Massachusetts Department of Children and Families

Five-Year Prevention Plan

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MASSACHUSETTS DEPARTMENT OF CHILDREN AND FAMILIES
FIVE-YEAR PREVENTION PLAN

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EXECUTIVE SUMMARY

The Massachusetts Department of Children and Families (the Department) appreciates the opportunity provided by the Federal Family First Prevention Services Act (FFPSA) to use Federal Title IV-E dollars for specific evidence based placement prevention services. The Department is using the planning and decision making process regarding prevention services not only to achieve a set of prevention goals but also to advance the Department's broader initiatives to address diversity, inclusion, and equity and to eliminate discrimination in the practice of child welfare. Therefore, the goals that guided this Prevention Plan are:

- Increased numbers of children who remain safe with their families, without removal to foster care, and
- Reduced numbers of children who reenter foster care after exiting to reunification, adoption, or permanent guardianship, and
- Equitable proportions of Black, White, Native American, Asian, Latinx, and mixed race children who remain safe with their families, without removal to foster care; and
- Reduced rate of disproportionate representation of Black, White, Native American, Asian, Latinx, and mixed race children in foster care placements.

Building on a five-year decline in the Department's foster care placement numbers, this Plan describes the Department's intention to maintain the existing array of prevention services and to use the Title IV-E reimbursement opportunity to expand the availability of evidence based practices that can be used to keep children safe with their families without removal to foster care.

The Department included several factors in the selection process for which evidence based practices to include in the service array. These factors included:

- Input from both internal and external stakeholders,
- Availability of evidence based practices delivered by other state agencies,
- History of the Department's procurement of evidence based practices,
- The ratings of evidence based practices on the federal government's Title IV-E Prevention Services Clearinghouse as "Well Supported," "Supported," or "Promising," and
- Review of the racial and cultural compositions of the samples used in the research base to establish a service as "evidence based."

Initially, the Department will seek Title IV-E funding to reimburse provision of the following evidence based practices:

- Multisystemic Therapy® rated as Well Supported
- Brief Strategic Family Therapy® rated as Well Supported, and
- Intercept® rated as Well Supported.

In addition, the Department will work with a subset of contracted providers for support and stabilization services to embed Motivational Interviewing (MI), which is rated as Well Supported, into their service delivery as a strategy for improving consumer engagement and retention. Several contracted providers already report using MI. The Department will work with providers to

build capacity to deliver MI and to monitor fidelity in ways that are consistent with FFPSA requirements.

To build the internal capacity to procure and manage evidence based practices in alignment with the requirements of the FFPSA, the Department will procure the services of an external evaluation partner.

The Department intends to amend this Prevention Plan as additional evidence based practices are posted to the Clearinghouse and as both internal and external capacity are developed for delivering and managing evidence based practices. Based on input from family stakeholders, the Department is particularly interested in adding evidence based practices that incorporate provision of concrete supports and delivery by individuals with lived experiences relevant to recipients of child welfare services.

1.0 INTRODUCTION

The Massachusetts Department of Children and Families (the Department) appreciates the opportunity provided by the Federal Family First Prevention Services Act (FFPSA) to use Federal Title IV-E dollars as reimbursement for evidence based prevention services.

1.1 Updated Prevention Framework

The Department's Five-Year Prevention Plan is informed not only by the conventional prevention framework applied in child welfare that includes three levels of prevention–primary, secondary, and tertiary – but also by recent prevention science in the medical field, which added a level of quarternary prevention[1].

The Child Welfare Information Gateway describes prevention efforts as occurring within a framework:

1. Primary prevention directed at the general population to prevent maltreatment before it occurs (universal);
2. Secondary prevention targeted to individuals or families in which maltreatment is more likely (high risk); and,
3. Tertiary prevention targeted toward families in which maltreatment has already occurred (indicated).

Source: https://www.childwelfare.gov/topics/preventing/overview/framework/

Quarternary prevention is used to reduce conditions induced by professionals merely through the use of an intervention for a different purpose. For example, in medical practice, statins are prescribed after heart attacks as a tertiary prevention measure to prevent the occurrence of another heart attack or a stroke. There are, however, adverse effects of statins, which might include muscle aches and damage, loss of cognitive function, and pancreatic and liver dysfunction[2]. There are calls in the medical profession to rein in use of prescription medications that have deleterious side effects unrelated to the condition for which the medicine is prescribed. The principle behind quarternary prevention is to protect patients from interventions that may cause unintended harm in areas unrelated to the original condition for which the intervention is given.

[1] Pandve, H.T. (2014). Quarternary prevention: Need of the hour. *Journal of Family Medicine and Primary Care*, *3*(4): 309 – 310. Martins, C., Godycki-Cwirko, M., Bruno, H., and Brodersen, J. (2018). Quarternary prevention: Reviewing the concept. *European Journal of General Practice*, Vol.*24*(1):106-111.

[2] Golomb, B.A. and Evans, M.A. (2008). Statin adverse effects: A review of the literature and evidence for a mitochondrial mechanism. *American Journal of Cardiovascular Drugs*, Vol. *8*(6): 373 – 418.

In child welfare, foster care placements are a form of tertiary prevention – i.e., placements used after abuse or neglect has occurred as an intervention for preventing reoccurrences of these adverse events. Yet in the context of the FFPSA, characterizing foster care placements as a type of prevention is discordant because the title of Section 50711 of Part I of the Act is "Foster Care Prevention Services." Foster care is identified as an experience that is to-be-prevented, not as an intervention to be used as a prevention strategy.

The Department is using a four-level prevention framework in this Plan to differentiate among the types of prevention services already being implemented in the Commonwealth by the Department or by other state agencies. Using the updated prevention framework helps clarify the goals of prevention services by focusing on the question, "what is to be prevented?" This clarification is essential to the planning of prevention strategies and to the evaluation of their effectiveness. Being intentional about "what is to be prevented?" guides decisions about what is to be evaluated, and ultimately the interpretation of evaluation findings.

1.2 Department Goals

The Department's decisions regarding what services to include in this Five-Year Prevention Plan were guided by the following outcome goals for children and families:

- Increased numbers of children who remain safe with their families, without removal to foster care,
- Reduced numbers of children who reenter foster care after exiting to reunification, adoption, or permanent guardianship,
- Equitable proportions of Black, White, Native American, Asian, Latinx, and mixed race children who remain safe with their families, without removal to foster care,
- Reduced rate of disproportionate representation of Black, White, Native American, Asian, Latinx, and mixed race children in foster placements.

The Department is using the opportunity presented through the FFPSA to review and redesign prevention services not only to achieve a set of prevention goals, but also to advance the Department's broader initiatives to address diversity, inclusion, and equity issues and to eliminate discrimination in the practice of child welfare.

To ensure responsible stewardship of public resources, the Department investigated prevention services provided by sister agencies within the Commonwealth. Through this investigation, the Department created a knowledge base of publicly-funded prevention services that appear on the Title IV-E Prevention Services Clearinghouse that are available to children and families regardless of their involvement with the Department. Using the knowledge base of existing evidence based prevention services allowed the Department to consider the strengths and gaps in the existing array of available evidence based prevention services.

The goal of this process was to make informed decisions about the prevention services that are most needed to fill gaps in the existing evidence based prevention services array available to families and children served by the Department. As new evidence based practices are added to

the Clearinghouse and as capacity for delivering and managing evidence based practices is developed, the Department intends to amend this Plan to add more services.

1.3 Child and Family Eligibility for Title IV-E Prevention Programs

The Department will provide the prevention services documented in the family's Action Plan to eligible children. The Department defines an eligible child, up to age 18, as either (a) a candidate for foster care, who is able to remain safely at home or in a kinship placement with receipt of services specified in this plan; or (b) a foster child who is pregnant or parenting.

The Department defines a "foster care prevention candidate" as a child in either of the following situations who can remain safe, without the need for entry or re-entry into foster care, as long as prevention services are provided:

- a child who is identified in a prevention plan documented in the family's Action Plan as being at imminent risk of entering foster care, which could include a child who has transitioned out of foster care to reunification, or
- a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.

The Department intends to use structured data elements from the completed Family Assessment and Action Plan and service referral information to identify children eligible for the Title IV-E prevention program.

To achieve the desired outcomes of prevention services, the services will be provided directly to the child and/or to the parents, guardians, or relative caregivers of the child. For pregnant or parenting foster youth, the services will be provided directly to the pregnant or parenting foster youth or to the parents, guardian, relative caregivers, or foster caregivers of the pregnant or parenting foster youth.

1.4 Prevention Plans

For each on-going case assignment, the Department completes a Family Assessment and Action Plan. The Family Assessment is organized around five protective factors:

1. Knowledge of parenting and child development
2. Social and emotional competence of children
3. Parental resilience
4. Social connections
5. Concrete support in times of need

Completion of the Family Assessment informs creation of an Action Plan. The Action Plan states the observable changes that are needed to maintain child safety, manage risk, and to achieve any additional goals jointly identified with the family. The Action Plan also includes the actions and services that will support achievement of the observable changes.

The Action Plan, including referrals for approved prevention services, is the Department's prevention plan for each child in the case. Action plans are reviewed and updated every six months[3] as well as whenever there is a significant family event such as a birth, death, addition of new household member, or loss of housing.

Family Assessments and Action Plans may also be updated, at the discretion of the Social Worker and Supervisor, in response to information or recommendations obtained from formal review processes, such as 6 Week Placement Reviews, Foster Care Review, court permanency hearings, or Permanency Planning Conferences.

1.5 Ongoing Safety and Risk Assessment

The Department currently utilizes Structured Decision Making (SDM) Safety and Risk Assessments. Use of the Risk Assessment and Risk Reassessment tools are mandatory during the initial response to a family and every six months thereafter. The Department is working with Evident Change to update the existing Safety Assessment, which is currently used on an optional basis. The Safety Assessment is being updated to include a structured framework for examining the potential safety and risk for a child within a family unit.

When updates to the Safety Assessment tool are complete, the Department's requirements for mandatory use of SDM tools will follow this schedule:

- Safety Assessments will be completed at the beginning of a response,
- Risk Assessments will be completed at the end of a response (i.e., 5 or 15 days later),
- Risk Reassessments will be completed at the conclusion of the initial FAAP, recurring every six months thereafter, as well as in response to any significant family event, and at the discretion of the Social Work and Supervisor, and
- Safety Assessments will be utilized at any time during the life of a case to assess if a child can safely remain in the home.

1.6 Participation Rates in Prevention Services

The Department respects that the concept of "reaching out for and engaging with services" is critical for designing effective prevention services. Whether referred to as "take-up rate,[4]" "propensity,[5]" "engagement,[6]" "enrollment," or simply "participation," the 2009 report on preventing mental and emotional disorders among young people by the National Research Council and the

[3] This timing aligns with the FFPSA requirements for periodic risk assessments throughout the 12-month period, redetermination at 12 months, and determination and documentation of eligibility for each additional 12 month period that prevention services are provided.

[4] Yoshikawa, H., Aber, J.L., and Beardslee, W.R. (2012). The Effects of Poverty on the Mental, Emotional, and Behavioral Health of Children and Youth: Implications for Prevention. *American Psychologist*, Vol. 67 (4): 272-284.

[5] Berg, J., Morris, P., & Aber, J. L. (2011). Two-year impacts of Opportunity NYC by families' likelihood of earning rewards. Evanston, IL: Society for Research on Educational Effectiveness. http://www.eric.ed.gov/PDFS/ED517882.pdf

[6] Spoth, R., Redmond, C. (2000). Research on Family Engagement in Preventive Interventions: Toward Improved Use of Scientific Findings in Primary Prevention Practice. *The Journal of Primary Prevention*, Vol. 21: 267–284.

Institute of Medicine emphasized that the effectiveness of any prevention service for families is especially susceptible to low participation because families have to make choices, both at the start of a service and throughout its duration, about becoming and staying involved.[7]

The District of Columbia's Title IV-E Waiver Demonstration Project provided an example in child welfare practice of the importance of attending to participation rates. The District's Title IV-E Demonstration Project included the introduction of evidence based practices into the Child and Family Services Agency's service array. The Interim Evaluation Report described the challenges with enrolling families and reported that four of nine programs had a lack of enrollment for a third or more of the families referred for services[8].

Having the capacity to reach out independently for services and to stay engaged with those services without support is not a reasonable expectation for most families served in child welfare agencies. Rarely is there a family in the system that struggles with a single issue, such as substance abuse, by itself. Rather, children and families in the child welfare system are likely to

> "The child welfare system and or child protection does not realize the difficulty that families have to try to receive the health care benefits to begin to access services."
>
> ~ Sandra Killett from New York with We All Rise and The Alliance and Casey Family Programs, quoted in *Family Voices on Mental and Behavioral Health Supports June 2021,* a perspectives paper from www.familyvoicesunited.org. Cited with permission.

experience substance use and mental health challenges with the concomitant factors of trauma histories, housing instability, high unemployment, domestic violence, and the unrelenting environmental stressors that accompany living in poverty. Many families served by the Department are headed by a single parent who, alone, faces all of the tasks of child rearing, housekeeping, and securing an income.

Services that may seem easily accessible to funders and service providers may remain out of reach to a parent who is in crisis or who lacks the physical or emotional energy or transportation to access it.

Families of color, families with a member who has an intellectual, sensory, or physical disability, families for whom English is a second language, and immigrant families may avoid connecting with available prevention services due to past experiences with racism, discrimination, language

[7] O'Connell, Boat, and Warner, Editors. (2009). Preventing Mental Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults,
Washington (DC): National Academies Press (US).

[8] Affronti, M.A., Collins, B., and DiLuglio, T.G. (2017). Title IV-E Waiver Demonstration Project: Interim Evaluation. Government of the District of Columbia, Child, and Family Services Agency.

barriers, cultural values about obtaining assistance, fear of government agencies, or a combination of these factors.

Designing community-based services for families served by public child welfare agencies requires reaching, engaging, and retaining families who are likely to be socially isolated and face multiple, intersecting challenges that interfere with accessing and completing the full course of a service. Stern et al.'s 2015 research[9] demonstrated that it is possible to increase connections with and retention of multi-stressed families in mental health services, but it requires a focus on and sustained attention to families' needs and the implementation of intentional intake and retention strategies to meet those needs.

Given the critical nature of participation for the effectiveness of prevention services, the engagement and retention of families in services is a theme that is repeated throughout the Department's Five-Year Prevention Plan. The intention is to build a service array of prevention services that will be effective in fulfilling the promise of evidence based practices for increasing the safety of children from all racial and cultural backgrounds while maintaining more children safely in their own homes without the need for out-of-home placements.

1.7 System-wide Readiness for Evidence Based Practices

For many evidence based practices, an initial step in preparation is for the organization that is considering offering an evidence based practice to assess organizational readiness to fulfill the requirements for implementation. The following aspects of the public-private child welfare system in Massachusetts affect understanding of and readiness for implementation of evidence based practices and hence inform this Plan.

Multiple definitions of evidence based practices

The Department's outreach to internal and external stakeholders, including other state agencies, revealed multiple definitions in use within the Department, in other state agencies, and within the provider community for the term "evidence based."

A few examples of the different definitions included descriptions of "evidence based" as meaning**:**

- Any service or treatment for which outcome data is collected,
- Use of a portion of a treatment that has been designated as "evidence based," such as using only the skills portion of Dialectical Behavioral Therapy, or developing an adapted version of Motivational Interviewing, or
- Combining aspects from different written treatment manuals to create a service tailored for a specific population of clients.

Multiple sources for determining what practices are evidence based

When working with other state agencies to assess and expand the array of prevention services and treatments available in the Commonwealth, the Department learned that different state agencies rely on different sources to designate a practice as "evidence based."

[9] Stern, S.B, Walsh, M. Mercado, M., Levene, K., Pepler, A.C., Heppell, A., and Lowe, E. (2015). When they call, will they come? A contextually responsive approach for engaging multi-stressed families in an urban mental health center: A randomized clinical trial. *Research on Social Work Practice*, *25*(5), 549 – 563.

In addition to the Title IV-E Prevention Services Clearinghouse https://preventionservices.abtsites.com/, examples of these sources include the:

- Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide https://ojjdp.ojp.gov/model-programs-guide/home,
- National Institute of Justice's Crime Solutions website Programs & Practices | CrimeSolutions, National Institute of Justice (ojp.gov),
- Agency for Healthcare Research and Quality's Evidence based Practice Centers' reports https://effectivehealthcare.ahrq.gov/health-topics, and
- Washington State Institute for Public Policy's (WSIPP) and the University of Washington's Evidence based Practice Institute's (EBPI) inventory of evidence based, research-based and promising practices for prevention and intervention services for children and juveniles in the child welfare, juvenile justice, and mental health systems https://www.wsipp.wa.gov/Publications, and
- California Evidence-Based Clearinghouse for Child Welfare https://www.cebc4cw.org.

The Department understands the requirements for Title IV-E reimbursement of prevention services, including that the service must be listed on the Title IV-E Clearinghouse as a "Promising," "Supported," or "Well-Supported" evidence based practice. The examples of different sources for determining whether a treatment is "evidence based" are provided to illustrate why the prevention services landscape in the Commonwealth includes prevention services that do not appear on the Title IV-E Clearinghouse yet are considered by professional colleagues both in and out of state government to be "evidence based."

Cultural match of evidence based practices

A special 2015 issue of the journal *Transcultural Psychiatry*[10] described the tensions between evidence based practices and culturally competent practices by contrasting the evidence based practice requirement for standardizing clinical practice with the cultural competency requirement to diversify clinical practice in ways that reflect and respect the cultural contexts of clients served. This Plan cannot address all factors that contribute to this tension but does attend to one of the key factors, specifically the need to attend to the racial, ethnic, and cultural backgrounds of the subjects in the research studies used to establish a practice as evidence based.

Therefore, this Plan attends to the cultural composition of the research base for each evidence based practice that is considered for implementation. Attention to the racial, ethnic, and cultural heritages of the subjects included in the research upon which a practice is deemed "evidence based" prompted the Department to ask, for each evidence based practice considered for inclusion in this Plan, "For what subset of the child welfare population has this treatment been judged to be evidence based?"

[10] Gone, J.P. (2015). Reconciling evidence-based practice and cultural competence in mental health services. *Transcultural Psychiatry*, 52(2), 139-149.

Expense of demonstrating that a practice is evidence based

The Department's existing Support & Stabilization (S&S) procurement includes contracts with more than 100 community-based providers that deliver an array of services to the children and families served by the Department. These services may be used flexibly to support children and families and may be delivered at any point in the life of an open case to promote safety, well-being, and permanency for children.

Some S&S providers contend that when their services are delivered to intact families that children are able to remain safe and stable with their families without removal to foster care, which is the desired outcome for the evidence based practices posted on the Title IV-E Prevention Services Clearinghouse. However, without published, rigorous research demonstrating the effectiveness of the services, which is expensive to conduct, the practices cannot obtain "evidence based" status, be posted on the Clearinghouse, and qualify for Title IV-E reimbursement.

In response to this concern voiced by contracted S&S providers, the Department's plan for Evaluation in Section 8 includes initial steps in gathering data not only about the prevention services from the Title IV-E Prevention Clearinghouse, but also about some historically funded S&S services. This work will begin the process of exploring effectiveness of some of the services in the longstanding S&S service array. This research will enhance not only the Department's knowledge of effective quarternary prevention services but may have the long-term potential to contribute to the knowledge base of evidence based practices in child welfare.

In sum, just as organizations preparing to deliver evidence based practices must ready themselves for effective and sustainable delivery, the Department must build the capacity to procure, manage, and evaluate evidence based practices in alignment with the requirements in the FFPSA. The Department intends to amend this Plan in the future to include additional evidence based practices to the service array. The advantages of this approach, which matches the incremental growth of the Title IV-E Prevention Services Clearinghouse, include opportunities to:

- Create the Department's internal infrastructure for purchasing and managing evidence based practices,
- Procure the services of an external evaluation partner to support the design and implementation of monitoring and evaluation,
- Build capacity in the contracted provider community for delivering and sustaining evidence based practices, and
- Benefit from evidence based practices not yet reviewed that will be posted to the Clearinghouse in the future, including services that incorporate provision of concrete supports and delivery by individuals with lived experiences similar to those of the recipients to services.

2.0 CURRENT PREVENTION SERVICES FOR CHILDREN AND FAMILIES IN THE COMMONWEALTH

2.1 Family Resource Centers – Primary and Secondary Prevention

Launched in 2015, Family Resource Centers (FRCs) provide parents, teens, and children a community-based, one-stop source for an array of direct services - from parent education to support groups to classes in household financial management. FRCs also provide referrals to obtain services such as childcare and behavioral health treatments that can strengthen families' capacities for safe parenting and self-sufficiency.
The philosophy of FRCs is to "do whatever it takes" to strengthen families using the same framework of five protective factors used in the Department's Family Assessment:

1. Knowledge of parenting and child development
2. Social and emotional competence of children
3. Parental resilience
4. Social connections
5. Concrete support in times of need

There are 27 FRCs under contract with the Department. The FRCs are geographically dispersed, with at least one in each of the Commonwealth's 14 counties. In addition, the Massachusetts Children's Trust operates six Family Centers that offer similar services and programming to the FRCs. Decisions related to the location of the FRCs and Family Centers were based on community indicators that included rates of poverty, crime, school discipline, single parent families, unemployment, and involvement with the Department.

The community-based center approach to prevention includes both the primary and the secondary stages in the prevention framework. The centers' services are available to the general public and provide direct delivery of services as well as information and referral to other community resources. FRCs direct services include programs on topics of interest to many parents, such as learning the developmental milestones for children of all ages, developing parenting skills, finding childcare, working with schools, and connecting with other parents through support groups. The FRCs also help with budgeting, finding jobs and developing a career, and securing concrete resources such as housing and utility assistance.

The siting of the FRCs and Family Centers in neighborhoods with multiple factors increasing risk of child abuse and neglect equates to services being more accessible and targeted to the community. Hence, the Centers' services are examples of secondary prevention for families at a higher risk for abuse or neglect.

The FRCs and Family Centers offer families accessible supports that have the potential to prevent cases of child abuse or neglect that bring families into the Department's formal caseload. For families capable of reaching out for and engaging with supportive services, the Family Resource Center system provides Commonwealth families with a community pathway for diversion from entry into public child welfare.

The parenting education programs offered through the FRCs or Family Centers are considered "evidence based" or "evidence informed" by different sources. The one parenting education program offered through the FRCs or Family Centers that currently appears on the Title IV-E Prevention Services Clearinghouse is Incredible Years – School Age Basic.

2.2 The Department's Support & Stabilization Services– Secondary, Tertiary and Quarternary Prevention

The Department's S&S service array is specifically for children and families on the Department's formal caseload, which means there has been an incident of indicated abuse or neglect. The current S&S procurement, which was issued June 1, 2006, establishes contracts with more than 100 community-based providers across the Commonwealth.

S&S is funded by state appropriation allocated to the Department and is used flexibly to provide support to families and children at different points in the life of a case. Arguably, any prevention service delivered to a family or child after abuse or neglect occurred could be categorized as tertiary prevention. There is benefit, however, to differentiating among the different uses of S&S services because the goals of services – i.e., what is the prevention objective – differs based on different points in the life of a case and on the recipient of the service.

The table below provides examples of the flexible ways the Department uses S&S services.

S&S Service	Point in Life of Case	Recipient of Service	Type of Prevention	Goal of Prevention
Recovery Coach and Parent Aide	Ongoing Case, no out-of-home placement	Intact Family Unit	Quarternary	Achieve permanency by safely preventing out-of-home placement
Youth Mentor	Foster Care Case, youth in foster family	One Adolescent	Secondary[11]	Achieve youth well-being by preventing school drop out
Specialized Service for Adolescent Sexual Exploitation	Care & Protection Case, no out-of-home placement	One Adolescent	Tertiary	Achieve safety by preventing subsequent sexual exploitation
Family Therapy	Adoption Case	Adoptive Family Unit	Secondary	Achieve permanency by preventing disruption in adoption and achieve youth well-being by treating mental health symptoms
Reunification Services	Care & Protection Case, transition home after out-of-home placement	Family Unit including child transitioning home after out-of-home placement	Quarternary	Achieve permanency by preventing another episode of out-of-home placement

[11] In this example, the level of prevention is based on the family unit, i.e., the foster family, where no instances of abuse or neglect have occurred; hence, the designation of "secondary" prevention.

Currently, the S&S services that appear on the Title IV-E Prevention Services Clearinghouse or in the list of programs and services scheduled for review are Multisystemic Therapy®, Intercept®, and Motivational Interviewing.

2.3 Consultation and Coordination with Other State Agencies

The Department's discernment process regarding which evidence based prevention services to include in a Five-Year Prevention Plan included an inventory of evidence based practices and related services provided to children and families by other state agencies[12] in the Commonwealth, including the Children's Trust, the Department of Public Health, and MassHealth, which is the Commonwealth's Medicaid and Children's Health Insurance Program.

This inventory of prevention programs is organized to correspond to the categories of evidence based services in the Title IV-E Prevention Clearinghouse – Parent Education, Mental Health, and Substance Use.

Parent Education

Home Visiting

The Massachusetts Department of Public Health manages the Massachusetts Home Visiting Initiative (MHVI), which is part of the national Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). The federal Health Resources and Services Administration (HRSA) website https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview states the four goals for every MIECHVP as:

1. Improve maternal and child health,
2. Prevent child abuse and neglect,
3. Encourage positive parenting, and
4. Promote child development and school readiness.

The HRSA website also states that grantees must give priority to families living in at-risk communities as identified by the statewide needs' assessment. Consistent with this focus on targeting at-risk communities, the geographic distribution of home visiting programs in Massachusetts makes its primary purpose secondary prevention.

The MHVI includes 7 different models of home visiting. Two of the models, Healthy Families and Parents as Teachers, are currently included in the Title IV-E Clearinghouse. The Department has quarterly meetings with the Department of Public Health' MHVI managers to discuss factors that will influence whether the Department will add evidence based home visiting programs to future submissions of this Prevention Plan. These factors include:

[12] As explained on the Massachusetts website, https://www.mass.gov/info-details/applications-for-dmh-services, the Massachusetts Department of Mental Health functions to supplement insurance-funded behavioral health services for eligible adults and youth with the most severe and long term mental illnesses and emotional disturbances. The Department of Mental Health service array, which is not focused on prevention and is not a resource for the majority of families served by the Department, was not included in this inventory.

- How to ensure that the programs are delivered in alignment with the requirements of FFPSA, including trauma-informed service delivery and assessment of fidelity to manualized service specifications,
- How referrals from the Department would be handled relative to referrals from other sources,
- How to reconcile the voluntary nature of the services with the Department's need to ensure that services are in place to prevent the need for out-of-home placement, and
- The role of providers of home visiting services in attending to child safety and risk and the arrangements for communicating about safety and risk with the Department's social workers and/or supervisors.

The Children's Trust network of Healthy Families programs, which is a partner in the MHVI, ensures that all 351 cities and towns are included in a catchment area for one of the Healthy Families providers. Hospitals, self-referrals, and the Department are the most common referral sources for the Healthy Families program. At initial contact, 91% of parents agree to participate in the service. The actual completion rate for first visits is 76%. The average length of time that a family participates in Healthy Families is 15.7 months.[13]

The other programs offered through MHVI are Welcome Home, Early Intervention Parenting Partnership, Young Parent Support Program[14], Pregnant and Parenting Teen Initiative, and Early Head Start Home-based. In addition, The Department of Public Health offers two specialized home visiting programs for parents and children - F.O.R. Families and (Follow-Up Outreach Referral) and First Steps Together. F.O.R. Families is a joint program between the Department of Public Health and the Massachusetts Department of Housing and Community Development (DHCD) that provides home visiting services for families transitioning from homelessness to stable housing. First Steps Together is a home visiting program for parents in recovery from substance use that relies on peer recovery coaches.

The Massachusetts Home Visiting Initiative (MHVI) is another example of a community pathway available to support Commonwealth families and to prevent involvement with public child welfare.

Mental Health

Children's Behavioral Health Initiative

In response to litigation filed in 2001, Massachusetts created the MassHealth-funded Children's Behavioral Health Initiative (CBHI) to assist families caring for children with serious emotional disturbances. At surface level, the purpose of CBHI and the purpose of FFPSA's allowance for states to access Title IV-E reimbursements for prevention services appear to be the same – to prevent out-of-home placements for children. It is essential to clarify the differences because they reveal the essence of what is meant by a "child protective service" that is designed and delivered to match the needs of families served in public child welfare agencies.

[13] Description of the Children's Trust network of Healthy Families programs and the data on initial contact, completion rate for first visit, and average length of service provided by Director of Home Visiting at the Children's Trust.

[14] The Department manages this service for young parents, which is funded by Medicaid through the Children's Health Insurance Program Health Services Initiatives (CHIPS HSI).

CBHI includes specific services designed to treat youths' behavioral health needs – Intensive Care Coordination, In-Home Therapy, Outpatient Therapy, In-Home Behavioral Services, Therapeutic Mentors for Youth, and Family Support & Training (Family Partner). The Intensive Care Coordination (ICC) service uses the National Wraparound Initiative engagement and planning process[15] and Wraparound Fidelity is assessed annually.[16] ICC is rated as "Promising" on the Title IV-E Clearinghouse.

The Department mentions MassHealth-funded CBHI services in the Five-Year Prevention Plan as a service that can be used with intact families to meet the quarternary prevention goal of preventing foster care placement and the secondary prevention goal of preventing youth moves from foster, kinship, or adoptive family homes, hence achieving better stability and permanency. However, the structure and implementation of CBHI make it a better match for the secondary prevention goal than the quarternary prevention goal.

In CBHI, the "client" is the child. Parents with their own mental health disorders, substance use disorders, and/or complex trauma histories are not a match for CBHI, which does not include treatment for parents'/caregivers' behavioral health needs. In addition, access to CBHI requires that the child be evaluated as meeting criteria for "medical necessity." Although a critical factor for determining eligibility for Medicaid-reimbursable treatment services, "medical necessity" determinations exclude children and youth served by the Department whose behaviors are challenging and must be addressed to support family stability, but that do not meet diagnostic criteria used in "medical necessity" decisions. Finally, CBHI was not designed for delivery in families with moderate to high risks for abuse and neglect. Although CBHI providers are mandated reporters for child abuse and neglect, the service was not designed to include attention to factors associated with child safety and risk[17].

In sum, the Department mentions CBHI, aspects of which use High Fidelity Wraparound, in the Five-Year Prevention Plan because it is an existing service available in the Commonwealth. The best match of CBHI for child welfare is use as a secondary prevention service for foster, kinship, and adoptive families who are caring for a child with a severe emotional disorder. The features of CBHI that are not a match for the Department's quarternary prevention needs are the lack of attention to factors associated with child safety and risk, the exclusion of families with caregivers who have their own behavioral health needs, and exclusion of families with youth who exhibit challenging behaviors but do not meet diagnostic criteria for "medical necessity."

[15] National Wraparound Initiative https://nwi.pdx.edu/

[16] Fiscal Year 2020 Intensive Case Coordination Wraparound Fidelity assessment https://www.mass.gov/doc/wfi-summary-2020-0/download

[17] See https://archives.lib.state.ma.us/handle/2452/266025 for a case that demonstrated that CBHI services were not designed to assess safety and risk.

Behavioral Health Road Map

Families and youth served by the Department are a subset[18] of Massachusetts' citizens enrolled in Medicaid (MassHealth). According to the February 2021 MassHealth enrollment snapshot,[19] there were 1,992,787 enrollees, which is 29% of the Commonwealth's population of 6.9 million citizens. Massachusetts' rate of Medicaid enrollment is higher than many states[20] because the Commonwealth's income eligibility rates for Medicaid are set at higher income levels than states with lower Medicaid enrollment. Medicaid is one of the concrete supports for families that is associated with decreased rates of abuse and neglect.[21] The approach of making Medicaid available to more families demonstrates the Commonwealth's commitment to promoting healthy and safe families for all Massachusetts citizens.

In February 2021, The Massachusetts Executive Office of Health and Human Services (EOHHS) announced a four-year Behavioral Health Roadmap for transforming the Commonwealth's ambulatory services for mental health and substance use, referred to collectively as "behavioral health." The goal is to improve access to ambulatory behavioral health services, funded by both public and private insurances, so that all Massachusetts residents are able to receive behavioral health treatments when and where they are needed. The Commonwealth will invest more than $200 million dollars to support the multi-year rollout of the public sector components of the behavioral health redesign.

This initiative includes restructuring the Commonwealth's behavioral health crisis response system for adults and children, which is available to residents regardless of insurance. For residents enrolled in MassHealth, the redesign will include incentives for providers to integrate behavioral health services with delivery of primary health care. Designated Community Behavioral Health Centers will be available throughout the Commonwealth with expanded urgent care hours on par with those available for physical health conditions and availability of same-day behavioral health evaluations and referrals for treatment.

The plan is for Community Behavioral Health Centers to serve individuals of all ages, provide evidence based behavioral health treatments, and be responsive to the cultural and linguistic needs of their communities. The plan for the Community Behavioral Health Center system includes the creation of specialty Community Behavioral Health Centers, where there will be a concentration of services for youth. Given the high rate of co-occurrence between mental health disorders and substance use disorders, the Behavioral Health Roadmap for Redesign includes

[18] At the end of state fiscal year 2020 the point-in-time count of children and adults being served by the Department was 86,315. Most but not all of the children and adults served the Department are eligible for and are enrolled in MassHealth, comprising approximately 4% of the Commonwealth's MassHealth enrollees.

[19] MassHealth Enrollment Snapshot, February 2021, https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-february-2021-0/download

[20] See Medicaid and CHIP enrollment rates by state at https://www.medicaid.gov/state-overviews/scorecard/percentage-of-population-enrolled-medicaid-or-chip-state/index.html

[21] Brown, E.C.B., Garrison, M.M., Bao, H., Qu, P., Jenny, C., & Rowhani-Rahbar, A. (2019). Assessment of rates of child maltreatment in states with Medicaid expansion vs states without Medicaid expansion. *JAMA Network Open*, 2(6); Klevens, J., Barnett, S.B., Florence, C., Moore, D. (2015) Exploring policies for the reduction of child physical abuse and neglect. *Child Abuse and Neglect*, 40: 1-11.

plans for integrating delivery of both mental health and substance use disorder treatments in the same locations, such as in primary care practices and in the plans for the new Community Behavioral Health Centers. The timeline is for these centers to be operational in January 2023.

Decisions regarding the specific evidence based mental health treatment services that will be offered at the Community Behavioral Health Centers are being finalized. The current list of services to-be-delivered in the new system includes the following seven services that also appear on the Title IV-E Prevention Services Clearinghouse:

1. Child-Parent Psychotherapy
2. Functional Family Therapy
3. Trauma-Focused Cognitive Behavioral Therapy
4. Adolescent Community Reinforcement Approach
5. Eye Movement Desensitization and Reprocessing
6. Motivational Interviewing
7. Prolonged Exposure Therapy for PTSD

Adolescent Community Reinforcement Approach, which is rated as "Promising" on the Title IV-E Prevention Services Clearinghouse, will be offered in the new Community Behavioral Health Center system. This will expand the existing network of community-based providers already offering Adolescent Community Reinforcement Approach through a network managed by the Massachusetts Department of Public Health's Bureau of Substance Addiction Services (BSAS). BSAS plans to expand availability of the Adolescent Community Reinforcement Approach throughout the Commonwealth, particularly in high need and underserved communities.[22]

BSAS selected the Adolescent Community Reinforcement Approach based on evidence based ratings for the treatment of "Supported" on the California Evidence based Clearinghouse for Child Welfare https://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/, "Effective" on the Federal Interagency Working Group on Youth Program's website https://youth.gov/content/adolescent-community-reinforcement-approach, and "Promising" on the National Institute of Justice's Crime Solutions website https://crimesolutions.ojp.gov/ratedprograms/137.

2.4 University of Massachusetts Medical School Child Trauma Training Center

The University of Massachusetts Medical School Child Trauma Training Center (UMMS-CTTC) is a statewide program within the Department of Psychiatry that is funded by the federal Substance Abuse & Mental Health Services Administration (SAMHSA), the National Child Traumatic Stress Network (NCTSN), the Massachusetts Department of Mental Health, and the Lookout Foundation.

[22] Information on BSAS' selection process for the Adolescent Community Reinforcement Approach and on plans for expansion of the service into high need and underserved communities provided by Director Office of Youth and Young Adult Services, Bureau of Substance Addition Services, Massachusetts Department of Public Health.

The mission of UMMS-CTTC is to improve the standard of care for traumatized youth across the Commonwealth, with a particular focus on court-involved youth and military families, emphasizing underserved and high risk populations of LGBTQ, Commercially Sexually Exploited Children (CSEC), youth of substance abusing parents, and transition-age youth.

The UMMS-CTTC trains professionals to deliver evidence based, trauma-informed treatments and operates Link-Kid, a centralized referral service to link families and community organizations with behavioral health professionals trained to deliver Trauma-Focused Cognitive- Behavioral Therapy (TF-CBT), Child Parent Psychotherapy (CPP), Attachment, Self-Regulation, and Competency (ARC), Parent Child Interaction Therapy (PCIT), and Alternatives for Families: Cognitive- Behavioral Therapy (AF-CBT).

The status of these treatment modalities in relation to the Title IV-E Prevention Services Clearinghouse is: TF-CBT rated as "Promising;" CPP rated as "Promising;" ARC is not rated and currently does not appear on the list of programs planned for review; PCIT rated as "Well-Supported;" and AF-CBT appears on the list of programs planned for review.

The work of the UMMS-CTTC touches the lives of many children and families in the Commonwealth. The children and families served by the UMMS-CTTC who are also served by the Department comprise only a subset of the beneficiaries of UMMS-CTTC. The characterization of where the UMMS-CTTC services fall within the prevention framework for abuse and neglect is not a simple categorization. However, based on the circumstances of each youth and family served, the services could be characterized as secondary, tertiary or quarternary prevention.

2.5 Ongoing Consultation to Create a Continuum of Care

As part of the Commonwealth's four-year Behavioral Health Roadmap for transforming and increasing access to ambulatory behavioral health services, MassHealth convenes monthly meetings across state agencies in the Health and Human Service Secretariat, which includes the Department of Mental Health, the Department of Public Health, the Department of Youth Services, and the Department of Children and Families. This monthly meeting provides a forum for the Department to continue consultation with state agencies that is aimed at creating a continuum of care for children and their caregivers.

The Department's existing S&S procurement includes contracts with more than 100 community-based providers of services for children and families. There are existing quarterly meetings, which will continue after the S&S services are reprocured and will serve as the forum for ongoing collaboration with the provider community aimed at creating and improving the continuum of care for children and their caregivers.

2.6 Title IV-B Funding

The Department uses Title IV-B funding in multiple ways, ranging from the administrative costs for social worker travel to the stipends for the individuals with lived experience with the Department (e.g., foster youth, biological parents, foster parents, grandparents) who serve on the Department's Family Advisory Committee to programs that provide direct services to families. The coordination of the prevention services funded through Title IV-B and those that will be funded through Title IV-E is based on the different purposes of these funding streams.

Multiple funding sources support the Commonwealth's system of previously mentioned Family Resource Centers, which are available in communities throughout the Commonwealth and deliver primary and secondary prevention services to families. Title IV-B funding supports a small number of Family Resource Centers as well as Departmental staff who oversee the Family Resource Center contracts. The Community Connections Coalition PATCH program approach is another prevention service delivery strategy that is funded through Title IV-B. Using a network of Community Connections Coalition PATCH programs, the Department engages in community-based child welfare work by partnering with families, courts, schools, and other community stakeholders to map the assets in communities that are available to support families.

Using this grassroots approach, the Coalitions take the lead both in identifying the most pressing unmet needs in a community and in determining the approaches for addressing the needs. Identified needs can span the range of primary, secondary, tertiary, and quarternary prevention. Examples include support and enrichment services for children in foster care, supportive services to assist families with preparing for reunification with a child returning from foster care, remedial experiences for families where escalating crises pose a significant risk for child placement, and neighborhood-based recruitment of foster and adoptive families.

In addition to Family Resource Centers and Community Connections Coalitions, another prevention service funded through Title IV-B is Family Support Services, which are flexible funds available at the Area Office level to provide concrete supports to families involved with the department that will allow them to keep children safe and stable at home. Examples of the concrete supports for which Family Support Service funding is used include payment of utility bills, purchase of mattresses and furniture, funding for transportation, and purchase of supplies for babies, such as clothing, diapers, and baby monitors.

To illustrate how prevention services funded through the different sources are coordinated, the table below compares and contrasts the different eligibility requirements, the services delivered, the needs addressed, and the prevention goal being served.

	Title IV-B – FRCs	Title IV-B – Community Connections Coalitions	Title IV-B – Family Support Services	Title IV-E – Evidence Based Practices
Eligibility	Unrestricted access to community members	Varies based on the specific service	• Open case with Department	• Open case with Department • Child identified in a prevention plan as a candidate for foster care • Pregnant/parenting youth in foster care • The family/kinship caregivers of the children and youth in the previous bullets
Services Delivered/Needs that are addressed	• Support groups, including stress management • Parenting classes • Information & Referral • Financial workshops • Family events • Playgroups	Varies. Services designed to meet the needs of a specific community that are identified through community asset mapping. All services aim to protect children by strengthening families.	• Provision of concrete resources not available through other sources	• Evidence-based services posted to the Title IV-E Prevention Services Clearinghouse • To address needs in three categories: 1) mental health, 2) substance use, and/or 3)parenting skills
Type of Prevention	primary, secondary	Varies – primary, secondary, tertiary, quarternary	quarternary	quarternary

2.7 Summary of The Prevention Services Array in the Commonwealth

Consistent with the categories of prevention services that are eligible for Title IV-E reimbursement, the Department compiled an inventory of evidence based prevention services available in the Commonwealth and organized the services into three groups: Parent Education, Mental Health, and Substance Use.

The Department took an additional step and organized the evidence based prevention services by the age of the intended target population. Using this developmental lens provides an overview, by age group, of both the:

- Evidence based prevention services rated as “Well-Supported,” “Supported,” and “Promising” on the Title IV-E Prevention Services Clearinghouse,[23] and

[23] Services are posted to the Clearinghouse on a rolling basis.

- Evidence based prevention services already available in the Commonwealth's service array.

Grouping the services developmentally aided the Department's ability to look at the service arrays holistically and identify overlaps and gaps in service availability for different ages of children. Using this developmental lens is consistent with the argument advanced by multiple researchers and experts[24] for increased attention within child welfare to the developmental phases of children's lives.

The table on the next page shows the available evidence based prevention services in the Commonwealth organized by both service category and age of the intended target population. In the table, the **gray** shading represents services currently available through state agencies and organizations other than the Department. The **green** shading represents services currently available through the Department's S&S program. The **blue** shading represents services that are anticipated in the near future through the Behavioral Health Roadmap described in Section 2.3.

[24] E.g., Chicchetti, D. & Lynch, M. (1993). Toward an ecological, transactional model of community violence and child maltreatment: Consequences for child development. In D. Reiss, J. Richters & M. Radke-Yarrow (Eds.) *Children and violence* (pp. 96-118). New York: Guilford Press.; Chicchetti, D. & Manley, J. (2001). Operationalizing child maltreatment: Developmental processes and outcomes. *Development and Psychopathology*: 13, 755-757.; Thornberry, T., Ireland, T., & Smith, C. (2001). The importance of timing: The varying impact of childhood and adolescent maltreatment on multiple problem outcomes. *Development and Psychopathology*, *13*, 957-979.; Wulczyn, F., Barth, R., Yuan, Y., Harden, B., Landsverk, J. (2005). *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform.* Aldine.

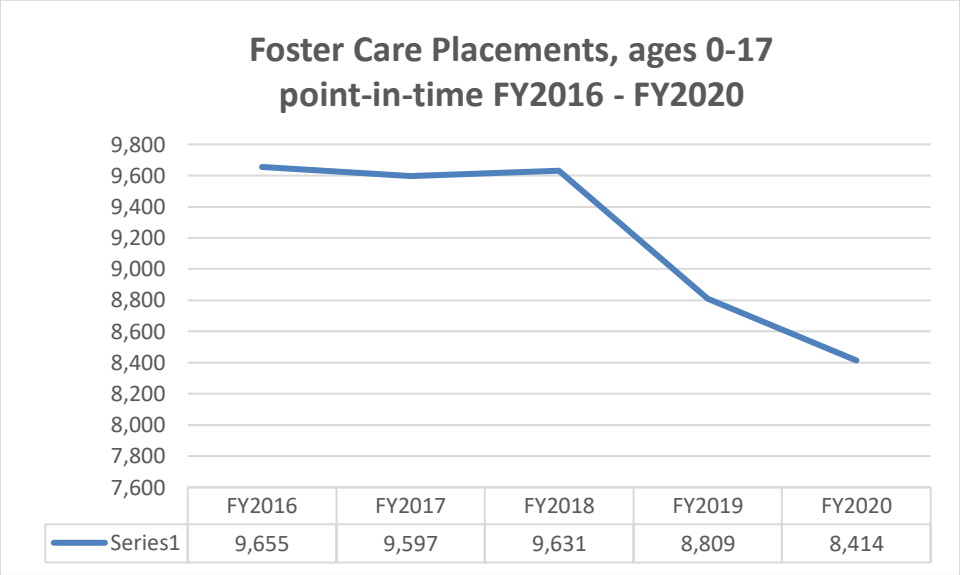
Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR YOUNG CHILDREN		
Parent Ed	Young Child	Healthy Families America, well-supported
		Nurse-Family Partnership, well-supported
		Parents as Teachers, well-supported
		Family Spirit®, promising
		SafeCare, supported
MH	Young Child	Child Parent Psychotherapy, promising
		Incredible Years - Toddler Basic, promising
		Parent-Child Interaction Therapy, well-supported
Parent Ed, MH	Young Child	Child First, supported
SA	Young Child	Sobriety Treatment and Recovery Teams, promising
FOR SCHOOL AGE CHILDREN		
MH	School Age	Incredible Years - School Age Basic, promising
		Triple P (Level 4) -Online, supported
		Triple P (Level 4) -Standard, Self-Directed, Group, promising
SA	School Age	Families Facing the Future, supported
FOR TEENS		
Parent Ed, MH	Teens	Parenting with Love and Limits, supported
MH	Teens	Functional Family Therapy, well supported
		Aggression Replacement Training, promising
		Prolonged Exposure Therapy for Adolescents with PTSD, supported
		Interpersonal Psychotherapy for Depressed Adolescents, promising
MH, SA	Teens	Multisystemic Therapy, well supported
SA	Teens	Adolescent Community Reinforcement Approach, promising
Parent Ed, MH, SA	Teens	Familias Unidas, well-supported
FOR ALL OR MOST AGES OF CHILDREN		
Parent Ed	All ages	Homebuilders, well-supported, ages 0-18
		Intercept®, well-supported, ages 0-18
		Family Centered Treatment, supported, ages 0-17
		Iowa Parent Partner Approach, promising, ages 0-17
Parent Ed, MH	All ages	Family Check up, well supported, ages 2-17
MH	All ages	Trauma-Focused Cognitive Behavior Therapy, promising, ages 3-18
		Eye Movement Desensitization and Reprocessing (EMDR) – Standard Protocol, supported, ages 2-adult
		ICC High Fidelity Wrap, promising, ages 0-21
		Trust-Based Realtional Intervention - Caregiver Training, promising, ages 0-17
		TBRI® 101 self-administered, promising, ages 0-17
Parent Ed, MH, and SA	All ages	Brief Strategic Family Therapy®, well supported, ages 6-17
		Multi-Dimensional Family Therapy, supported, ages 9-26
FOR OLDER TEENS AND ADULTS		
Parent Ed, MH, SA	Teens - Adults	Motivational Interviewing, well supported
Parent Ed, MH, SA	Parents of children ages 2-18	Parents Anonymous®, supported
MH	Adult	Interpersonal Psychotherapy, (Weissman et al.), supported
		Prolonged Exposure Therapy for PTSD, promising
SA	Adult	Methadone Maintenance, promising

3.0 FOSTER CARE DEMOGRAPHICS

3.1 Decline in Number of Children Served in Foster Care

The Department's commitment to serving children in their own homes safely is illustrated by a five-year decline in the number of children served in foster care.

As shown in the graph and table below, across five years from state Fiscal Year 2016 through state Fiscal Year 2020 the census for children in out-of-home placements decreased by 12.85% - a reduction of 1,241 children.



At the end of FY2020, 80% of the Department's caseload was intact families with whom the Department was working to keep children safe and well cared for at home. As of February 2021, 41% of all children served in out-of-home placements were placed with relatives.

At the end of FY2020, there were 8,414 children ages 0-17 and 1,592 young adult ages 18 through 22nd birthday in foster care. The following demographics provide insights into which children and youth are served in foster care placements.

3.2 Age

Among youth ages 0-17 in foster care, 37% are children under six years of age, who are at highest risk for protective concerns. Children ages 6-11 comprise 29% of the foster care population. Adolescents ages 12-17 comprise the remaining 34% of youth served in out-of-home placements.

3.2 Birth Gender, Gender Identity, and Sexual Orientation

For birth gender, youth in foster care are 50% female and 50% male. Tables 1 and 2 show the gender identity and sexual orientation of youth in foster care, respectively.

TABLE 1. Gender Identity of Children/Youth in Placement	FY2020
Androgynous	0.1%
Female	47.6%
Gender Nonconforming	0.3%
Genderqueer	0.1%
Male	49.9%
Questioning	0.6%
Transgender (Female to Male)	0.7%
Transgender (Male to Female	0.3%
Other	0.6%
Total Child/Youth (0-17) in Placement	**8,414**

Gender Identity is an individual's internal view of their gender, one's innermost sense of being male, female, both or neither. Gender Expression is the manner in which a person expresses their gender through clothing, appearance, behavior, speech, etc.

Note: The capacity to collect Gender Identity as a structured data element was introduced in 2017 with the implementation of the DCF Family Assessment and Action Planning Policy. The Department is working to improve the quality of data collection.

TABLE 2. Sexual Orientation of Children/Youth in Placement	FY2020
Asexual	1.3%
Bisexual	2.4%
Gay/Homosexual	1.3%
Heterosexual	85.3%
Lesbian/Homosexual	0.3%
Pansexual/Omnisexual	0.5%
Queer	-
Questioning	1.5%
Other	7.4%
Total Child/Youth (0-17) in Placement	**8,414**

Sexual Orientation describes patterns of sexual, romantic, and emotional attraction—and one's sense of identity based on those attractions.

Note: The capacity to collect Sexual Orientation as a structured data element was introduced with the implementation of the DCF Family Assessment and Action Planning Policy in 2017. The Department is working to improve the quality of data collection.

3.3 Race and Ethnicity

As Table 3 on the next page shows, White (40%), Hispanic/Latinx (32%), and Black (14%) children (0-17) accounted for the majority of children served in out-of-home placements.

TABLE 3. Race/Ethnicity of Children and Young Adults in Placement FY2020 [1]

	Children (0-17)		Young Adults (18 & Older)	
White	3,377	40%	607	38%
Hispanic/Latinx (of any race)	2,688	32%	504	32%
Black	1,205	14%	327	21%
Asian	66	1%	45	3%
Native American	20	*	-	-
Pacific Islander	2	*	-	-
Multi-Racial (two or more races)	752	9%	77	5%
Unable to Determine/Declined	303	4%	32	2%
Missing	1	*	-	-
Total in Placement Fiscal Year End	**8,414**	**100%**	**1,592**	**100%**

[1] All races exclude children of Hispanic/Latinx origin. *Less than 1% after rounding.

Figure 3 shows the Rate-of-Disproportionality (RoD) for children in out-of-home placements.

FIGURE 3. Consumer Children (0-17) in Out-of-Home Placement by Race/Ethnicity FY2020

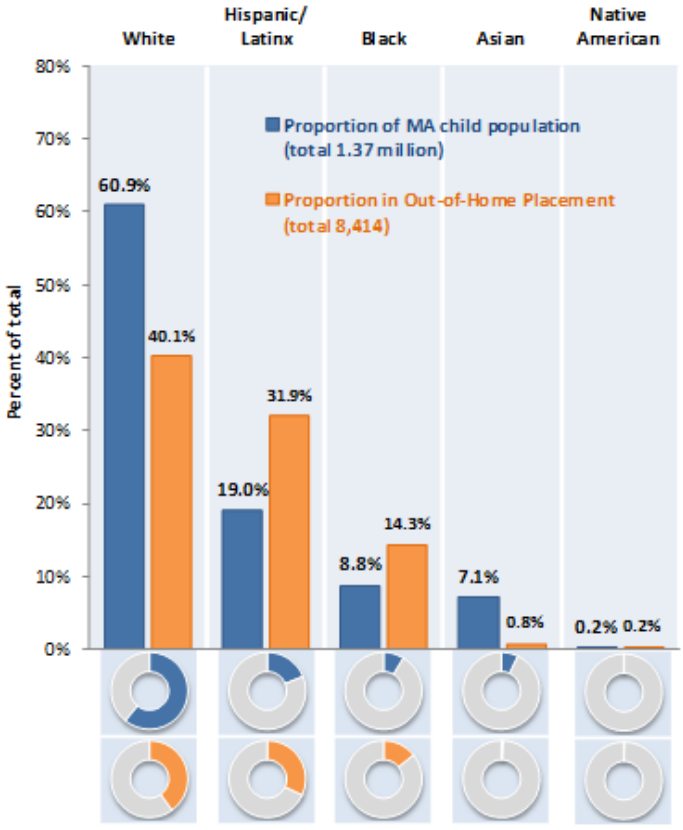


TABLE 3a. Out-of-Home Placement

	RoD	RRI
White	0.7	n/a
Hispanic/Latinx	1.7	2.6x
Black	1.6	2.5x
Asian	0.1	0.2x
Native American	1.3	2.0x

The *Rate-of-Disproportionality* (RoD) is an indicator of inequality. RoDs are calculated by dividing the actual DCF open case rate for a given race/ethnicity by the MA population rate for that specific race/ethnicity.

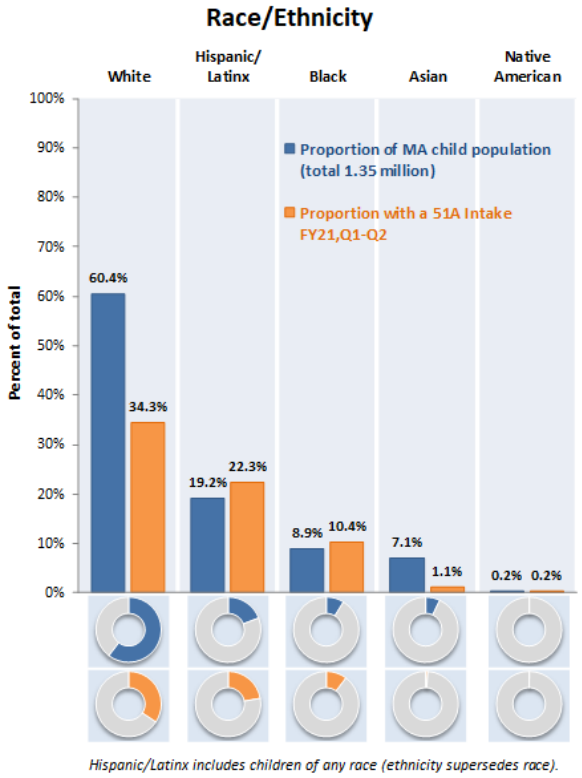
- *RoDs > 1.0 indicate overrepresentation.*
- *RoDs < 1.0 indicate underrepresentation.*

Relative Rate Index (RRI) compares the rate of White children to the rate for children of color.

Figure/Table 4 show the RoD for children subject to a report of maltreatment (51A) filed between July and December 2020. Of note, Black and Hispanic/Latinx children were subject of

a report of maltreatment at 2.1x to 2.0x the relative rate (RRI) of White children.

Figure/Table 4. Children (0-17) with a 51A Intake within FY21, Q1-Q2

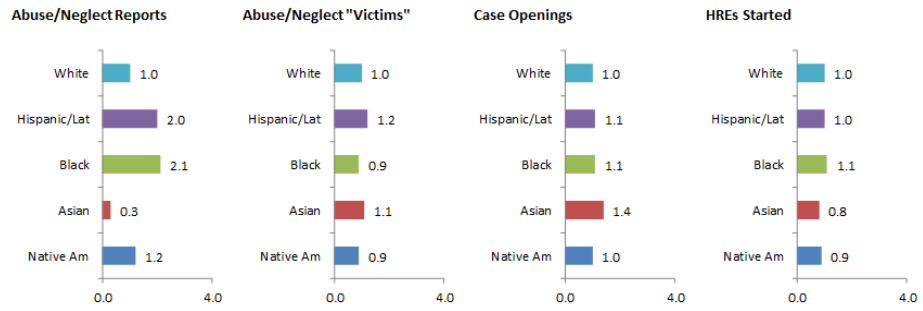


	RoD	RRI
White	0.6	n/a
Hispanic/Latinx	1.2	2.0
Black	1.2	2.1
Asian	0.1	0.3
Native American	0.9	1.5

Hispanic/Latinx includes children of any race (ethnicity supersedes race).

Figure 5 shows that while disproportionality evidenced at the “front door” rolls forward (i.e., not reversed), the relative rates tend not to be cumulative across key decision points (e.g., response determination, case opening, or home removal (HRE)).

Figure 5. RRIs for Key Decision Points for Children by Race/Ethnicity*



**The base RoD for each decision point is pinned to the racial/ethnic distribution of abuse/neglect reporting.*

3.5 Child Requiring Assistance

Massachusetts' child welfare statutory changes include a transition from a Child in Need of Services (CHINS) law to a Child Requiring Assistance (CRA) law in 2012.

The intent of the legislative change was to reduce reliance on punitive measures through the juvenile justice system while increasing reliance on community-based services to support families in caring for their children.

A Child Requiring Assistance (CRA) is defined as:

- A runaway who repeatedly runs away from the home of the parent, legal guardian, or custodian, or
- A stubborn child who doesn't obey lawful and reasonable commands of the parent, legal guardian, or custodian, which interferes with their ability to care for the child, or
- A student who is habitually absent and doesn't attend school for more than 8 days in a quarter without a proper excuse, or
- A habitual school offender who doesn't obey the lawful and reasonable commands of the school.

Through the CRA process, the juvenile court may place a youth into the custody of the Department. In March 2021, there were 526 youth with CRA custody being served by the Department, which represented slightly less than 5% of all the youth in the Department's custody. Ninety percent of the youth in CRA custody were age of 12 to 17. For the youth with identified race and ethnicity, 63% identified as Hispanic and 33% identified as non-Hispanic. Fifty-five percent identified as White, 21% identified as Black, and 7% identified as mixed race. Less than 1% identified as Asian and less than 1% identified as Native Hawaiian or Pacific Islander.

3.6 Summary Foster Care Demographics

The Department's commitment to serving children in their own homes is illustrated by a five-year decline in the number of children served in foster care. The Department tracks the age, gender orientation, sexual identify, racial identification, and ethnic identification for all children placed in foster care.

Throughout the course of this Five Year Plan, the Department intends to continue tracking youth in foster care by these demographic factors, providing insights into any changes in these factors that will occur during the implementation of this Plan. This aggregate view of the demographics of children in foster care will be complemented by the evaluation strategy for prevention services that is presented in Section 8.

4.0 STAKEHOLDER OUTREACH

The Department started information gathering to prepare for prevention planning and the re-procurement of S&S services during 2019. Starting in March 2020, the COVID-19 pandemic interrupted daily operations and the Department's efforts to plan for the health and safety of children, families, and staff required the Department's full attention. The Department relied on work completed in 2019 and well as new information gathering to develop this Five-Year Prevention Plan.

4.1 Internal Stakeholders

During the summer of 2019, the Department held focus groups with representatives from the Department's 29 Area Offices. Focus group participants were specialists whose primary daily responsibilities are assisting Departmental social workers and families with determining the best S&S service to meet a family's needs. These staff members have responsibility for making referrals to S&S providers, entering referrals into the Department's IT system, facilitating progress reviews, and documenting the ending of S&S referrals in the IT system.

The focus group discussions gathered information from these front-line staff regarding the three categories used on the Title IV-E Prevention Clearinghouse – Parent Education, Mental Health, and Substance Use. Regardless of service type, the internal group stressed the importance of having S&S services that provide families with 24/7 crisis assistance, with in-person assistance preferred by the focus group participants to phone assistance[25]. Participants also mentioned the need for S&S providers to be "looking out" for the safety of children in a home and making sure the Department knows about any safety risks for children.

Skill-Based Parent Education

Focus group participants viewed parent education services that are delivered directly in a family's home as more appropriate for most families needing services than parent education services delivered in groups in community-based locations. In-home service delivery removes multiple barriers to participation, including transportation and inconvenient hours.

Regarding parent education groups available in community locations, the groups expressed the need for different options for parents to choose from in case one curriculum did not meet a parent's needs. In addition to parent education, the groups mentioned the need parents and caregivers have for social support groups with people going through or having triumphed over challenges similar to their own.

Mental Health

Services for survivors of intimate partner violence were mentioned as one of the most important types of mental health supports needed by parents. Another frequently mentioned need focused on developing interventions that have sustainable impact. For example, parent aides assist a parent with housekeeping, scheduling and attending children's medical appointments, and completing grocery shopping on a consistent basis. A focus group member noted: "… when the

[25] The use of virtual meetings for crisis assistance was not mentioned because the focus group happened prior to the COVID-19 pandemic when virtual meetings and telehealth were not widely used and not considered as options.

parent aide leaves everything goes back to the way it was before." The focus group participants emphasized the need for services that make a lasting change that builds parenting capacity. The most frequently mentioned need for youth was for effective treatment for adolescents with behavioral health challenges that include aggressive and assaultive behaviors. Often, these adolescents enter the agency through the Child Requiring Assistance (CRA) pathway described in Section 3.5.

Substance Use

Participants were familiar with insurance-funded substance use services for parents available in their areas, but participants explained that the waiting lists for parents to obtain these services often made them impractical referrals. Further, participants had the impression that available substance use services focused exclusively on the parent's recovery without addressing parenting skills and family functioning while in recovery.

Participants described an existing S&S service that relies on in-home recovery coaches as a beneficial service for parents dealing with substance use challenges. This service was identified as especially beneficial because recovery coaches provide not only encouragement and support to parents to connect with and maintain substance use treatments, but also hands-on practical support for managing the everyday stresses of parenting, budgeting and money management, and housework that, if not addressed, can significanlty interfere with starting and sustaining substance use treatment and sobriety. Participants explained that without the in-home recovery coach as a supportive supplement, many parents involved in child welfare would not be able to benefit from substance use treatments alone. Participants stated that this type of "add on" support is often needed by parents to assist them with accessing and actually benefitting from a service.

Other Services

In addition to parent education, mental health, and substance use services, the internal focus groups discussed the needs for:

- Afterschool care for children with disabilities who are on Individual Education Programs (IEPs) and/or who have behavioral health challenges, such as impulsiveness and aggression, that make them ineligible for afterschool programs delivered by schools and community-based organizations,
- Overnight childcare for parents who work nights, and
- Concrete services, such as food, clothing, housing assistance, cash assistance and linkage to government and community services designed to assist low-income families.

Participation Rates

Currently, service referrals are not entered into the IT system until an S&S service actually starts. An Area Office Resource Coordinator (ARC) or Lead Agency staff person contacts a potential S&S provider who then reaches out to a family. After the S&S provider and the family agree to begin services, the ARC or Lead enters the referral into the IT system. Based on this process, there is no current data that provides insight into the comparative success of different S&S providers for enrolling families into their service.

Focus group participants had perceptions of which S&S providers were better than others at motivating families to participate in services, with some S&S providers establishing their own internal goals for enrolling families. Focus group participants mentioned families who have had multiple generations involved with the Department as having the most significant challenges engaging with and actually participating in S&S services.

4.2 Support & Stabilization Providers

In the Fall of 2019, the Department surveyed S&S providers in preparation for the re-procurement of S&S, which was anticipated in 2022. However, as the Commonwealth prepares for a new gubernatorial administration in January 2023, the posting of this procurement will be delayed until early 2023.

Fifty-four percent (61 out of 114) of S&S providers responded to the online survey. Given the opportunity to pick multiple selections, the totals for the top three S&S needed services for children, as identified by providers, totaled more than 100%, the top three selected were: social skill development (92%), mental and behavioral health treatment (90%), and specialized services for commercially sexually exploited youth (89%). There was less agreement among providers about the top three S&S services needs for parents and caregivers. The identified services were: concrete services, such as food, clothing, housing, and income assistance (56%); substance use disorder treatment (54%); and in-home parent education programs (51%).

Further clarity about the type of mental and behavioral health treatment that the provider community views as needed by youth was obtained during a series of listening sessions conducted during 2019. During these sessions, representatives from providers who offer congregate care services were asked to rate the most pressing needs for youth in the Commonwealth. Although these sessions focused on congregate care providers, several of the Department's 54 congregate care providers are multi-faceted community organizations that also provide contracted S&S services. Of the 103 participants in these listening sessions, 85 (83%) rated "Youth with highly aggressive behaviors and youth involved with juvenile justice" as having the most pressing needs for which there is a gap in available services.

In response to the importance in internal focus groups given to the availability of 24/7 support, the survey of providers included a question about the type of 24/7 service availability included with a service. Providers responded that 20% (25 out of 123 services) provided 24/7 in-person support and 59% (73 out of 123 services) provided 24/7 phone support to families.

In the comment section, one provider wrote, "DCF asks my staff to be 'another set of eyes' in the home. I want to say that is not the role of our counseling service." This comment, which was opposite to the internal focus groups' expectation that S&S providers need to "look out" for factors that affect children's safety and risk, demonstrates the need for the S&S re-procurement to clarify the Department's expectation for S&S providers to partner with the Department in promoting children's safety and reducing risks – making it clear that child safety comes first in child welfare

work. An in-home counselor might focus exclusively on treating a parent's anxiety or depression without considering how the therapy helps build parenting protective capacities or without noticing aspects of the home environment that pose risks to family members' safety. There are other state agencies besides the Department that deliver supportive services to families without the requirement for the services to be attentive to protective factors and issues of safety and risk. Those services play an important role within the broad array of services that can support and assist families. However, when the Department procures services specifically for families with an open child welfare case, the expectation for service providers to attend to factors that affect children's safety and risk is essential for establishing providers as partners in building protective factors and achieving child safety, both of which reduce the need for out-of-home placement.

Another provider wrote, "DCF needs to educate families better on ways to engage with community services like ours." This comment reflects what is known nationally and was summarized in Section 1.6 of this Prevention Plan about the challenges of engaging families in services. This comment also communicated the provider's point-of-view that engagement work is the responsibility of the Department. The S&S re-procurement will clarify that addressing the challenges of connecting families with services and ensuring that families are retained in services are essential aspects of the work. And addressing the challenges of engagement and retention in services requires a coordinated partnership between the Department and contracted service providers.

The mere availability of prevention services is not adequate to achieve the Department's goals for children and families. Enrolling and keeping families engaged with services requires both the Department and service providers to contribute to boosting participation.

4.4 Families

During December 2020, the Department facilitated two focus groups with family members who serve on the Department's Family Advisory Council. The purpose of the focus groups was to discuss the prevention focus of the FFPSA and to obtain their input. During the summer and fall of 2020, the Department held listening sessions with foster parents that included discussion of the FFPSA. The themes that emerged from both the focus groups and listening sessions are summarized below.

- Services need to be culturally appropriate and competent, including for families that culturally do not believe in mental illness and services need to be delivered in a family's preferred language. Use demographics of communities to guide what services are needed for different cultural groups.
- Provide a range of peer support (i.e., parent-to-parent) services, including recovery coaches.
- Consider providing services from organizations with which families are familiar, such as church and faith-based organizations and social organizations. For children, consider schools as service delivery sites and partners for delivering services to children.
- Need more services to serve individuals who are LGBTQ, with special emphasis on more services for the transgender population.

- Focus on the basic needs that families have, such as food, housing, clothing, and cash assistance.
- Ensure services are trauma-informed.
- Make services convenient; for example, provide them in families' homes. If transportation is a barrier to an appropriate service, the service is not accessible.
- Focus on the family unit as a whole with family therapies and family conferencing and action plans for the entire family.
- Provide more early support to young and teen parents.
- Include more fathers in services.
- Provide more services to support kin and grandparents who are taking care of children.
- Do more work asking families what they need rather than telling them what services they will be receiving.

To assist the Department in obtaining input about prevention services from families, parent partners from FRCs, and advocacy groups, the Massachusetts Office of the Child Advocate arranged 10 focus groups during January through March 2022. Two of the groups were conducted in Spanish and one of the groups was conducted in Cape Verdean Creole. A total of 80 individuals participated in these groups.

Themes shared by participants in these focus groups included:

- Caregivers mainly need resources like transportation, housing, furniture, clothing, and childcare.
- If there is no nearby public transportation, families can't get to a service.
- Parent Partners are the most helpful service due to shared lived experiences.
- Caregivers need help with financial literacy and credit repair courses.
- Increase sensitivity to the unique needs of children and families, including race, ethnicity, culture, language, mental health, disability, and trauma.
- Provide more services and supports for fathers.
- Expand the duration of services. If services are too short, it limits provider's ability to build rapport with a family.
- Enhance trainings for clinicians to ensure service delivery includes empathy, support, and is not judgmental.
- Promote agency and self-efficacy among caregivers by explaining the value of parenting classes.

4.6 Request for Information (RFI) and Future Request for Response (RFR)

Obtaining input from stakeholders is an ongoing process and will continue after submission of this Prevention Plan. The Department publicly posted and disseminated a Request for Information (RFI) in October 2021 to obtain input about the design and procurement of prevention services (i.e., S&S services) from a broad range of stakeholders, including but not limited to:

- Community-based service providers currently providing S&S services, interested in providing S&S services in the future, or motivated to provide insights regardless of status as a provider of S&S services,

- Families with experience receiving S&S services, families with experience in the child welfare system, family advocates, and child advocacy organizations,
- Young adults and adolescents who have received S&S services, child advocates, and child advocacy organizations, and
- Academic institutions and scholars with expertise in child welfare.

The RFI elicited input about the full array of prevention services that can be used to promote safety, permanency, and well-being at any point in the life of a case. The RFI also included specific questions regarding the procurement, delivery, and evaluation of evidence based practices that will be aligned with the requirements in the FFPSA.

The Department received more than 50 responses to the RFI. The responses, which were from both organizations and individuals, will be used to inform development of a Request for Responses (RFR), which will be the Department's procurement mechanism for obtaining an array of prevention services that will include evidence based practices aligned with the requirements in the FFPSA for which the Department will seek Title IV-E reimbursement. Posting of the S&S RFR is anticipated in early 2023.

4.7 Summary Stakeholder Input

Collecting input from different stakeholder groups allows the Department to consider diverse viewpoints and to incorporate multiple perspectives into the discussions about the integral role of prevention services for increasing not only the number of children who remain safe at home without the need for foster care, but also for advancing the Department's broader initiatives to address diversity, inclusion, and equity issues and to eliminate discrimination in the practice of child welfare.

Given the different backgrounds, roles, responsibilities, and experiences of the various stakeholder groups as well as the different methods used to collect their input, the differences in the viewpoints shared are understandable. A notable similarity mentioned across all stakeholder groups is the importance of concrete resources as a form of prevention. All stakeholder groups contributed the view that helping families meet the basic needs for food, clothing, housing, and adequate income is a method for keeping families intact and children safe. The Department's solicitation of stakeholder input included the dissemination of an RFI in the Fall of 2021. All stakeholder input, including responses to the RFI, will be used to inform development of an RFR, which is the Department's procurement mechanism for obtaining an array of prevention services, including evidence based practiced that will be managed in alignment with the requirements in the FFPSA.

5.0 SERVICE SELECTIONS

To determine which services and treatments to include in the Five-Year Prevention Plan, the Department started from the position that the Prevention Plan will expand, not decrease, evidence based practices for families and children involved with the Department. Therefore, any services already procured by the Department that are posted to the Title IV-E Prevention Services Clearinghouse as "Well-Supported," "Supported," or "Promising," are retained and included in the Department's Prevention Plan.

To comply with the Administration for Children and Families Program Instruction (ACYF-CB-PI-18-09) that the Department be the payer of last resort for a service allowable under the title IV-E prevention program, the Department conducted an inventory of Clearinghouse evidence based practices delivered by other public agencies in the Commonwealth.

To determine which services and treatments to include in the Prevention Plan, the Department applied a developmental lens to the array of services reviewed by and ranked on the Title IV-E Prevention Services Clearinghouse. Using the developmental lens, evidence based practices rated "Well-Supported," "Supported," and "Promising" were grouped into five categories based on the age of an evidence based practice's target population. The five categories are: Young Children, School Age Children, Teens, All or Most Ages of Children, Older Teens and Adults.

The advantage of using this developmental approach is that it creates a systematic way to compare the available services to the ages of youth in foster care and to the landscape of prevention services available in the Commonwealth. In addition to applying a developmental lens to the decision making process, the Department reviewed the racial and cultural compositions of the samples used in the research base for any evidence based practice considered for selection. This review was necessary to answer the question, "Evidence based for whom?" and to align the selection of services with the Department's intention to use this Prevention Plan to advance the broader initiatives of addressing diversity, inclusion, and equity issues and to eliminate discrimination in the practice of child welfare.

Evidence Based Practices with Young Children as the Target Population

Young children under age six comprise 37% of the Department's foster care youth. Due to the vulnerability of young children, protective concerns for this age group are the highest.

The Commonwealth's public agencies and organizations offer an array of services to support families with children in this age range. Within the array of services for young children, four services, shown with **gray** highlight below, are available through other state agencies and organizations and one (1) with blue highlight is planned for delivery in the near future. Given the availability of services for this target age, the Department currently is not selecting additional evidence based services for this age range from the Clearinghouse to include in this Prevention Plan. Services for this age group may be added in future amendments.

Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR YOUNG CHILDREN		
Parent Ed	Young Child	Healthy Families America, well-supported
		Nurse-Family Partnership, well-supported
		Parents as Teachers, well-supported
		Family Spirit®, promising
		SafeCare, supported
MH	Young Child	Child Parent Psychotherapy, promising
		Incredible Years - Toddler Basic, promising
		Parent-Child Interaction Therapy, well-supported
Parent Ed, MH	Young Child	Child First, supported
SA	Young Child	Sobriety Treatment and Recovery Teams, promising

Evidence Based Practices with School Age Children as the Target Population

School age children, ages 6 - 11, currently comprise 29% of the Department's foster care youth. This is the lowest percentage of any age group in foster care.

The Commonwealth's state agencies and organizations offer an array of services to support families with children in this age range. Family Resource Centers (FRCs), in particular, provide parenting education and support for families with children of all ages, including school age children. Currently, Incredible Years – School Age Basic is the only parenting education being delivered that is posted to the Title IV-E Prevention Services Clearinghouse or included in the list of services in queue for review. However, other parenting education programs as delivered through the FRCs.

The Department is not selecting any additional evidence based practices from the short list below, which are exclusively targeted for school age children. Services for this age group may be added in future amendments. None of the practices in this short list is rated at the "Well-Supported" level. The level of evidence based support is significant because Title IV-E reimbursement requires no less than 50% of the Department's total amount expended during a fiscal year shall be for services rated as "Well Supported." The evidence based rating level of services in this grouping, combined with the ability to obtain services for this age group through selecting services described under the heading below "**Evidence Based Practices with All or Most Ages as the Target Population**,**"** informed the decision to select services from other developmental groupings rather than from this grouping, which is focused exclusively on school age children.

Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR SCHOOL AGE CHILDREN		
MH	School Age	Incredible Years - School Age Basic, promising
		Triple P (Level 4) -Online, supported
		Triple P (Level 4) -Standard, Self-Directed, Group, promising
SA	School Age	Families Facing the Future, supported

Evidence Based Practices with Adolescents (Teens) as the Target Population

Adolescents, ages 12 to 17, currently comprise 34% of the Department's foster care youth.

The Adolescent Community Reinforcement Approach (ACRA) is provided by another state agency (i.e., the Department of Public Health's BSAS), with expansion planned through the Commonwealth's Behavioral Health Roadmap funded by MassHealth and Functional Family Therapy is planned for delivery through the Behavioral Health Roadmap funded by MassHealth.

The Department currently purchases a small amount of Multisystemic Therapy through the existing S&S procurement. Consistent with the principle to use this Prevention Plan to increase, not decrease, the availability of evidence based practices for delivery to children and families served by the Department, Multisystemic Therapy (MST), a "Well-Supported" evidence based practice, is included in this Prevention Plan. Additional services for this age group may be added in future amendments.

Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR TEENS		
Parent Ed, MH	Teens	Parenting with Love and Limits, supported
MH	Teens	Functional Family Therapy, well supported
		Aggression Replacement Training, promising
		Prolonged Exposure Therapy for Adolescents with PTSD, supported
		Interpersonal Psychotherapy for Depressed Adolescents, promising
MH, SA	Teens	Multisystemic Therapy, well supported ★
SA	Teens	Adolescent Community Reinforcement Approach, promising
Parent Ed, MH, SA	Teens	Familias Unidas, well-supported

Service	Multisystemic Therapy (MST®)
Level of Evidence on Title IV-E Clearinghouse	Well-Supported
Service Category	Mental Health and Substance Abuse

Plan to Implement	To implement, the following steps will be completed: • Included questions in the Support and Stabilization (S&S) Request for Information (RFI), issued in 10/2021, to assess interest and capacity in provider community to continue offering MST® or to start offering MST® as a provider licensed by MST Services (https://www.mstservices.com). • Include request for bids to deliver MST® in the upcoming S&S Request for Responses (RFR). • Establish contracts with selected providers. • Distribute information packets about MST® service availability to Area Office staff (ARCs and Lead Agency staff) responsible for referrals to contracted services and for keeping Area Office social workers, supervisors and program manager updated on available contracted services, including evidence based practices.
Plan to Monitor Fidelity	Include language in the S&S procurement requiring providers of MST® to: • Be licensed by MST® Services to be a provider of MST® as listed on the MST® Services website https://www.mstservices.com/licensed-organizations • Deliver MST®, not enhancements or other versions of MST®. • Follow the Multisystemic Therapy QA/QI Program requirements as stipulated by the MST® Institute. • Submit to the Department, every 6 months, a copy of the written Program Implementation Review (PIR) completed by the team's supervisor and MST® expert as evidence of

	compliance with the MST Institute's QA/QI Program requirements. The version of the manual used by MST® providers will be consistent with the requirements of MST® Services for licensing standards. The current version of the manual is Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents.* (2nd ed.). New York and London: Guilford Press.
Plan to Determine and Use Outcomes to Improve Practice	The S&S RFR will include the requirement for all providers awarded a contract to deliver S&S services to develop and implement an internal Continuous Quality Improvement (CQI) policy and process that includes both use of the provider's own data and reviewing any data provided by the Department for the purpose of using the data to improve processes and outcomes. To ensure that providers understand the Department's commitment to using outcomes to improve practice, the S&S RFR will include a statement such as the following: "Should findings from CQI yield insights that could improve the quality of services and achievement of outcomes, the Department reserves the right to amend contract requirements and to work with contractors on implementing improvements."
How Selected	MST® is selected because it is already part of the Department's contracted service array. MST® is already part of the Department's contracted service array because a provider proposed MST® through the Department's most recent S&S procurement. Through the proposal review process, MST® was identified as a valuable service for a portion of the population served by the Department. See "Target Population" in the row below for a description of MST's® target population. The proposal passed the quality review process, was recommended for contract award, and a contract was negotiated with a provider. MST®'s inclusion in the Prevention Plan is consistent with the Department's commitment to ensure that the Prevention Plan increases

	the availability of evidence based practices available to children and families served by the Department.
Target Population	Youth between the ages of 12 and 17 and their families, including youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Assurance for Trauma-Informed Service Delivery	The Assurance for Trauma-Informed Service Delivery is provided in Attachment III. To implement an effective approach to trauma-informed service delivery, the Department issued an S&S RFI that asked providers to respond to the following: • How will your organization ensure compliance with this requirement for trauma-informed service delivery? • What documentation will you be able to submit to the Department on an annual basis to demonstrate that your organization is sustaining the requirement for trauma-informed service delivery?" Based on the responses received in the RFI, the Department will filter and synthesize provider responses to create a list of methods that providers can use to ensure compliance with the trauma-informed service delivery requirement and to create a process, or potentially a range of processes, from which providers can choose to report annually their sustained compliance with the trauma-informed service delivery requirement. The S&S RFR will state that all providers selected for contract must meet the trauma-informed service delivery requirement and follow the annual process for submitting to the Department evidence of sustained adherence to the trauma-informed service delivery requirement. For contract monitoring, the Department will develop and implement, with assistance from the external evaluation partner described in Section 8 Evaluation Strategy, an annual process for assuring trauma-informed service delivery.

How Evaluated (Well-Designed and Rigorous Process)	See Section 8 Evaluation Strategy. A waiver will be requested for this Well-Supported practice.

Evidence Based Practices with All or Most Ages as the Target Population

This section focuses on those evidence based practices that have a target population that spans age categories, ranging from infants or school aged children through older adolescents or young adults.

Through the Behavioral Health Roadmap and funded by MassHealth, Trauma-Focused Cognitive Behavior Therapy (TF-CBT) for families and EMDR for individuals are expected to be added to the state-wide service array.

From this developmental category, the Department is including the evidence based practices of Intercept® and Brief Strategic Family Therapy® in the Prevention Plan. Intercept®, which is already procured as a prevention service, is selected consistent with the Department's commitment to using this Prevention Plan to increase, not decrease, the availability of evidence based practices for families and children. Brief Strategic Family Therapy® is selected to address the gap identified by both internal and external stakeholders for more services to address the needs of families with children who have behavioral health profiles that include aggressive behaviors and substance use. Additional services for this age group may be added in future amendments.

Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR ALL OR MOST AGES OF CHILDREN		
Parent Ed	All ages	Homebuilders, well-supported, ages 0-18
		Intercept®, well-supported, ages 0-18 ★
		Family Centered Treatment, supported, ages 0-17
		Iowa Parent Partner Approach, promising, ages 0-17
Parent Ed, MH	All ages	Family Check up, well supported, ages 2-17
MH	All ages	Trauma-Focused Cognitive Behavior Therapy, promising, ages 3-18
		Eye Movement Desensitization and Reprocessing (EMDR) – Standard Protocol, supported, ages 2-adult
		ICC High Fidelity Wrap, promising, ages 0-21
		Trust-Based Realtional Intervention - Caregiver Training, promising, ages 0-17
		TBRI® 101 self-administered, promising, ages 0-17
Parent Ed, MH, and SA	All ages	Brief Strategic Family Therapy®, well supported, ages 6-17 ★
		Multi-Dimensional Family Therapy, supported, ages 9-26

Service	Intercept®
Level of Evidence on Title IV-E Clearinghouse	Well Supported

Service Category	Parent Education
Plan to Implement	• To implement, the following steps will be completed: Include request for proposals to deliver Intercept® in the Support & Stabilization (S&S) Request for Responses (RFR). • Establish contracts with selected providers. • Distribute information packets about Intercept® availability to Area Office staff (ARCs and Lead Agency staff) responsible for referrals to contracted services and for keeping Area Office social workers, supervisors, and program managers updated on available contracted services, including evidence based practices.
Plan to Monitor Fidelity	Include language in the S&S procurement requiring provider of Intercept® to: • Use the Intercept® manual: Goldsmith, T. (Ed.). (2007). *Youth Villages clinical protocols treatment manual.* Youth Villages. • Submit to the Department annually the results of the Intercept® fidelity review process, which is called "Program Model Review" and is already conducted annually per the Youth Villages' established fidelity procedure.
Plan to Determine and Use Outcomes to Improve Practice	The S&S RFR will include the requirement for all providers awarded a contract to deliver S&S services to develop and implement an internal Continuous Quality Improvement (CQI) policy and process that includes both use of the provider's own data and reviewing any data provided by the Department for the purpose of using the data to improve processes and outcomes. To ensure that providers understand the Department's commitment to using outcomes to improve practice, the S&S RFR will include a statement such as the following: "Should findings from CQI yield insights that could improve the quality of services and achievement of outcomes, the Department

	reserves the right to amend contract requirements and to work with contractors on implementing improvements."
How Selected	Intercept® is selected because it is already part of the Department's contracted service array. Youth Villages, creator of Intercept®, proposed Intercept® through the Department's most recent S&S procurement. Through the proposal review process, Intercept® was identified as a valuable service for a portion of the population served by the Department. See "Target Population" in the row below for a description of Intercept's® target population. Intercept's® inclusion in the Prevention Plan is consistent with the Department's commitment to ensure that the Prevention Plan increases the availability of evidence based practices available to children and families served by the Department.
Target Population	Intercept® targets children from birth to age 18 who are at risk of entry or re-entry into out-of-home placements (e.g., foster care, residential facilities, or group homes) or who are currently in out-of-home placements.
Assurance for Trauma-Informed Service Delivery	The Assurance for Trauma-Informed Service Delivery is provided in Attachment III. To implement an effective approach to trauma-informed service delivery, the Department issued an S&S Request for Information (RFI) that asked providers to respond to: • How will your organization ensure compliance with this requirement for trauma-informed service delivery? • What documentation will you be able to submit to the Department on an annual basis to demonstrate that your organization is sustaining the requirement for trauma-informed service delivery?" Based on the responses received in the RFI, the Department will filter and synthesize provider responses to create a list of methods that providers can use to ensure compliance with the trauma-informed service delivery requirement and to create a process, or potentially a range of processes, from which providers can choose to report annually their

	sustained compliance with the trauma-informed service delivery requirement. The S&S RFR will state that all providers selected for contract must meet the trauma-informed service delivery requirement and follow the annual process for submitting to the Department evidence of sustained adherence to the trauma-informed service delivery requirement. For contract monitoring, the Department will develop and implement, with assistance from the external evaluation partner described in Section 8 Evaluation Strategy, an annual process for assuring trauma-informed service delivery.
How Evaluated (Well-Designed and Rigorous Process)	See Section 8 Evaluation Strategy

Service	Brief Strategic Family Therapy (BSFT®)
Level of Evidence	Well-Supported
Service Category	Parent Education, Mental Health, and Substance Abuse
Plan to Implement	• The S&S Request for Information (RFI), posted in October 2021, included questions to assess interest and capacity in the provider community to become BSFT® providers, which requires commitment to readiness assessment process, training, supervision, licensure, and sustained fidelity assessments and maintenance. • Include request for bids to deliver BSFT® in the S&S Request for Responses (RFR). • Include statement in S&S RFR that funding for start-up resources for BSFT® will be available to bidders awarded contracts to deliver BSFT® in compliance with the manual created by the University of Miami Brief Strategic Family Therapy® Institute and in compliance with

	requirements to become certified providers of BSFT® • Establish contracts with selected providers and establish arrangements for selected providers to obtain training and supervision from BSFT® authorized faculty. • Distribute information packets about BSFT® service availability to Area Office staff (ARs and Lead Agency staff) responsible for referrals to contracted services and for keeping Area Office social workers, supervisors, and program managers updated on available contracted services, including evidence based practices.
Plan to Monitor Fidelity	Include language in the S&S procurement requiring the following: • Providers of BSFT® must be licensed by the BSFT® Institute of the University of Miami, following the most current manual[26]. • During the training and licensure process, fidelity measures, including the BSFT® Therapist Adherence Form & Clinical Supervision Checklist, will be administered by the BSFT® training faculty and submitted to the Department no less frequently than annually. • After each contracted BSFT® program in the Commonwealth achieves the goal of developing its own BSFT® Certified Supervisor, each program's BSFT® Certified Supervisor will be responsible for conducting fidelity assessments, including the BSFT® Therapist Adherence Form & Clinical Supervision Checklist, and ensuring

[26]Manual used for review by Clearinghouse: Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse. MA intends to use the updated version of the manual: Szapocznik, J., & Hervis, O. E. (2020). *Brief strategic family therapy*. American Psychological Association.

	their submittal to the Department no less frequently than annually.
Plan to Determine and Use Outcomes to Improve Practice	The S&S RFR will include the requirement for all providers awarded a contract to deliver S&S services to develop and implement an internal Continuous Quality Improvement (CQI) policy and process that includes both use of the provider's own data and reviewing any data provided by the Department for the purpose of using the data to improve processes and outcomes. To ensure that providers understand the Department's commitment to using outcomes to improve practice, the S&S RFR will include a statement such as the following: "Should findings from CQI yield insights that could improve the quality of services and achievement of outcomes, the Department reserves the right to amend contract requirements and to work with contractors on implementing improvements."
How Selected	Both internal Departmental stakeholders and contracted providers identified a service gap for youth with conduct disorders, aggressive and assaultive behaviors, and substance use. The Department compared the evidence based practices designed for this target population and selected BSFT® based on the following considerations: • An Engagement Model is built into the treatment. This treatment is specially designed to bring families into treatment and retain them for the duration of treatment. The developers of BSFT® contend that the same family dynamics that underlie symptoms such as drug use, bullying, and aggression also underlie resistance to engagement with treatment. The 2011[27] study reported, "Adolescents in Treatment as Usual (TAU) were 2.5 times more likely to fail to engage and 1.41 times more likely to fail to retain in treatment than

[27]Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K., Hodgkins, C., Carrion, I., Vandermark, N., Szapocznik, J. (2011). Brief Strategic Family Therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. *Journal of Consulting and Clinical Psychology*, 79(6), 713-727.

	adolescents in the BSFT®." This built-in commitment to engagement makes the treatment a match for the families and youth the Department would refer for this type of service. • The research used to establish this treatment as evidence based on the Title IV-E Clearinghouse provides evidence that it was developed with a focus on ensuring cultural competency. The 2019[28] study stated, "Every effort was made to maximize racial and ethnic representation by inclusion of treatment providers that serve Hispanics and Blacks." The sample was comprised of youth and families who identified as White 30%, Black 23%, and Hispanic 44%. • The target age range for children eligible to participate with their families in BSFT® is age 6 to 17. Rather than waiting for the adolescent years, which is required by some of the evidence based practices that also address target behaviors of aggression, substance use, family conflict, BSFT® can be used in a proactive manner to address the issues with school age children, starting as young as age 6, at the first signs of symptomology.
Target Population	BSFT® is designed for families with children or adolescents (age 6 to 17) who display or are at risk for developing problem behaviors including, drug use and dependency, conduct disorders, delinquency, antisocial peer associations, bullying, or truancy.
Assurance for Trauma informed Service Delivery	The Assurance for Trauma-Informed Service Delivery is provided in Attachment III. To implement an effective approach to trauma-informed service delivery, the Department issued an S&S RFI that asked providers to respond to:

[28] Robbins, M. S., Szapocznik, J., Horigian, V. E., Feaster, D. J., Puccinelli, M., Jacobs, P., Burlew, K., Werstlein, R., Brigham, G. (2009). Brief Strategic Family Therapy for adolescent drug abusers: A multi-site effectiveness study. *Contemporary Clinical Trials*, 30(3), 269-278.

	• How will your organization ensure compliance with this requirement for trauma-informed service delivery? • What documentation will you be able to submit to the Department on an annual basis to demonstrate that your organization is sustaining the requirement for trauma-informed service delivery?" The S&S RFR will state that all providers selected for contract must meet the trauma-informed service delivery requirement and follow the annual process for submitting to the Department evidence of sustained adherence to the trauma-informed service delivery requirement. For contract monitoring, the Department will develop and implement, with assistance from the external evaluation partner described in Section 8 Evaluation Strategy, an annual process for assuring trauma-informed service delivery.
How Evaluated (Well-Designed and Rigorous Process)	See Section 8 Evaluation Strategy. A waiver will be requested for this "Well-Supported" practice.

Evidence Based Practices with Older Adolescents (Teens) and Adults as the Target Population

This section focuses on those evidence based practices that have a target population of older adolescents and adults. Methadone Maintenance is currently available through support from BSAS at the Department of Public Health. Prolonged Exposure Therapy for PTSD is anticipated through the Behavioral Health Roadmap. Some of the Department's S&S providers report delivering Motivational Interviewing; however, there is not information about whether the delivery is consistent with FFPSA requirements. The Department will work with providers to build capacity for delivering Motivational Interviewing as an evidence based practice with fidelity monitoring. The Department will not seek federal reimbursement for Motivational Interviewing through this Plan but may do so in future amendments.

MA plans for contracted service providers to implement MI in conjunction with other S&S services that are used to keep children safe and stable in their own homes without the need for out of home placement. The implementation of MI as a service embedded with another S&S service will be achieved through the Department's S&S Request for Responses (RFR), which is scheduled for release in early 2023.

Title IV-E Prevention Clearinghouse Category	Target Population Age	Title VI-E Prevention Clearinghouse Practices rated as Well-Supported, Supported or Promising as of 1/28/2022
FOR OLDER TEENS AND ADULTS		
Parent Ed, MH, SA	Teens - Adults	Motivational Interviewing, well supported ★
Parent Ed, MH, SA	Parents of children ages 2-18	Parents Anonymous®, supported
MH	Adult	Interpersonal Psychotherapy, (Weissman et al.), supported
		Prolonged Exposure Therapy for PTSD, promising
SA	Adult	Methadone Maintenance, promising

6.0 NON-DISCRIMINATION IN PROCUREMENT PRACTICES

Addressing issues of diversity, inclusion, equity, and racial justice in child welfare requires considering not only individual biases that may affect casework decisions, but also the influence of organizational factors and institutionalized systems. Through public procurement, public child welfare agencies obtain services to support children and families. The Department's implementation of the FFPSA will be achieved through procurements of prevention services. Therefore, consideration of the procurement process is essential for ensuring that the Department's implementation of the FFPSA advances the Department's broader initiatives to eliminate discrimination and to achieve racial equity in the practice of child welfare.

State-level

To guard against discrimination toward potential contractors in public procurement, the Commonwealth of Massachusetts operates a Supplier Diversity Program (SDP) that encourages the award of state contracts in a way that strengthens and increases business opportunities for Minority-Owned Business Enterprises (MBEs), Minority Non-Profit Organizations (M/NPO), Women-Owned Business Enterprises (WBEs), Women Non-Profit Organizations (W/NPO), Service-Disabled Veteran-Owned Business Enterprises (SDVOBEs),Veteran-Owned Business Enterprises (VBEs), Lesbian, Gay, Bisexual, and Transgender Business Enterprises (LGBTBEs), and Disability-Owned Business Enterprises (DOBEs).

Only businesses certified by the Massachusetts Supplier Diversity Office (SDO) or an SDO-recognized third-party certification organizations qualify for inclusion in the SDP. The SDO, working with the Governor's Office of Access, Opportunity, and Community Affairs, sets spending goals or benchmarks for Executive Departments for purchasing from MBE, WBE, and SDVOBE / VBE businesses. While spending goals have not yet been established by the SDO for DOBE and LGBTBE businesses, state agencies are encouraged to include them in their purchasing efforts.

The extent to which the Department's direct purchases meet established benchmarks for diverse purchasing is reported in the benchmark report for the Massachusetts Executive Office of Health and Human Services. The Commonwealth's supplier diversity benchmarks will apply to the Department's purchase of prevention services through the S&S procurement.

The SDP also targets the procurement process with indirect requirements. The SDP policy itself includes the requirement that 25% of evaluation points for procurements with projected annual spending of at least $250,000 per year are dedicated to the evaluation of SDP Plans as submitted during the RFR response by bidders. These points are awarded based on the meaningful financial commitment of a bidder to partnering with one or more SDO-certified or recognized diverse business enterprise or non-profit organization. The commitments can be made through planned subcontracting or through the purchase of ancillary products and services and represents indirect spending by the Department with SDO-certified or recognized diverse business enterprises or non-profit organizations.

The Commonwealth also maintains non-discrimination requirements that target the delivery of services and the treatment of employees by all providers of publicly contracted services. Specifically, these state-level requirements prohibit discrimination in the delivery of services against any consumer who otherwise meets the eligibility criteria for services and in hiring and employment practices on the basis of race, color, national origin, ancestry, age, sex, religion, disability, status as a Vietnam Era Veteran, sexual orientation or for exercising any rights or benefits afforded by law.

7.0 TRAINING AND SUPPORT FOR CHILD WELFARE WORKFORCE

7.1 Prevention Caseloads

The Department's point-in-time case counts are shown in Table 5.

TABLE 5. Case Counts Fiscal Year End	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Clinical (i.e., ongoing) Case Counts	26,488	25,044	25,392	23,784	22,088	23,938

The Department's point-in-time and 12-month average weighted caseload counts from FY2016 to FY2020 are shown in Table 6.

TABLE 6. Weighted Caseload [1]	FY2016	FY2017	FY2018	FY2019	FY2020
Weighted Caseload Ratio – End of Fiscal Year	**18.61:1**	**16.54:1**	**16.11:1**	**15.56:1**	**13.73:1**
Total Weighted Caseload – End of Fiscal Year (denominator)	36,954.42	35,568.07	35,463.41	33,126.58	29,386.42
FTE Count of Case Carrying Workers – End of Fiscal Year (numerator)	1,985.80	2,150.10	2,201.73	2,128.91	2,139.76
Weighted Caseload Ratio – 12-Month Average	**17.63:1**	**16.32:1**	**15.80:1**	**15.30:1**	**14.74:1**
Total Weighted Caseload – 12-month average (denominator)	34,677.63	34,398.51	34,389.51	33,501.14	31,241.81
FTE Count of Case Carrying Workers – 12-month average (numerator)	1,966.91	2,107.66	2,176.58	2,189.21	2,119.29

[1] Weighted Caseloads (recast in FY20 to 15:1) are pro-rated by each worker's FTE (full-time equivalency) value. **NOTE: 15:1 = 15 families**

The Department considers current caseload size to be consistent with capacity for effective case management for families and children receiving prevention services.

There are multiple quantitative reports that the Department uses to inform the oversight and management of caseload size. Within iFamilyNet, the Department's SACWIS, there is a caseload report that provides real time caseload numbers. This report can be generated by any employee, including senior leaders, managers, and front line social workers, who has access to iFamilyNet. In addition, the Department's Office of Management and Planning Analysis (OMPA) generates and distributes multiple reports to support equitable and manageable caseload size. On a weekly basis, OMPA generates the Ongoing Caseload Distribution report, which is sent to Central Office and Regional leaders. On a monthly basis, OMPA generates the Caseload Summary report, which is sent to Central Office and Regional leaders and posted on the Department's Intranet site for access by managers and bargaining unit members.

The Commonwealth's Collective Bargaining Agreement with bargaining unit employees of the Department includes acknowledgement that a workload that exceeds caseload goals and/or workload standards adversely influences a worker's ability to complete all casework assignments. Therefore, the Collective Bargaining Agreement also includes workload support systems, at both the Area Office and Central Office levels, that are implemented to provide relief whenever caseload sizes exceed agreed upon levels. For example, within five working days of a monthly caseload report that identifies any worker with a caseload that exceeds the agreed upon level for the reporting month, Area Office relief factors must be used to alleviate the caseload. Area Office relief factors can include:

- Reassignment of cases within a supervisory unit
- Reassignment of excess cases within an Area Office
- Reassignment of vacant positions within a Region

- Reassignment of excess cases to other Area Offices within a Region
- Reassignment of staff to offices with excess cases

In the event there are not sufficient Area Office relief factors to reduce the workload excess within 10 working days of implementation, the Department's Central Office will reassign staff from other Regional Offices to the affected Area Office within 20 working days.

Currently, the Department has sufficient resources to manage the caseload. In the event of a future caseload challenges, the Department would work with the Executive Office of Health and Human Services to problem solve capacity issues.

7.2 Training and Support for Child Welfare Workforce

Trainings on Assessment, Clinical Formulation, and Planning
Informed by input from the Massachusetts Office of the Child Advocate and SEIU Local 509, the Department is implementing a training plan designed to improve child welfare workforce skills that are necessary to perform the fundamental responsibilities of family assessment, child safety and risk assessment, clinical formulation, action planning, and reunification planning. The training will emphasize the critical thinking and information synthesizing that underpin the ability to connect these tasks to each other and to the overarching goals of child safety, permanency, and well-being.

Child welfare social workers may be capable of completing the distinct tasks of conducting a family assessment, writing a clinical formulation, and developing an action plan without recognizing the essential connections among those tasks. A task-oriented approach to child welfare lacks the depth of clinical understanding required to identify family needs, assess parental capacity and strengths, assess child safety and risk, determine service needs, develop action plans, and guide families through stages of growth and skill building that eventually lead to the safe and sustainable closing of a child welfare case.

Creation of service/action plans for families is an essential skill throughout human service organizations. The distinguishing characteristic of services plans (i.e., prevention plans) in the child welfare profession is the linkage between actions with the elimination of safety risks for children. The necessity for the processes of assessment, clinical formulation, and action planning to be repeated regularly to monitor family progress and child safety is often lost on staff who are new to the child welfare profession. Novices view requirements to repeat the processes as redundant "busy work." When approached with that attitude, mandated requirements to re-assess, re-formulate, and re-plan yield written products that are created to meet mandates rather than written tools that guide intentional interactions and constructive engagement with families and other service providers.

The Department's training agenda is much broader than training skills for completing tasks and extends beyond a focus on frontline social workers to include the introduction of new, evidence based tools and collaborative processes that support the specialized work of child welfare

professionals. The areas for training do not merely correspond to a list of titles for training, rather, the following sections describe areas of change that will be supported by training, policy, practice, and process for continuous learning.

Supervision

The Department recently revised its Supervision Policy to include expectations for supervisory time for frequent and structured focus on interpreting assessments on family, safety and risk, and information from prevention service providers in ways that inform clinical formulations, safety plans, and action plans. Training supervisors to implement the new expectations will include developing supervisors' pedagogical abilities to elicit and promote critical thinking and information synthesis. Reports from prevention service providers will be added to families' files but integrating the information from those reports into casework practice requires that supervisors ask to see the reports, discuss their contents with social workers, describe how to evaluate the information, and promote critical thinking about how to use the information.

Safety and Risk Assessment

The Department currently has Structured Decision Making (SDM) Safety and Risk Assessments. The Safety Assessment will be updated by June 2023 and will be accompanied by training for the Department's social workers, supervisors, and managers on use of the new tool and its integration into practice.

Ongoing Casework and Documentation Policy and Family Assessment and Action Planning Policy

Updates to the Ongoing Casework and Documentation Policy and the Family Assessment and Action Planning Policy will focus on obtaining and synthesizing information from multiple sources, including prevention service providers. The updates will include expectations for the frequency of contact with prevention service providers, the minimum important information to obtain from them, how to use assessments to guide the type of information to elicit from prevention service providers, and how to integrate that information into casework practice.

Availability of Evidence Based Prevention Practices

Selection of the prevention services that are appropriate for a specific family and/or child and referrals to prevention service providers is managed by a specialized workforce, consisting of Area Resource Coordinators (ARCs) and contracted Lead Agency staff who are co-located in the Department's 29 Area Offices. To implement this Prevention Plan, ARCs and Lead Agency staff will receive training on key points, including but not limited to the:

- Department's definition, provided in Section 1.3, of "foster care candidates" who are eligible for Title IV-E evidence based prevention services,
- Information that must appear in the prevention plan for a child or caregiver to be eligible for Title IV-E evidence based prevention services,
- Target population for each of the Title IV-E evidence based prevention services and the applicability of each service to meet the needs for skill based parent education, mental health prevention or treatment, and/or substance use, and

- Rationale for a new two-step process that will be used to enter referrals for services into the Department's IT system. By using a two-step process, the Department will obtain needed information about both consumer engagement and retention in services.

Consistent with their existing job expectation to educate their local Area Office about contracted prevention services, the specialized workforce of ARCs and Lead Agency staff will be responsible for training their Area Offices about the new evidence based prevention services using materials provided by DCF's Services Network team that will describe the target population, duration of service, expected outcomes, and other characteristics of each evidence based service.

Trainings on Trauma-Informed Practice

Recognizing the importance of both trauma-informed practice and the provision of a trauma-informed work environment, the Department provides multiple trainings to build the trauma-informed knowledge and skills of the child welfare workforce.

Pre-Service Training for New Social Workers

Pre-Service training for all new social workers includes a module dedicated to trauma-informed practice and focused on:

- Understanding the impact of trauma and Adverse Childhood Experiences on brain development and the long-term physiological and psychological consequences of abuse and neglect,
- Learning the principles of trauma-informed practice in child protection, with an emphasis on:
    - Engaging children and adults who are trauma survivors,
    - Anticipating and planning responses to emotional and behavioral dysregulation,
    - Understanding the effects of trauma on attachment, relationships, and self-regulation skills, and
    - Identifying resources and supports to promote resilience and personal wellness for the child welfare workforce.

Self-Care Trainings

The Department offers, for all staff, a two hour training called *Vicarious Trauma and Self-Care Planning*.

Trauma-Informed Trainings for Supervisors and Managers

There are two, multi-part training series especially for supervisors and managers:

- A six-part certificate program in Trauma-Informed Supervision.
- A four-part Trauma-Informed Conflict Resolution series.

Specialized Trauma-Informed Trainings During Pandemic

To address the unprecedented challenges presented by the COVID-19 pandemic, the Department developed and delivered the following specialized trainings:

- Working in the Midst of a Pandemic: Trauma Monitoring and Intervention (specifically for supervisors and managers)

- An Introduction to Trauma-Informed Leadership during a Pandemic: The Role of Staying Connected in a Virtual World
- Supervision in the Midst of Pandemic: Trauma Monitoring and Intervention
- Helping the Helpers: Understanding Stress and Secondary Trauma in the Context of the Pandemic

8.0 EVALUATION STRATEGY AND WAIVER REQUEST

8.1 Evaluation Strategy

Multiple factors contributed to the Department's five year reduction – from 2016 through 2020 – in children placed in foster care. One of the contributing factors may be the effectiveness of existing S&S services for achieving quarternary prevention. But without an evaluation strategy to provide insights, it is not possible to know which S&S services are most effective and whether they are effective for families of all races, cultures, and lived experiences. The Department's contracted provider community contends that some of the services they provide are as effective as services that earn evidence based status, but they lack the funding required to conduct the rigorous research needed to demonstrate an evidence base.

Therefore, to gain insights into the effectiveness of S&S services, to respond to those providers who seek feedback about the effectiveness of their services, and to contribute to the knowledge base about prevention strategies in the child welfare profession, the Department is taking the opportunity presented through this Prevention Plan to build capacity for evaluating S&S services procured by the Department.

The Department is seeking evaluation waivers for the "Well-Supported" evidence based practices, MST®, BSFT®, and Intercept®. These waivers are provided in Attachment II Number 1, Attachment II Number 2, and Attachment II Number 3.

Rationale for evaluation waiver for MST®

There is a large research base that earned MST® a "Well-Supported" rating on the Title IV-E Prevention Services Clearinghouse. The research base includes not only violent and chronic juvenile offenders (e.g., Henggeler et al., 1997[29]), more likely to be served by the Massachusetts Department of Youth Services, but also youth with less severe conduct problems (e.g., Weiss et al., 2013[30]), which is consistent with the child welfare population of youth that is served by the Department. In addition, the research base indicates that MST® achieves positive youth outcomes though positive improvements in parenting practices achieved by empowering parents to regulate events in their families (e.g., Scherer et al., 1994[31]) and by improving parents' mental health (e.g., Borduin et al., 1995[32]), which are consistent with the desired outcome for MST® of achieving a safe home environment that negates the need for foster placement.

[29] Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. *Journal of Consulting and Clinical Psychology*, *65*(5), 821-833.

[30] Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., Gallop, R., and Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. *Journal of Consulting and Clinical Psychology*, 81(6), 1027-1039.

[31] Scherer, D.G., Brondino, M.J., Henggeler, S.W., Melton, G.B., and Hanley, J.H. (1994). Multisystemic Family Preservation Therapy: Preliminary Findings from a Study of Rural and Minority Serious Adolescent Offenders. *Journal of Emotional and Behavioral Disorders*, *2*(4):198-206.

[32] Borduin, C.M, Mann, B.J., L T Cone, L.T., Henggeler, S.W., Fucci, B.R., Blaske, D.M., and Williams, R.A. (1995). Multisystemic treatment of serious juvenile offenders: long-term prevention of criminality and violence *Journal of Consulting and Clinical Psychology*, *63*(4):569-78.

The characteristics of the youth and parents included in the studies conducted in Europe[33] are not a cultural match for the population served by the Department. The racial backgrounds from multiple studies conducted in the United States (e.g., Borduin, 1995; Henggeler, 1997 and 2006; Scherer, 1994; Weiss, 2013) included Black and White youth but ethnicity of Hispanic/Latino was not mentioned.

In light of the research base demonstrating the desired outcomes of MST® with a similar population as served by the Department, there is justification for not requiring inclusion of MST® in the evaluation strategy.

Rationale for evaluation waiver for BSFT®

The research base that earned BSFT® a "Well-Supported" rating demonstrated the cultural competency of this intervention for achieving positive outcomes for children and families who identified as White, Black, and Hispanic. The Robbins et al., 2009[34] study stated, "…every effort was made to maximize racial and ethnic representation by inclusion of treatment providers that serve Hispanics and Blacks." The emphasis on cultural competency influences the way that BSFT® practitioners are trained, ensuring that therapists are attuned to the ways that consumers from different cultures define "family," the ways that these definitions affect the implementation of therapy with the family, and strategies for including fathers in the service[35]. The inclusion of families and children of color in the research base is a match for the population served by the Department, as described in Section 3. The emphasis on training therapists in strategies for including fathers in the service is consistent with the input from families described in Section 4.

The research results (e.g., Robbins et al., 2011[36]) demonstrating that BSFT® is more effective than other treatments in engaging and retaining families and children in the service is a match for the population served by the Department, for whom, as explained in Section 1, it is not a reasonable expectation that they reach out independently for services and stay engaged with services without support.

[33] Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., . . . Goodyer, I. M. (2018). Multisystemic Therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): A pragmatic, randomised controlled, superiority trial. The Lancet. Psychiatry, 5(2), 119-133.: Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of Multisystemic Therapy and a statutory therapeutic intervention for young offenders. Journal of the American Academy of Child & Adolescent Psychiatry, 50(12), 1220-1235; Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., & Prins, P. J. M. (2013). A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. Journal of Experimental Criminology, 9(2), 169-187; Asscher, J. J., Dekovic, M., Manders, W., van der Laan, P. H., Prins, P. J. M., van Arum, S., & Dutch MST Cost-Effectiveness Study Group. (2014). Sustainability of the effects of Multisystemic Therapy for juvenile delinquents in the Netherlands: Effects on delinquency and recidivism. Journal of Experimental Criminology, 10(2), 227-243.

[34] Robbins, M. S., Szapocznik, J., Horigian, V. E., Feaster, D. J., Puccinelli, M., Jacobs, P., Burlew, K., Werstlein, R., Bachrach, K., and Brigham, G. (2009). Brief Strategic Family Therapy for adolescent drug abusers: A multi-site effectiveness study. *Contemporary Clinical Trials*, 30(3), 269-278.

[35] Dr. J. Szapocznik, personal communication, October 4, 2020.

[36] Robbins, M. S., Feaster, D. J., Horigian, V. E., Puccinelli, M. J., Henderson, C., & Szapocznik, J. (2011). Therapist adherence in Brief Strategic Family Therapy for adolescent drug abusers. *Journal of Consulting and Clinical Psychology*, 79(1), 43-53.

In addition, the research results from Horigian et al., 2015[37] indicating the mediating effect that BSFT®'s improvements of family functioning have for reducing substance use by parents is consistent with the desired outcome for BSFT® of achieving a safe home environment that negates the need for foster placement.

In light of the research base demonstrating the desired outcomes of BSFT® with a similar population as served by the Department, there is justification for not requiring inclusion of BSFT® in the evaluation strategy.

Rationale for evaluation waiver for Intercept®

The goal of Intercept® is to reduce the utilization of foster care by preventing entry into care, reducing the time spent in care, and/or reducing the risk of re-entry. The research base for Intercept® consists of evaluations[38] conducted by Huhr and Wulczyn using administrative data from the Tennessee Department of Children Services.

The first article in this series (Huhr & Wulczyn, January 2020) focused on the impact of Intercept® on foster placement. The second article (Huhr & Wulczyun, September 2020) focused on the impact of Intercept® on permanency for children who were placed in foster care. The third study (Huhr & Wulczyn, 202) was a replication of the January 2020 evaluation that investigated whether, across a different time period, the same outcomes for preventing foster care would be found in a different sample of children.

This body of research used a matching methodology that included race/ethnicity as a matching characteristic. So, the race/ethnicity characteristics of the samples were reported both before and after matching. The tables are presented below to provide a full view of the race/ethnicity of the samples. The race/ethnicity data includes African American and White, but ethnicity of Hispanic/Latino was not mentioned.

[37] Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive Behaviors*, *42*, 44-50.

[38] Huhr, S., & Wulczyn, F. (January 2020). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/10/YV-Intercept-Results-1-8-2020-final.pdf; Huhr, S., & Wulczyn, F. (September 2020). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2020/09/Permanency-YVIntercept-final-982020.pdf; Huhr, S., & Wulczyn, F. (2021). The impact of Youth Villages' Intercept program on placement prevention: A second look. The Center for State Child Welfare Data.

Huhr & Wulczyn, January 2020		Before Matching			After Matching	
Characteristic	Value	Treatment Group	Comparison Group	Percent Served	Treatment Group	Comparison Group*
Race/Ethnicity	African American	203	12,240	1.6%	167	3,295
	White	872	39,378	2.2%	841	14,683
	Other	128	7,972	1.6%	88	1,140
	Unknown	696	127,490	0.5%	682	67,136

* As shown, the comparison group frequencies are unweighted. The weighted cell percents (not shown) for the comparison group are identical to the cell percents for the treatment group because of exact matching.

In the January 2020 article, the authors made two notes about "unknown" race/ethnicity stating that 1) as children moved through the system, the number of children with unknown race/ethnicity decreased, and 2) to the extent that unknown race is correlated with lower risk, then unknown race/ethnicity is still useful from the perspective of matching and statistical adjustment.

Huhr & Wulczyun, September 2020	Before Matching					After Matching				
	Treatment		Comparison		Percent	Treatment		Comparison		Percent
Characteristic	Number	Percent	Number	Percent	Referred	Number	Percent	Number	Percent	w/ Weight
Race/Ethnicity										
African American	84	23.20%	1,240	18.10%	6.80%	72	22.00%	410	11.10%	22.00%
White	251	69.30%	4,951	72.30%	5.10%	236	72.00%	3,169	85.60%	72.00%
Other	27	7.50%	661	9.60%	4.10%	20	6.10%	122	3.30%	6.10%

Huhr & Wulczyun, 2021	Before Matching					After Matching				
	Treatment		Comparison		Referred -	Treatment		Comparison		Percent w/
Characteristic	Number	Percent	Number	Percent	Tx. Group	Number	Percent	Number	Percent	Weight
Race/Ethnicity										
African American	177	8.6%	5,450	4.1%	3.2%	146	7.8%	1,949	2.5%	7.8%
White	417	20.3%	15,466	11.5%	2.7%	358	19.1%	5,241	6.6%	19.1%
Other	90	4.4%	4,568	3.4%	2.0%	57	3.0%	831	1.0%	3.0%
Unknown	899	43.8%	103,197	77.0%	0.9%	847	45.2%	67,679	85.4%	45.2%
Missing	470	22.9%	5,425	4.0%	8.7%	465	24.8%	3,505	4.4%	24.8%

In light of the research base demonstrating the desired outcomes of Intercept® with a similar population as served by the Department, there is justification for not requiring inclusion of Intercept® in the evaluation strategy.

8.2 Process Evaluation

Using a participatory framework that will involve contracted providers of services, the Department will evaluate process aspects of how the services are being implemented. The process evaluation will be conducted on the three evidence based services included in this Prevention Plan. Process evaluation will focus on:

- Delivering services within a trauma-informed service delivery framework,
- Delivering services with fidelity,
- Engaging families and children to participate in services, and
- Retaining families and children to complete the entire course of a service.

The participatory framework for the process evaluation was selected because the benefits[39] of a participatory evaluation framework include:

[39] Cousins, J. Bradley and Earl, Lorna M., "The Case for Participatory Evaluation" (1992). Evaluation/ Reflection. 58. https://digitalcommons.unomaha.edu/slceeval/58

- Gaining acceptance for desired goals,
- Improving program performance, and
- Building capacity for organizational learning and growth.

These benefits of a participatory evaluation framework will allow the Department to use the evaluation work as a form of technical assistance for contracted providers. This participatory work started in the Department's RFI for S&S services, which asked the provider community for input on how they will achieve trauma-informed service delivery and for what evidence they could submit to the Department on a regular basis to demonstrate their sustained achievement of trauma-informed service delivery. By asking for contracted providers' input on this issue, the Department is starting the process of engaging the provider community in the work of developing a feasible yet meaningful way to assess trauma-informed service delivery and to ensure sustainability.

The participatory framework for the process evaluation will be implemented by promoting a peer learning community among contracted service providers. Those service providers who achieve, for example, an engagement rate for families that is higher than the average engagement rate will be invited to give presentations on how they achieve such high engagement rates. There are existing quarterly meetings for S&S providers in each of the Department's five regions. Using a portion of these meetings to discuss results from the process evaluations and to promote peer-to-peer sharing of successful processes among contracted service providers will create the infrastructure for the peer learning community that is consistent with the participatory evaluation framework. For sharing the process results with families and children and obtaining their input and reflections, the Department's existing Family Advisory and Youth Advisory Committees will be used.

Through an RFQ and funded by the FFPSA Transition Grant allocation to the Commonwealth, the Department will obtain an external evaluation partner to assist with the development of internal processes for effective and efficient process evaluation of prevention services. To determine which historic S&S services to include in the evaluation work, the Department will rely on the services of the external evaluation partner to ensure that the scope of the evaluation matches capacity for conducting high quality evaluation work.

8.3 Outcome Evaluation

The Department's external evaluation partner will manage the outcome evaluation aspects of the evaluation strategy, which will focus on the research questions of children's safety and permanency. The purpose of the outcome evaluation is to answer the overarching question, "What is the quarternary prevention value of the Department's S&S services, including the evidence based prevention services included in this Plan?"

The quarternary prevention impact of a service will be defined by both its effectiveness in preventing occurrence or reoccurrence of child abuse/neglect and its effectiveness in preventing foster care placement. The rates of both occurrence/reoccurrence of child abuse/neglect and foster care placement must be low for a service to be considered an effective quarternary

prevention service, i.e., a child must be both safe and stable. Stability without safety will not be considered an effective quarternary prevention impact.

As with the process evaluation, the evaluation framework for the outcome evaluation will be participatory because of the focus of building the capacity in the contracted service provider community to deliver effective quarternary prevention. However, in contrast to the process evaluation in which provider input will be sought on how to gather data that will inform the evaluation, the data definitions for the outcome evaluation are already established and non-negotiable – child safety and permanency. As with the process evaluation work, the existing quarterly, regional S&S meetings will be used as the infrastructure for sharing outcome evaluation reports and for promoting peer-to-peer sharing among the contracted provider community. The Department's existing Family Advisory and Youth Advisory committees will be used as the forums for sharing the outcome results with families and youth and obtaining their comments and insights.

8.4 Logic Models

Through use of evidence based practices, the Department intends to improve both process outcomes and service outcomes, which are explained in the four logic model graphics below – one for the three evidence based practices included in this Prevention Plan as well as one for Motivational Interviewing. As described by McLaughlin and Jordan[40] logic models help describe the assumptions underlying expectations for what a what a program or service will achieve and provide insights about how to evaluate both the assumptions and achievements.

Logic models use the terms "inputs," "outputs," and "impact" to differentiate different aspects of the service delivery process. For evidence based practices, delivering the service with fidelity to the manual on which the practice is based is an "input." The assumption is that when this input criterion is met, the results (i.e., outputs, impact) will be the same as the results found in the research that established the practice as "evidence based."

The "outputs" are changes in knowledge, attitudes, and/or behaviors that occur as a result of service delivery. Examples of outputs, which can also be labeled "process outcomes," include changes such as, improved family functioning, improvements in a child's emotional/behavioral functioning, increased parental resiliency. "Impacts" are the ultimate desired service outcomes. Examples of impacts/service outcomes include safety for children and stability for children.

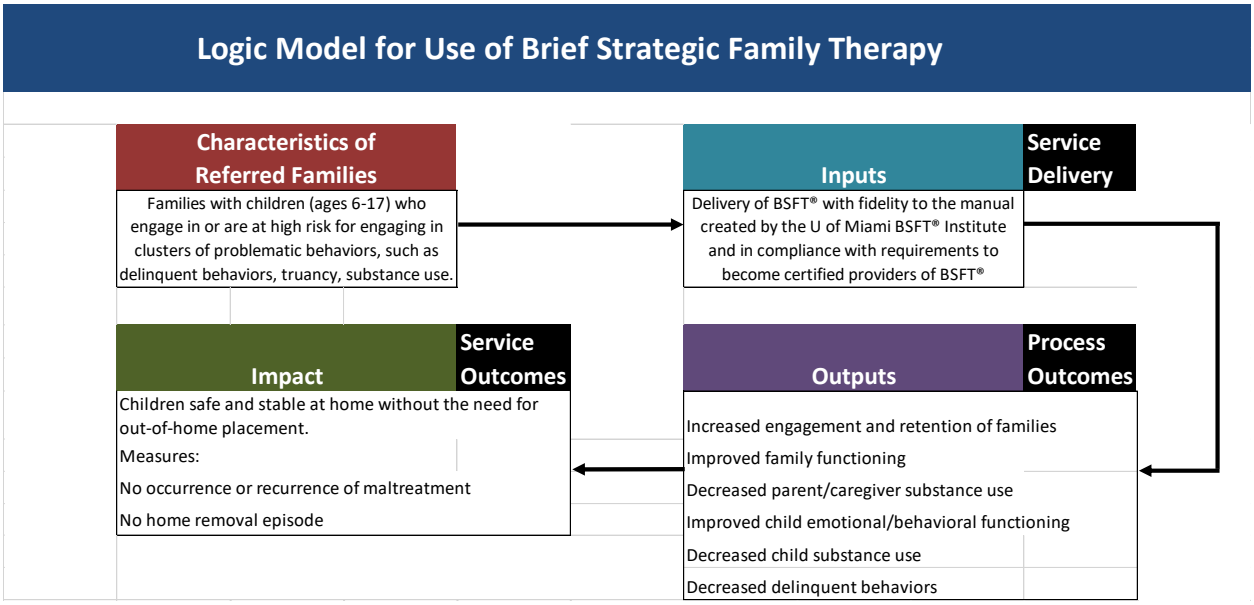
The outputs/process outcomes (e.g., improved family functioning) can be understood as the mechanisms through which a particular evidence based practice yields the desired impact/ service outcome. Using logic models illustrates understanding of how services are expected to lead to improvements in the lives of children and families.

So, for example, when delivery of an evidence based practice leads to improvements in family functioning or improvements in a child's emotional/behavioral functioning, these improvements,

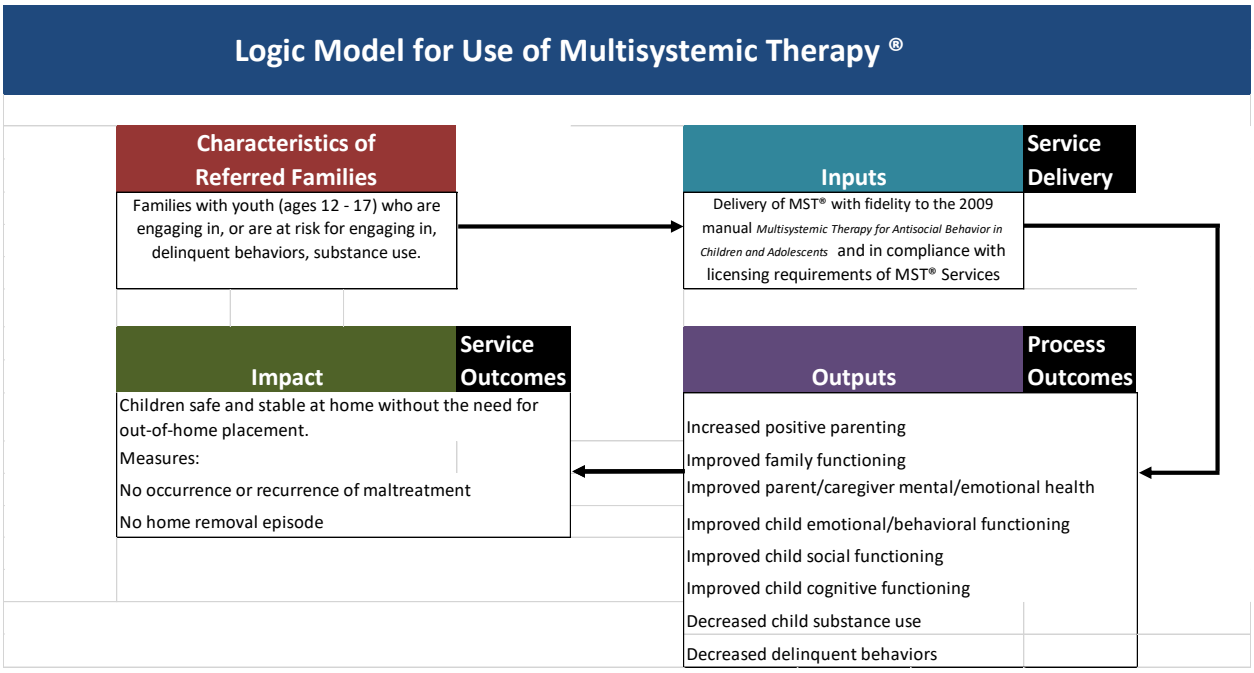
[40] McLaughlin, J.A. and Jordan, G.B. (1999). Logic models: a tool for telling your program's performance story, *Evaluation and Program Planning*, Vol. 22, Issue 1, pps. 65-72. https://doi.org/10.1016/S0149-7189(98)00042-1.

in turn, lead to children remaining safe and stable at home without the need for out-of-home placement. The outputs/process outcomes help explain the strategies through which an evidence based practice produces the desired impact/service outcome.

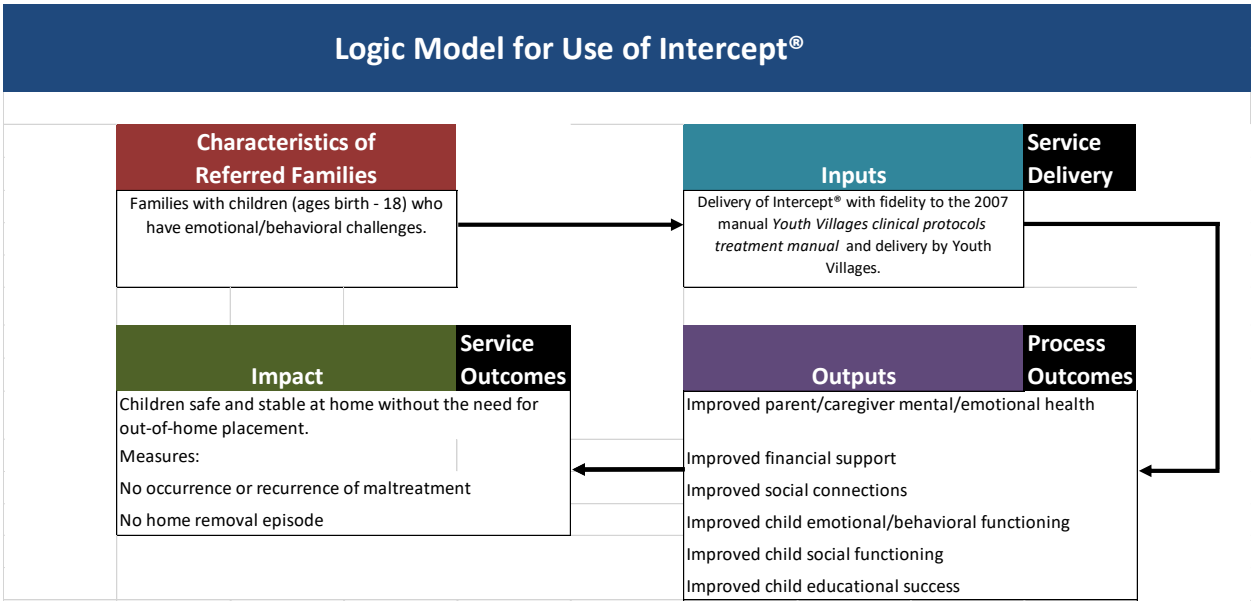
For each evidence based practice selected in this Prevention Plan, the specific list of outputs/process outcomes differs and is based on the research base for the evidence based practice. The specific outputs/process outcomes for each evidence based practice are listed in the following logic models. In contrast to the outputs/process outcomes, which differ across evidence based practices, the desired impact/service outcome is the same for every evidence based practice. The common impact/service outcome is – keeping children safe at home without the need for out-of-home placement.



Source for BSFT® outputs: https://preventionservices.acf.hhs.gov/programs/251/show



Source for MST® outputs: https://preventionservices.acf.hhs.gov/programs/257/show



Source for Intercept® outputs: https://youthvillages.org/wp-content/uploads/2019/10/Intercept-A-Program-of-Youth-Villages.pdf

The logic model for Motivational Interviewing (MI) differs from the logic models for the other evidence based practices because the Department will be pairing MI with other S&S services. The underlying assumption illustrated in the MI logic model is that delivery of MI with fidelity will yield improvements in the engagement of families and in the retention of families through the full course of a service. Use of MI will influence the desired impact/service outcomes, but those results

cannot necessarily be fully attributed to MI. Rather, the impact/service outcomes will need to be understood as emanating from the combined influence of MI and the service with which it will be paired.

As detailed in the Introduction of this Prevention Plan, overcoming the challenges of engaging and retaining families in services is a critical challenge for the child welfare profession. Given the centrality of this challenge to advancing child welfare practice, the Department intends to probe questions relevant to understanding the flexible use of MI in the delivery of child welfare. The potential applications of MI for child welfare are quite broad. The Department anticipates looking at outcomes associated with MI paired with another S&S service as a first installment in exploring MI's flexible use as a prevention service in child welfare.

8.5 Data Collection and Analysis Plan

Process Evaluation

Trauma-Informed Service Delivery

The Department, with input from the provider community and guidance from the external evaluation partner, will develop a feasible yet meaningful process for providers to submit assurance of trauma-informed service delivery for the Department's annual review and approval.

Fidelity

For continuous monitoring of fidelity, the Department will require providers of BSFT® to obtain and maintain licensure from the BSFT® Institute of the University of Miami. A condition of this licensure is consistent use of the BSFT® Therapist Adherence Form & Clinical Supervision Checklist to maintain fidelity to the model. The Department will require BSFT® providers to submit documentation of their BSFT® licensure and fidelity status to the Department no less frequently than annually and to notify the Department if there are changes to their licensure status.

The Department will require providers of MST® to obtain and maintain licensure from MST® Services. A condition of this licensure is use of the prescribed Quality Assurance/Quality Improvement process prescribed by MST® Services to maintain fidelity, including self-administration of the Program Implementation Review (PIR) and administration of the PIR by an MST® expert. The Department will require MST® providers to submit documentation of their MST® licensure to the Department no less frequently than annually and to notify the Department if there are changes to their licensure status.

The Department will purchase Intercept® only from Youth Villages, the creator of the service. The Department will require Youth Villages to submit annually a copy of their Program Model Review report, which is the Intercept® process for maintaining fidelity.

Measured outcomes for BSFT®, MST®, and Intercept® will be:

- Process Outcomes

    - Engagement of families
    - Retention of families

- Service Outcomes
    - Occurrence or recurrence of maltreatment
    - Home removal episodes

For data collection, the Department will modify iFamilyNet to allow linkage of a service to a family as well as to a specific child within a family. Both process and service outcomes will be measured as rates. For example, the number of families who actually engage with a specific service will be divided by the number of total families referred to that service to yield an engagement rate (i.e., # of families that engage with BSFT® / total # of families referred to BSFT®. This will yield a percentage.). This type of measurement will be used for all the process and service outcomes of interest.

Engaging Families and Children and Retention of Families and Children

The Department intends to modify the IT system to include a two-step documentation of the referral process. The two steps will be:

1. Documentation that a referral was sent to a provider.
2. Documentation of family or child engagement with a service.

Currently, a referral is entered only after a family or child engages with a service, which does not allow an assessment of the rate with which a service provider engages with a family or child. Should there be any delay in the recoding of the Department's IT system, service providers will be asked to track their own engagement data and submit it to the Department on a monthly basis until the Department's IT system is able to accommodate the two-step documentation process.

Knowing whether families and children were retained through the entire course of a service requires documenting the reason for ending a service referral in the IT system. The IT system currently has "ending" reasons available for selection when a service referral is ended. These reasons will be reviewed to determine whether additional options need to be coded into the system. As described in Section 7, staff members responsible for documenting referrals for contracted services into the IT system will receive training on entering the documentation into the system in a consistent manner so that process evaluation reporting will be possible.

The Department's external evaluator will be responsible for the summary of statistics about engagement and retention.

Outcome Evaluation

The Department will work with the external evaluator to confirm the data collection and analysis plan, which will be informed by the context for the evaluation and the size of the data set for each prevention service included in the outcome evaluation.

8.6 Safeguarding Data and Protecting Participants

The initial phase of work with the external evaluator will be dedicated to confirming plans that will ensure that the research is conducted ethically, including arrangements for:

- Safeguarding the confidentiality of all data, whether from electronic or hard-copy data sources, in a manner that will prevent evaluators from ascertaining the identities of the families and children in the data sets, and
- Assuring that the research is conducted in alignment with the requirements of the U.S. Department of Health and Human Services' Office for Human Research Protections (OHRP), which provides leadership in the protection of the rights, welfare, and well-being of human subjects involved in research conducted or supported by the U.S. Department of Health and Human Services (HHS).

8.7 Using, Reporting and Disseminating Findings

The Department will use the findings from the process and outcome evaluations to inform improvements in the delivery of services to families and children. Contracted providers of selected prevention services will receive regular reports of their performance on both process measures and outcomes, which will allow them to use the reports in their internal CQI processes.

Providers of BSFT, MST, and Intercept will be required to develop an internal CQI process that identifies which members of their leadership team and other staff will meet on a regular basis to engage in the iterative CQI process of reviewing data, planning actions, and implementing changes. The information obtained from continuous monitoring will be provided as "fuel" for the provider's own CQI process that uses feedback to generate changes aimed at improving process and outcomes.

To inform and support the providers' internal CQI processes, the Department's external evaluation partner will facilitate learning communities for providers, with the aim of motivating peer-to-peer support for providers to inform each other's improvement work.

When there is adequate data, the Department will work with the external evaluation partner to discern when there is reliable information about patterns in performance to inform contract management decisions about the expansion, reduction, continuation, or termination of contracts.

The Department will use information from the process and outcome evaluation reports to facilitate discussions about system improvements with the provider community, with family and youth advisory groups, with internal clinical teams, the specialized staff members responsible for decision making about utilization of contracted services, and with other stakeholders.

Findings from the evaluation work that have the potential for advancing knowledge in the child welfare profession will be shared with a broader audience through conference presentations and journal article submissions.