

**Kentucky Cabinet for
Health and Family
Services, Department for
Community Based
Services**

**TITLE IV-E
PREVENTION
PLAN**

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KENTUCKY
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Approval

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Introduction

The Kentucky Department for Community Based Services (DCBS), within the Cabinet for Health and Family Services (CHFS), is leading the State's child welfare system through a radical transformation focused on the achievement of three priority outcomes:

1. Safely reduce the number of children entering out of home care
2. Improve timeliness to appropriate permanency
3. Reduce staff caseloads

Committed to making the Kentucky child welfare system a national model, DCBS is joined in these efforts by Governor Bevin, First Lady Bevin, and a wide range of private and community agency partners, child welfare advocates, and key stakeholders. State legislators expressed their investment in transforming Kentucky's child welfare system through the 2018 passage of House Bill 1, landmark state child welfare legislation creating a statewide Child Welfare Oversight & Advisory Committee; increased attention to child welfare caseloads; improved quality and access to family preservation services for vulnerable families; increased supports for kin caregivers; streamlined processes for prospective foster and adoptive parents; and the requirement for the State to implement performance based contracting with its provider network.

Key accomplishments thus far in the transformation include a statewide commitment to establishing a culture of safety within the child welfare system; a recently codified Foster Child Bill of Rights; expanded supports for relative caregivers and the addition of a fictive kin placement option; a substantial increase in the number of licensed family foster homes; an increase in the number of children exiting to reunification and adoption; and a decrease in the number of children exiting care without achieving permanency.

DCBS and its partners are equally committed to early implementation of the Family First Prevention Services Act (Family First). Family First's key provisions around prevention and ensuring appropriate placements reflect Kentucky's commitment to reorienting around prevention and family preservation and utilizing foster care as an intervention of last resort.



When foster care is needed, DCBS and its network of private partners are invested in creating a placement array that best meets the needs of children and youth, includes relative and fictive kin placements whenever possible, and reserves residential care as a temporary placement only for youth with a clinical need to receive the treatment available in these settings.

Kentucky's child welfare transformation is building off successes and lessons learned within its title IV-E waiver demonstration, focused on addressing substance use disorders among child-welfare involved families through the implementation of Sobriety Treatment and Recovery Teams (START) and Kentucky Strengthening Ties and Empowering Parents (K-STEP). Both of these programs represent important dimensions of Kentucky's preventive service array and have demonstrated considerable success in helping families overcome substance use disorders and safely care for their children. Substance use disorders, especially opioid use, are a significant problem in Kentucky and represent a major contributing factor for many families' child welfare system involvement.

Building upon the successes of the title IV-E waiver demonstration, Kentucky is dedicated to developing a full continuum of preventive services that addresses not only substance abuse prevention and treatment, but the full array of needs present in families with children at risk of entering foster care. This effort represents a substantial increase in the State's investment in and commitment to preventive services. In State Fiscal Year 2019, DCBS spent \$476,176,222 on out of home care costs relative to its \$18,443,365 investment in preventive services designed to mitigate risk factors, promote child safety, and avoid the need for foster care (Sammons, 2019). DCBS believes that this misalignment of resources between preventive and foster care services is not in the best interest of families and does not reflect the values of the Kentucky child welfare system. DCBS intends to build on the programs that are successfully strengthening families and preventing children from entering out of home care. In SFY19 96% of the children served through in-home services under the Family Preservation Program (FPP) remained safely in their home at the end of the intervention. Family First will be used as a lever to increase the capacity of the Evidence-based Programs (EBP) utilized by FPP.

To inform the development of this Title IV-E Prevention Plan and the selection of proposed interventions, DCBS conducted a rigorous analysis of its child welfare data to understand the reasons children were entering care, risk factors for maltreatment present in families, and their geographic representation across the State and its nine regions. Complementing this analysis of the child welfare population, DCBS engaged its provider network in a readiness assessment for Family First to better understand, among many factors, the array of evidence-based interventions in place around the State, provider capacity to serve children and families, and capacity to monitor fidelity and assess program impact on outcomes. DCBS will leverage these

survey findings in partnership with state sister agencies and the provider community to inform the development of a full continuum of preventive services in Kentucky and expand access to services for families at risk of experiencing child maltreatment. Please see Appendix A for DCBS' overarching theory of change for its Title IV-E Prevention Plan.

Stakeholder involvement in Title IV-E Prevention Plan development

DCBS welcomed the opportunity to create the Title IV-E Prevention Plan in partnership with its stakeholders. Efforts related to the development of the provider readiness assessment and analysis of the data represent just one mechanism in which stakeholders contributed to the development of this Title IV-E Prevention Plan. DCBS has created a broad governance structure to guide its transformation, inclusive of a steering committee, a stakeholder advisory committee, and nine transformation workgroups. Family First implementation represents a fundamental part of the broader child welfare transformation, and the Preventive Supports transformation workgroup was specifically charged with developing the Title IV-E Prevention Plan. Workgroup members represent a broad cross-section of internal and external stakeholders, including sister agency partners and child welfare advocates. DCBS leadership and staff also integrated the readiness assessment results and preventive planning into a number of stakeholder meetings. Specifically, DCBS partnered with Kentucky Youth Advocates and other stakeholders to host nine regional forums specifically focused on Family First education, engagement, and planning.

In addition, DCBS has ensured that legal and judicial partners have been meaningfully included in the development of the Title IV-E Prevention Plan. The Family First Judicial Workgroup, chaired by Supreme Court Justice Debra Lambert, was developed and began meeting in March 2019. DCBS and the Administrative Office of the Courts (AOC) have worked jointly to prepare the courts and DCBS staff for Family First implementation. An overview of Family First and the provider readiness assessment results were presented to the workgroup comprised of judges and AOC staff. Judges provided integral input to inform the provision of prevention services throughout the State. Additionally, DCBS and AOC are working collaboratively to present on Family First at the annual judicial college with district and circuit court staff. AOC staff were part of the planning and agenda for the Family First regional forums. Additionally, AOC presented on the impact of Family First to the courts during the forums. There was a substantial presence from the courts at each forum. In one region, the courts canceled all activities that day to attend and participate in the forum. AOC has engaged DCBS in the changes to the family court rules to reflect Family First requirements.

All in all, DCBS engaged with 1150 stakeholders across the State in Family First planning and Prevention Plan development. In addition to talking with stakeholders specifically about the opportunities inherent in Family First and their interconnection with the larger transformation, the child welfare data and provider readiness assessment findings were also presented and discussed. Stakeholder input was gathered and ultimately informed the development of this submission. DCBS is very grateful for the amount of time and efforts its partners invested in the development of this Title IV-E Prevention Plan and the child welfare transformation more broadly.

Section 1: Eligibility and Candidacy Definition

There are two populations eligible for Family First preventive services: 1) Children who are determined to be candidates for foster care, and 2) Pregnant and parenting youth.

DCBS used calendar year (CY) 2018 data to get a sense of the size and scope of children already known to DCBS that are likely to meet the candidacy criteria. Through that analysis, Kentucky identified 27,522 children who could potentially be identified as candidates under Family First. Potential Family First candidates include children involved in a substantiated or family in need of services finding. This identifies children at risk for future or immediate removal from their home. See Appendix B for further detail about the CY2018 candidacy estimates and the pathways by which candidates and their families are involved with the Kentucky child welfare system. Further detail is available in Appendix C which includes a geographical representation of the potential candidates as represented in the CY2018 data. Children newly coming to the attention of the department will be assessed for candidacy eligibility using the criteria and processes identified in the subsequent subsection of this report.

Of the potential Family First candidate pool identified in the CY2018 data, data suggest only one in five is receiving contracted in-home service intervention highlighting an opportunity to expand service provision. Regionally, the Eastern Mountain Service Region utilizes more in-home services than any other region in the State. When considering the rate of youth entering out of home care in comparison to the rate of youth utilizing in-home services, regional service needs have been identified in Kentucky's eight remaining regions, with the greatest need occurring in the Cumberland, Jefferson, Northern Bluegrass, Salt River Trail, and Southern Bluegrass Service Regions.

Identifying candidates

A child meets the criteria for foster care candidacy when they are determined to be at imminent risk for removal, but the identified risk and safety issues can be mitigated through the provision of child-specific preventive services, including one or more of the evidence-based interventions designed to build parents' skills and protective capacities, treat mental health issues, and/or prevent or treat substance abuse.

The majority of the candidates for foster care who will receive prevention services as described in the Act will be identified during the investigative phase utilizing the agency's existing safety and risk assessment procedures. These children and families will come to the attention of the agency via a referral that meets acceptance criteria for investigation. Additional candidates for foster care will include children who have recently exited foster care whose families are in need of services to prevent further maltreatment and re-entry into care, with identification of these children occurring prior to reunification. Children identified as candidates for foster care will meet one of the following criteria:

1. A victim of substantiated maltreatment in which existing safety and risk factors can be mitigated by provision of in-home services;
2. A child for whom maltreatment has not been substantiated, however, moderate to severe risk factors for maltreatment are present and services are necessary to prevent maltreatment and subsequent entry into foster care;
3. A child who has recently been reunified for whom services to the family will mitigate identified risks, preventing further maltreatment and re-entry into care; or

Identifying pregnant and parenting youth

The agency will identify pregnant and parenting youth in out of home care through a variety of methods. Enhancements to the state's CCWIS system are currently underway to assist with identification of this population. These enhancements will be in place by October 1, 2019. There are multiple opportunities in routine casework for Social Service Workers (SSWs) to identify pregnant or parenting youth through routine casework including monthly home visits, ongoing assessments, supervisory consultation, case planning meetings, as well as youth transition planning meetings. Additionally, the enhancements to the data system will allow reports to be generated on a monthly basis to embed a quality assurance measure regarding referral and provision of prevention services as appropriate to this population.

The SSW will determine foster care candidacy in consultation with the candidate's family and the Family Services Office Supervisor. During the investigation, SSWs will identify high-risk behaviors of family members or case circumstances, which will result in removal of the child from the home, immediately or in the future, if intervention does not occur. A comprehensive prevention strategy for each identified candidate or pregnant/parenting youth will be developed in partnership with the candidate's family. SSWs will utilize the EBP Selection Document to identify appropriate Evidence-based Practice interventions to mitigate the specific, identified risk(s) for the family. EBPs will be selected methodically, reviewing the appropriate target population and outcomes associated with each EBP.

Please see Section 2, Title IV-E Prevention Services, for the referral process for services and child specific prevention plans.

Section 2: Title IV-E Prevention Services

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

Substance abuse treatment and prevention

Substance abuse disorders, by youth or caretaker, are prevalent among Kentucky's child welfare population and represents a specific area DCBS intends to target through this prevention plan. Kentucky has existing infrastructure to address a portion of the needs of this population with the Title IV-E Waiver programs, START, and KSTEP. When considering Kentucky's potential Family First candidates, 17,471 children are involved in a case with substance abuse as an identified risk factor within the family. The more vulnerable population of Family First potential candidates under 10 years of age, with substance abuse as a case characteristic, totals 12,164 in the CY2018 cross-section. Sixty-six percent of the potential candidates are under 10 years old. When considering potential Family First candidates, under

10 years of age, with a case characteristic of substance abuse in comparison to the current population being served by in-home services, Kentucky has identified regions where a gap exists in service delivery. The need for additional substance abuse interventions is indicated for one county in the Eastern Mountain service region, four counties in the Northeastern Service Region, six counties in the Northern Bluegrass service region, four counties in the Cumberland service region, three counties in the Salt River Trail Service Region, three counties in the Southern Bluegrass Region, seven counties in the Lakes Service Region, and one county in the Two Rivers Service Region. See Appendix D, Potential Family First Candidates with Substance Abuse as a Case Characteristic map, and Appendix E, Potential Family First Candidates Under 10 with Substance Abuse as a Case Characteristic map.

Addressing family violence

The presence of family violence is another significant risk factor for entry into foster within Kentucky's child welfare population. While family violence is not one of the three service categories supported within the Family First legislation, recent State data indicate that 12,280 families experience challenges with family violence. Therefore, addressing family violence remains a key priority area for DCBS as efforts continue to expand and align the State's service array with the needs of the families served by the agency. Some examples of current services and interventions include EBPs that embed strategies to address underlying contributing factors of violence within the family. Additionally, there are 5,369 potential Family First candidates known to DCBS with co-occurring substance abuse and family violence as case characteristics (See Appendix F). Existing programs have the ability to serve both needs.

Provider readiness assessment

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

The provider assessment addressed both the preventive and congregate care provisions of Family First and contained a number of domains: Trauma-Informed Care, Implementation of Evidence-Based Practice, Federal Qualified Residential Treatment Program Criteria, and Continuous Quality Improvement and Data Use. With regard to evidence-based practices, the

survey specifically asked which interventions provider agencies were implementing and assessed their current capacity to monitor model fidelity and impact on intended outcomes. In addition, the survey inquired about provider capacity, specifically the number of children and families that could be served within each program on an annual basis.

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

Proposed Evidence-Based Preventive Services

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

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

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

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING
MENTAL HEALTH TREATMENT	Functional Family Therapy	Well-Supported
	Multisystemic Therapy	Well-Supported
	Parent-Child Interaction Therapy	Well-Supported
SUBSTANCE ABUSE TREATMENT AND PREVENTION	Trauma Focused-Cognitive Behavioral Therapy	Promising
	Multisystemic Therapy	Well-Supported

This next set of interventions, Table 2, are not currently rated by the Title IV-E Prevention Services Clearinghouse, but they have been rated by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare and they align with the needs of Kentucky's child welfare population. Many represent important elements of Kentucky's service array that would be beneficial to expand. In particular, the Commonwealth has invested significant effort in

implementing and evaluating START to the benefit of Kentucky children and families. Ideally, Kentucky seeks the Children's Bureau's approval of these preventive programs as well, and the State is exploring mechanisms for conducting independent systematic reviews per federal guidance. Given the significant level of effort and capacity such an independent review requires, Kentucky respectfully requests that the Title IV-E Prevention Services Clearinghouse review and rate these programs as soon as possible so that DCBS can meet the needs of families in a timely manner.

Table 2: DCBS proposed preventive programs rated by the CEBC

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	CEBC RATING
MENTAL HEALTH TREATMENT	Cognitive Behavioral Therapy	Well-Supported
SUBSTANCE ABUSE TREATMENT AND PREVENTION	Motivational Interviewing Sobriety Treatment and Recovery Team (START)	Promising Promising
IN-HOME, SKILL-BASED PARENTING PROGRAMS	1-2-3 Magic: Effective Discipline for Children 2-12 Sobriety Treatment and Recovery Team (START)	Promising Promising

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

Brief narrative summary of evidence-based programs

➤ Cognitive Behavioral Therapy (CBT)

CBT 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. The target population is adults (18 and over) diagnosed with a mood disorder, including Unipolar Major Depressive Disorder (MDD), Depressive Disorder Not Otherwise Specified, and minor depression. CBT is another Evidence-Based Practice model utilized by the majority of Kentucky's public and private providers of Child Welfare clients with depression or depression-like behaviors or mood. Cognitive skills are used to identify the typical "thinking traps" (cognitive distortions) that clients commit and challenge them to consider the evidence more fairly. 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.

The California Evidenced-Based Clearinghouse (CEBC) rates CBT as being Well-Supported. Several studies have been conducted over the years documenting the effectiveness of CBT for adults and adolescents. CBT was somewhat superior to antidepressants in the treatment of adult depression. CBT was equally effective as behavior therapy in the treatment of adult depression and obsessive-compulsive disorder (Butler, Chapman, Forman, & Beck, 2005). Short- and long-term effectiveness is shown with cognitive-behavioral approaches for treating depressive symptoms with this population (Reinecke, Ryan, & Dubois, 1998).

➤ **Functional Family Therapy**

Functional Family Therapy (FFT) is a family intervention program for youth experiencing dysfunction with disruptive, externalizing problems. The target population is 11-18 year olds with serious concerns such as conduct disorder, violent acting-out and substance abuse. FFT is rated Well Supported with the Title IV-E Prevention Services Clearinghouse.

➤ **Motivational Interviewing**

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance a person's internal motivation to change, to reinforce this motivation, and develop a plan to achieve change. The target population includes caregivers of children referred to the child welfare system and it has also been used with adolescents. MI is rated Well-Supported with Medium child welfare relevance per the CEBC. Kentucky is looking forward to the Title IV-E Prevention Services Clearinghouse's release of the rating for MI as it is an intervention deeply embedded in the agency's services array designed to address the opioid epidemic and other substance use disorders challenging families within the Commonwealth.

Several studies have been conducted to determine the efficacy of MI; leading the CEBC to give it a Well-Supported rating. Studies report that when compared to other active treatments such as 12-step and cognitive behavioral therapy (CBT), the MI interventions took over 100 fewer minutes of treatment on average yet produced equal effects. Furthermore, MI is likely to lead to client improvement when directed at increasing healthy behaviors and/or decreasing risky or unhealthy behaviors as well as increasing client engagement in the treatment process (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). A study examined the efficacy of Motivational Interviewing (MI) as an enhanced treatment initiation with substance abusers. Participants were randomly assigned to receive either standard treatment or standard treatment with MI. Measures utilized include the rates of participants who attended one or three subsequent drug abuse treatment sessions after the evaluation as well as basic demographic data and substance abuse history was also collected. Results showed that significantly more participants in the MI group went on to attend treatment sessions than in the standard group (59.3% versus 29.2%). However, this advantage did not persist beyond treatment initiation. Limitations include small

sample size, lack of follow up, and generalizability of findings due to ethnicity (Carroll, Libby, Sheehan, & Hyland, 2001). The evidence base for MI is strong in the areas of addictive and health behaviors. Useful as a brief intervention in itself, MI also appears to improve outcomes when added to other treatment approaches (Hettema, Steele, & Miller, 2005).

➤ **Multisystemic Therapy**

Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The target population is 12 to 17 year olds who are at risk of out-of-home placement due to delinquent behavior. MST is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse.

➤ **Parent-Child Interaction Therapy**

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

➤ **Trauma Focused-Cognitive Behavioral Therapy**

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

The majority of Kentucky providers in community mental health centers, private foster care agencies, and residential programs utilize TF-CBT. There are several journal reviews discussing the efficacy of TF-CBT (Cohen, Mannarino, & Iyengar, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Results indicated that TF-CBT, regardless of the number of sessions or the inclusion of a Trauma Narrative (TN) component, was effective in improving participant symptomatology as well as parenting skills and the children’s personal safety skills. The eight-session condition that included the TN component seemed to be the most effective and efficient means of reducing parents’ abuse-specific distress as well as children’s abuse-related fear and general anxiety

(Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Among treatment completers, TF-CBT resulted in significantly greater improvement in anxiety, depression, sexual problems, and dissociation at six-month follow-up and in PTSD and dissociation at 12-month follow-up. Intent-to-treat analysis indicated group x time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems (Cohen, Mannarino, & Knudsen, 2005).

➤ **Sobriety Treatment & Recovery Team**

Sobriety Treatment and Recovery Team (START) is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START serves families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. Families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload of 15 families, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity. START is rated promising with “High” child welfare relevance per the CEBC. Kentucky first implemented START in 2007 and has gradually expanded since that time, investing in the staff, collaboration, infrastructure, and outcome studies of START.

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

within 12 months compared to 31% of a propensity score-matched comparison group. In summary, two independent evaluations of START report that 21% of children in families served by the program enter out-of-home care within 12 months, a rate that is significantly lower than similar children receiving usual child welfare services.

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

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

➤ **1-2-3 Magic: Effective Discipline for Children 2-12**

1-2-3 Magic is a group format discipline program for parents of children approximately two to 12 years of age. The program can be used with average or special needs children. 1-2-3 Magic divides the parenting responsibilities into three straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking. 1-2-3 Magic is rated Promising with “Medium” child welfare relevance per the CEBC. 1-2-3 Magic is utilized by every in-home service provider with which the state child welfare agency contracts. This intervention is shown to result in a significant decrease in disruptive child behavior, permissive parenting, and parental depression and stress. Limitations include the lack of a comparison group and small sample size (Porzig-Drummond, Stevenson, & Stevenson, 2015). The intervention has also shown participants in the 1-2-3 Magic group reported significantly less problem behaviors for their children, and significantly less dysfunctional parenting, at the end of the intervention when compared to the control group (Porzig-Drummond, Stevenson, & Stevenson, 2015).

Interventions for future consideration

➤ **Kentucky Strengthening Ties and Empowering Parents (KSTEP)**

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

Kentucky's in-home service delivery model

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

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

Table 3 reflects a summary of EBPs administered by DCBS' in-home service providers. This includes the FPP providers as well as START and K-STEP. While START and KSTEP each represent a comprehensive and unified program model, discrete EBPs are made available to families as part of the models' service delivery approach.

Table 3: Evidence-Based Practices administered by DCBS in-home service providers

	COGNITIVE BEHAVIORAL THERAPY	FUNCTIONAL FAMILY THERAPY	MOTIVATIONAL INTERVIEWING	MULTI- SYSTEMIC THERAPY	PARENT-CHILD INTERACTION	TRAUMA FOCUSED- COGNITIVE BEHAVIORAL THERAPY	SOBRIETY TREATMENT AND RECOVERY	1-2-3 MAGIC TEAM
FPP	X		X		X	X		X
KSTEP	X	X	X		X	X		
START	X		X			X		X
TBD				X				

Ensuring trauma-informed service provision

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

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

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

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

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

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

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

Implementation approach

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

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

Current contracted providers have established relationships with trainers and purveyors of current EBPs. Kentucky will examine and modify these existing relationships as necessary to accommodate additional training needs moving forward. In addition, Kentucky will utilize Learning Collaboratives to strengthen the quality of implementation and provide peer-learning

opportunities for contracted agencies. Experienced providers may serve as facilitators and mentors in quarterly provider meetings to coach and mentor newly contracted agencies.

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

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

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

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

To ensure tracking of prevention services for appropriate Title IV-E claiming, information technology staff have been an integral part of preparation for Family First implementation. System enhancements for candidacy identification, EBP selection, and billing processes are occurring to support workforce both in the public and private agencies. Kentucky's contracted providers will provide monthly invoices to both programmatic and financial staff for review. Kentucky is collaborating with Public Consulting Group (PCG) to develop an invoice template to include the potential candidate, date of service, EBP utilized, and amount billed with each EBP,

for Family First funds. An accounting code will be assigned for each EBP billed and for each agency. This will assist financial management staff in managing funds appropriately.

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

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

Section 3: Developing the Prevention Plan

The development of the child specific prevention plan will follow a specified process. First, the SSWs will complete the Preventative Services Referral Form, identifying the date of candidacy determination for each child, the high-risk behaviors or circumstances which could lead to removal and the appropriate EBP intervention(s) needed to mitigate the risk. Upon approval, the referral form will populate the identified risk factors and identified EBP into an in-home case plan within TWIST, Kentucky's child welfare information system. The in-home case plan will include candidates' child specific prevention plans embedded within the broader case

planning platform. In addition, the child-specific prevention plans (within the in-home case plan) will include the date that candidacy was established, along with a child specific prevention strategy, known as an objective within DCBS case planning parlance. Each objective will be accompanied by several tasks outlining the identified family strengths and strategies for keeping the foster care candidates in their home. The objective will also reference the risk factors identified and link to the appropriate EBP(s) needed to mitigate the risk factors for maltreatment. This process, together with the expectations for SSWs casework practice, will be clearly outlined in DCBS' standard operating procedures (SOP), issued to the in-home workforce, and incorporated into child welfare policy and training curricula.

Prevention plan for pregnant and parenting youth

Upon identification of a pregnant or parenting youth and assessment of the need, a service referral will be made for prevention services. The services to be provided will be outlined on the youth's foster care case plan. The services will be listed on the case plan and specifically targeted to ensure that the youth is prepared and able to parent successfully. The foster care prevention strategy for any child born to a youth in out of home care will be clearly identified within the youth's case plan. The prevention plan will be developed in partnership with the pregnant or parenting youth, services providers, and natural supports during case planning conferences and/or youth transition planning meetings. The CCWIS and SOP enhancements will ensure identification of parenting fathers as well to be included in these prevention efforts.

Assessment and consultation processes

The process for assessing families' strengths, needs, and the services needed to mitigate risk factors for maltreatment will occur using structures that are already in place. DCBS already uses a collaborative and ongoing assessment model that includes contributions from the investigator, in-home services worker, and the supervisor and is continually revisited during on-going case consultation. All case types receive monthly consultation between supervisor and worker. Within these consultations, workers and supervisors will consider together at a minimum, safety and risk issues, candidacy status, appropriateness of prevention strategies, and progress toward case plan goals. High-risk investigation consults occur with the worker, supervisor, and regional staff within 72 hours, with a follow-up within 14 days.

Case planning processes already in place will continue with the implementation of the Title IV-E Prevention Plan. Case plan meetings, and task negotiation and development occur initially when a case is opened and every six months thereafter. A formal review of candidacy and continued eligibility will occur every six months. Candidacy redetermination will occur at 12 months if needed. Case plan modifications will also occur when candidacy ends, due to a

candidate completing the course of treatment/service delivery associated with the assigned EBP or due to a candidate's removal from the home.

Children will be assessed on an ongoing basis to determine if risk factors are still present or if they have been reduced and parental capacity has been enhanced, negating the need for prevention services. This will be achieved through ongoing provider consultation utilizing assessment tools, such as the NCFAS, and ongoing frontline worker assessment and periodic case plan assessment.

Supervision and oversight strategies to promote quality practice

Supervisors assess the appropriateness of the risk level assigned by their staff and support workers in making that decision. They also provide support and oversight in ensuring that the preventive strategies and EBPs identified in the child-specific plans are appropriate and effective.

Workers will consult with their supervisor regarding child-specific candidacy determinations and associated service need(s) based upon identified risk factors. Workers will begin the referral process to evidence-based interventions following supervisor consultation. A description of services/target population resource form will be provided to workers and regional in-home services gatekeepers to utilize as a reference and to guide decision-making regarding referral to appropriate services. It will also be available for access within standards of practice (SOP). The form is designed as a resource that guides decision-making to ensure referrals are made to the most appropriate program to meet the family's needs.

Workers provide ongoing oversight during monthly home visits to assess and monitor family progress in mitigating risk factors. This is also assessed during the consultative process between workers and supervisors to assess case plan progress. DPP central office will also serve as oversight by providing consultation as needed and developing a case review process with random selection of cases for review as part of DCBS' ongoing CQI processes.

Regional gatekeepers play a critical role in the decision-making and oversight processes related to service provision and monitoring. Gatekeepers are experienced child welfare staff with a knowledge of risk and safety assessments along with evidence-based practices. They also have an established professional relationship with the prevention services provider network. They serve as a support to frontline workers and supervisors for consultation related to prevention services selection and act as a liaison between field staff, families and service providers. Regional gatekeepers for preventative services will also promote quality preventive casework practice by performing quality assurance measures on candidacy selections and referrals to

services. Gatekeepers will review the risk identified to ensure candidacy determinations are appropriate. Gatekeepers will have the ability to send referrals back to workers for changes and are assigned the responsibility for ultimately sending referrals to contracted providers. The referral for services requires consent from family, supervisor approval, and regional gatekeeper oversight and approval. Referrals for services and candidacy status will be captured in the state CCWIS system for data collection and monitoring.

See Appendix I for an illustration of the business process and roles associated with determining candidacy and linking families to the appropriate EBP.

Coordinating Title IV-B and Title IV-E Funded Services

Kentucky's Title IV-B funded preventative services, Families & Children Together Safely (FACTS) and Family Reunification Services, will be implemented in conjunction with Family First funded preventative services. SSWs will ensure families' case plans, and by extension, child-specific prevention plans, contain the right constellation of services needed to address risk factors for maltreatment and maintain the child safely in their home. This preventive service package in its entirety will likely be funded by a variety of federal, state, and local funding streams, including Title IV-B and Title IV-E. SSWs will ensure that all services for the child and family, regardless of funding stream, are well-coordinated, mutually reinforcing, and appropriate for achieving the case plan goals for the family.

Section 4: Monitoring Child Safety

Safety and risk will be assessed on an initial and ongoing basis for all foster care candidates without exception. All case types receive monthly consultation between supervisor and worker to assess for safety and necessary case provision/goals. High-risk investigation consults occur with the worker, supervisor, and regional staff within 72 hours, with a follow-up within 14 days for new investigations involving physical abuse allegations for children under age four. This provides an opportunity for regional office staff to provide support to frontline workers and supervisors in identifying risk factors and potential preventive interventions early in the agency's contact with a family.

DCBS staff complete at least monthly home visits with all family members, unannounced if necessary. Workers also meet with children privately in their home during monthly home visits to assess safety. During home visits the worker:

1. Assesses for new immediate safety issues, high-risk behaviors, or unaddressed risk factors;
2. Evaluates the family's progress toward reducing the immediate safety issues and/or reducing the risks that necessitated case action;
3. Reviews the family's progress toward accomplishment of their case planning tasks;
4. Reviews the tasks of other service providers and progress toward accomplishment of these;
5. Identifies and resolves barriers to completing case objectives; and
6. Prepares for the next ongoing assessment, case planning conference/periodic review and court hearing.

Each unique in-home service program also implements different levels of familial contact based upon the risk and family's level of need. All in-home service programs require collaboration with DCBS, this may include joint meetings with the family in the home, joint treatment planning meetings with the family, weekly contact between providers for progress updates, etc.

The Department trains and provides SOP guidance to field personnel in completing a thorough risk assessment with each case. Workers are required to fully assess a family for high-risk patterns of behavior and needed services with each intake accepted whether the intake is accepted for physical abuse, sexual abuse, neglect, or dependency. This assessment includes face-to-face interviews with all household members, interviews with children's school collaterals if appropriate, and other collateral interviews to assist in fact-finding and assessment of the incident that led to referral. Workers also collect evidence and documentation from photographs, medical records, criminal history, and child abuse and neglect history. Workers continuously evaluate risk throughout each phase of a case to determine if safety issues require intervention, and consult with supervisors to discuss any concerns or barriers presented. This practice considers the totality of the family's situation, overall safety threats to the child, protective capacity of the parent/caregiver, perpetrator access, and prediction of recurrent maltreatment. Workers provide appropriate service matching to the family's needs in order to mitigate the safety threats and risk factors. This is discussed in SOP 2.11 Investigation Protocol and SOP 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding.

The Department is also currently in the process of negotiating a contract to purchase a national safety model, Structure Decision Making (SDM), for implementation in 2020. SDM will help guide the decision making process and prioritize the delivery of services to families across the State. The model will be utilized throughout all phases of the case to assist workers in monitoring safety and risk. The tools being evaluated for purchase are the intake screening tool known as the base assessment, the safety assessment, and risk assessment. The base assessment will assist workers from the start of the case by providing consistency to acceptance determination. The safety assessment will help guide decisions about current danger to the child and acceptable interventions for families. The risk assessment will assist workers in making a determination on when to open a case with a family and the appropriate frequency of contact for cases. These tools will be utilized during major case decision points throughout the life of the case from intake to reunification. Title IV-E Prevention Plan updates will be submitted to the Children's Bureau if the implementation of the national safety model influences or changes the information reflected in this initial submission.

Section 5: Evaluation Strategy and Waiver Request

The Kentucky's evaluation strategy for Family First implementation will apply a mixed-methods (quantitative and qualitative) evaluation model that includes process, outcome, and impact measures. While DCBS is contemplating an over-arching evaluation strategy for Family First implementation as a whole within the State, the agency will be working with CHFS evaluators and an internal CQI team to ensure that there is a discrete evaluation or CQI strategy for each EBP proposed within this Title IV-E Prevention Plan.

An evaluation/CQI team of CHFS Family First research/evaluation staff, program leadership, front line staff, community stakeholders, and client stakeholders is being developed. The evaluation team will be led by Dana Quesinberry, JD, DrPH, and Matthew Walton, PhD, from the Division of Analytics in the Office of Health Data and Analytics at the Cabinet for Health and Family Services. Dr. Quesinberry practiced law for 15 years with a focus in child abuse and neglect cases. Under multiple federal grants, Dr. Quesinberry conducted evaluations of existing prevention programs, implementation of new programs, and health policy. Dr. Walton was on the team that conducted the evaluation of the START program that is included in the promising strategies to be implemented.

While DCBS is proposing that a formal evaluation will apply to some EBPs and CQI strategies will apply to others, this evaluation/CQI team will work in partnership to ensure a shared conceptual framework, promote collaboration and information sharing, and create a sound foundation for DCBS' broader Family First implementation.

Evaluation waiver and CQI strategy for well-supported interventions

Kentucky will be seeking a waiver request for the evidence-based practices included in this plan that are rated as well supported in the Title IV-E Prevention Services Clearinghouse. Those EBPs include multisystemic therapy (MST), functional family therapy (FFT) and parent child interaction therapy (PCIT). See Appendix J for the requested waivers.

A consistent, statewide CQI strategy will be utilized to monitor fidelity to the interventions and achievement of intended outcomes by those well supported EBPs. CQI processes may also measure additional performance outcomes to the extent possible, like families' experiences and/or satisfaction with the programs or treatment models included in the candidates' child-specific prevention plan. Kentucky is building CQI capacity and integrating CQI activities into existing practice in several ways. In addition to including CQI processes within Standards of Practice (SOP), DCBS is also hiring a Family First program specialist within the Prevention Branch of the Division of Protection and Permanency (DPP) to support statewide CQI activities and provide additional contributions and oversight to regional Family First liaisons as well as gatekeepers. CQI processes will include quality periodic case reviews conducted with providers to ensure alignment with the practice models.

Data will be collected and stored in both the state CCWIS system, as well as an in-home provider database. Data will also be collected utilizing a screening tool to ensure data are collected consistently and accurately. Quality Control Analysts within the Information and Quality Improvement Unit will assist with regard to any data issues encountered. The sample size reviewed will be large enough to make statistical inferences and reviewed with regard to geographical location and population. Specific caseload data will be screened to provide context and address agency performance. Quarterly CQI meetings will be held with a variety of providers reviewing administrative reports consisting of key data points, assessing challenges to successful implementation and planning for solutions to eliminate the barriers identified by stakeholders. Data collected during the case review process will also be shared with providers during quarterly meetings. This will allow for providers to inform analysis and to increase collaborative efforts. Furthermore, focus groups with families and providers will be conducted annually.

Evaluation Strategy

Once the initial list of preventive programs is reviewed and approved by the Children's Bureau, the evaluation team will develop an evaluation plan to determine the evaluation questions, appropriate measures, indicators, data sources and analytic approaches for each intervention that is not rated as well-supported by the Title IV-E Prevention Services Clearinghouse using the Clearinghouse standards as a guide. The evaluation team will also plan for the inclusion of provider and client surveys in the evaluation plan. A dissemination plan for evaluation findings - both interim, periodic, and final – will be developed and will include report to the Clearinghouse of evidence that supports the inclusion or identification of these interventions as well-supported.

While DCBS is not proposing a cross-site evaluation at this time, KY CHFS is willing to participate in a cross-site evaluation of any of the EBPs proposed in this Title IV-E Prevention Plan should the opportunity become available.

Research questions

Several preliminary research questions have been identified to guide the overall evaluation strategy applied to Family First preventive programs.

Overall program

1. Has the implementation of Family First Prevention Services kept at-risk children from being removed from their homes after six months, one year, and two years?
2. What is the contribution of each EBP to the reduction of removals of at-risk children?
 - a. Is there a dose-response effect for referrals to more than one service?
 - b. Are there better outcomes when services are provided to the both caregivers and children than when provided only to the children or only to the caregivers?
 - c. Is there a synergistic effect when two or more services are provided? What are the more effective combinations?
3. Do families with Medicaid have better (worse) outcomes after the provision of services than families privately insured or uninsured? (Florence, Brown, Fang, & Thompson, 2013; Fang, Brown, Florence, & Mercy, 2012; Johnson-Reid, Drake, Kohl, 2009)

Program specific

1. Do the families that participate in (insert name of service) have better outcomes than families who do not?

2. Do the families who participate in (insert name of service) complete the program?
3. What are the costs, and who bears them, for providing this service? Is the program cost effective? (Johnson-Motoyama, Brook, Yan, & McDonald, 2013)
 - a. By family served
 - b. By reduction of removals of at-risk children

Additional outcomes that may be examined include:

- No additional substantiated claims of abuse/neglect up to one year after identification.
- Increase in provider capacity to provide evidence-based programs.
- Fewer children placed in out of home care.

Table 4: Evaluation strategy for promising programs to be implemented

Program	CEBC Rating	Title IV-E Prevention Services Clearinghouse Rating	Program Specific Evaluation plan	Overall Kentucky Evaluation Analysis Plan
1-2-3 Magic: Effective Discipline for Children 2-12	Promising	Not applicable	This program focuses on three straightforward parenting tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. Program specific evaluation will assess the number and proportion of families referred to services who complete the program. Both qualitative and quantitative data will be collected to evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one year after the initiation of services.	The evaluation will be a prospective cohort study. The cohort is defined as families who have been identified as containing at least one child at risk for removal from the home. Stratification of the cohort will be families received referrals to services in the identified programs. The outcome of interest is the lack of removal of child(ren) from home at six months and twelve post referral.
Cognitive Behavior Therapy	Well Supported	Not applicable.	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. Program specific evaluation will assess the number and proportion of families referred to services who	Additional stratification will be on the type of programs provided

Program	CEBC Rating	Title IV-E Prevention Services Clearinghouse Rating	Program Specific Evaluation plan	Overall Kentucky Evaluation Analysis Plan
			complete the program. Both qualitative and quantitative data will be collected to evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one year after the initiation of services.	and the number of services provided for a dose-effect response the number of types of services provided and the number of encounters with each service.
Motivational Interviewing (MI)	Well supported	Not applicable.	MI is a client-centered, directive method designed to enhance client motivation for behavior change. This program will be evaluated based on the number/proportion of families referred to service who meet program goals, engage in other services – if applicable, and have no removal of at risk child(ren) at six months and one year after initiation of services.	
Sobriety Treatment & Recovery Team (START)	Promising	Not applicable.	This program has independent evaluation embedded in the program delivery.	
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	Well supported	Promising	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. This program will be evaluated based on the number/proportion of families referred to service who meet program goals, and have no removal of at risk child(ren) at six months and one year after initiation of services.	

Section 6: Child Welfare Workforce Training and Support

Ensuring a well-trained provider agency workforce

As indicated earlier in the Prevention Plan, all EBPs are administered within a trauma-informed framework. To accomplish this objective, all clinicians within Kentucky's provider agencies and broader service array receive trauma training. In addition, DCBS recognizes that ongoing trauma training is necessary to sustain and grow knowledge and skills around trauma-responsive practice. As such, DCBS is exploring mechanisms to ensure that the provider workforce has access to ongoing training opportunities together with the public agency workforce. Creating joint learning opportunities will ensure that both public and private workers and clinicians have the opportunity for a shared knowledge base and peer-learning opportunities. Provider contracts require that providers be trained/certified in intensive evidence-based in home service models as well as research-based nationally recognized curricula, assessments or other appropriate tools with demonstrated effectiveness in reducing or avoiding the need for out of home placement. Documentation of EBP model training and certification is maintained by the agency to be reviewed annually by contract monitors for fiscal and programmatic compliance.

As mentioned above, Kentucky will initially expand practices that are currently available. As such, there are existing mechanisms in place to ensure child welfare and provider staff receive relevant training and coaching in these practices. Existing relationships with trainers and purveyors will be examined and updated as necessary to accommodate additional training needs and establish learning collaboratives as needed. Additionally, DCBS will seek opportunities to collaborate with the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) and other agencies within the Cabinet for Health and Family Services to integrate existing or create new contracts with training entities that are providing training to multiple agencies within the Cabinet (i.e., Motivational Interviewing, Parent Child Interaction Therapy). Likewise, DBHDID will extend invitations to non-Community Mental Health Center (CMHC) providers to join new and ongoing learning collaboratives in evidence-based practices.

As DCBS expands contracts to new providers and/or for new interventions, the contracts will require that clinicians are appropriately trained and certified in the models they administer. Compliance with these requirements will be addressed through contract monitoring activities and other technical assistance and support provided by DCBS.

Ensuring a well-trained child welfare agency workforce

Every Protection and Permanency Employee receives the Training Academy for new employees. The Academy is a credit-for-learning initiative, which is a collaborative partnership between the public universities and DCBS. The Training Academy provides college graduate credit from accredited graduate social work programs for job related learning for new employees in the Academy. The Training Academy has four courses: Course 1: Introduction to Child Welfare; Course 2: Collaboration Assessment and Documentation, Course 3: Case Management and Course 4: Child Sexual Abuse. New employees of DCBS will receive training on the service array and child specific prevention plans through the Case Management course, in the DCBS Academy Training.

In preparing for Family First, the Training Academy will be enhanced and modified to include training on trauma-informed, evidence-based services. Current DCBS Staff will receive training through web-based and face-to-face trainings designed to educate staff on the evidence-based services along with the referral process to each service to ensure families have access to these services. Regional Family First liaisons will be trained on Family First provisions and their practice implications and requirements to help support front line staff. Front line staff will receive a Web-based Training about implications and expected changes to preventive case work practice under Family First, including content related to candidacy definition, child-specific prevention plan development, and identification, linkage, and monitoring receipt of evidence-based interventions. EBP providers will also have access the Web-based Training. Staff will continue to receive training on the case planning process to ensure families are receiving and making progress on their goals and objectives supported by evidence-based treatment programs.

To reinforce the Academy Training Material and the implementation of Family First Legislation, supervisor engagement strategies have been incorporated into the Training Academy. This allows new workers opportunities to practice skills learned in the classroom, enables new employees and their supervisors to gain a better understanding of the new employees' abilities, and provide supervisors with a clear focus for continued coaching activities. During the Assessment Phase, new employees' strengths and areas in need of further development are identified, Coaching Action Plans for development of those areas in need of improvement are created, the regional training coordinator facilitates a face-to face meeting with the new worker and supervisor to discuss the Coaching Action Plan, and information gathered through the Assessment Phase is shared with designated regional staff and the DCBS Training Branch. Coaching Action Plans will be modified to reflect language around Family First and the EBP

Models. This will be one way for supervisors to coach and mentor new staff around Family First Legislation.

The training branch also conducts the Advanced Supervisory Series, which is comprised of three credit-for-learning courses. The courses focus on the knowledge, skills and opportunities for application of critical supervisory skills. The training branch will make adjustments and modify training content to include Family First requirements along with material on how supervisors support their staff around the Family First implementation and oversight of ongoing casework.

Section 7: Prevention Caseloads

Please see Appendix K, Program Descriptions, for contracted in-home service provider caseload size.

When discussing prevention caseloads, it is important to distinguish between the caseloads maintained by the DCBS in-home workforce, and the caseloads maintained by the private providers administering the EBPs. Public agency caseworkers and private providers work in partnership to serve the family, keep children safe, and achieve case plan goals.

DCBS strives to reduce DCBS case manager caseloads by enlisting support from private providers to work with families through in-home prevention services. DCBS struggles with workforce challenges and contracting with private EBP providers ensures prevention EBP caseloads have capacity to allow closer contact and input on safety and risk assessments. Additionally, DCBS is working on a hiring effort to meet caseload standards of 18:1. Decreasing caseloads is a primary Child Welfare Transformation goal, and there are a number of strategies underway to promote achievement of this goal. Regardless of current caseload size, DCBS case managers maintain at least monthly contact with families to assess safety and risk. In addition, the prevention service providers maintain more frequent and intensive contact with families.

Private contracted prevention services providers are able to regulate their caseloads at a more manageable level based on needs of the families they serve through the contract. Those caseloads vary based on composition of family risk level as well as worker experience. In-home services where children have been identified as being at imminent risk for removal require provider staff hold no more than four cases at a time due to the service intensity necessary. In-home services for moderate risk cases extend provider staff caseloads to no more than six cases at a time. Kentucky's Title-IV E Waiver and substance abuse in-home services range from nine cases at a time for KSTEP and 15 cases at a time for START.

In-home service provider caseloads are determined, managed and overseen by contracted provider leadership for all programs, excluding START. START caseworkers are determined, managed and overseen by DCBS supervisors, regional staff, START leadership, and Kentucky's Personnel Cabinet.

Section 8: Assurance on Prevention Program Reporting

Appendix L contains DCBS' assurance (CB-PI-18-09 Attachment I) that it will comply with all prevention program reporting requirements put forward by the Children's Bureau. At a minimum, DCBS will provide the following information for each child that receives Title IV-E prevention services:

- The specific services provided to the child and/or family
- The total expenditures for each of the services provided to the child and/or family
- The duration of the services provided
- If the child was identified in a prevention plan as a “child who is a potential candidate for foster care:”
 - the child’s placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a “child who is a potential candidate for foster care” in a prevention plan
 - whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period
- Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity).

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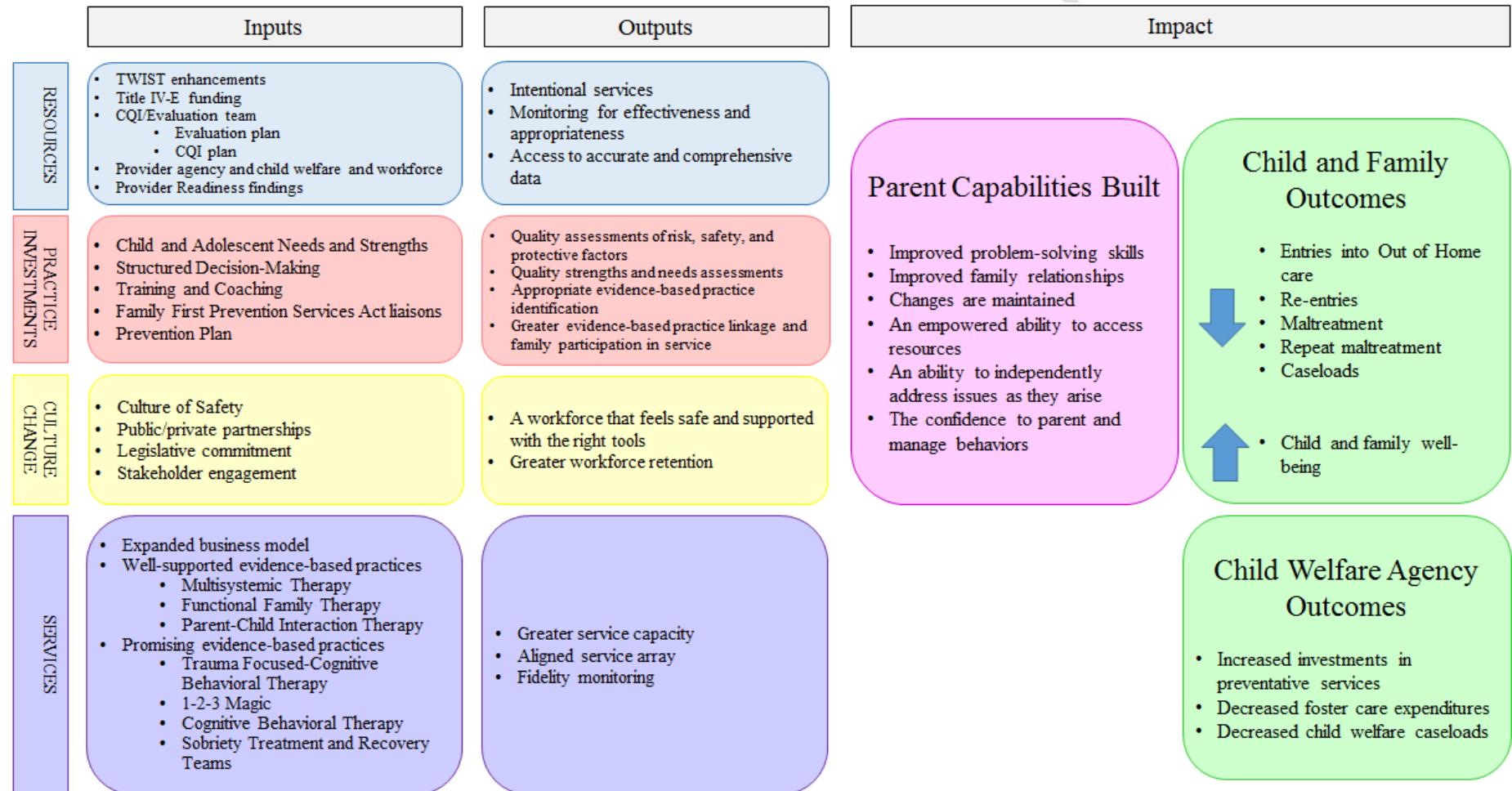
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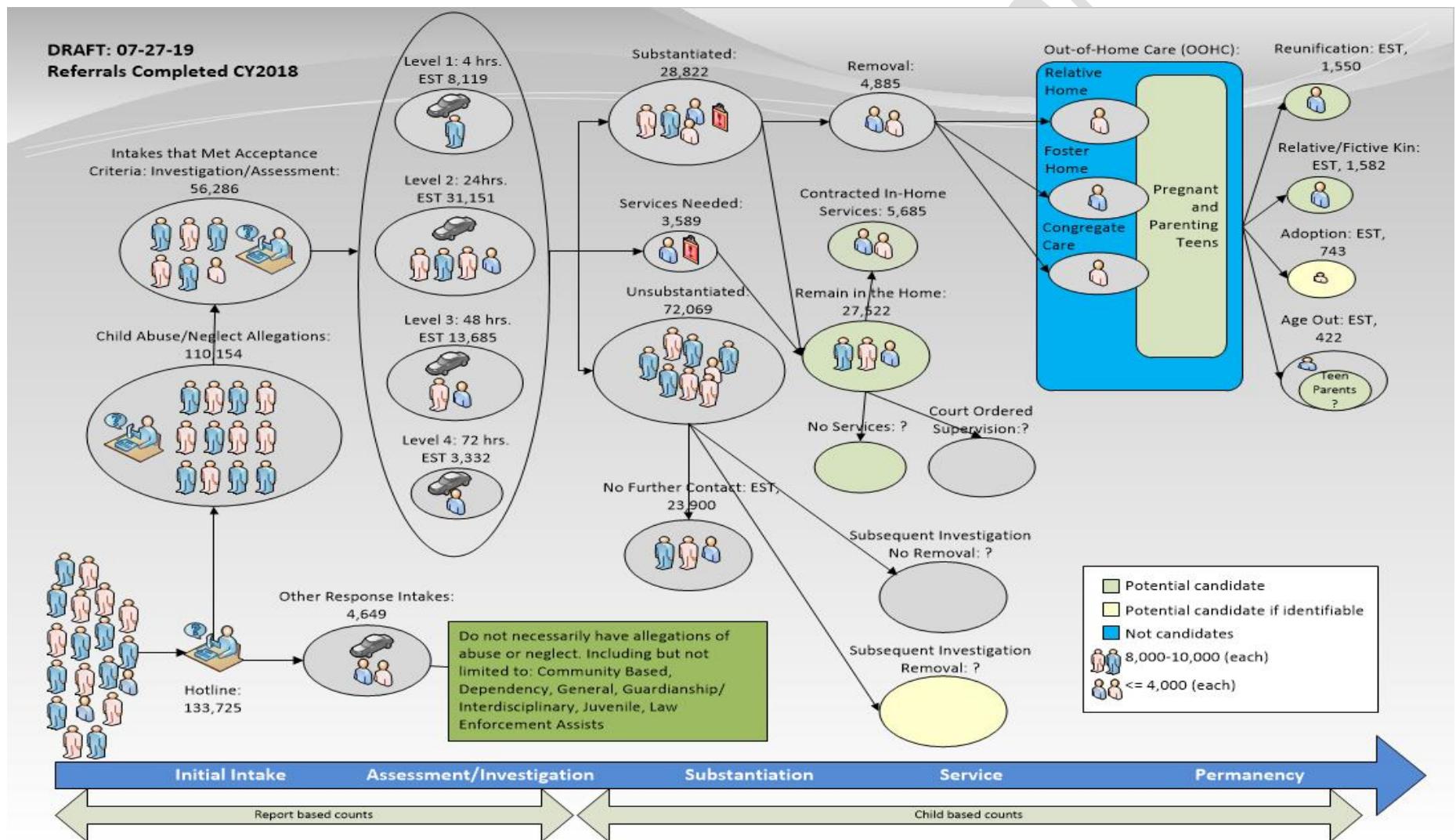
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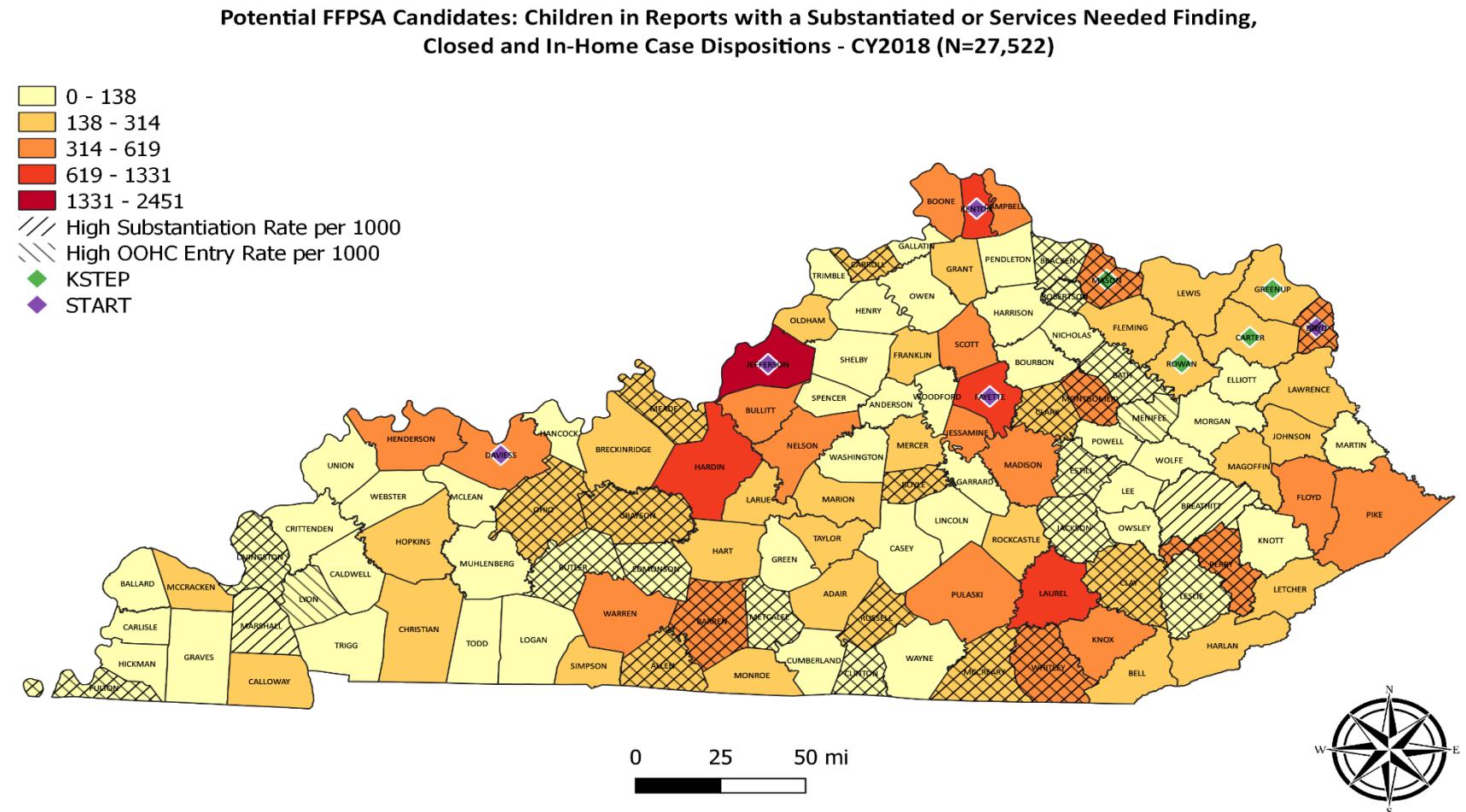
Appendix A: DCBS' Overarching Theory of Change for its Title IV-E Prevention Plan



Appendix B: Referrals Completed in CY2018

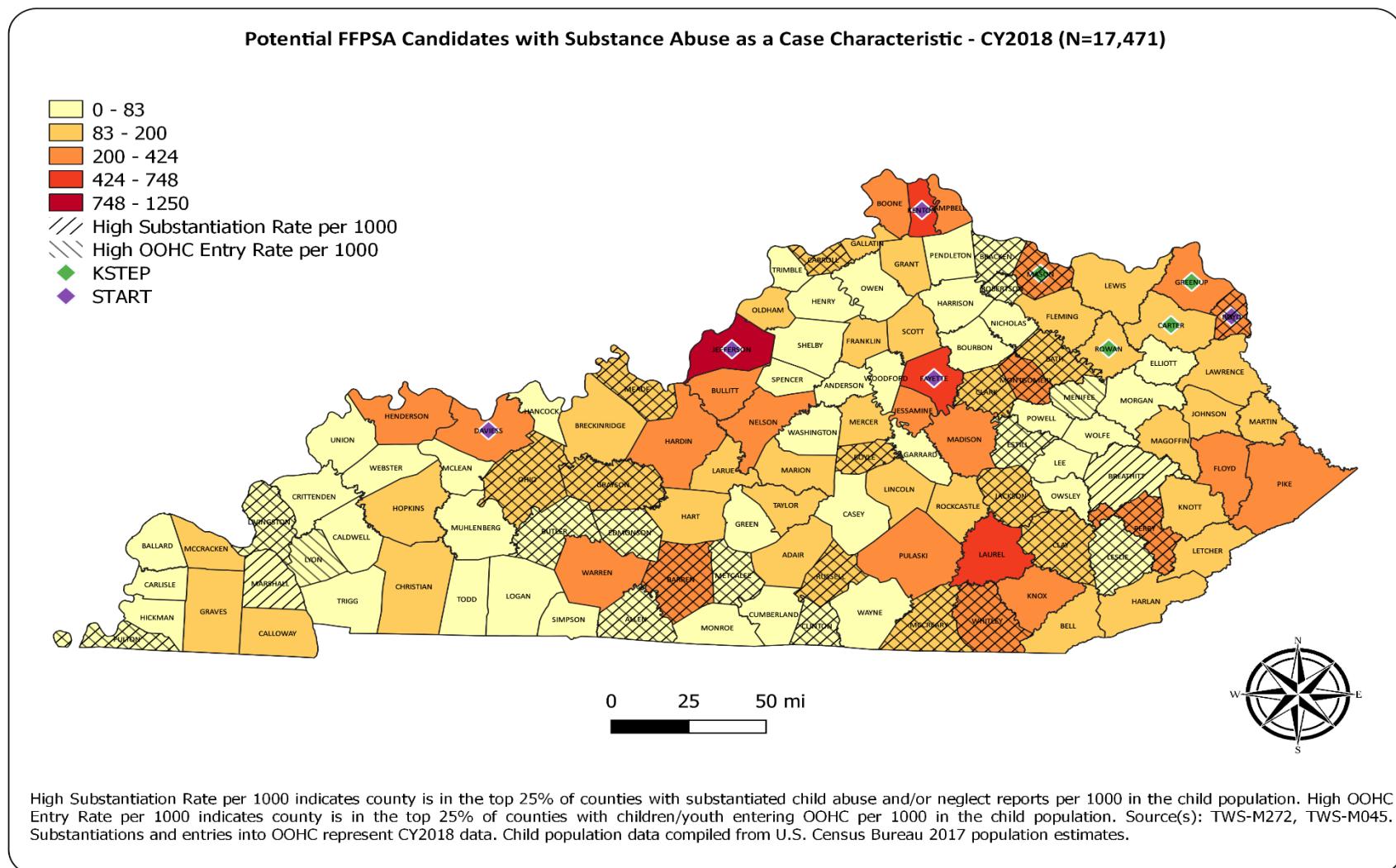


Appendix C: Potential Family First Candidates State Map



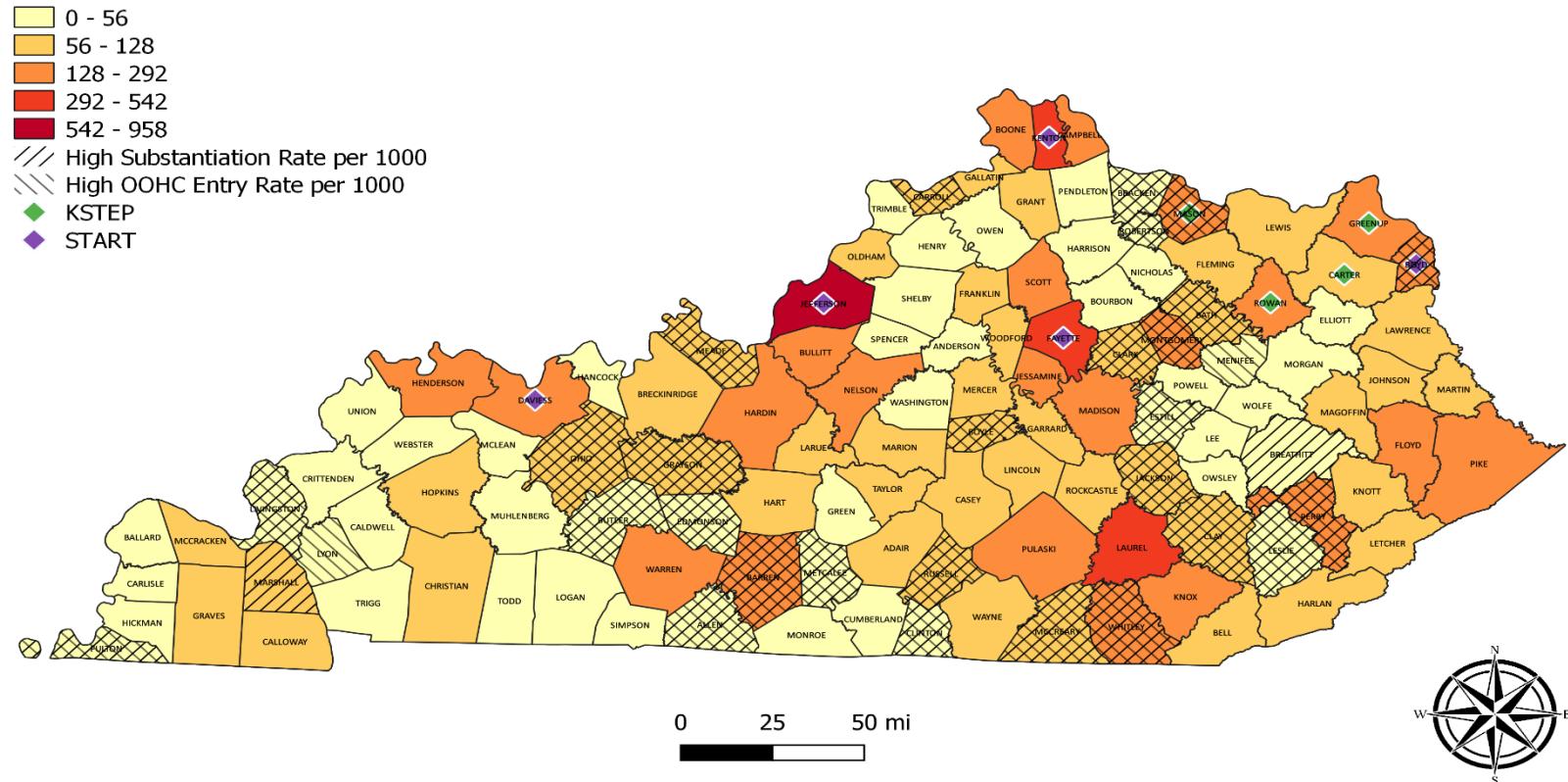
High Substantiation Rate per 1000 indicates county is in the top 25% of counties with substantiated child abuse and/or neglect reports per 1000 in the child population. High OOHC Entry Rate per 1000 indicates county is in the top 25% of counties with children/youth entering OOHC per 1000 in the child population. Source(s): TWS-M272, TWS-M045. Substantiations and entries into OOHC represent CY2018 data. Child population data compiled from U.S. Census Bureau 2017 population estimates.

Appendix D: Potential Family First Candidates with Substance Abuse as a Characteristic State Map



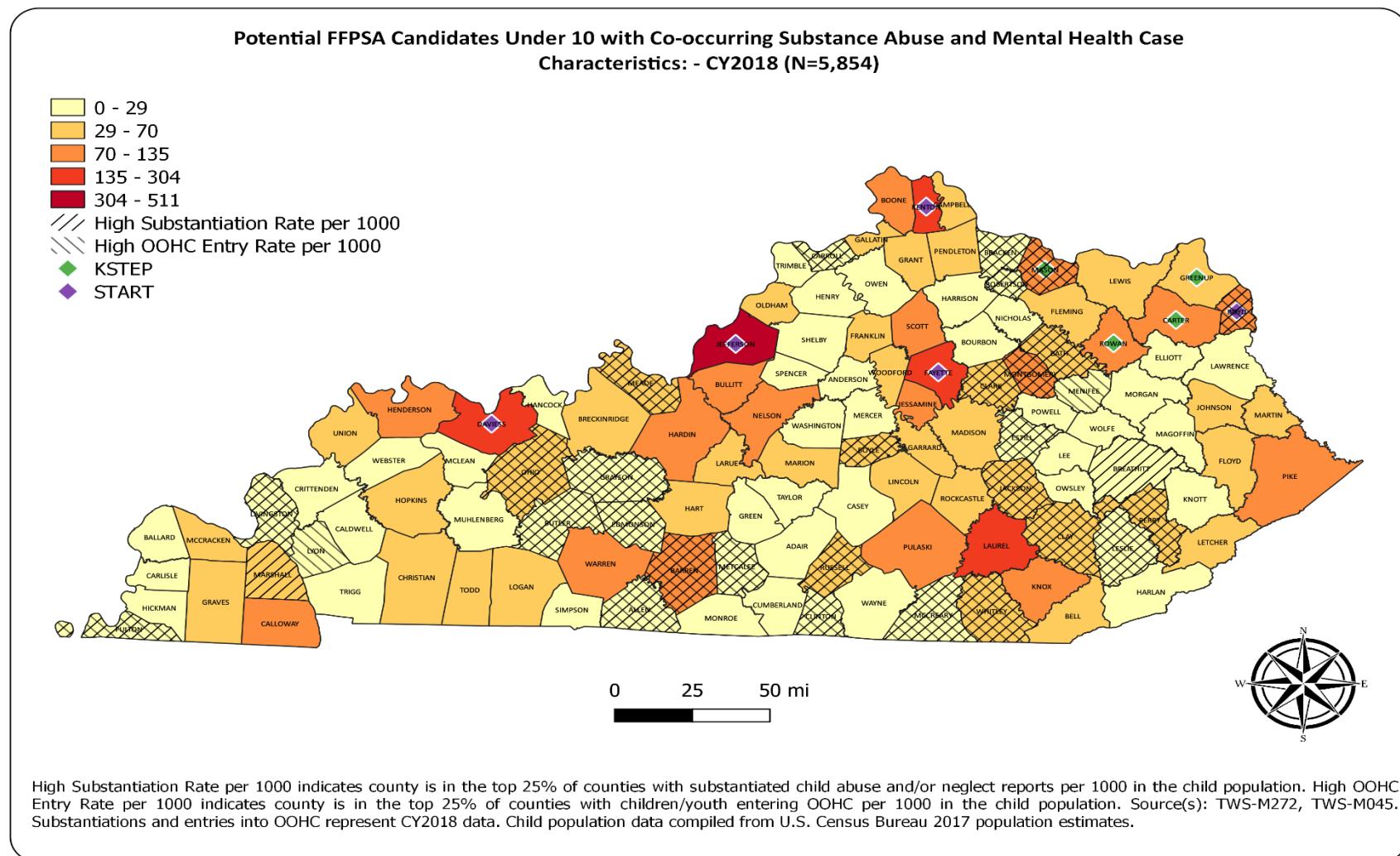
Appendix E: Potential Family First Candidates Under 10 with Substance Abuse as a Characteristic State Map

Potential FFPSA Candidates Under 10 with Substance Abuse as a Case Characteristic: - CY2018
(N=12,164)



High Substantiation Rate per 1000 indicates county is in the top 25% of counties with substantiated child abuse and/or neglect reports per 1000 in the child population. High OOHC Entry Rate per 1000 indicates county is in the top 25% of counties with children/youth entering OOHC per 1000 in the child population. Source(s): TWS-M272, TWS-M045. Substantiations and entries into OOHC represent CY2018 data. Child population data compiled from U.S. Census Bureau 2017 population estimates.

Appendix F: Potential Family First Candidates Under 10 with Substance Abuse and Mental Health as a Characteristic State Map



Appendix G: Overview of Proposed Evidence-Based Interventions

Following is an overview of each of the proposed evidence-based interventions, including the evidence rating by the CEBC, brief description of the program, target population, and intended outcomes.

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
MENTAL HEALTH TREATMENT	Cognitive Behavioral Therapy	Not Applicable	Well-Supported	<p>Adults (18 and over) diagnosed with a mood disorder, including Unipolar Major Depressive Disorder (MDD), Depressive Disorder Not Otherwise Specified, and minor depression.</p> <p>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.</p> <p>Ruminative 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.</p> <p>Depressed adults also demonstrate increased isolation, withdrawal, simultaneous rejection of others and sensitivity to rejection, and decreased activity and enjoyment in</p>	<ul style="list-style-type: none"> • Distinguish between thoughts and feelings. • Become aware of how thoughts influence feelings in ways that are not helpful. • Evaluate critically the veracity of automatic thoughts and assumptions. • Develop the skills to notice, interrupt, and intervene at the level of automatic thoughts. • Use behavioral techniques to identify situations that trigger distress and sadness. • Use behavioral activation to become more attuned with meaningful reinforcement in their lives. • Develop active problem-solving skills. 	<p>Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services Clearinghouse is well supported)</p>

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				<p>activities. They typically experience a number of functional impairments including disrupted sleep cycles, eating and appetite issues, and increased thoughts of death and dying.</p> <p>Behavioral interventions can often help these interpersonal and functional impairments.</p> <p>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.</p>		
	Functional Family Therapy	Well-Supported	Well-Supported	<p>For children/adolescents ages: 11 – 18. 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.</p> <p>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</p>	<ul style="list-style-type: none"> • Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e., school attendance) • Improve family and individual skills 	<p>Evaluation waiver will be requested and CQI strategy to be implemented for EBP.</p>

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				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.		
	Multi-systemic Therapy	Well-Supported	Well-Supported	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). 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	<ul style="list-style-type: none"> • Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) • Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents • Empower youth to cope with family, peer, school, and neighborhood problems 	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				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.		
	Parent-Child Interaction Therapy	Well-Supported	Well-Supported	Children ages 2 - 7 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers. 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.	Child-Directed Interaction component: <ul style="list-style-type: none">• Build close relationships between parents and their children using positive attention strategies• Help children feel safe and calm by fostering warmth and security between parents and their children• Increase children's organizational and play skills• Decrease children's frustration and anger• Educate parent about ways to teach child without frustration for parent and child• Enhance children's self-esteem• Improve children's social skills such as sharing and cooperation	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				<p>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.</p>	<ul style="list-style-type: none"> Teach parents how to communicate with young children who have limited attention spans <p>Parent-Directed Interaction component:</p> <ul style="list-style-type: none"> Teach parent specific discipline techniques that help children to listen to instructions and follow directions Decrease problematic child behaviors by teaching parents to be consistent and predictable Help parents develop confidence in managing their children's behaviors at home and in public 	
	Trauma Focused-Cognitive Behavioral Therapy	Promising	Well-Supported	<p>Children, 3-18 years of age, with a known trauma history who are experiencing significant posttraumatic 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. TF-CBT is a conjoint child and parent psychotherapy</p>	<ul style="list-style-type: none"> Improving child PTSD, depressive and anxiety symptoms Improving child externalizing behavior problems (including sexual behavior problems if related to trauma) Improving parenting skills and parental support of the child, and reducing parental distress 	Rigorous evaluation strategy

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				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.	<ul style="list-style-type: none"> Enhancing parent-child communication, attachment, and ability to maintain safety Improving child's adaptive functioning Reducing shame and embarrassment related to the traumatic experiences 	
SUBSTANCE ABUSE TREATMENT AND PREVENTION	Motivational Interviewing	TBD	Promising	Caregivers of children referred to the child welfare system, has been used with adolescents. 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.	<ul style="list-style-type: none"> Enhance internal motivation to change Reinforce this motivation Develop a plan to achieve change 	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services Clearinghouse is well supported)
	Multi-systemic Therapy	Well-Supported	Well-Supported	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). Multisystemic Therapy (MST) is an intensive	<ul style="list-style-type: none"> Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in 	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
	Sobriety Treatment and Recovery Team (START)	Not Applicable	Promising	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.	raising children and adolescents • Empower youth to cope with family, peer, school, and neighborhood problems	
				Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family	• Ensure child safety • Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible • Achieve child permanency within the Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services Clearinghouse is well supported)

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.	or, if that is not possible, with a relative <ul style="list-style-type: none"> • Achieve parental sobriety in time to meet ASFA permanency timeframes • Improve parental capacity to care for children and to engage in essential life tasks • Reduce repeat maltreatment and re-entry into out-of-home care • Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues • Improve collaboration and the system of service delivery between child welfare and mental health treatment providers 	
IN-HOME, SKILL-BASED PARENTING PROGRAMS	1-2-3 Magic: Effective Discipline for Children 2-12	Not Applicable	Promising	1-2-3 Magic is a group format discipline program for parents, grandparents, teachers, babysitters, and other caretakes working with children approximately 2-12 years of age. The program can be used with average or special needs children. 1-2-3 Magic divides the parenting responsibilities into three	Parents/caregivers will: <ul style="list-style-type: none"> • Be able to use one simple tactic to manage obnoxious behavior without arguing, yelling, or spanking • Be able to use six 	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
	Sobriety Treatment and Recovery Team (START)	Not Applicable	Promising	straightforward tasks: controlling negative behavior, encouraging good behavior, and strengthening the child-parent relationship. The program seeks to encourage gentle, but firm, discipline without arguing, yelling, or spanking.	different tactics for encouraging routines for positive behavior • Master four strategies for strengthening relationships with their children • Understand how to recognize and manage the six kinds of testing and manipulation • Learn appropriate expectations for children's behavior.	Services Clearinghouse is well supported)
				Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry	• Ensure child safety • Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible • Achieve child permanency within the Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents or, if that is not possible, with a relative • Achieve parental sobriety in time to meet ASFA permanency timeframes	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services Clearinghouse is well supported)

PREVENTION PROGRAM CATEGORIES	DCBS PROPOSED EVIDENCE-BASED PROGRAMS	TITLE IV-E PREVENTION SERVICES CLEARING-HOUSE RATING	CEBC RATING	BRIEF DESCRIPTION AND TARGET POPULATION	INTENDED OUTCOMES	EVALUATION STRATEGY
				<p>into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.</p>	<ul style="list-style-type: none"> • Improve parental capacity to care for children and to engage in essential life tasks • Reduce repeat maltreatment and re-entry into out-of-home care • Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues • Improve collaboration and the system of service delivery between child welfare and mental health treatment providers 	

Appendix H: DCBS' Signed Assurance for Trauma-Informed Services

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

Title IV-E Prevention and Family Services and Programs Plan
State of Kentucky

ATTACHMENT III

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.

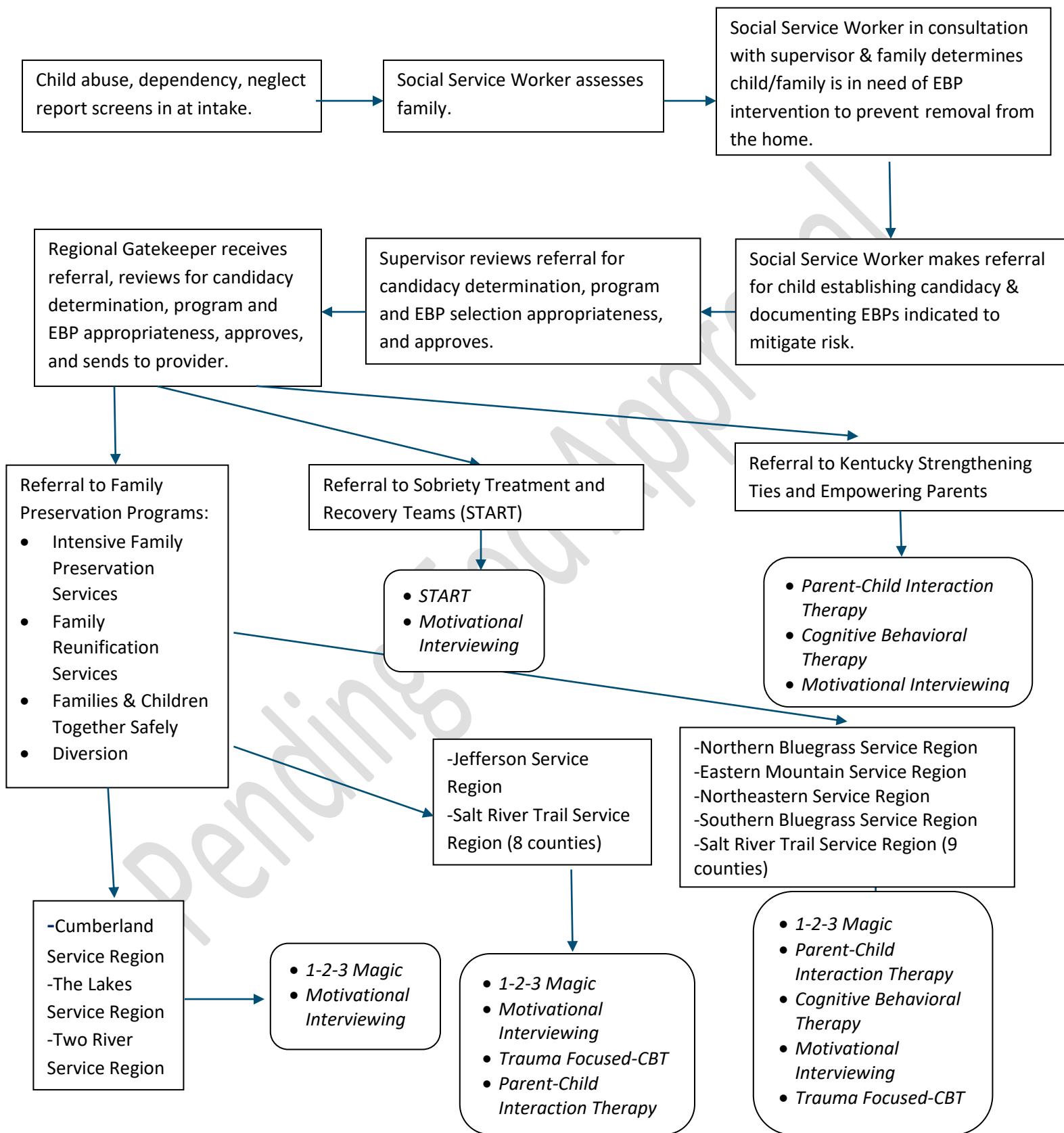
The Department for Community Based Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

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.

8/23/2019
(Date)

Eric L. Lewis
(Signature and Title)
Commissioner

Appendix I: Evidence-based Practice Selection Process Mapping



Appendix J: Waiver Requests

Title IV-E Prevention and Family Services and Programs Plan
State of Kentucky

ATTACHMENT II

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 Department for Community Based Services (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.

8/23/2019
(Date)

Evi S. Lue Commissioner
(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 Department for Community Based Services (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 Mutisystemic 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.

8/23/2019
(Date)

E. V. L. C. Commissioner
(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 Department for Community Based Services (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.

8/23/2019
(Date)

Eric N. Clark Commissioner
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

Appendix K: Program Descriptions for contracted in-home service provider

Prevention Services Description and Eligibility Criteria	Duration and Service Intensity
Intensive Family Prevention Services (IFPS) Eligibility Criteria: Imminent risk of removal of child from home	Duration: Average 4-6 weeks Service Intensity: Intensive in-home services provided for 6-10 direct hours per week Caseload: 2 – 4 families at a time Age limit: 0-17 years old Accessed Statewide
Family Reunification Services Eligibility Criteria: A plan to return child home from out-of-home care	Duration: Average 3-6 months <ul style="list-style-type: none"> • Extensions permitted up to 15 months • Extensions determined by a risk assessment completed every three months Service Intensity: Average minimum 3-8 direct hours per week Caseload: Not to exceed 6 cases at a time Age limit: 0-17 years old Accessed Statewide
Families & Children Together Safely (FACTS) Eligibility Criteria: Moderate risk of removal of a child from the home	Duration: Average 3-6 months <ul style="list-style-type: none"> • Extensions permitted up to 15 months • Extensions determined by a risk assessment completed every three months Service Intensity: Average minimum 3-8 direct hours per week Caseload: Not to exceed 6 cases at a time Age limit: 0-17 years old Accessed Statewide
Diversion Eligibility Criteria: Imminent risk of removal of an older child from the home, with a larger clinical focus	Duration: Average 3-6 months <ul style="list-style-type: none"> • Extensions permitted up to 15 months • Extensions determined by a risk assessment completed every two months Service Intensity: Average minimum 3-8 direct hours per week Intensity is determined based on needs of family Caseload: Not to exceed 6 cases at a time Age limit: 5-17 years old Accessed Statewide

Prevention Services Description and Eligibility Criteria	Duration and Service Intensity
<p>KSTEP (Kentucky Strengthening Ties and Empowering Parents)</p> <p>Eligibility Criteria: Child(ren) at moderate to imminent risk of removal from the home, with parental substance abuse as a primary feature affecting child safety</p>	<p>Duration: Up to 8 months, with extensions permitted beyond this, as assessed by family progress/phase completion.</p> <p>Service Intensity:</p> <ul style="list-style-type: none"> • 5-10 hours per week, 2 contacts a week (1 must include children) for 2-5 months • 2-10 hours per month, 1 contact a week (must include children) for 1-3 months • 1-8 hours per month, 1 contact a month (must include children) for 1-2 months <p>Caseload: Not to exceed 9 cases at a time</p> <p>Age limit: Under 10 years</p> <p>Counties Served: Bath, Carter, Fleming, Greenup, Mason, Lewis, Montgomery, and Rowan</p>
<p>START (Sobriety Treatment and Recovery Team)</p> <p>Eligibility Criteria: New referral (not an active case), substantiated finding or FINSA, one child 0-5 in the home, primary risk factor of parental substance abuse, Medicaid/TANF eligible or work towards insurance</p>	<p>Duration: On average 14 months, with no maximum duration</p> <p>Caseload: Not to exceed 15 cases at a time</p> <p>Age limit: Under 6 years</p> <p>Counties Served: Boone, Boyd, Campbell, Daviess, Fayette, Jefferson, and Kenton</p>

Appendix L: DCBS' Reporting Assurance (CB-PI-18-09 Attachment I)

Title IV-E Prevention and Family Services and Programs Plan
State of Kentucky

ATTACHMENT I

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, Department for Community Based Services, (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.

8/23/2019

(Date)

Eric N. Cox

(Signature and Title)

Commissioner

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)