointments that are missed without good cause will be documented in the Required Contact Narrative – Efforts to Contact.
- C. The frequency of contact is based on the risk levels.
1. Low or Moderate Risk – One face-to-face contact per month.
 2. High or Very High Risk – Two face-to-face contacts per month.
- D. When more than one contact per month is required, one contact can be via SKYPE or other electronic means if an in-person contact cannot occur, with supervisory approval.
- E. The CFS Specialist will have a monthly private face-to-face visit with the non-custodial parent in court cases.
- F. Regular efforts to locate and engage the non-custodial parent must be documented in the Required Contacts Narrative – Efforts to Contact.
- G. **Topics to be Covered/Focus of the Visit:**
1. Discussion should include the following:
 - a. Current safety threat(s) identified
 - b. Safety plan
 - c. Risk levels
 - d. Family strengths and needs
 - e. Establishing a permanency objective and case plan
 - f. Ongoing evaluation of the permanency objective and case plan
 - g. Discussion of concurrent planning (when needed); and
 - h. Visitation issues
 - i. Upcoming court hearings such as the Permanency Hearing and the 15 out of 22 Month provisions
 2. Discussion should also include information on the child's:
 - a. Health and treatment needs
 - b. School performance and peer relationships
 - c. For older children, discussion about their skills and abilities towards achieving independence
 - d. Discussion on psychotropic medications being taken by the child and the parent's observations of how psychotropic medications are working and any side effects the youth may be experiencing
 - e. When any child in the home is under the age of 2, the CFS Specialist will have a discussion about Safe Sleep and observe the child's sleeping arrangement utilizing the Nebraska Safe Sleep Environment Checklist as a guide. The CFS Specialist will encourage the parent to address any identified concerns regarding the child's safe sleep environment and assist the parent in making any necessary changes, if requested.

4. **Visitation with Out of Home Care Providers**

- A. The CFS Specialist will have monthly contact with the child's out-of-home care provider as follows:
1. Caregiver of each ward in out-of-home care;

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 5 of 7

- 2. Caregiver of each child in an Informal Living Arrangement in a non-court involved case; and
 - 3. Caregiver of each child in out-of-home care under the auspices of ICPC and ICJ.
 - B. At a minimum every other month the visit must be face-to-face, in the caregiver's home. For caregivers out of state, the visit may be by phone or email. For out of state, contact must be made in addition to contact that may be made by an ICPC Courtesy worker.
 - C. If the caregiver refuses or cancels contacts without good cause the CFS Specialist will document this in the Required Contacts – Efforts to Contact and consult with the supervisor to consider whether or not the current placement continues to be suitable and in the child's best interest.
 - D. **Topics to be Covered/Focus of the Visit:**
 - 1. Discussion should include the following:
 - a. Child's health status including any recent treatment, unmet medical needs, and current medications, including psychotropic medications
 - b. Child's school performance and educational plan
 - c. Peer relationships or needs
 - d. Behavioral needs
 - e. For children 14 and older discussion of the child's independent living knowledge, skills and abilities should occur with a plan as to what action the foster family or caregiver will do to support teaching, coaching, and mentoring
 - f. Issues around visitation with parents and siblings
 - g. Status of court process
 - h. Any issues, concerns or needs in the caregivers' household should also be discussed.
 - i. When any foster child in the home is under the age of 2, the CFS Specialist will have a discussion about Safe Sleep and observe the foster child's sleeping arrangement utilizing the Nebraska Safe Sleep Environment Checklist as a guide. The CFS Specialist will address any identified concerns regarding the foster child's safe sleep environment and assist the parent in making any necessary changes.
 - j. The CFS Specialist should regularly reassess the caregiver's commitment to the child and willingness to provide continued care including the caregiver's willingness and ability to provide permanency when needed.
5. Waiver of Case Manager's Contacting Parent in the Parent's Home:
- A. When the home environment of the parent presents a threat to the safety of a CFS Specialist, a supervisor may waive the requirement for face-to-face contact with the parent in the home. This decision must be documented in N-FOCUS. The decision to waive the requirement must be made and reviewed and documented each month.
6. **Documentation of Visits:**
- A. Documentation of all monthly contacts (and information about contacts that were attempted and not successful) with children, parents, and caregivers must be documented in the Required Contacts narrative within seven (7) calendar days of the contact. The following information must be included:
 - 1. Location of visit

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 6 of 7

- 2. Date of visit
 - 3. Who was present at the visit identified by first and last name
 - 4. If the visit was not private, describe why
 - 5. Observations of the child, parent, and caregivers and interactions noted
 - 6. Assessment of child safety and risk which reflects the child, parent and caregiver's input
 - 7. Issues discussed which reflect the child, parent and caregivers
 - 8. Actions needed by whom and by when
7. **Immediate Alternative:** When a visit cannot occur due to an unforeseen emergency, the supervisor must be notified in advance. The supervisor will make arrangements for alternative coverage. If alternative coverage cannot be arranged a written exception to this requirement must be approved by a CFS Administrator. Exceptions will be documented by the CFS Specialist in the Consultation Narrative within seven (7) calendar days of the decision, and include the name of the administrator approving the decision.

Expected Results: CFS Specialists will have more thorough and informative monthly contact with children, parents and out of home care providers. They will have a clear understanding of what should be documented from these contacts and when and documentation will reflect that monthly contacts are being completed in a more comprehensive manner.

References: Protection and Safety Procedure on Health Care Coordination and Psychotropic Medication Guidelines.

Protection and Safety Procedure #28-2017; Protection and Safety Procedure #29-2017

Nebraska Safe Sleep Environmental Checklist

Revision History:

REVISION LEVEL	DESCRIPTION	AUTHOR	APPROVAL DATE	EFFECTIVE DATE
Initial		Jamie Kramer	4-5-19	4-5-19

Approval by: Jamie Kramer

Date: 4-5-19

State of Nebraska WORK INSTRUCTION DOCUMENT FOR:	Author: Jamie Kramer	Effective Date: 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	Version #: 1	Page: Page 7 of 7

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 1 of 11

Purpose: To provide a guidance on the Initial Assessment Process to ensure consistency across the state.

Scope: Division of Children and Family Services Protection and Safety (DCFS)

Responsibilities: Children and Family Services Specialists will respond to all accepted reports of abuse and neglect. CFS Specialist will assess for child safety and risk of future maltreatment through the use of Structured Decision Making tools. CFS Specialist will ensure families are provided with resources to maintain children safely in their home whenever possible and to reduce reoccurrence future maltreatment.

Rescinds: Administrative Memo 2-2018 Initial Assessment

Procedure:

I. **INITIAL ASSESSMENT PROCESS.**

- A. An initial assessment will be completed on all Intakes accepted for assessment. A CFS Specialist will assess the child's situation to determine if threats to safety or risk of future maltreatment exist through completion of the SDM Safety Assessment and the Initial Risk Assessment. In the case of Dependent Child cases, Alternative Response, Direct Commits, Disrupted Guardianships or Adoptions, and Mentally Ill and Dangerous (3a) cases, the Prevention Assessment will be completed instead of the Risk Assessment.
- B. Children under the age of 11 may be referred to Division of Child and Family Services (DCFS) by law enforcement or the county attorney because they have committed a traffic offense, misdemeanor, felony or exhibit status offender behaviors. These youth will be assessed for safety and risk.
- C. Definitions:
 - 1. Victim(s): Youth age 18 or younger identified or subsequently identified as possible victims of child abuse and neglect.
 - 2. Identified child(ren): Youth age 18 or younger in a Dependency Intake or Alternative Response who are characterized as the primary subject of concern.
- D. Response Times:

The CFS Specialist will respond to Intakes by making contact with the alleged victim(s) or identified child(ren)within the following time frames:

 1. Priority 1 Intakes have an expected contact response time of 0-24 hours from the time the intake was accepted for assessment. These are Intakes that may be life threatening and require immediate response. If a CFS Specialist is unable to respond they must notify law enforcement of the emergency nature of the Intake and request that law enforcement respond immediately. The State Patrol may be contacted if local law enforcement is not available.
 2. Priority 2 Intakes require a 0-5 calendar day contact response time from the date and time the intake was accepted for assessment.
 3. Priority 3 Intakes require a 0-10 calendar day contact response time from the date and time the Intake was accepted for assessment.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 2 of 11

- 4. All children in the household who are not a victim or an identified child in an abuse/neglect or dependency intake must be contacted within 30 days of the date the Intake was accepted for assessment. If allegations are identified during the safety assessment, all children must be contacted within the priority timeframe as outlined above.
- 5. All intakes will immediately be assigned to a CFS Specialist who is available to respond and coordinate the response with law enforcement per local area protocols. Contact with the victim(s) or identified child(ren) will be documented in Contact Detail in the Safety Assessment.
- E. When Law Enforcement contact is used to meet Priority Response time
 - 1. The CFS Specialist will complete the assessment process if required. The CFS Specialist may use the law enforcement contact date as the first contact with the victim(s) or identified child(ren) if the law enforcement contact occurs after the date of the Intake and it is clear in the report that the child(ren) were seen and immediate safety concerns were addressed.
 - a. CFS will follow up by next business day.
- F. Response Time Exceptions: There are circumstances in which the CFS Specialist will not be able to meet the identified response time. Please see **Initial Response Time Exceptions SWI** for guidance.
- G. Conflicts of Interest:

If the CFS Specialist has a conflict of interest in a specific case due to a personal relationship with parties in the case, the case may be reassigned. The CFS Specialist will notify the CFS supervisor immediately. The CFS supervisor and appropriate CFS Administrator will make the decision about whether the assessment will be assigned to another CFS Specialist or, if necessary, to a CFS Specialist in another office within the Service Area, or if a request will be made for assignment of a CFS Specialist from a different Service Area.
- H. Preparation for Initial Assessment:
 - 1. Review available information. The CFS Specialist assigned will thoroughly review information gathered at Intake and in any existing case record, specifically any previous SDM Assessments or assessments conducted prior to SDM. It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact the parent's ability to safely parent their child. The CFS Specialist will contact the reporter and collaterals for additional information as necessary.
 - 2. Coordinate with Law Enforcement. The CFS Specialist will:
 - a. Contact the appropriate law enforcement agency prior to initiating an assessment of child and family to request that a joint investigation and assessment be completed unless Investigative (1184) Team protocols have established a different response.
 - b. Coordinate with law enforcement to schedule interviews if law enforcement plans to investigate the situation in cooperation with the CFS Specialist conducting the assessment.
 - c. Discuss any requested delays by Law Enforcement with the CFS supervisor, if concerned that a delay will be unsafe for the children involved. CFS Supervisor will document consultation on NFOCUS.
- I. Gathering Information:

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 3 of 11

1. The CFS Specialist will have face to face contact with the alleged child victim(s) or identified child within the established timeframe as determined by the priority, unless a different response is requested by law enforcement. The CFS Specialist will interview each member of the household in the following order:
 - a. The alleged child victim(s) or identified child(ren);
 - b. Siblings and other children in the household or children who regularly visit. CFS Specialist will use critical thinking skills to determine when to add additional children.
 - c. Non-maltreating parent/caretaker;
 - d. Other adults in the home; and
 - e. The alleged perpetrator.
2. If interviews cannot be conducted in this order, the CFS Specialist will clearly document the reason for variance in the N-FOCUS Contact Detail Narrative.
3. Face to face contact is required with all the children and all adults in the household to ensure a thorough assessment of safety and risk.
4. In some situations, the CFS Specialist may not be able to interview everyone on the first contact with the child/family, but should make a good faith attempt to interview all parties the same day. If all interviews cannot be conducted initially, the CFS Specialist must make a decision as to the child's safety based on the information they have available. The CFS Specialist must decide that the child is safe to remain in the home, or he/she must take additional action to ensure the child's safety.
5. Subsequent interviews (with others in the household) which are conducted after the CFS Specialist's initial determination of child safety will be analyzed to determine if the initial safety decision needs to be changed. If so, the CFS Specialist will complete and document a new safety assessment based on the additional information.
6. The CFS Specialist will utilize the narrative sections within the SDM safety assessment to document all supporting information regarding the decisions on each of the items.
7. Additional information gathered not related to the assessment being completed will be documented in Family Functioning narratives.
8. The CFS Specialist will observe the home environment and interactions between family members whenever possible.
9. The non-custodial parent will be contacted as soon as possible to:
 - a. Obtain information on the non-custodial parent's current involvement with the child(ren) such as contact, child health, education. etc.
 - b. Obtain information from him/her about their knowledge of the situation with the children and to determine the non-custodial parent's potential to be a Safety Plan participant or to care for the children as an alternative living arrangement for safety planning should removal from the custodial parent's home be necessary.
 - c. The CFS Specialist will gather information from the custodial parent as a collateral contact in situations when an allegation is on the non-custodial parent.
10. The CFS Specialist can share basic facts about the child's situation. Only information about the custodial parent that directly impact the safety of the child should be shared. Information about the child's current situation may be shared with the non-custodial parent without a release of information form signed by the custodial parent. Non-custodial and custodial parents have the right to know what is happening with their children.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 4 of 11

11. The CFS Specialist will gather and analyze information from sources other than the family. Verbal and written reports from law enforcement, therapists, school personnel, juvenile probation, diversion and others will also be obtained. Written reports will be reviewed and scanned into Document Imaging. For any assessment involving medical issues or where the alleged child victim is seen by a doctor or hospital, written information from medical providers will be obtained and placed in Document Imaging.
12. The CFS Specialist will document these collateral contacts utilizing the Maltreatment Summary & Findings Narrative in N-FOCUS in chronological order. This includes noting the relationship of the individual to the case, all available contact information and the date of the contact.
 - a. The CFS Specialist will engage collateral sources and encourage them to support the family through sharing their own concerns with CFS as well as with the family.
 - b. The CFS Specialist will also discuss with the collateral source(s) that CFS shares the assessments with families upon their request and will address any concerns the collateral contacts may have. If the collateral source is concerned about the anticipated response the family will have to the collateral's involvement or information shared with CFS or if the collateral source requests to remain anonymous, the CFS Specialist will document this concerns under a Contact Narrative.
13. The CFS Specialist will develop a genogram for each family. The genogram developed during the IA process must include, at a minimum, the child(ren), parent(s), and grandparent(s). The CFS Specialist may utilize information available to the Department in drafting a genogram, then finalizing it with the family or may use a genogram previously developed by previous CFS Specialists and review with the family for any updates.
 - a. The genogram will be documented and placed in the most current case file or scanned into Document Imaging in the Genogram Subcategory. Casework Category/tab.
 - b. The genogram is tool to help identify supports to ensure immediate and ongoing safety for the child(ren) and should be referred to and updated throughout the life of a case.
14. The CFS Specialist will discuss the results of each SDM Assessment with the family, explaining any identified safety threats and the results of the SDM Risk or Prevention Assessment. If there is not agreement with the family on the results of a specific SDM Assessment or the answer to a specific item within the SDM Assessment, the CFS Specialist will work with the family to obtain agreement. If agreement cannot be made, the CFS Specialist will ensure documentation is in NFOCUS in the appropriate assessment and identifies the specific evidence that supports the CFS Specialist's decisions. If agreement occurs, the CFS Specialist will document that agreement with the family was established in N-FOCUS.

I. SDM SAFETY ASSESSMENT OVERVIEW.

- A. The purpose of the safety assessment is to assess whether a household presents imminent danger of serious harm to any child, and if so, to determine what interventions should be initiated or maintained to provide appropriate protection or if protective placement is necessary.

II. SAFETY ASSESSMENT PROCESS.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 5 of 11

- A. The CFS Specialist is required to complete the initial safety assessment within 24 hours of initial contact with first alleged victim(s), or identified child(ren).
- B. Additional safety assessments are required when:
 - 1. There is a change in family conditions (ex: someone new moves into the home); or
 - 2. The original safety decision changes (ex: safe to unsafe); or
 - 3. Not all household members are initially interviewed, however upon subsequent interview new information is obtained which results in a change to the original safety decision; or
 - 4. A recommendation is made to close an ongoing case.
- C. Each safety assessment is documented on N-FOCUS within 24 hours of the date/time the CFS Specialist makes contact with the first victim or identified child whether or not a Safety Plan is required. Narrative documentation must be provided that supports and explains the rationale/reason related to child vulnerability; the existence of any safety threats; interventions; worker conclusions and may include Provisional Harm and Danger Statements. The CFS Specialist will utilize the narrative sections within the SDM safety assessment to document this information. The safety assessment is used to guide decisions on whether or not the child may remain in the home, the need for interventions to eliminate the threat of immediate harm, or if the child must be placed out of the home. **A Safety Plan is required when any safety threat has been identified but the child(ren)may remain in the home with interventions or with an agreed upon caregiver.**
- D. Safety Threat: The CFS Specialist will review and/or reference the safety threats during the safety assessment process and the assessment should be completed immediately.
- E. Interventions: When a safety threat is identified and a safety plan is required, the CFS Specialist will employ interventions that utilize family strengths and informal supports such as: family and friends, community and agency resources
- F. Safety Decision: The safety decision is the result of careful consideration of the safety threats present and any available safety interventions taken or immediately planned by the family, community partners, or agency to protect the child. The CFS Specialist will identify the safety decision based on the CFS Specialist's independent assessment of all safety threats, safety interventions, and any other information known about the case. The CFS Specialist will determine if the child is:
 - 1. Safe. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in imminent danger of serious harm.
 - 2. Conditionally safe. One or more safety threats are present, and protective safety interventions have been identified and agreed to by caregiver(s). A Safety Plan is required.
 - 3. Unsafe. One or more safety threats are present, and an out-of-home placement is the only protective intervention possible for one or more children. Without out-of-home placement, one or more children will likely be in imminent danger of serious harm. A Safety Plan is not required for any children who are removed from the home and placed in out-of-home care.

III. SAFETY PLAN.

- A. The CFS Specialist must explore alternatives with law enforcement and the family to identify a Safety Plan that will be sufficient to assure the child's safety without removal from the home or family whenever possible. Removing a child from their home will be the last option, when it has been determined that there are no interventions available that can maintain the child safely in the home.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 6 of 11

- B. When a safety threat is identified, interventions are necessary to ensure child safety. If the child is to remain in the home or with an identified Informal Living Arrangement an immediate Safety Plan must be developed. The CFS Specialist cannot leave the home without developing a Safety Plan.
- C. Refer to **Safety Planning SWI** for steps on creating, implementing and monitoring a Safety Plan.

IV. CHILD UNDER THE AGE OF TWO.

- A. When any child in the home is under the age of two (2), the CFS Specialist will provide and review with the family the Under 2 Packet, which can be found [here](#). The CFS Specialist observe the child's sleeping arrangement utilizing the Nebraska Safe Sleep Environmental Checklist as a guide and have a discussion with the caregivers about Safe Sleep. The CFS Specialist will encourage the parent to address any identified concerns regarding the child's safe sleep environment and assist the parent in making any necessary.

V. ASSESSMENT OF PLACEMENT SAFETY & SUITABILITY OVERVIEW.

- A. SDM Assessment of Placement Safety and Suitability (APSS) is the tool that is used to assess safety and care concerns of a child in a foster home placement. Foster home placements include agency based, traditional, relative, kinship, or adoptive homes. Please refer to the **APSS SWI** for guidance.

VI. CASE STATUS DETERMINATION.

- A. At the conclusion of the safety and risk assessments, the CFS Specialist will arrive at a finding regarding the maltreatment allegations based on information gathered and analyzed. The decision at this point is whether one or more allegations are classified as defined in Neb. Rev. Stat. 28-720: Court Substantiated, Court Pending or Agency Substantiated, or Unfounded as defined in Neb. Rev. Statute 28-720.01. This finding is called the case status determination. The case status determination will be entered into N-FOCUS within 3 business days of a case status decision approved by the CFS Supervisor.
 - 1. The CFS Specialist and CFS supervisor will follow the **Central Registry Entries SWI and Placing Minors on the Central Registry SWI** when recommending the Case Status Determination.

VII. OUT OF HOME ASSESSMENTS/FACILITY ASSESSMENTS OVERVIEW.

- A. CFS will conduct assessments of allegations of child abuse and neglect in day care homes (licensed and unlicensed), day care centers and child care facilities such as group homes and other residential care facilities where there is responsibility to provide for and to oversee the physical care of children. Please refer to the **Out of Home Assessment SWI** for guidance.

VIII. RISK AND PREVENTION ASSESSMENT OVERVIEW.

- A. The risk and prevention assessments completed by the CFS Specialist with the assistance of the family to determine of the future risk of harm and if ongoing services are needed.
 - 1. The risk assessment is used with families where maltreatment has been alleged in the current referral.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 7 of 11

- 2. The prevention assessment is used with families where there is no current child abuse or neglect alleged, however there is an identified safety concern. The goal of the prevention assessment is to mitigate future abuse or neglect from occurring.
- B. The risk and prevention assessments provide an objective appraisal of the likelihood that children in a household will experience maltreatment in the next 12-18 months. When completing the risk or prevention assessment, the family will be determined to be at a low, moderate, high or very high probability of experiencing future abuse or neglect. Low risk families have a significantly lower rate of subsequent referral and substantiation than high risk families.
- C. The risk assessment instrument is based on research of abuse and neglect cases that examined the relationships between family characteristics and confirmed abuse and neglect. The assessment does not predict recurrence; it assesses whether a family, absent invention by the agency, is more or less likely to experience a future incident of abuse or neglect. Separate indices are used to assess the future probability of abuse and neglect in each assessment.
 - 1. The CFS Specialist will conduct a risk or prevention assessment on all reports when contact is made with the family, except in rare circumstances, with approval from the CFS Administrator. This is a mandatory consultation point. The CFS Administrator will document the reason for the request and approval in N-FOCUS.
 - 2. The CFS Specialist will utilize information gathered from various sources and behavioral observations in completing the risk or prevention assessment. The assessment will be completed regardless of whether:
 - a. The parent shares information.
 - b. The parents not accepting of services.
 - c. The family will be in the state to receive services.
 - 3. The CFS Specialist will conduct the Risk or Prevention assessment prior to the decision to recommend ongoing services or to close the case. The CFS Specialist has 30 days to complete this process from the date the intake was accepted for assessment.
- D. The CFS Specialist will document the Risk or Prevention Assessment on N-FOCUS within 30 days of the Intake being accepted for assessment. Documentation Narrative must support and explain the rationale/reason for items R7 through R16 in the Risk Assessment and for items P6 through P15 in the Prevention Assessment regardless of the risk level.
- E. The CFS Specialist may utilize the Family Functioning narratives to document any additional information not captured in the Risk or Prevention assessment.

IX. DETERMINING RISK OR PREVENTION ASSESSMENT RESPONSE.

- A. Following the completion of the safety and risk or prevention assessments, the CFS Specialist determines the DCFS response. The response by DCFS must be the least intrusive, most appropriate level of service necessary to meet the identified needs of the family.
- B. The risk level informs the decision to open an ongoing services case. If an ongoing service case is opened, the risk level helps the CFS Specialist prioritize the intensity of service coordination provided to each family.
- C. An on-going case will be considered in the following circumstances:
 - 1. The family has an unsafe or conditionally safe child; and/or
 - 2. The family is at high or very high risk for future child abuse or neglect of their children unless the family is currently involved with community supports; and/or

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 8 of 11

3. DCFS is court ordered to provide services to the family regardless of Safety/Risk Assessment determinations.

X. DRUG FACTORS.

- A. Based on information gathered during the Risk or Prevention Assessment, the CFS Specialist will document determine whether substance use was a factor when the child initially became involved in DCFS. This information is based on what was gathered during the Risk or Prevention Assessment, not on what was alleged in the Intake.
- B. This information is person specific and does not require a diagnosis.
- C. The CFS Specialist will document the specific drug(s) that are a contributing factor in the family for each individual where drugs impact the family. The CFS Specialist will indicate which drug is the primary drug of choice for the individual.
- D. The CFS Specialist will not conduct or authorize any drug testing. CFS Specialist will refer the **Program Guidance on Drug Testing Protocol.**

XI. ENGAGING FAMILIES WITH SERVICES.

- A. The CFS Specialist will make efforts to engage the family, explain the use of family and informal supports, and assist in connecting them with available services in the community. The CFS Specialist will also work with the family to identify interventions that they believe will be helpful.
- B. When there are no safety threat(s) present, but the risk level is high or very high and the family is unwilling to engage with ongoing services, the CFS Specialist will consult with a CFS supervisor to determine:
 - 1. What, if any, referrals were made to community supports;
 - 2. What efforts were made by the CFS Specialist to engage the parent(s);
 - 3. What is needed to ensure the parent has information on supports and resources that may assist them.
- C. If the following circumstances are present, and a safety threat is identified or the risk level is high or very high, a mandatory consultation with CFS Supervisor is necessary to determine whether DCFS should request a filing by the County Attorney. The CFS Supervisor must document their decision in N-FOCUS.
 - 1. Domestic Violence;
 - 2. Previous Termination of Parental Rights;
 - 3. Serious Physical Abuse (i.e. head trauma, broken bones, multiple injuries);
 - 4. Sexual Abuse by a Parent
- D. If the decision is to complete a 'request to file,' it should be based on:
 - 1. A presence of any safety threat(s) and the family is unwilling to engage in interventions.
 - 2. There are no safety threat(s), but the risk level is high or very high and the evidence leading to those decisions is based on one of the four situations listed above.
- E. Ongoing cases may be court or non-court involved. All cases will be assessed to determine if a child or family is Native American. If the Department knows or has reason to know a child is Native American, ICWA will be followed. Please refer to **ICWA SWI**. The CFS Specialist will send ICWA notices and/or inquires when applicable. Please refer to **ICWA SWI** and **Creating ICWA Notice SWI** for guidance.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 9 of 11

XII. REASONABLE EFFORTS.

- A. Reasonable efforts are those supports and services, both informal and formal, that are needed to preserve and reunify families and should be related to the reason(s) the child is involved with CFS. Please refer to **Reasonable Efforts SWI** for guidance.

XIII. ACTIVE EFFORTS.

- A. The CFS Specialist will provide active efforts to provide remedial services and rehabilitative programs to prevent the breakup of the Indian family. The CFS Specialist must consider services available through tribal social services, Native American service providers, and service providers with appropriate cultural components, experience or knowledge as well as individual Indian caregivers (traditional healers, spiritual leaders, etc.) and extended family members. Please refer to **Providing Active Efforts SWI** for guidance.

XIV. REMOVAL and PLACEMENT

- A. If safety cannot be controlled with supports and services in the home, then placement out of the home must be considered.
 - 1. For Native American children the CFS Specialist will follow provisions of the Indian Child Welfare Act (ICWA). The CFS Specialist will contact the appropriate tribe for placement options and recommendations, and will document the contacts and information received in the ICWA narrative on N-FOCUS.
 - 2. The non-custodial parent will be the first placement option considered, prior to a relative or foster care, in the event the child must be removed from his/her home due to safety concerns.
 - 3. If the non-custodial parent is not available, or is not appropriate, placement preference will be given to the parent(s) of the siblings in order to place with siblings. This includes siblings who may have been adopted. Relatives will be considered before foster care.
 - a. When a child is removed from the home, the CFS Specialist will notify all adult siblings to determine if any are a placement option.
 - b. When a sibling strip is removed from the home, the CFS Specialist will make all attempts to place the siblings together.
 - 4. Whenever possible, children will be consulted about possible placement options.
- B. CFS Supervisor must pre-approve all requests to place a child(ren) in foster care. Documentation must list all efforts to place with non-custodial and relatives prior to considering foster care. CFS Supervisor will document consultation on NFOCUS.

XV. NOTICE TO THE EARLY DEVELOPMENT NETWORK.

- A. It is important to have children assessed early for any educational needs. Federal law requires a referral to the Early Development Network (EDN) for early intervention services in substantiated cases involving children under the age of three (3). Referring for EDN services early in the child's development may prevent or minimize negative effects of exposure to risk factors such as abuse and neglect. Please refer to **Early Development Network Referral Process SWI** for guidance.

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 10 of 11

XVI. SDM CASE REVIEWS.

- A. At a minimum, the CFS Supervisor will conduct the following reviews of SDM Assessments. The CFS Supervisor will utilize discretion and the work performance of individual CFS Specialists to determine the frequency of additional SDM Reviews.
 - 1. The CFS Supervisor will review every SDM Assessment in which an Override is utilized;
 - 2. The CFS Supervisor will review every SDM Assessment for CFS Trainees for the first 6 months or until the CFS Trainee has been promoted to CFS Specialist
 - 3. The CFS Supervisor will conduct a random sample of SDM Assessments for CFS Specialists. One SDM Assessment will be selected each month for each CFS Specialist. The CFS Supervisor will conduct an in-depth review of one SDM Assessment for each CFS Specialist.

XVII. CASE CLOSURE.

- A. The decision to close a case is based on safety and risk. High and very high risk families should be offered ongoing services beyond what their network and community resources can provide, if needed.
- B. If a Safety Plan which requires case monitoring and/or resources of agencies contracted with CFS is needed, the child is not safe and the case will not close.
- C. The CFS Specialist must assist the family in applying for any necessary DHHS services, including but not limited to: Supplemental Nutritional Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF or ADC), Medicaid, and Developmental Disabilities.
- D. The Initial Assessment case closes when:
 - 1. There are no active safety threats and the risk level is low or moderate and there is no juvenile court intervention.
 - 2. The family is unable to be located or they have moved and the CFS Supervisor has determined that a good faith effort was made to locate the family. CFS Supervisor will document consultation on NFOCUS.
 - 3. A child has been determined safe, and
 - a. a high or very high risk family refuses services, and
 - b. the CFS supervisor has determined that the county attorney should not be contacted (CFS Supervisor will document consultation on NFOCUS), or
 - c. the County Attorney has determined that there will be no court intervention.
 - 4. A child has been determined safe but the family is determined as high or very high risk based solely on risk factors that are related to the family's history and the family has been involved in prior services or currently working with community services.
 - 5. There is an active safety threat, the family will not engage in services and, the county attorney will not file a petition.

Expected Results: Children's safety will be ensured and services will be provided to enhance protective capacities.

References:

- Neb. Rev. Statute 28-457 Methamphetamine; prohibited acts; violation; penalties
- Reasonable Efforts: Neb. Rev. Statute 43-283.01

State of Nebraska WORK INSTRUCTION DOCUMENT FOR: Initial Assessment	Authors: Toni Bonsera Suzana Borowski	Effective Date: 04/01/2020
	Version #: 1	Page: Page 11 of 11

- Early Development Network: Neb. Rev. Statute 43-1501 – 43-1516
- Child Abuse Prevention and Treatment Act (P. L. 111-310)
- Initial Response Time Exceptions SWI
- Safety Planning SWI
- APSS SWI
- Central Registry Entries SWI
- Placing Minors on the Central Registry SWI
- Out of Home Assessment SWI
- Program Guidance on Drug Testing Protocol
- ICWA SWI
- Creating ICWA Notices SWI
- Reasonable Efforts SWI
- Providing Active Efforts SWI
- Early Development Network Referral Process SWI
- Initial Assessment Narrative Guidelines
- Case Management Desk Aid

Revision History:

REVISION LEVEL	DESCRIPTION	AUTHORS	APPROVAL DATE	EFFECTIVE DATE
Initial	Initial Assessment	Toni Bonsera Suzana Borowski	3/26/2020	4/1/2020

Approval by: *Sherri Haber* **Date:** 3/26/2020

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, NE DHSS Division of CFS, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

6-5-19

(Date)

Angie, Director

(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Healthy Families America (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020

(Date)

Jeanie L. Brashy, Director CFS

(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Multi-systemic Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020
(Date)

Stephanie Brashy Director CFS
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE. Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parent-Child Interaction Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020
(Date)

Stephanie Brasly, Director CFS
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020

(Date)

Stephanie Brashy, Director CFS

(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE. Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Homen Builders (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020

(Date)

Stephanie Beasley, Director CFS

(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Poverts As Teachers (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020
(Date)

Stephanie Brashy, Director CFS
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The NE Dept. of HHS (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Motivational Interviewing (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

7/13/2020
(Date)

Stephanie Brashy, Director CFS
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child 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 and trauma-specific interventions to address trauma's consequences and facilitate healing.

The NE DHS Division of CPS (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

6-5-19

(Date)

Arthur, Director

(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
Administration on Children, Youth and Families
Children's Bureau

State Annual Maintenance of Effort (MOE) Report

State: Nebraska	FFY: N/A
Baseline Year:	2014
Baseline Amount: \$	3,578
Total Expenditures for Most Recent FFY:	N/A

This certifies that the information on this form is accurate and true to the best of my knowledge and belief.

This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.

Signature, Approving Official:



Typed Name, Title, Agency:

Director, CFS, DHSS

Date:

5-15-19