Missouri Department of SOCIAL SERVICES

Title IV-E Prevention Plan

August 2022

Missouri Department of Social Services

Children's Division

Family First Prevention Services Act

TITLE IV-E PREVENTION PLAN
Revision 08/2022

Contents

Title IV-E Plan Adherence Statement

As a condition of the receipt of Prevention Services and Program funds under Title IV-E of the Social Security Act (Title IV-E), the Missouri Department of Social Services, Children's Division (DSS/CD), submits this plan to provide, in appropriate cases, Prevention Services and Programs under Title IV-E of the Act. DSS/CD hereby agrees to administer the programs in accordance with the provisions of this plan, Title IV-E of the Act, and all applicable Federal regulations and other official issuances of the U.S. Department of Health and Human Services. DSS/CD understands that if and when Title IV-E is amended or regulations are revised, a new or amended plan for Title IV-E that conforms to the revisions must be submitted.

Forward:

Everyone deserves a safe place to call home.

Let those words sink in for a moment.

Everyone. Safe. Home.

At the core, this phrase is the bedrock of Missouri Children's Division. 'Everyone deserves a safe place to call home' is the reason our team members work the grueling hours and give of their own family time to ensure a child is safe. It is the reason our staff engage with families to understand their stories before jumping to conclusions. It is the reason our staff persevere in the midst of chaos to provide support to Missouri families because they know a safe place to call home is worth it.

This simple phrase carries more weight than one person could carry alone which is why Missouri Children's Division believes in a team approach to advancing child welfare. It takes Hotline workers screening calls on the front end; Investigators braving uncertainty to ensure safety; Family Centered Service workers seeing the best in families while addressing safety concerns; Alternative Care workers being transparent with families and offering hope to kids; Supervisors providing essential support and guidance to workers; Specialists providing clinical expertise when a clear path forward does not seem visible; Circuit Managers building relationships with court and community partners because they recognize it takes a team to reach success for our children; Field Support Managers supporting every person in the field through some of the most traumatic events one may experiences; Regional Directors who never lose focus on where we are steering the ship; Program Development Specialists who synthesize complicated legislation and create applicable and meaningful guidance; Licensing workers who seek out the best families to care for our children in their time of need; Adoption Specialists who never stop fighting to find a child's forever home; Trainers who impact every person at the organization from developing new talent to enhancing practice; Out of Home Investigators who ask the hard questions to find the truth; Residential Licensing workers who ensure specific behavioral needs are met in a safe environment; Quality Assurance Specialists who keep us grounded in the facts and use data to propel us forward; Health Information Specialists who advocate for our children's medical safety; Office Administration who are the glue to all we do; Unit Mangers who strategically implement macro level change; Legal counsel who think through every angle to ensure we get it right; Deputy Directors who are servant hearted and keep their integrity regardless of the situation, and a Director who always brings it back to the 'why' of our core values.

Together our Children's Division team supports the families within our local communities, through support, practice enhancement, and positivity, and our own Children's Division family as well who drive change every single day.

With our mission in focus, and a committed team, we respectfully submit Missouri's Title IV-E Prevention Plan in an effort to leverage resources because *everyone deserves a safe place to call home.*

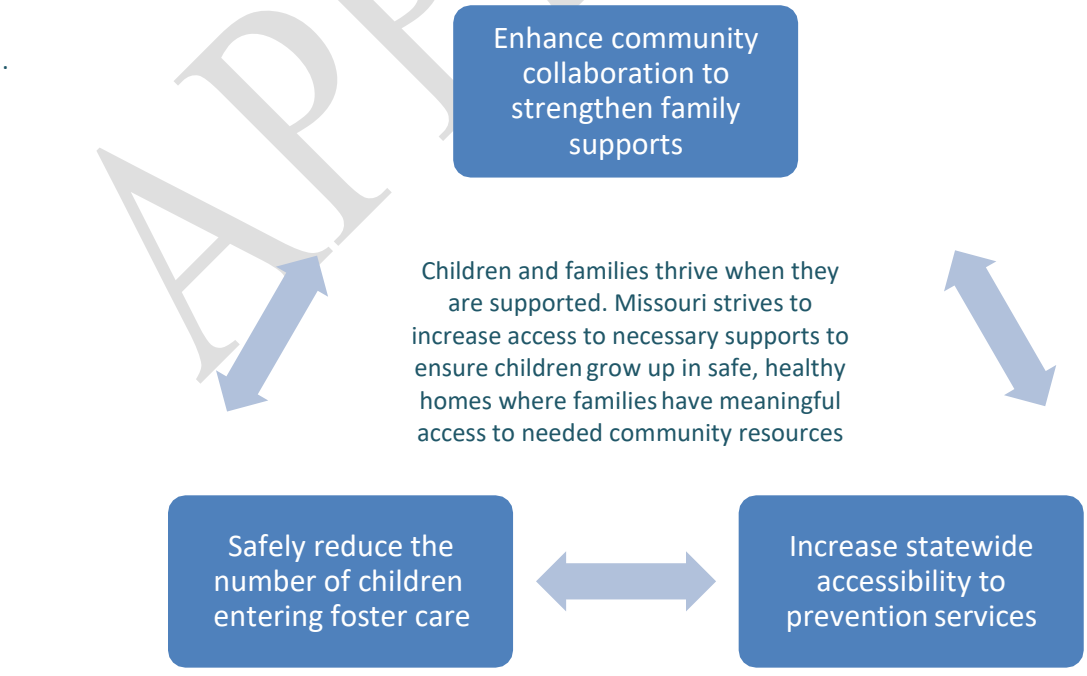
Section 1: Introduction

Missouri Children's Division believes everyone deserves a safe place to call home and envisions a system in Missouri where children and families are safe and able to thrive within their communities. To that end, the Department of Social Services (DSS), and Missouri Children's Division (CD) exist to empower Missourians to live safe, healthy, and productive lives.

The Family First Prevention Services Act (FFPSA) serves as a catalyst for bolstering Children's Division's vision by providing avenues to develop a prevention service array within a family's local community to promote safety and well-being of children. The Title IV-E Prevention Services opportunity, authorized through FFPSA, provides an unprecedented opportunity for Title IV-E dollars to be invested on front end prevention for specific evidence-based programs encompassing parenting skills, substance abuse, and mental health services for families. Missouri is taking advantage of the opportunity by building towards a future that is prevention focused and evidence based.

The overall strategy to align the FFPSA with Children's Division's purpose of protecting children and having safe, thriving, and supported families is to create a culture of innovation, support, transparency, and community. To ensure a well-thought-out plan to address Missouri's current landscape and where Missouri is headed, strategic direction was necessary. Through data analysis within the Statewide Advisory Team, composed of community partners and cross-departmental leadership, Missouri is committed to three priority outcomes:

1. Enhance community collaboration to strengthen family supports.
2. Increase statewide accessibility to prevention services.
3. Safely reduce the number of children entering foster care.



The aforementioned goals collaboratively identified with the FFPSA Statewide Advisory team speak to the mission of Children's Division, within the Department of Social Services which is responsible for the administration of child welfare services. Children's Division works diligently to strengthen partnerships with families, communities, state and local agencies, and the court system to ensure the safety, permanency, and wellbeing of Missouri's children. Working in collaboration with all parties, Children's Division strives to keep children safely in their home whenever possible. Teamwork across agencies is the lynch-pin to transforming Missouri's child welfare system.

Consultation and Coordination on the Continuum of Prevention Services

Collaboration has been the foundation for Missouri's development of the Title IV-E Prevention Plan and FFPSA implementation strategy. In early January 2019, Children's Division, with the support of Casey Family Programs, held six regional convenings throughout the state to focus on meaningful conversations around community resources, challenges, next steps, and a statewide implementation strategy. The purpose of the convenings were to educate community stakeholders on FFPSA, obtain feedback from community stakeholders about the new legislation, answer questions, and provide opportunities for networking and collaboration related to development and implementation of FFPSA within Missouri's child welfare system.

Approximately 500 community stakeholders including representatives from the Missouri Department of Social Services, Children's Division, Division of Youth Services (DYS), judges, court officials, child placing agencies, residential treatment agencies, mental health organizations, drug and alcohol treatment providers, foster families, Court Appointed Special Advocates (CASA), guardian ad litems (GAL), Child Advocacy Centers (CAC), contracted services providers, and domestic violence shelters and organizations attended the events. Participants received information about the Children's Division's progress toward implementation of the FFPSA and engaged in meaningful conversation, using the World Café model, related to continued implementation throughout the state. Participants were offered eight topics and asked to participate in three World Café discussions based upon their level of interests in the topics. Each topic was led by a facilitator who utilized the Signs of Safety (SOS) framework. The engagement component of the SOS framework allowed the facilitator to involve participants in each of the eight topics as it relates to identifying worries, what is working well, and next steps for each of the topics. The topics for discussion included:

1) What effective prevention services and other successful innovations should Missouri consider expanding?
2) How might we expand the availability of parent-child substance abuse treatment facilities in Missouri?
3) How might we create a continuum of behavioral health supports for high needs youth? (in community, day treatment, etc.)
4) What will a Qualified Residential Treatment Program (QRTP) look like? How might current programs be repurposed and what would services look like?
5) How might we involve courts and legal partners in the Family First vision for child welfare transformation?
6) How might we structure the Independent Assessor requirements in order to ensure

the highest quality care for youth?
7) How might we improve engagement with and support for kinship caregivers?
8) What does joint development and joint ownership of 21st Century Child Welfare system look like?

Out of these six statewide convenings, a Statewide Advisory Team and Regional Implementation teams were created to brainstorm and strategize a path forward from the World Café feedback. The Statewide Advisory Team convenes once a month and is comprised of community partners and cross-departmental leadership including the Missouri Department of Mental Health, DSS MO Healthnet Division, Missouri Department of Elementary and Secondary Education (DESE), Missouri Department of Health and Senior Services, Office of State Courts Administrator (OSCA), Missouri Department of Social Services, Missouri Office of Administration Office of Child Advocate, DSS State Technical Assistance Team, Missouri Juvenile Justice Association (MJJA), Missouri Kids First, Missouri Office of Administration Children's Trust Fund, Missouri Coalition of Children's Agencies, University of Missouri Center For Excellence, and the DSS Division of Finance and Administration (DFAS). This group advises Children's Division on state proposals and regulatory considerations developed to meet federal requirements, as well as to strategically address service gaps and needs within the state.

Missouri has six Regional Implementation teams, one in each region of the state, with members of varying backgrounds throughout the community who are passionate about driving change and enhancing the lives of the children and families within their local communities. During the COVID-19 pandemic, the frequency with which these teams met was put on hold. However, we are re-exploring opportunities for collaboration to begin once a defined, operational, implementation strategy is set forth. As such, these teams will be tasked with the responsibility of identifying key needs and opportunities in the communities served through data analysis, community partnerships, and creating a roadmap for local implementation. Regional implementation teams throughout Missouri have utilized (and will continue to utilize) data to determine the appropriate gaps in service provision. Each region will take an innovative approach tailored to their community to eliminate stigma and build wrap-around supports for families whose children are at risk of entering the foster care system.

The Statewide Advisory Team meetings (and Regional Implementation Teams when they are re-engaged) occur in a manner to allow a continuous feedback loop. Regional Implementation Teams are led by the Children's Division Regional Directors, and these Regional Directors are participants in the Statewide Advisory Team Meetings, which allows for continuous information sharing of what is occurring at the regional level to be shared with the Statewide Advisory team, and vice versa. This ensures open communication and that Missouri's partner's voices are heard. Through this process, Children's Division's mission and practice model can be aligned with child welfare partners in the local communities, which builds strong bridges to assist in prevention services for children and families.

All statewide efforts are funneled to the FFPSA Internal Leadership team comprised of Children's Division staff experienced in the transitional elements of the legislation as well as project management. The leadership team performs a strategic and project management function by acting as a liaison between the Statewide Advisory Team, Regional Implementation Teams and multiple state agencies to deliver and oversee FFPSA implementation and expansion.

The overall strategy to align the Family First Prevention Services Act with Missouri's values is to create a culture of innovation, support, transparency, and community to obtain the vision of supporting children and families. Strategies include**:**

- Convening monthly advisory meetings with statewide partners to gain feedback on regulatory enhancements;
- Creating regional teams throughout Missouri to plan implementation in the communities they serve;
- Partnering with the Office of State Court Administrators and judges throughout Missouri to educate, train and gain feedback on FFPSA regulatory procedures;
- Conducting internal bi-monthly deep dive meetings to track progress with FFPSA and measures in accordance with project goals and objectives;
- Expanding online presence to create an informative environment for our community partners;
- Evaluating funding availability to further develop and build the prevention service array as the Children's Division's budget allows; and
- Examining service availability by location and strategizing how to bolster infrastructure in areas where there is greater need – our rural areas.

Community commitment and focus is key. Aligning priorities, determining focal points, and building key partnerships will help teams establish wrap-around approaches for community involvement in order to create better outcomes for families and children. Utilizing a data-driven approach, Children's Division surveyed Missouri's child welfare landscape to identify target populations and prevention services to equip local communities with the tools they need to support families in their efforts to provide safe and healthy homes for their children.

Missouri's Child Welfare Landscape

Performance based strategies with a data-driven approach is the driving force behind Children's Division's decision for identifying populations of need and service array. Children's Division utilized information around the amount of front end work to include investigations and assessments, number of family-centered service cases opened, and some information about the foster care population from data published on fiscal years 2019 to 2021. As of February 28, 2022, there were 14,026 children in Children's Division custody.[1]

[1] DSS Children's Division Children's Services Management Report, 2022

Children's Division's Annual Report State Fiscal Year 2019 (July 2018 – June 2019)

88,032 CHILD ABUSE/NEGLECT HOTLINE TOTAL REPORTS
64,980 INVESTIGATION & ASSESSMENTS (NON-REFERRALS)

89,738 children represented	3,954 Family Centered Services Cases opened	6,754 children entered into Children's Division custody (4.74 per 1,000)

CHILDREN IN CARE IN CHILDREN'S DIVISION CUSTODY IN FISCAL YEAR 2019:
20,144

Average length in foster care: 23.2 months	New Entries: 5,693	Re-entries: 1,061

AGES OF CHILDREN IN FOSTER CARE:

Average Age of Entry: 6.9 Years	Average Age of Exit: 8.8 Years	0-5 Years: 38%	6-11 Years: 27%	12+ Years: 35%

Children's Division's Annual Report State Fiscal Year 2020 (July 2019 – June 2020)

81,587 CHILD ABUSE/NEGLECT HOTLINE TOTAL REPORTS
55,853 INVESTIGATION & ASSESSMENTS (NON-REFERRALS)

78,328 children represented	3,781 Family Centered Services Cases opened	6,912 children entered into Children's Division custody (4.85 per 1,000)

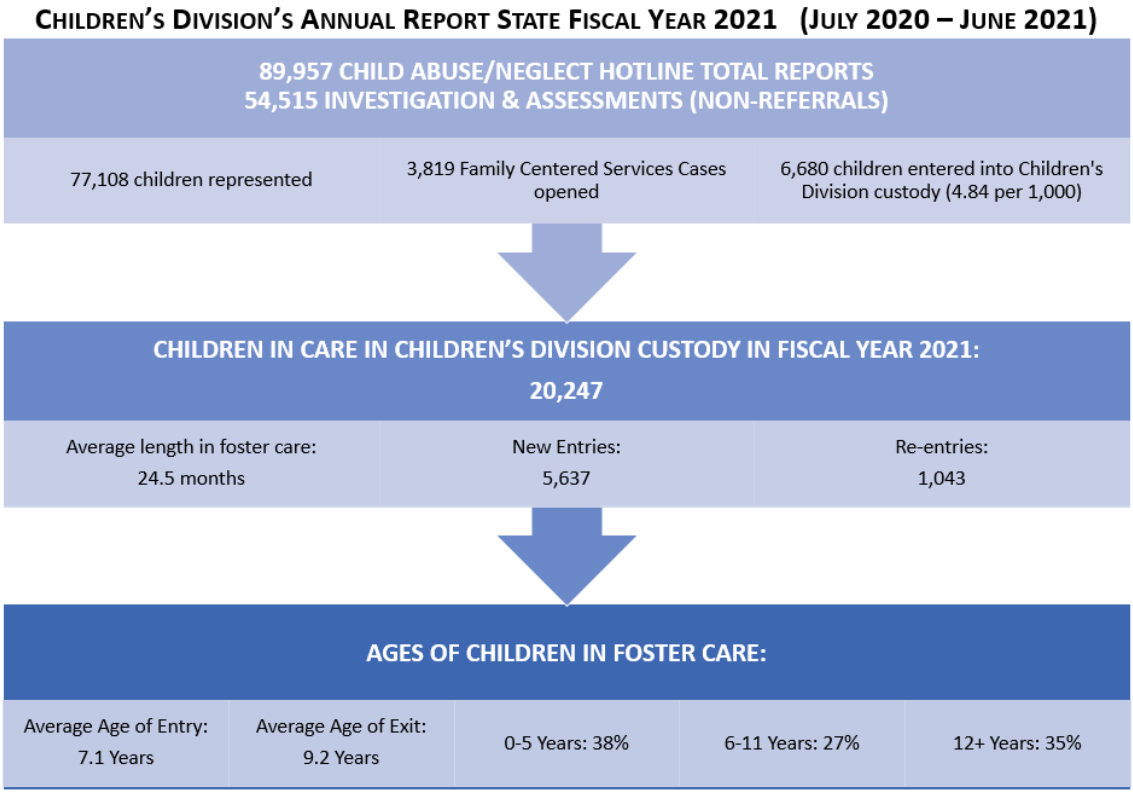
CHILDREN IN CARE IN CHILDREN'S DIVISION CUSTODY IN FISCAL YEAR 2020:
20,226

Average length in foster care: 24 months	New Entries: 5,821	Re-entries: 1,091

AGES OF CHILDREN IN FOSTER CARE:

Average Age of Entry: 7.1 Years	Average Age of Exit: 9.1 Years	0-5 Years: 34%	6-11 Years: 40%	12+ Years: 26%

[2] DSS Annual Children's Division Report, 2019
[3] DSS Annual Children's Division Report, 2020



Data trends have remained consistent for the number of children in Children's Division custody, (re)entries, and exits over time. To address these trends, Children's Division offers Family-Centered Services (when appropriate), which allows for resource referral and case management for intact families. Children's Division would like to see a greater decline in the number of children entering care. The data illuminates the opportunity for FFPSA to drive targeted change for engaging families in preventative services. It is the intention of Children's Division to work towards an expansive prevention service array to address prevalent conditions identified at removal, thus leading to a decrease in the number of children removed from the parental home. We hope to deliver services that have a lasting, positive impact to the children and families whom our agency interacts through the more than 88,000 hotline reports and referrals. In conjunction with the opportunities FFPSA provides and Children's Division's commitment to child safety, our child welfare landscape will begin to move the needle towards prevention. This will mitigate the trauma of removing children from their homes and strengthen wrap-around services to families.

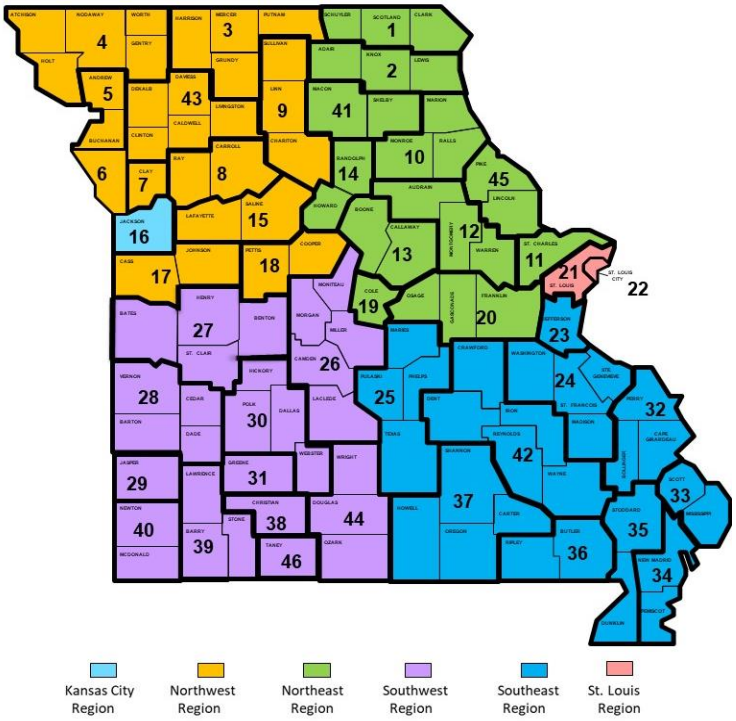
Overview of Missouri Children's Division

FFPSA supports the work being administered by Children's Division. Currently, Children's Division oversees state administered child welfare services, including the operation of the 24-hour Child Abuse/Neglect Hotline; completion of child abuse and/or neglect investigations,

[4] DSS Annual Children's Division Report, 2021

assessments, and referrals; Children's Treatment Services; Family-Centered Services; Intensive In-Home Services; Foster Care Case Management; Foster Home Licensing; Relative Care; Guardianship and Adoption support; and Residential Treatment licensing. The aforementioned services are administered statewide within a centralized organizational framework. Services are provided directly by the agency or through contracted providers and community partnerships.

Children's Division is composed of six regions, 46 judicial circuits, and 114 counties plus the City of St. Louis,
Within this organizational structure, there are layers of leadership and management to provide support and ensure adherence to policies and procedures. Each region has a Regional Director, who oversees field administration and reports to the Children's Division Director. There is a Circuit Manager within each judicial circuit who oversees local functions. Circuit Managers are supported by Field Support Managers, who report to Regional Directors. Agency administration and oversight occurs through leadership within the central office including the Director and three Deputy Directors, as well as inclusion of Department staff. Within central office, oversight and evolution of programs occurs by Program Development Specialists, who are managed and supported by Unit Managers, who work collaboratively with DSS special counsel and judicial circuits. Unit Managers report to the Deputy Directors.



Children's Division has a multi-faceted approach to empowering families and ensuring child safety and well-being. The Missouri Practice Model[5] uses foundational elements and framework which is anchored in Children's Division's values of engaging, communicating, and supporting families. All components of the practice model provide the ability to see families accurately through a trauma-informed lens, engage with families and communities, make informed decisions, and strengthen frontline practice.

Frontline staff, including supervisors as well as Children Service Workers I, II, III, IV (classification based on experience and skill), who physically go to homes and assess children's safety, are in a position to be agents of positive change in the lives of children, youth, and families.

[5] Children's Division, Child Welfare Manual: Philosophical Basis, 2019

Children's Division staff are child welfare practitioners driven by a sense of mission, purpose, and professionalism. Missouri's child welfare system is driven by four key priorities focused on increasing safety, permanency, and well-being:

1. Seeing families accurately through the full frame of their lives. This allows a better understanding of family behaviors, emphasizes curiosity and critical thinking, minimizes tradeoffs, and moves beyond symptoms and compliance to sustainable change.
2. Engaging children, youth, families, and communities as partners improves working relationships, which are fundamental to developing safety and well-being networks within families and communities.
3. Making informed decisions through inclusive processes, data, research, and evaluation ensures decisions are based on reliable information, includes diverse perspectives, and leads to individualized and realistic goal setting and cross-system accountability.
4. Strengthening frontline practice with a clear and evolving practice model based on values, principles, experience, and results[6].

To create change that will last, systems and services must help families minimize personal tradeoffs, which are decisions to decrease or lose something in order to obtain an increase in another area. The Five Domains of Wellbeing[7] is a strengths-based, evidence-informed framework which recognizes all people have universal, interdependent needs for Social Connectedness, Safety, Stability, Mastery and Meaningful Access to Relevant Resources. Children's Division's application of the Five Domains of Wellbeing focuses practice on people-centered and family-centered responses that improve outcomes and increase the efficiency of existing programs and systems. This framework ultimately improves the well-being of the families we serve. The Five Domains are critical for all people and families, not only those served by the Children's Division. How a person meets their needs in each domain may look different depending on many factors, including family culture, economic status, caregivers' capacities, and family structure. When strengthening one domain creates problems in another domain, maintaining well-being means that families have to balance trade-offs to minimize losses in a given domain. By building enough assets in each domain over time, trade-offs can be made without compromising overall well-being. Families are then empowered to make change that is sustainable.

Utilizing an engagement approach provides a framework for continuous focus on the reasons for Children's Division's involvement in a family's life and assessment of safety throughout the life of a case. This concentration emphasizes building families' natural support system. It is built upon solution- focused therapy which stresses the importance of relationships, critical thinking, and practitioners as change agents. Scaling questions (of which there are many) allow us to have transparent conversations with families about child safety and their progress towards case closure and/or permanency. It keeps all parties focused on issues of child safety, and provides structure to drive change.

[6] Children's Division, Child Welfare Manual, Philosophical Basis, 2019
[7] The Full Frame Initiative, Five Domains of Wellbeing, 2018

Our Missouri Practice Model is embedded into a trauma-informed approach when working with families. To guide the process of being trauma-informed as an agency, Children's Division uses the Missouri Model: A Developmental Framework for Trauma-Informed Approaches[8]. This model relies on the Trauma Informed Principles, including safety, trustworthiness, choice, collaboration, and empowerment, developed by Maxine Harris and Roger Fallot.[9] It is critical for staff to understand how trauma can impact children and families. To be trauma-informed means Children's Division realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.[10]

Children's Division utilizes a holistic approach in how we see, assess, and engage families, but a critical component is being able to articulate those findings. It is essential that we are able to effectively communicate in a legal based system, guided by federal and state law. Thus, the Framework for Safety model is included in our Missouri Practice Model and is the mechanism to assist our workers in being able to articulate safety within the legal system. It is a model that has already been embraced by many of our court partners, and we feel strongly that it is a model that allows for a merge between social work and legal work. It is this vision and goal that has motivated Children's Division to develop the strong Missouri Model where skills are enhanced and children are safe.

Missouri continues to evolve and strengthen its practice model in supporting children and families by creating strategies to achieve better outcomes for the families whom Children's Division serves. Missouri is committed to improving service provisions to better meet the needs of families through Missouri's practice model, vision, and FFPSA implementation.

Where Missouri Is Headed

Child welfare is an arena that is ever-changing. It is an evolving landscape which shifts to meet the needs of families through some of their most vulnerable moments. To best assist these needs, child welfare agencies and advocates need to be adaptable to find services, community support, and progressing research and practice. Service provision from the workforce is strengthened and reinforced in a practice model that can evolve to meet the needs of children and families. As such, Missouri is building upon the components of the current practice model to empower families based upon the belief that everyone deserves a safe place to call home.

[8] Center for Excellence in Child Well-Being, Missouri Model: A Developmental Framework for Trauma Informed Approaches, 2019

[9] Fallot & Harris, Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol, 2009

[10] Children's Division, Child Welfare Manual, Section 1, Chapter 1.2 (Practice Model Overview), 2019; National Child Traumatic Stress Network, Child Welfare Trauma Toolkit, 2013

DOMAIN GOALS

Missouri Child Welfare Practice Model

Safety	To use evidence-based safety and risk assessments with structured decision-making to provide an equitable, comprehensive appraisal of any safety threats and/or harm and ensuring an inclusive view of the family's protective capacities as it pertains to a child's vulnerabilities.
Well-Being	To use the 5 Domains of Well-Being for a holistic view of the family through the lens of Social Connectedness, Stability, Safety, Mastery, and Meaningful Access to Relevant Resources.
Service	To respond, investigate, assess, and provide support and prevention efforts to Missouri children and their families in order to assist them in leading healthy, safe, and productive lives.
Innovation	To better serve Missouri children and families while equipping our team for success and continuing to assess capacity to provide streamlined, efficient, and effective child welfare services.
Integrity	To respectfully and professionally engage with stakeholders while advocating for the safety, permanency, and well-being of children and families.
Permanency	To use the provided case plan and tools to attain stability and permanency for children in our care. A comprehensive approach to stability & permanency includes engaging parents, identifying relatives, building community partnerships, and investing in our resource parents all to ensure the best interest of the child is at the forefront of every decision.

Missouri Department of SOCIAL SERVICES

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Missouri's Child Welfare Practice Model not only defines the vision for our work, but embodies our values as an agency. We believe that everyone deserves a safe place to call home with the understanding home can look many different ways and can support various types of family structures. However, having a strong practice, a key tenet remains the same: a strong foundation is critical to build upon. Children's Division's foundation is rooted in strength by how staff see and assess families, how we engage families, and how we articulate safety to families and our partners is a key component to success.

Each area of our model is a key element to not only working with and achieving the goals for children and families, but also identifying our consistent approach to better our practice, processes, and services, as an agency, for the families we serve.

Missouri's practice model is the bedrock of our vision, beliefs, and values. It provides a strong foundation as to how we are weaving prevention work, through the help of FFPSA, in the work we do every day on behalf of families.

Section 2: Eligibility and Candidacy Identification

States may provide FFPSA prevention services and programs to the following two populations:

1) children who have been identified as a candidate for foster care; and
2) pregnant and parenting youth who are in foster care.
3) When a child is determined to be eligible for services, the child, parent, and/or kinship caregiver of the child may also receive prevention services.

Children's Division identified target populations for children who qualify as candidates for foster care after an exhaustive analysis of state fiscal year 2019 child welfare data. Following this analysis, we conducted a review of legal definitions for candidacy from other states to arrive at Missouri's definition for candidacy. Following this review, the Department of Social Services, in conjunction with our Statewide Advisory team, determined which children and families could be eligible to receive services under Missouri's prevention plan.

Defining Candidacy

For the purposes of Title IV-E Prevention Services, children under the age of 18 identified as being candidates for foster care are those at imminent risk of entering foster care, but can remain safely in the home with family engagement in supportive services to address mental health, substance use, or in-home parenting services. Eligibility for Title IV-E Prevention Services must be defined in each child's prevention plan.

The following target population groups for FFPSA eligibility may include:

1.) Children identified as needing services through an active investigation or assessment, or are already receiving services by the state agency, which can include both non-court and court-involved cases.
2.) Children involved in a newborn crisis assessment where the mother or child had a positive toxicology screening during pregnancy or at the time of birth.
3.) Children (including pre or post-natal infants) of pregnant or parenting youth currently in foster care, or who have exited foster care within the past five years.

4.) Children who have exited foster care through reunification, guardianship, or adoption within the past five years, and are at risk of disruption. This may include youth who were in foster care up until the age of 13 or beyond, but youth must be under the age of 18 for eligibility as a candidate for foster care.
5.) Siblings of children in foster care who still reside in the family home with identified safety concerns and are at risk of entering foster care.

Children's Division acknowledges that the child welfare system is an ever-evolving system. During the initial five years of implementation, Children's Division will continuously review child welfare data and elicit feedback and suggestions from community partners and providers, as well as parents, to ensure that the appropriate populations are being served and to make any necessary adjustments to the candidacy definition.

Identifying Pregnant and Parenting Youth

FFPSA provides the opportunity to serve pregnant and parenting youth in foster care as well as such youth who have exited foster care within the past five years as an eligible population for prevention services. For pregnant or parenting youth who are currently in the custody of Children's Division, there are many opportunities in routine casework to provide supports for this population. Such supports are provided through monthly home visits, supervisory consultation, Chafee Older Youth activities, and Family Support Team Meetings. These routine case functions provide the opportunity to assess the youth's parenting abilities and further help determine if a prevention plan may be needed to mitigate a specific, identified risk. Further exploration of a potential prevention case plan may also be discussed with the youth and the Family Support Team[11] to further identify the needs of the pregnant and parenting youth. The Family Support Team is composed of parties involved in the case, and may include the youth, family, natural family supports, legal counsel for parents, Guardian ad Litem, Juvenile Office, multidisciplinary team members, Court Appointed Special Advocates (CASA), and resource providers.[12]

In addition to services provided in routine casework, Children's Division utilizes the Children of Youth in Alternative Care (CYAC) Program to provide maintenance support and special expenses (including clothing and infant allowance), as well as Medicaid for a child who is in the physical and legal custody of his/her CYAC parent. The parent and child must reside in the same eligible placement.

Children's Division has identified that young parents have many responsibilities and pressures caring for their child's developmental needs while still growing and meeting their own developmental needs. Ensuring that young parents are connected to supportive resources is vital for their success as well as their child's growth and development. As the primary nurturer for their child, it is important for the parenting youth to have individuals in his/her life who can coach and model positive ways to nurture their child. As Children's Division has identified the importance of the aforementioned points, new requirements surrounding the CYAC program have been drafted and are in review (as of state fiscal year 2021). The new proposed

[11] Missouri Revised Statute § 210.762, Family Support Team Meetings, 2007
[12] Children's Division, Child Welfare Manual, Section 4, Chapter 7 (Family Support Teams)

requirements are outlined as follows. Youth enrolled in the CYAC program with a child under the age of three shall be referred to a parenting and early childhood education program, such as Home Visiting, First Steps, Parents as Teachers, or other evidence-based FFPSA prevention services as identified and approved in this plan and future addendums. As financial support is provided, youth enrolled in the CYAC program will receive assistance with budgeting and expenses through the Children's Service Worker, the foster parent (placement provider), or through the youth's Chafee provider if identified as a goal on the youth's Individualized Action Plan goals.

In addition, appropriate discipline will be addressed with all young parents enrolled in the CYAC program and safe sleep[13] education, to ensure an appropriate sleep environment and to prevent sleep related infant deaths. Such education will be provided to pregnant and parenting youth with children under the age of two. A comprehensive resource listing for pregnant and parenting youth has also been developed to include information surrounding basic supports such as: developmental intervention programs, health care, support and education, father-specific resources, and national resources.

The CYAC program has operated at Children's Division for the last two decades serving 138 CYAC children during state fiscal year 2019 and 119 CYAC children during state fiscal year 2020. CYAC are identified within FACES, which is the electronic case management system for Children's Division.

Eligibility Determination and Documentation

With the exception of pregnant and parenting youth already in the custody of Children's Division, the majority of the candidates for foster care will come to the attention of Children's Division through the investigation/assessment process. Existing safety and risk assessment procedures will be utilized to fully assess the family and to determine the appropriate service provision to mitigate the identified concerns. For populations identified within Missouri's candidacy definition for whom a time limitation applies (such as those who have exited foster care within the past five years) eligibility will be determined by the date of exit from foster care. This will be identified by looking at the date of case closure within the electronic case management system. The time frame for eligibility will be within 5 years of the date of case closure.

FFPSA blends seamlessly into initiatives occurring within the Division simultaneously to better serve families and children without children being taken into care whenever it is deemed safe. Candidates for foster care may come to the attention of Children's Division through the investigation/assessment process the Birth Match Program; or may be closely aligned with Children's Division's Temporary Alternative Placement Agreement (TAPA).

Birth Match Program

[13] American Academy of Pediatrics, Safe Sleep: Recommendations, 2021

The purpose of Birth Match[14] is to identify infants who are at high risk for abuse or neglect based on the parents' previous actions. Birth Match will allow staff to assess the family and determine if services are needed before abuse or neglect occur. Missouri House Bills 429 and 432 established section 210.156 RSMo[15], which requires the Children's Division to provide the Missouri Registrar of Vital Statistics identifying information for persons who are in at least one of the following two categories: (1) individuals whose parental rights have ever been involuntarily terminated in Missouri AND who are identified in the Central Registry as having a finding by the Division or a court adjudication of child abuse or neglect within the previous ten years; or (2) individuals identified in the Central Registry who have also pled guilty or been found guilty of specific crimes, within the previous ten years, provided the victim was less than eighteen years of age, including:

- Chapter 566 RSMo. includes offenses of rape, sodomy, child molestation, sexual misconduct, sexual abuse, and trafficking.
- Section 565.020 RSMo. First degree murder
- Section 565.021 RSMo. Second degree murder
- Section 565.023 RSMo. Voluntary manslaughter
- Section 565.024 RSMo. Involuntary manslaughter
- Section 567.050 RSMo. Promoting prostitution in the first degree
- Section 568.020 RSMo. Incest
- Section 568.065 RSMo. Genital mutilation of a female child
- Section 573.023 RSMo. Sexual exploitation of a minor
- Section 573.025 RSMo. Promoting child pornography in the first degree
- Section 573.035 RSMo. Promoting child pornography in the second degree
- Section 573.037 RSMo. Possession of child pornography
- Section 573.040 RSMo. Furnishing pornographic materials to minors
- Section 573.200 RSMo. Child used in sexual performance
- Section 573.205 RSMo. Promoting sexual performance by a child

The Registrar will give the Division the birth record information of any child born to any individual whose identifying information has been provided by the Division. The Division will then verify the match and Child Abuse and Neglect Hotline Unit (CANHU) will create a Newborn Crisis Assessment designated as "Individual on child's birth certificate meets Birth Match criteria". The Newborn Crisis Assessment will then be sent to the county for assignment.

Temporary Alternative Placement Agreement (TAPA)

Pursuant to Section 210.123[16], RSMo, a TAPA is a voluntary agreement between the Children's Division, a relative of the child, and the parent or guardian of the child to provide a temporary, out-of-home placement for a child. Such placement may occur if the parent or guardian is

[14] Children's Division, Child Welfare Manual Section 2, Chapter 2.1.3.4.1 Birth Match Program, 2021

[15] Missouri Revised Statute § 210.156, Identifying information provided to state registrar, 2021; Children's Division, Child Welfare Manual Section 1, Chapter 5, Understanding and Assessing Child Safety Child Welfare Manual, 2019

[16] Missouri Revised Statute § 210.123, Temporary Alternative Placement Agreements, 2020

temporarily unable to provide care or support for the child and the child is not in imminent danger of death, serious bodily injury, or sexual abuse. If such danger existed, the Children's' Division would make a referral to the juvenile office with a recommendation to file a petition or to remove the child.

A TAPA requires the agreement of the following parties:

1. The parent/guardian;
2. The relative placement; and
3. The Children's Division

The term "relative" includes any actual relative OR any non-related person, but has a close relationship with the child or the child's family.[17] The legal definition of "relative" can be found at Section 210.565, RSMo.

When staff determine a child is unsafe based upon the staff's assessment, [18] they must take one of the following actions:

1. If the child is determined to be in imminent danger, staff should request emergency protective custody;
2. An Immediate Safety Intervention Plan is completed that allows the child to remain or be placed with a parent; or,
3. Child is placed with a relative as a diversion and a Temporary Alternative Placement Agreement (TAPA) is entered into.

If a child is determined to be unsafe, there may be times when they can be temporarily placed outside of the home with a relative. The temporary placement can provide time to reduce or eliminate the safety threat to the child and to attempt to prevent the child from being involuntarily removed from their parent/caregiver. These types of placements are called diversion placements. All diversions must be entered into the Diversion Screen in FACES.

The Children's Division may enter into a TAPA if:

- The child cannot remain safely in the home;
- The child is not in imminent danger of death or serious bodily injury, or being sexually abused such that an immediate referral for removal to the juvenile office is warranted[19];
- There is a ready and willing relative available to provide care;
- The Children's Division has available services for the child and family to support and supervise the agreement;
- The child's parent or guardian voluntarily enters into the agreement; and,
- The child's parent or guardian executes all necessary documents and consents to implement the agreement.

[17] Missouri Revised Statute § 210.123, Temporary Alternative Placement Agreements, 2020

[18] Children's Division, Child Welfare Manual Section 1, Chapter 5, Understanding and Assessing Child Safety Child Welfare Manual, 2019

[19] Children's Division, Child Welfare Manual, Section 1, Chapter 9.1.1, Referral for Emergency Protective Custody, 2019

Once staff complete their Structured Decision Making (SDM) safety assessment and determine the child to be safe with a plan, they must immediately complete the Immediate Safety Intervention Plan if the child is placed with the non- offending parent or is to remain in the home. If the child has been placed with a relative, staff must complete the TAPA form. The applicable sections of the TAPA form should be completed immediately and shall be signed by the parent/guardian, the relative, and appropriate Children's Division staff. The Safety Intervention Plan or TAPA must be uploaded into OnBase (the Children's Division electronic database).

A copy of the Safety Intervention Plan or TAPA shall be provided to the parent/caregiver and the relative placement provider. The juvenile office should also receive a copy immediately upon completion, but, in any event, no later than three (3) business days from the date of the diversion placement.

To further assist in monitoring the safety of the child and the parent/caregiver's progress with the plan developed through the TAPA, the following must also occur:

1. A Family Centered Services (FCS) case must be opened within ten (10) days of the execution of the TAPA and the case must remain open during the duration of the agreement;
2. Staff must have personal contact with all the children on the TAPA to ensure that the TAPA is being safely implemented as appropriate, but no less than two (2) times per month. One (1) contact with the child must be in child's relative placement. Additional contacts with the child may occur virtually or in the community.
3. One (1) face-to-face home visit per month must be completed on all FCS cases with the parents involved in the TAPA.
4. A Team Decision Making (TDM) meeting must occur within the first ten (10) days of entering a TAPA and at least once every month thereafter for the duration of the TAPA.

A TAPA shall be valid for no longer than ninety (90) days. If the goals of the TAPA cannot be accomplished within ninety (90) days and the child cannot yet be safely returned home, a referral to the juvenile office must be made prior to the end date of the TAPA.

For a TAPA to end successfully and the child to safely return home, staff should identify the action steps needed, and by whom, to resolve each identified safety threat to each child named in the TAPA form. There should be an action step/plan to resolve each identified safety threat for each child, including time frames for completion, as well as behavioral changes that need to be seen by each parent/legal guardian in order to ensure each child's safety and well-being upon returning home. When identifying specific steps that need to happen for the TAPA to successfully terminate, staff should be sure not to be heavily reliant on services, but rather on the behavioral changes needed to ensure safety. Similarly to completing a safety plan, the TAPA should:

- Be realistic and time limited;
- Ensure the parent(s)/guardian(s) and relative placement provider(s) are in

agreement with the TAPA plan;

- Utilize the family's own resources by focusing on existing strengths and natural family support network;
- Assess the reliability of resources and providers of the action/steps;
- Develop interventions to accommodate time elements (for example, weekends and holidays may require different actions than daytime hours during the week, etc.);
- Take into consideration the tradeoffs the family may have to make in order to successfully terminate a TAPA; and
- Be conscious to not create further trauma to the family/child

Staff shall identify the services, service providers, and specific resources being offered to any and all parties involved in the TAPA, as well as what resources and supports in which the family still needs to be connected. Services and resources will include those offered directly by Children's Division, as well as outside sources, and include an explanation as to how they will assist with resolving the threat(s) to safety that led to the implementation of the TAPA. Staff should include time frames for each service/resource and how the implementation of such service(s)/resource(s) will assist with the successful termination of the TAPA. Many individuals who meet the qualifications for TAPA could be potential candidates for foster care and coordination between FFPSA and TAPA should be coordinated.

During the investigation/assessment process the Children's Service Worker, in consultation with the Children's Service Supervisor, will make the informed decision as to the need for a referral for case opening, eligibility determination, and which service provision would be the most beneficial for the family. The Structured Decision Making Family Risk Assessment Tool must be discussed and completed between the Children's Service Worker and the Supervisor prior to case closure.[20] The supervisor is responsible for entering the Risk Assessment into FACES. The purpose of the Risk Assessment is for the Worker and Supervisor to gain a better understanding of the family's history, and behaviorally specific characteristics which can inform the worker of potential risk factors and areas that might warrant further services. After risk is defined, Children's Division can ensure that resources and supports are provided to families in order to enhance the caregivers' parenting capacity and to lessen the family's need for outside intervention.

The FCS referral form is an additional tool to capture necessary information captured through conversations with the family that lead to a balanced risk assessment. This particular tool captures pertinent information all on one form, such as:

- threats to the child's safety;
- harm statement information;
- existing safety and family strengths;
- danger statement;
- worries and reason for the referral;
- next steps to address the worries;
- any immediate safety plans, diversions, or Team Decision Making meeting

[20] Children's Division, Practice Alert: Structured Decision Making Family Risk Assessment Tool Instructions, 2020

information;
- additional safety services and/or referrals made through the child abuse/neglect report; and
- FFPSA specific information including candidacy identification and identified services for each family member.

There are three possible service tracks available to families to prevent foster care entry. These service tracks include Family-Centered Services Family First Prevention case, Family-Centered Services (FCS), and Intensive In-Home Services (IIS).

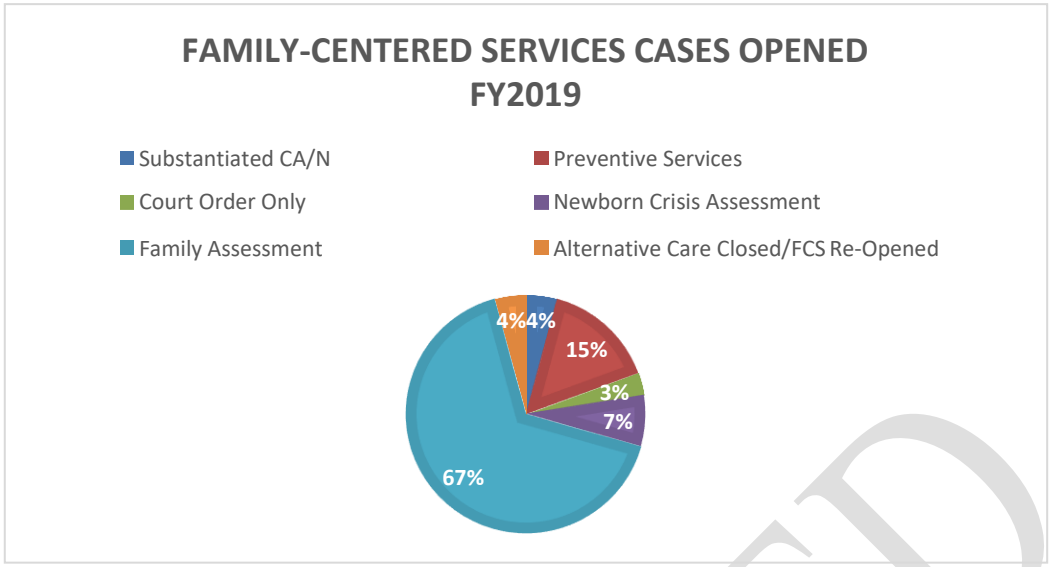
1. A FCS Family First Prevention case is provided when a family, or pregnant foster youth could benefit from a targeted evidence-based service to address mental health, substance abuse, or parenting skills and is determined to be a candidate for foster care.
2. FCS is provided to intact families when the family, Children's Division, and/or the courts determine a family would benefit from services. FCS includes a range of treatment and support services that may be provided directly by Children's Division or through community agencies.
3. IIS is provided to prevent the out-of-home placement of children and are intensive short-term, home-based, crisis intervention services. IIS is targeted to families that have a child at imminent risk of removal from the home due to neglect, abuse, family violence, mental illness, delinquency, or other circumstances. Children's Division staff and the family collaborate to develop a plan and service provision to address concerns related to child safety and wellbeing.

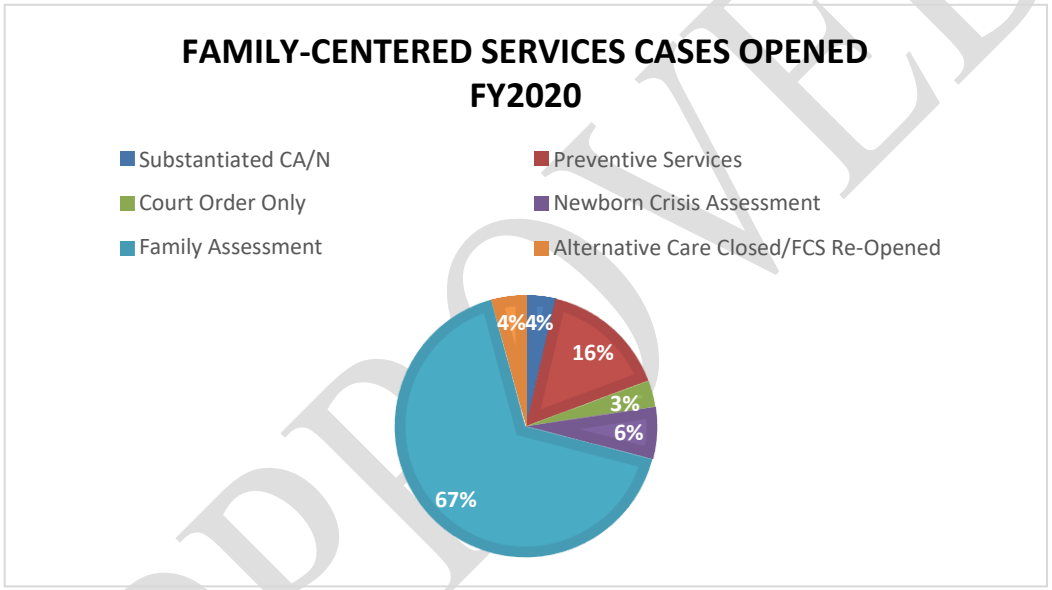
FCS Family First Prevention Services

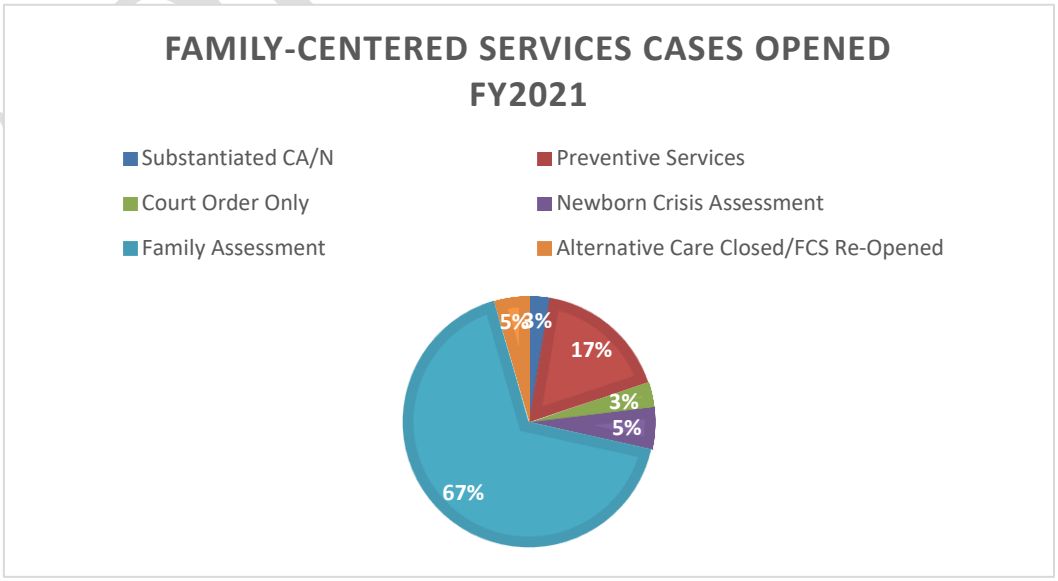
FCS Family First Prevention Services cases will be opened primarily as a result of an investigation or assessment after the child has been determined to be a candidate for foster care. The worker will determine what evidence-based services would best meet the need of the family to rectify safety and risk concerns. The worker and family will work together to develop the prevention plan to ensure the family understands the safety and risk factors and is open to receiving services.

FCS

In state fiscal year 2019 a total of 3,954 FCS cases were opened. In state fiscal year 2020, a total of 3,781 FCS cases were opened. In state fiscal year 2021 a total of 3,819 FCS cases were opened. FCS cases may open for reasons of a substantiated child abuse/neglect report (substantiated CA/N), preventive services, court ordered case, newborn crisis assessment, family assessment, or due to a foster care case closing as a result of reunification and FCS being opened to continue working with the family.


FAMILY-CENTERED SERVICES CASES OPENED
FY2019
Substantiated CA/N
Preventive Services
Court Order Only
Newborn Crisis Assessment
Family Assessment
Alternative Care Closed/FCS Re-Opened
4%
4%
15%
3%
7%
67%


FAMILY-CENTERED SERVICES CASES OPENED
FY2020
Substantiated CA/N
Preventive Services
Court Order Only
Newborn Crisis Assessment
Family Assessment
Alternative Care Closed/FCS Re-Opened
4%
4%
16%
3%
6%
67%


FAMILY-CENTERED SERVICES CASES OPENED
FY2021
Substantiated CA/N
Preventive Services
Court Order Only
Newborn Crisis Assessment
Family Assessment
Alternative Care Closed/FCS Re-Opened
5%
3%
17%
3%
5%
67%

Throughout the duration of creating this plan, FCS data was assessed in state fiscal years 2019, 2020, and 2021. Through a comparison of the data there were only slight differences between each year. Children's Division will continue to strive to increase access to prevention services for families through the assistance of FFPSA that match the reason for a case being opened.

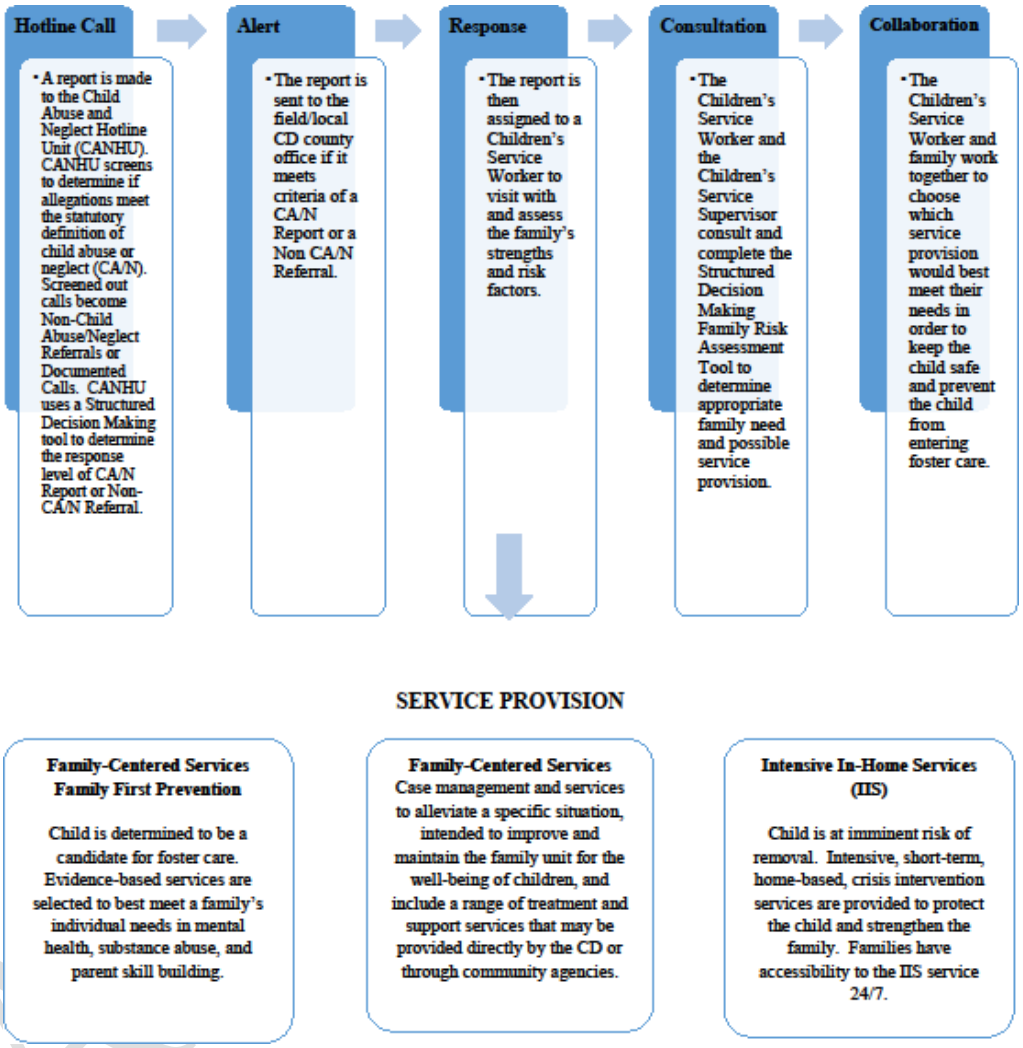
IIS

When Children's Division identifies that a family's situation may necessitate a recommendation to the courts for out-of-home placement, caseworkers first assess the situation to determine if an IIS referral is appropriate to keep the child safe and to avoid the unnecessary removal of the child. These services are offered statewide in an effort to provide supports in the family's local community to allow the parent to work on parenting skills, nurturing skills, and skills to safely keep the family intact. In state fiscal year 2019 there were 1,611 total families accepted into IIS, with 3,391 total at risk-children accepted. Of the families involved in the IIS program in state fiscal year 2019 1,136 (75.5%) remained safely in the home. In state fiscal year 2020 there were 1,354 total families accepted into IIS, with 3,362 total at risk-children accepted. Of the families involved in the IIS program in state fiscal year 2020 1,022 (77.5%) remained safely in the home. In state fiscal year 2021, there were 1,577 total families served, with 3,874 total at risk-children served. Of the families involved in the IIS program in state fiscal year 2021, 1,209 (77.8%) remained safely in the home.

The utilization of the pre-existing assessment procedures through family engagement and supervisory consultation will lead to a better understanding of the family as well as identification and selection of the best service provisions to meet the needs of the family. Eligibility determinations and any services offered to the family will be dated and documented in the FCS referral form and entered into FACES. In the event that a FCS Family First Prevention case needs to remain open longer than the initial 12-month eligibility period, all redeterminations of candidacy will be documented in the FCS referral form and in FACES.

Below is a Prevention Services Roadmap to illustrate how families are assessed and offered support and services once alerted to Children's Division's attention.

Prevention Services Roadmap



Section 3: Title IV-E Prevention Services

Selection of Proposed Evidence Based Prevention Services

Children's Division embarked on development of the Title IV-E Prevention Plan with the intended purpose of selecting a service array of prevention programs to best meet the needs of children identified as candidates for foster care. To inform this thought process, data was reviewed to isolate and understand the prevalent conditions identified at the time of removal, illuminating key areas of need. Historically, the most prevalent observed conditions at removal include parental drug abuse, neglect, and inadequate housing. For pre-teen and adolescent youth, child behavior is also observed as a prevalent condition at removal. Conditions at removal reveal

the potential impacts and trauma a child may have experienced before entering the custody of the State. These experiences impact children differently and may manifest through disruptive behaviors which require specific, targeted services to meet the child's needs.

Child welfare requires teamwork across agencies and community partnerships to best meet the needs of children and families in Missouri. To garner a better understanding of services available throughout Missouri, a request for information was distributed to the provider network, service providers who are contracted with Children's Division, and entities not currently contracted but who may have interest in partnership for meeting the goals of FFPSA. The request for information yielded multiple responses identifying what services entities offered, location of service provision, alignment of service provision with the Title IV-E Prevention Services Clearinghouse (Clearinghouse), capacity for service provision, and potential program evaluations to explore programs provided but not yet on the Clearinghouse.

Through data analysis and stakeholder feedback, Children's Division selected initial programs which would best address the current trends revealed in the data. Key target populations emerged as the focus for phase one of our prevention rollout and Missouri will continue to build towards a more expansive service array as additional services are rated by the Title IV-E Prevention Clearinghouse and internal capacity grows. Through our Continuous Quality Improvement (CQI) process and partnership with the Family First Statewide Advisory team and Regional Implementation teams, data will continue to be explored and assessed to further address the most prevalent conditions identified at the time of removal for prevention services.

Proposed Evidence-Based Prevention Services

Children's Division has identified the evidence-based programs, represented in Table 1, as the initial preventive programs of phase one to align with the needs of the children and families whom Children's Division serves. The evidence-based programs selected are currently rated by the Clearinghouse as having achieved a well-supported rating.

Table 1 identifies the prevention services proposed by Children's Division at this time to work towards and below are short descriptions of each program as articulated by the Clearinghouse:[21]

[21] Title IV-E Prevention Services Clearinghouse (2021). Find A Program or Service

Table 1: Children's Division proposed prevention programs with a Title IV-E Prevention Services Clearinghouse Rating

Prevention Program Category Programs and Services	**Evidence-Based Program Name and Description**	**Target Age & Clients**	**Targeted Outcomes**	**Title IV-E Prevention Services Clearinghouse Rating**	**Adaptation or Model Book Version or Manual**
In-home Parent Skill-based Mental Health; Substance Abuse;	Brief Strategic Family Therapy	Families with children ages 6-17 years who display or are at risk for developing problem behaviors in substance abuse, conduct problems, and delinquency	<u>Favorable Impacts</u>: Child well-being: Behavioral and emotional functioning; Child-well-being: Substance use; Child well-being: Delinquent behavior; Adult well-being: Parent/caregiver substance use; Adult well-being: Family functioning <u>Goals:</u> Reduce behavior problems, while improving self-control; Reduce associations with antisocial peers; Reduce drug use; Develop prosocial behaviors; Improvements in maladaptive patterns of family interactions (family functioning); Improvements in family communication, conflict-resolution, and problem-solving skills; Improvements in family cohesiveness, collaboration, and child/family bonding; Effective parenting, including successful management of children's behavior and positive affect in the parent-child interactions	Well-Supported	Model as approved; 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.

Mental Health	Functional Family Therapy	11 to 18 year old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.	Favorable Impacts: Child well-being: Behavioral and emotional functioning; Child-well-being: Substance use; Child well-being: Delinquent behavior; Adult well-being: Positive parenting practices; Adult well-being: Family functioning Goals: Eliminate youth referral problems; Improve prosocial behaviors; Improve family and individual skills	Well-Supported	Model as approved; Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavioral problems.* American Psychological Association.
Mental Health Substance Use Disorders	Multisystemic Therapy	Youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.	Favorable Impacts: Child permanency: Out-of-home placement; Child well-being: Behavioral and emotional functioning; Child well-being: Social functioning; Child well-being: Cognitive functions and abilities.; Child-well-being: Substance use; Child well-being: Delinquent behavior; Adult well-being: Positive parenting practices; Adult well-being: Parent/caregiver mental or emotional health; Adult well-being: Family functioning Goals: Eliminate or significantly reduce the frequency and severity of problem behaviors; Parents and youth to learn skills on how to better cope with family, peer, school, and neighborhood problems; Parents to learn skills to independently address the inevitable difficulties that arise in raising children and adolescents;	Well-Supported	Model as approved; Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press.
Mental Health	Parent-Child Interaction	Families with children ages 2-7	Favorable Impacts: Child well-being:	Well-Supported	Model as approved; Eyberg, S., &

	Therapy (PCIT)	with emotional and behavioral problems that are frequent and intense	Behavioral and emotional functioning; Adult well-being: Positive parenting practices; Adult well- being: Parent/caregiver mental or emotional health; Child-well-being: Social functioning; Adult well-being: Family functioning <u>Goals</u>: Build close relationships between parents and their children using positive attention strategies; Help children feel safe and calm by fostering warmth and security between parents and their children; Increase children's organizational and play skills; Decrease children's frustration and anger; Educate parent about ways to teach child without frustration for parent and child; Enhance children's self- esteem; Improve children's social skills such as sharing and cooperation; Teach parents how to communicate with young children who have limited attention spans; Teach parent specific discipline techniques that help children to listen to instructions and follow directions; Decrease problematic child behaviors by teaching parents to be consistent and predictable; Help parents develop confidence in managing their children's behaviors at home and in public		Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011.* PCIT International, Inc.

"Brief Strategic Family Therapy (BSFT) is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT is based on three basic principles: First, BSFT is a family systems approach. Second, patterns of interaction in the

family influence the behavior of each family member. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors." [22]

"*Functional Family Therapy (FFT)* is a family intervention program for dysfunctional youth with disruptive, externalizing problems. *FFT* has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While *FFT* targets youth ages 11-18, younger siblings of referred adolescents often become part of the intervention process. The average number of intervention session range from 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. *FFT* has been conducted both in clinic settings as an outpatient therapy and as a home-based model. The *FFT* clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success".[23]

"Multisystemic Therapy" (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of *MST* are to decrease youth criminal behavior and out-of-home placements. Critical features of *MST* include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change."[24]

"*Parent-Child Interaction Therapy"* is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. *PCIT* is time-unlimited. Families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Treatment length varies, but averages

[22] California Evidence Based Clearing House, Brief Strategic Family Therapy, 2022
[23] California Evidence Based Clearing House, Functional Family Therapy, 2022
[24] California Evidence Based Clearing House, Multisystemic Therapy, 2022

approximately 14 weeks of hour-long weekly sessions."[25]

The programs and services identified above were selected to match the needs of Missouri's candidacy populations, including those where services would be initiated based on the behavior and needs of the youth. Oftentimes, youth who enter care due to child behavior are placed in residential settings. It is intended that the identified services and programs will decrease entry into foster care and subsequently decrease placements in residential settings. The selected programs and services are intended to service the target populations and clients identified on the Clearinghouse. So as to be consistent with the identified favorable impacts and goals for each service, expected outcomes for children and families in Missouri were developed and are identified in Section 6: Evaluation and Continuous Quality Improvement Strategy.

Trauma-Informed Framework

Evidence-based interventions included in the Children's Division's prevention plan will be provided in a trauma-informed framework. This will be a requirement for FFPSA program contracts. The Trauma-Informed definitions, processes, and indicators established in Missouri Model: A Developmental Framework for Trauma-Informed Approaches[26] shall be used to assess compliance with the principles of trauma-informed service delivery. Contractual language will incorporate the Missouri Model as a stipulation of expectations for any entity to provide services to families served by Children's Division. The contractor shall be required to utilize the Trauma Informed Organization Self-Assessment for Child Abuse Prevention Agencies within ninety (90) calendar days after authorization to proceed with services and within ninety (90) calendar days of each contract renewal. The self-assessment will be submitted to the Children's Division by the contractor. The contractor must describe and rate their perceived performance for each component and create an improvement plan for any item not indicated as "Strongly Agree." The improvement plan must include a description of the contractor's policies for each component, and what actions must be put into place to become a trauma-informed organization. The improvement plan will be addressed through contract monitoring. In addition to contractual requirements identifying the importance of being trauma-informed, the Children's Division will explore additional opportunities to work with entities to be trauma-informed through various avenues such as a conference for trauma training. More information surrounding this training is included in Section 7 of this Plan.

Please see Appendix F for Children's Division's signed assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma-informed framework.

Implementation Approach

Children's Division recognizes the current selected programs do not provide an exhaustive reach to target the identified needs of children and families whom we serve, in particular surrounding substance abuse. As additional resources and capacity become available, the Children's Division will explore the option for an independent evaluation of modalities currently having a positive

[25] California Evidence Based Clearing House, Parent-Child Interaction Therapy, 2022

[26] Center for Excellence in Child Well-Being, Missouri Model: A Developmental Framework for Trauma Informed Approaches, 2019

impact on Missouri children and families. Children's Division intends to submit additional amendments to this Plan as our service array may expand. Expansion and evolution of the selected service array may be impacted by the addition of approved programs on the Clearinghouse, alignment with current service providers and capacity, or identification of the ability for expansion amongst current service providers. Children's Division will also continue to collaborate with partners through the Statewide Advisory team to identify how to effectively address service gaps to meet the needs of children who are identified as candidates for foster care. Implementation of prevention services will not be instantaneous and will continue as a multi-year initiative.

The FFPSA Implementation Team will approach implementation of prevention services through a phased-in approach. Through this method, it will create a foundation to build upon, with pilot sites, and provide the ability to use learning to improve future implementation. The phases are planned as follows:

- Phase I: Finalization of the pilot site implementation plan by December 31, 2022. 3-5 pilot sites would begin in 2023 with existing service providers with services and working with model purveyors for site development from the approved FFPSA Prevention Plan. These sites will run for one year with constant monitoring of quality and outcomes, structure analysis, and feedback loops. Utilizing this data, along with development of providers in other areas, based on the service heat map and needs assessment from the child welfare system, a plan for expansion to be developed. Pilot sites developed in phase 1 will run for one year after sites begin providing services. Begin date will depend on services providers who currently provide approved services, and purveyor ability to develop new services.
    - Team Structure: In Phase I, Children's Division will utilize the current Family Centered Services Workers in the pilot sites to be the case managers for FFPSA cases with supervision provided by local supervisors, and monitoring and fidelity support provided by the Family First Prevention Team and the Quality Assurance Unit.
- Phase II: Utilizing the expansion plan developed in Phase I, an additional 5-7 pilot sites will be implemented to allow for continuous expansion of both the service provision systems, internal staffing structures, and the data system for development of continuous monitoring of outcomes. These additional sites, along with the original sites, will run for one year with constant monitoring of quality and outcomes, structure analysis, and feedback loops. Development of other needed services, service providers, and future development opportunities will be ongoing throughout this phase.
    - Team Structure: In Phase II, Children's Division will utilize the current Family Centered Services Workers in the additional pilot sites to be the case managers for FFPSA cases with supervision provided by local supervisors, and monitoring and fidelity support provided by the Family First Prevention Team and the Quality Assurance Unit. The existing prevention case managers from Phase I will become resident experts and mentors in Phase II. Phase II will run pilot sites for an additional year to begin after implementation of year two. This will begin after year one in Phase I is complete.

- Phase III: Statewide expansion will occur after Phases I and II are complete. Service provider and purveyor development will occur continuously throughout the phases of expansion based on providers around the State of Missouri for statewide roll-out.
    - Team Structure: Prevention case managers will be moved under one centralized team and will have support, supervision, and oversight that works in tandem with local leadership for referrals and ongoing evaluation. This team will be supervised at a central office level with supervisors reporting to the Prevention Unit Manager. This team will work in tandem with the Quality Service Unit for ongoing outcome evaluation and local circuits for education and referral needs.

After statewide expansion, the Prevention Team will be required to continuously monitor services that are approved for plan modification; expansion and development of service providers; and expansion of Children's Division structure for case management.

Throughout each phase, the following tasks will occur to evaluate outcomes, team structure, and success of implementation:

- Fidelity monitoring to each approved service
- Outcomes of all children in FFPSA cases
- Caseload sizes for each Prevention Case Manager
- Monitoring of contracts
- Service provider development

To fully implement the Children's Division's prevention service array, evidence-based programs identified within this plan will complete a competitive bid process. Implementation steps will include: a solicitation of bids through a Request for Proposal; a thorough evaluation of received proposals; and awarding of contracts in accordance with applicable statutes, policies, and guidelines. Requests for Proposals will be completed by Children's Division to include program-specific information and contractual requirements. The procurement process will occur through the Missouri Office of Administration.

Oversight of contracts will occur through contract monitoring and case file reviews to ensure fidelity to the practice model. This process will include a review of personnel requirements and performance metrics outlining overall satisfactory service delivery. The contracts will specify expected service outcomes for the specified service. Technical assistance will also be provided by Children's Division staff overseeing the contract. In addition to Children's Division oversight, the services will have fidelity measures in which adherence is required. Fidelity monitoring is further explained in Section 6: Evaluation and Continuous Quality Improvement Strategy. Moreover, all contracts include clauses providing the option to require corrective action plans in the event of an identified non-compliance or if the contractor is at risk of non- compliance with the terms of the contract.

Information obtained from the continuous quality improvement process and evaluation activities will be utilized to ensure proper implementation of the prevention plan. An assessment of goals completion, as well as any challenges that may need to be addressed and resolved, will be reviewed by Children's Division staff and discussed with contract recipients. See Section 6 of

this Plan for information regarding Missouri's continuous quality improvement and evaluation plan.

Section 4: Child Specific Prevention Plan

Development of the Prevention Plan

The prevention plan will be developed after identification of the need to open an FCS Family First Prevention case. As identified in the overview of Children's Division's integrated practice model in Section 1 of this Plan, Children's Division values engagement with children and families, and this practice will be embedded in the development of the prevention plan. Child participation will be dependent upon age and developmental appropriateness. The Children's Service Worker identified as the prevention worker will collaborate with the child (ren), family, and safety network or family support team to develop the appropriate prevention plan to address and mitigate the risk factors leading to the child being identified as a candidate for foster care. A parallel process will occur for pregnant or parenting youth in foster care who are identified as being in need of prevention services; however, the Alternative Care Case Manager will remain as the prevention worker for the youth to ensure continuity of service provisions. Subsequently, after a pregnant or parenting youth in foster care is identified in the alternative care case as being in need of prevention services, the processes and tools referenced below will be completed by the Alternative Care Case Manager.

To achieve a balanced view of risk and safety, the Children's Division utilizes a comprehensive and balanced child protection risk assessment approach. This approach considers the family's strengths, family experience and knowledge, and the professional's experience and knowledge. This information is obtained utilizing an inquiry approach. Before an FCS Family First Prevention case is opened, the investigator/assessment worker completes the FCS Referral as referenced in Section 2 of this Plan. This referral form helps to organize information about the circumstances connecting the family to Children's Division from the family and other relevant sources the referral form should be reviewed with the family for input, clarity, and accuracy. This referral form should be reflective of the family's own words when possible and should accurately capture everyone's perspectives. The purpose of this document is to ensure a shared understanding and sharpened focus of concerns, strengths, and next steps to rectify safety concerns. The form will also address what we are worried about, what's working well, and what needs to happen next.

The referral form specifies and clearly outlines the threats to child safety. Deeper exploration is detailed through specific information surrounding the harm statement on the referral form. The harm statement provides a clear picture of what has happened to the child (ren) and how this has impacted them. This also explains why Children's Division became involved. A harm statement should be based upon factual information about what has happened in the past, including severity, the incidents, and the impact. This particular section of the referral identifies the date the harm occurred to the child (ren) and specifically what happened to the child (ren) as well as who caused or contributed to the harm. Physical impact and emotional impact to the child (ren) as a result of the harm are also captured within this section of the referral form. A danger statement explains what keeps Children's Division involved. This is a behavioral statement of the specific worry Children's Division has about the child (ren) now and into the future. This

statement captures the nature of the worries and what could happen if nothing changes. Worries and the reason for referral are further detailed within the referral form.
What is working well is identified through existing strengths and existing safety. Existing strengths are the good things happening within the family that make life better in general. Existing safety is identified actions that have been taken to make sure the child is safe when danger is present and are things that can be built upon to keep the child safe in the future. Existing safety should be relevant to the danger. The referral form identifies what actions the parent/caregiver/guardian has taken in the past to keep the child(ren) safe when the concerning behaviors were occurring, what supports they utilized to keep the child(ren) safe, and what is currently occurring to keep the child(ren) safe.

Ensuring the safety of the child (ren) remains paramount and is clearly articulated within the referral form through identification of the next steps, or immediate actions, to address the worries and reasons for the referral. The referral form also includes detailed information pertaining to the immediate safety plan; TAPA and/or Team Decision Making information; and additional safety services or referral made through the child abuse/neglect report. This information should be directly targeted to building safety in relation to the danger statement. The referral form also identifies candidacy requirements and identified prevention services to applicable household members.

Following the referral, within 30 days of a FCS Family First Prevention case opening, an initial assessment must be completed. The assessment statement is the product of the worker and the family's review of the information shared by the family to develop plans for the worries. The Children's Service Worker checks for understanding of what was discovered in order to clarify details with the family. Strengths of the family members are recognized and shared by the worker to boost confidence in both the family and the process. Any missing information is gathered so that a clear picture can be painted for the worker and the family to begin establishing a plan for change. The initial assessment includes the FCS Assessment and Social Service Plan; Safety Assessment; and Risk Re-Assessment Tool.

The FCS Assessment and Social Service Plan will encompass the necessary information for a clearly articulated prevention plan. The FCS Assessment and Social Service Plan further assesses the information contained in the referral in a deeper manner. Perspective of the family and others (including natural supports, service providers, and Children's Division) regarding worries, family strengths, and suggestions to remedy the worries are identified. The FCS Assessment and Social Service Plan also further assesses the family as a whole, including basic needs, substance use, caregiver ability, physical health, mental health, and well-being. A safety goal is identified within this plan, which encompasses positive behaviors to rectify the harm and danger along with positive impacts on the child (ren) once accomplished. The plan also confirms the behaviors the parent/guardian/caregiver will demonstrate when the goal is successfully reached and protective capacities needed to build on by the parent/caregiver/guardian to reach and maintain the goal. Within planning of the safety goal, next steps to accomplish the goal are identified as well as who will assist and the services to be accessed. Complicating factors, issues that may make the case more difficult, or worsen the concerns are identified to address them. This document further details a well-thought-out long term safety/support plan around the specific danger, including: triggers that may lead to harmful behavior; preventative action plan to help reduce the triggers

from occurring; red flags or signs the harmful behavior may be started or has started; response action plan including who is responsible for keeping the child(ren) safe if the harmful behaviors do occur; dates that the practice drill occurred and who was involved; and the date the long term/safety plan was reviewed with the family and safety network at case closure. The Family First Prevention Strategies section of this Plan further identifies child-specific identifying information, candidate for foster care identification and specification, reasons for imminent risk of removal, identified prevention services for household member(s), service provider(s) and service date initiation.

A thorough, detailed FCS Assessment and Social Service Plan is a valuable tool utilized to assess need and ensure appropriate service referral and initiation to meet the needs of the child (ren), family and/or caregivers. Shared understanding through the assessment process can assist in a continued collaborative development of an informed and intentional prevention plan to address and mitigate the safety concerns. In addition to direct work with the family, development of the plan will also occur within the safety network or Family Support Team. The safety network is comprised of individuals who ensure safety for the children and support the parents during times of struggle by being actively involved in the family's day-to-day life. The family support team, as identified in Section 2 of this Plan, is a group of individuals involved with the family, both personally as well as professionally. Inclusion of the safety network or family support team in the development of the prevention plan may occur in a meeting setting.

Monitoring of the Prevention Plan

Ongoing review of case progress will occur throughout the duration of the case. Prevention workers (or case managers for pregnant and parenting youth in care) will meet with the child (ren) and family in the home monthly (refer to Section 5 of this Plan for visit frequency). Ongoing contact with service providers will also occur to discuss progress and recommendations. Case consultations occur at least once per month, per case between the prevention worker or case manager and their supervisor. These consultations consist of discussing the prevention case plan, family progress, and safety and risk considerations with the family. A review shall be completed of the FCS Assessment and Social Service Plan. The case consultation with the supervisor is an additional opportunity to assure appropriate service provision and to review achieved outcomes.

Revisions to the prevention plan will be driven by quarterly risk reassessments. Please see Section 5 of this Plan for additional information regarding the reassessment. Moreover, identification of new risk factors, through case management or through an additional hotline call, as well as changes within the household composition or family dynamic, will be considered compelling reasons to revisit the prevention plan.

The FCS Assessment and Social Services Plan will be documented through paper tracking until all updates are made for both the FCS and Social Service Plan to be tracked in FACES. Entry and/or revisions to the plan, eligibility determination, and case opening and closing dates will be documented and tracked in FACES. To comply with the 12-month eligibility requirement, a FACES alert to the Prevention Worker or Case Manager will occur at the 11-month mark to begin an assessment regarding the candidacy eligibility, and eligibility re- determination, if necessary. An assessment will occur to determine if the service provisions offered have mitigated

the risk factors and if candidacy requirements are no longer met. If risk factors have not been mitigated, or there are new risk factors, eligibility will be re-determined and the prevention plan will be revised to determine appropriate service provision.

Coordination of Services

An FCS Family First Prevention case will not be an independent effort, but rather will enhance current available services through community resources to provide a system wrap-around approach. Collaboration with community resources will continue to provide services to address the needs of children, families, and caregivers to create safe environments. Children's Division will continue to refer to family-centered, strength-based treatment services, as identified in the 2020-2024 Child and Family Services Plan.[27] Services considered for children under the age of five include:

- infant developmental stimulation/early childhood education;
- specific rehabilitation and medical services;
- respite care;
- home-based services to provide instructions on infant development and child development (including Parents as Teachers and Home Visiting Providers);
- First Steps services for ages birth through-three with a policy requirement for mandatory referral for Preponderance of Evidence investigation findings for child(ren) under the age of three;
- school district services referral for children over the age of three with a developmental concern or delay;
- special or therapeutic preschool, including day treatment or child care facilities which can meet the child's needs;
- referrals to Early Head Start and Head Start;
- parent aide services for parents; and
- Mental health services for the child (ren) or parents.

The Home Visiting program is an in-home service designed to assist with the prevention of child abuse and neglect. This program offers additional in-home supports for at-risk families to help link them to additional resources in the community, to help build their knowledge and skill base related to parenting, and to model appropriate parenting skills. The Home Visiting program is available to families starting with prenatal support up to a child's third birthday. The program supports parents through various opportunities to gain skills in the areas of child abuse and neglect prevention, early childhood development and education, parenting skill development, and school readiness.

Missouri Department of Social Services, Missouri Department of Health and Senior Services, Missouri Department of Elementary and Secondary Education, Missouri Department of Mental Health, and Missouri Head Start State Collaboration Office have been operating under a Memorandum of Understanding (MOU) since 2017. The MOU addresses collaboration between all entities serving children ages zero to five. Children's Division local circuits also enter into local collaboration plans designed to improve the coordination of services for the children and

[27] Children's Division, Title IV-B Child and Family Services Plan, 2019

families served by Children's Division and Head Start/Early Head Start. Such collaboration plans help families ensure their children are receiving quality child care services in a continuous, intensive, and comprehensive child development program to help with school readiness.

In addition to services for children under the age of five, Children's Division will also continue to access and utilize family preservation services. These services include Intensive In-Home Services, Intensive Family Reunification Services, the child care subsidy program, and Crisis Care services.

As identified in Section 2 of this Plan, Intensive In-Home Services are intensive short-term, home-based, crisis intervention services. These services are offered so that families can (through skill-based intervention) learn nurturing skills, improve their functioning, and gain support within their community to help the family remain safely together. IIS is typically provided to families with a significant risk of maltreatment.

Intensive Family Reunification Services (IFRS) is a short-term, intensive, family-based program for children who are in out-of-home care and who, with intensive intervention, can reunify with their family. The goals of this program are to assist the family in removing barriers to the return of their child(ren); assist in the transition of returning the child(ren) home; and develop a plan with the family who will maintain the child(ren)'s safety in the home following the intervention.

Crisis Care provides temporary care for children age's birth through 18 years whose parents are experiencing a crisis or emergency situation that requires immediate action for children who may be at risk for child abuse or neglect. Crisis Care facilities provides crisis care services 24-hours a day, seven days a week. This is a free service to families and is designed to alleviate immediate crisis or emergency situations, but is also designed to enhance the family's capability of preventing future crisis or emergency situations from occurring.

Children's Treatment Services (CTS) are intended to supplement casework and should be helpful in reducing risk and improving family functioning. These services are purchased by Children's Division on behalf of the family and are to be used with children and families to prevent child abuse and neglect and to treat the negative consequences of child abuse and neglect. These services are administered by third-party providers, which may include the provisions of counseling and therapy, parent aide and education services, and/or, intensive in-home services (family preservation). Services are provided in order to keep children from entering out-of-home care as well as to return children safely to their homes or other arrangements identified through the child's permanency plan.

Section 5: Monitoring Child Safety

Safety of children is paramount throughout the entirety of Children's Division service delivery. Safety assessment is ongoing, and Children's Service Workers assess if there is a threat to the child's safety, if the child is vulnerable to the threat, and if the caregiver has sufficient protective capacities to protect the child from the threat. Child safety will continue to be monitored throughout the duration of an FCS prevention case through direct work with the families, the safety network, and the caseworker's direct supervisor to ensure a multi-layered, structured approach.

As identified in Section 2 of this Plan, during the investigation/assessment process, the Children's Services Worker (in consultation with the Children's Services Supervisor) completes the Structured Decision Making Family Risk Assessment Tool[28] at the 72-hour case consultation.

The Structured Decision Making Family Risk Assessment is intended for the worker and supervisor to gain a better understanding of the family's characteristics and informs the worker of potential risk factors and areas that might warrant further services. The Risk Assessment is based on research of cases with substantiated abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect. The tool does not predict recurrence, but simply assesses whether a family is more or less likely to have another incident without intervention by Children's Division. The Risk Assessment tool is composed of two indices: the neglect assessment index and the abuse assessment index. This tool helps define risk for the family through an initial risk level of low, moderate, high, and very high, based upon a score for each assessment item derived from the worker's observation of the characteristics described.

If the investigation/assessment process results in the opening of an FCS Family First Prevention case, the initial time frame for when the worker must meet with the family will be determined based upon the initial risk level. Face to face contact by the Children's Division worker should occur in the family's home. The additional contacts may be met by a contracted service provider who is working with the family as part of the family's case plan either in-home or by a virtual visit. Contact with all the child (ren) listed on the FCS Family First Prevention case must be no less than two (2) times per month. This is consistent with requirements for FCS cases as well. A risk level of very high will necessitate the initial home visit with the family to occur within two (2) working days. A risk level of high will require the initial home visit with the family to occur within three (3) working days. Risk levels of moderate and or low requires the initial home visit with the family to occur within five (5) working days.

The identified risk level will also guide the minimum number of visits with the child (ren) and family in the home that must occur each month. Cases with an identified risk level of very high or high will require, at a minimum, one face-to-face visits per month with two (2) additional contacts per month, either virtually or by an in- home service provider. Cases with an identified risk level of moderate or low will require, at a minimum, one (1) face-to-face visit per month and one (1) additional contact per month, either virtually or by an in-home provider. To ensure child safety, the Children's Division Worker must meet with the child (ren) individually during the home visits.

Upon the opening of an FCS Family First Prevention case, the FCS Referral, identified in Section 4 of this Plan, will be completed (if not done so already). Such Referral will be reviewed with the family for engagement, shared understanding, and a balanced risk assessment by identifying concerns and family strengths. This tool also identifies next steps to rectify safety concerns. Prevention workers will need to purposefully ask questions to gather details about existing safety to develop the building blocks and gather information to develop the FCS Assessment and Social Services Plan (as identified in Section 4 of this Plan). The FCS

[28] Children's Division, Practice Alert: Structured Decision Making Family Risk Assessment Tool Instructions, 2020

Assessment and Social Services Plan is intended to guide the family, staff, and involved parties from the danger statements through a structured process to create the final safety plan to ensure safety after the case is closed.

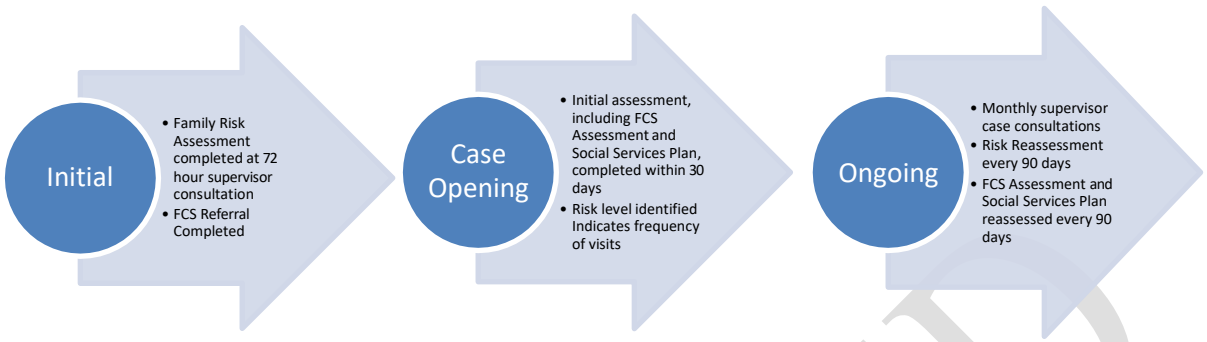
If there is an identifiable and likely danger to the child (ren), insufficient safety to mitigate the danger, and some relatively immediate action is needed to keep the danger from actually occurring, an Immediate Safety Intervention Plan (which is time limited) is to be used. The Plan will document any necessary interventions to address immediate safety concerns. Safety interventions are actions or supports put in place to manage the safety threat to the child. Immediate safety interventions are used to manage the safety threat to the child when a child has been determined to be unsafe to allow for a more thorough assessment and long-term safety plan development.

Immediate safety interventions that address imminent danger should be readily available, action-oriented, and lead to immediate impact with no promised commitments. The use of an Immediate Safety Intervention Plan should be given high priority, and shall be monitored through announced and unannounced home visits by the worker or trusted safety network member. Supervisors must staff cases with an open Immediate Safety Intervention Plan at the time safety is re-assessed, which occurs at the end of each ten day period.

The FCS Assessment and Social Services Plan is utilized for conversations with the family and their safety network to develop the plan that will enable the family to achieve and maintain the safety goal(s) for their child (ren). The focus of this should be on how people will be living differently to help keep the children safe now and in the future, even after the prevention case with Children's Division is closed. A safety network should be involved in the creation, implementation and monitoring of this document. As the FCS Assessment and Social Services Plan is utilized, it must be constantly evaluated, monitored, and adjusted as necessary. Families should be given opportunities to incrementally demonstrate how they are using their plan as the case progresses.

Ongoing monitoring will also occur through supervisory case consultations. Children's Service Workers and Children's Service Supervisors will meet at least monthly on each case. The case consultation leads to supervisory evaluation of potential safety concerns, risk to the children, and overall family situation. The Family Risk Reassessment will be completed between the worker and supervisor every 90 days during a supervisory case consultation.

The Family Risk Reassessment is a tool utilized to reevaluate the familial risk level based upon observations during the 90 days for new allegations of abuse or neglect, difficulties with identified areas of concern, and progress on the case plan. The risk level identified from the Family Risk Reassessment tool will continue to guide the minimum number of monthly face-to-face visits the worker must make with the child (ren) and family. As safety concerns are mitigated, the scores and subsequent risk level are anticipated to decrease. The FCS Assessment and Social Services Plan will also be reassessed during the same 90-day intervals to ensure appropriate depiction of the case plan and progress.
Figure 1. FCS assessment process



Section 6: Evaluation and Continuous Quality Improvement Strategy

Compelling Evidence for EBP Effectiveness and Waiver Justification

FFPSA requires every program in a state's Prevention Plan to have a well-designed and rigorous evaluation strategy, unless a state is granted a federal waiver. Missouri is seeking a waiver request for the evidence-based programs included in the plan which are rated as well supported in the Title IV-E Prevention Services Clearinghouse. These Evidence Based Practices (EBPs) include Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Parent Child Interaction Therapy (PCIT), as identified in Table 2. Missouri is committed to developing a continued prevention service array as we build towards the future. Missouri focuses on three main goals for measuring successful outcomes: safety, well-being, and permanency. The programs selected each have evidence that they improve outcomes in the domains of child safety, child permanency, child well-being, and/or adult well-being, and have data outcomes that will be utilized to determine if the programs are successful for Missouri's child welfare population.

See Appendices B, C, D, and E for Missouri's official evaluation waiver requests for well-supported interventions.

Table 2. Evaluation Waivers for Well-Supported Interventions

Type	Evidence-Based Program	Planned/Future Evaluation	CQI (evaluation waiver request)
Parenting	Brief Strategic Family Therapy		✓
Mental Health	Brief Strategic Family Therapy		✓
	Functional Family Therapy		✓

	Multisystemic Therapy		✓
	Parent Child Interaction Therapy		✓
Substance Use Disorder	Brief Strategic Family Therapy		✓
	Multisystemic Therapy		✓

Brief Strategic Family Therapy (BSFT)

The Title IV-E Prevention Services Clearinghouse rated Brief Strategic Family Therapy as well-supported after findings from 5 studies that were eligible for review. These reviews indicated favorable effects in child well-being: behavioral and emotional functioning; child well-being: delinquent behavior; adult well-being: parent/caregiver substance use; and adult well-being:family functioning[29]. BSFT has been demonstrated to have favorable effect in adult well-being, indicated by improved family functioning. "BSFT focuses on improving family functioning by identifying and altering patterns of family interaction that are directly related to adolescent's substance abuse and related behavioral problems. BSFT aims to improve parental leadership, parent involvement, and positive parenting practices, all of which have been shown to serve as protective factors aganst adolescents' later substance use and the negative effects of deviant friends, neighborhood crime, and underperforming schools." (Horigian et al, 2015) [30] In addition, a study also identified BSFT as effective in reducing alcohol use in parents, and in reducing adolescents' substance use in families where parents were using substances (Horigian et al., 2015)[31]. At least one study of BSFT has shown effectiveness in engaging and retaining family members in treatment and in improving family functioning (Robbins et al., 2011).[32]Furthermore, BSFT was effective in engaging and retaining adolescents across all racial/ethnic groups, demonstrating ability for utilization in various populations (Robbins et al., 2011). BSFT has been demonstrated to have favorable effect in child well-being, indicated by reduction in delinquent behavior. A study demonstrated that participants in BSFT improved behavioral and emotional functioning by reducing externalizing behaviors. The study also identified favorable impact and long term effect in reducing arrests, incarcerations, and externalizing (Horigian et al., 2015).

The California Evidence-Based Clearinghouse identifies the goals of Brief Strategic Family Therapy as reducing youth behavior problems while improving self-control; reducing youth associations with antisocial peers; reducing youth drug use; developing prosocial behaviors in youth; improving family functioning; improving family communication, conflict-resolution, and problem solving skills; improving family cohesiveness, collaboration, and parent-child bonding; and improving effective parenting, including successful management of children's behavior and

[29] Title IV-E Prevention Services Clearinghouse, Brief Strategic Family Therapy, Summary of Findings, 2022
[30] A Cross-Sectional Assessment of the Long Term Effects of Brief Strategic Family Therapy for Adolescent Substance Use, 2015
[31] The Effects of Brief Strategic Family Therapy (BSFT) on Parent Substance Use and the Association Between Parent and Adolescent Substance Use, 2015
[32] Brief Strategic Family Therapy Versus Treatment as Usual: Results of a Multisite Randomized Trial for Substance Using Adolescents, 2011

positive affect in the parent-child interactions. The goals of the program coupled with review of the research suggests that implementation of BSFT in Missouri can provide clinicians with an effective model to work with families in a manner to increase involvement and retention in services, decrease youth externalizing behaviors, and improve family functioning. Furthermore, BSFT has demonstrated effectivenesss with target populations similar to those that meet FFPSA eligibility within Missouri. In FY2021, observed characteristincs of families involved in substantiated incidents in Missouri indicated lack of parenting skills in 14.2% of incidents, and 64% of substantiated children during FY2021 were within the targeted age range for BSFT[33]. While this does not identify that all 64% of children within the targeted age range would benefit from this specific service, this does indicate an area of need for such age range in which there may be applicablilty of BSFT to improve child well-being and adult well-being.

Functional Family Therapy (FFT)

The Title IV-E Prevention Services Clearinghouse rated Functional Family Therapy as well-supported after findings from 9 studies that were eligible for review. These reviews indicated favorable effects in child well-being: behavioral and emotional functioning; child well-being: substance use; child well-being: delinquent behavior; and adult-well being: family functioning.[34] At least one study has shown that FFT significantly reduced adolescent alcohol and drug use, as well as improvement in family and adolescent functioning. Improvements were identified in areas of family functioning including verbal aggression, family cohesion, and conflict; psychological functioning including psychiatric diagnoses, externalizing problems, delinquent behaviors, and days living at home; and substance use, including number of substance use diagnoses, adolescent drinking index score, and number of problem consequences (Slesnick & Prestopnik, 2009).[35] Participation in FFT has been shown to address delinquent behavior and significantly reduce the likelihood of out of home placement for youth (Darnell & Schuler, 2015).[36]An additional study identified improved functioning in life domains for youth, including living situation, school behavior, achievement, attendance, and legal and vocational concerns, as well as a significant reduction in emotional and behavioral needs and in risk behavior among particpants (Celinska, Furrer, & Cheng, 2013).[37]

The California Evidence-Based Clearinghouse identifies the goals of FFT as eliminating youth referral problems including delinquency, oppositional behaivors, violence, and substance abuse; improving prosocial behaviors, and improving family and individual skills. The goals of the program coupled with review of the research identifies that implementation of FFT in Missouri will prove to target problematic youth behaviors by decreasing delinquent behavior, improve family functioning, and decrease the number of out of home placements of these youth. FFT has demonstrated effectiveness with target populations similar to those that meet FFPSA eligibility within Missouri. In FY2021, observed characteristincs of families involved in substantiated incidents in Missouri indicated lack of parenting skills in 14.2% of incidents, and 40% of

[33] Missouri Children's Division Child Abuse and Neglect Annual Report Fiscal Year 2021
[34] Title IV-E Prevention Services Clearinghouse, Functional Family Therapy, Summary of Findings, 2022
[35] Comparison of Family Therapy Outcome with Alcohol Abusing, Runaway Adolescents, 2009
[36] Quasi-Experimental Study of Functional Family Therapy Effectiveness for Juvenile Justice Aftercare in a Racially and Ethnically Diverse Community Sample, 2015
[37] An Outcome-based Evaluation of Functional Family Therapy for Youth with Behavioral Problems, 2013

substantiated children during FY2021 were within the targeted age range for FFT[38]. While this does not identify that all 40% of children within the targeted age range would benefit from this specific service, this does indicate an area of need for such age range in which there may be applicablilty of FFT to improve child well-being and adult well-being.

Multisystemic Therapy (MST)

The Title IV-E Prevention Services Clearinghouse rated Multisystemic Therapy as well-supported after findings from 16 studies that were eligible for review. These revies indicated favorable effects in child permanency: out-of-home placement; child well-being: behavioral and emotional functioning; child well-being: substance use; child well-being: delinquent behavior; adult well-being: positive parenting practices; adult well-being: parent/caregiver mental or emotional health; and adult well-being: family functioning.[39] MST was shown to be an intensive home and community based interevention for youths with serious behavior problems and be more effective than regular services in reducing out of home placement and behavioral problems (Ogden & Hagen, 2006).[40] Several studies show significant improvement in youth behavioral and emotional functioning. MST has been shown to be effective in decreasing externalizing behavior, oppositional defient disorder, conduct disorder, and property offenses and was shown to be effective for adolescents of different ages and with different ethnitcites (Asscher et al., 2013).[41] A study concluded that MST was effective at reducing youth internalizing and externalizing behaviors and out of home placements, as well as increasing youth social competence and family satisfaction with treatment (Ogden & Halliday-Boykins, 2004).[42] Additionally, MST has also been shown to be an effective in respect to youth who may have faced emergency hospitalization, with "findings supporting the view that an intensive, well-specified, and empiraclly supported treatment model, with judicious access to placement, can effectively serve as a family-and community-based alternative to the emergency hospitalization of children and adolescents." (Henggeler, et al., 1999).[43] MST was shown to be more effective than emergency hospitalization at decreasing youths' externalizing symptoms and improving their family functioning and school attendance, though hospitalization was more effective at improving youths' self esteem (Henggeler, et al., 1999). MST has been shown to have positive impact on parenting competence. MST was shown to enhance growth in parental sense of competence and positive discipline, no deterioration in relationship quality, and resulted in a decrease in adolescent externalizing problems (Deković et al., 2012).[44] Another study showed several secondary and intervention targets pertaining to family functioning and parent psychopathology to have positive effects of MST, with no negative effects identified (Weiss, et

[38] Missouri Children's Division Child Abuse and Neglect Annual Report Fiscal Year 2021
[39] Title IV-E Prevention Services Clearinghouse, Multisystemic Therapy, Summary of Findings, 2022
[40] Multisystemic Treatment of Serious Behaviour Problems in Youth: Sustainability of Effectiveness Two Years after Intake, 2006
[41] A Randomized Controlled Trial of the Effectiveness of Multisystemic Therapy in the Netherlands: Post-Treatment Changes and Moderator Effects, 2013
[42] Multisystemic Treatment of Antisocial Adolescents in Norway: Replication of Clinical Outcomes Outside of the US, 2004
[43] Home-Based Multisystemic Therapy As An Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes, 1999
[44] Within-intervention Change: Mediators of Intervention Effects During Multisystemic Therapy, 2012

al., 2013).[45]

The California Evidence-Based Clearinghouse identifies the goals of MST to include eliminate or significantly reduce the frequency and severity of problem behavior(s) for youth/adolescents; learn skills on how to better cope with family, peer, school, and neighborhood problems for youth/adolescents; learn skills to independenthly address the inevitable difficulties that arise in raising children and adolescents for parents/caregivers; and learn skills to help youth cope with family, peer, school, and neighborhood problems for parents/caregivers. The goals of the program in conjunction with review of the research show that MST will prove to target problematic youth behaviors by decreasing delinquent behavior, improving youth emotional and behavioral functioning, improve family functioning, improving positive parenting practices, and decrease the number of out of home placements of these youth. MST has demonstrated effectiveness with target populations similar to those that meet FFPSA eligibility within Missouri. In FY2021, observed characteristincs of families involved in substantiated incidents in Missouri indicated lack of parenting skills in 14.2% of incidents, and 35% of substantiated children during FY2021 were within the targeted age range for MST[46]. While this does not identify that all 35% of children within the targeted age range would benefit from this specific service, this does indicate an area of need for such age range in which there may be applicablilty of MST to improve child well-being and adult well-being.

Parent-Child Interaction Therapy (PCIT)

The Title IV-E Prevention Services Clearinghouse rated Functional Family Therapy as well-supported after findings from 21 studies that were eligible for review. These reviews indicated favorable effects in child well-being: behavioral and emotional functioning; adult well-being: positive parenting practices; and adult well-being: parent/caregiver mental or emotional health[47]. PCIT has been shown to greatly reduce behavior problems in children and great improvement in their parents' parenting skills (Bjørseth & Wichstrøm, 2016).[48] A study also found completion of PCIT effective in the prevention of child maltreatment in mothers who had a history or were at high risk of maltreating their children. There was observed improved parent-child interactions, reported better child behavior, reported decreased stress, decreased likelihood of notification to child welfare, greater reductions in child abuse potential, and improvement in parental sensitivity (Thomas & Zimmer-Gembeck, 2011).[49] Continued evidence of improvement in child behavior and improvement in parenting was identified in a study that showed increased positive parent and child interaction, increased parental success in gaining their child's compliance, decreased parenting stress, increased internal locus of control, and statistically and clinically significant improvements in child behavior (Schuhman et al., 1998)[50]. Furhter evidence was shown

[45] An Independent Randomized Clinical Trial of Multisystemic Therapy With Non-Court-Referred Adolescents With Serious Conduct Problems, 2013
[46] Missouri Children's Division Child Abuse and Neglect Annual Report Fiscal Year 2021
[47] Title IV-E Prevention Services Clearinghouse, Parent-Child Interaction Therapy, Summary of Findings, 2022
[48] Effectiveness of Parent-Child Interaction Therapy (PCIT) in the Treatment of Youth Children's Behavior Problems. A Randomized Controlled Study, 2016
[49] Accumulating Evidence For Parent-Child Interaction Therapy in the Prevention of Child Maltreatment, 2011
[50] Efficacy of Parent-Child Interaction Therapy: Interim Report of a Randomized Trial With Short-Term Maintenance, 1998

supporting improved child behavior and improved parental ability in a study that identified a decrease in attention problems, decrease in aggressive behaviors, decrease in externalizing and internalizing behavior problems, compliance with parental commands, as well as increase in parent and child interactions, decrease in parenting stress related to difficult child behavior and improved parenting practices (Bagner et al., 2010).[51]

The California Evidence-Based Clearinghouse identifies the goals of PCIT to include build close relationships between parents and their children using positive attention strategies; help children feel safe and calm by fostering warmth and security between parents and their children; increase children's organizational and play skills; decrease children's frustration and anger; educate parent about ways to teach child without frustration for parent and child; engance children's self-esteem; improve children's social skills; teach parents how to communication with young children who have limited attention spans; teach parent specific discipline techniques that help children to listen to instructions and follow directions; decrease problematic child behaviors by teaching parents to be consistent and predicable; and help parents develop confidence in managing their children's behaviors at home and in public. The goals of the program in conjunction with review of the research show that PCIT will prove to target problematic child behaviors by improving child emotional and behavioral functioning and imporoving positive parenting practices, and decrease the number of out of home placements of these youth. PCIT has demonstrated effectiveness with target populations similar to those that meet FFPSA eligibility within Missouri. In FY2021, observed characteristincs of families involved in substantiated incidents in Missouri indicated lack of parenting skills in 14.2% of incidents, and 31% of substantiated children during FY2021 were within the targeted age range for PCIT.[52] While this does not identify that all 31% of children within the targeted age range would benefit from this specific service, this does indicate an area of need for such age range in which there may be applicablilty of PCIT to improve child well-being and adult well-being.

CQI & Evaluation Strategy

Missouri will implement a continuous quality improvement (CQI) process including outcomes measured by both Missouri and providers to monitor activities provided under the Title IV-E Prevention Plan. This CQI process will ensure participants are provided quality services that continually promote the safety, well-being, & permanency of every child and family. The process will also determine the impact of those services on child- and family-level outcomes and functioning.

Missouri is currently utilizing a statewide CQI strategy to monitor fidelity to the model for each well-supported prevention program identified in Table 2 alongside a team of internal Children's Division experts to evaluate outcomes for Missouri's children as it relates to prevention. Children's Division has implemented operational excellence tools (including Lean Six Sigma methodology) into our CQI process to ensure our service delivery to Missouri's citizens is meeting expectations with meaningful impact. When assessing programs, the Children's Division is looking at the continuous improvement cycle to clarify program objectives; to help

[51] Parenting Intervention for Externalizing Behavior Problems in Children Born Premature: An Initial Examincation, 2010

[52] Missouri Children's Division Child Abuse and Neglect Annual Report Fiscal Year 2021

lead staff and stakeholders to focus on what matters most when deciphering next steps; and provide transparency for decision making. A focus on data metrics and Specific, Measurable, Achievable, Realistic, and Timely (SMART) goals has propelled Children's Division forward by asking how we, as and organization, are meeting the needs and goals of our agency with the assistance of FFPSA.

As a part of continuous monitoring, Children's Division will implement contracts with providers where the providers are required to follow the fidelity practices of the evidence-based practice interventions they have chosen. BSFT fidelity monitoring includes completion of the BSFT Therapist Adherence Form and the Clinical Supervision Checklist. FFT utilizes two measures for fidelity monitoring: Weekly Supervision Checklist and the Global Therapist Ratings. MST fidelity measures occur thourgh the MST Therapist Adherence Measure and the MST Supervisor Adherence Measure. PCIT fidelity monitoring occurs with a prescribed clinical tool called the Treatment Integrity Checklist. As services are provided, contracted providers must implement fidelity-monitoring procedures for each program as part of their service contract. Providers must submit a written report noting the model that was used for each child and family to Children's Division.

Through the use of visual data management dashboards, the State has utilized technology to help move progress forward quickly and in more sustainable ways. Tableau Dashboards and project management tools will continue to be developed and utilized to support the work of FFPSA and ensure the Children's Division is making good performance management decisions when assessing prevention program effectiveness.

Effective management and continuous improvement are driven by a basic cycle

Through Tableau and Lean Six Sigma principles, our three main goals will continue to be reassessed for quality, impact, and efficiency. Our three goals, as developed through our Statewide Advisory Team, are to:

1. Enhance community collaboration to strengthen family supports;

2. Increase statewide accessibility to prevention services; and
3. Safely reduce the number of children entering foster care.

As outlined in section 3 through the Implementation Approach, the continuous monitoring for fidelity will be implemented and expanded through phases. This will align with workforce expansion and service arrays offered in the State of Missouri. All data will be collected and stored in the State's data system known as FACES. Data will be collected through Children's Division staff and contracted providers monthly for all cases through administrative data. Data collection is expected to be completed accurately and timely to reflect impacts and status of the services provided to the family.

Utilizing the data dashboards and administrative data, outcomes will be monitored for the requirements for each program implemented. Use of the risk assessments currently completed on every family will also be tracked to look at decrease of risk factors, assessment of safety, and prevention of children entering into foster care. Ensuring program fidelity will be essential. Through the use of the existing survey process for families, federal case review process, and worker feedback loops, the FFPSA Implementation Team will be assessing on a monthly and quarterly basis for each circuit that has implemented these services. The implementation of the monitoring pieces will time with the phased-in approach of the pilots as outlined in section 3, and continuously expand based on the approved services in the FFPSA Prevention Plan. Lastly, the State of Missouri will report annually based on outcomes for every child through the program-specific services by looking at the data sets. Such outcomes include whether the child remained in the home, repeat of maltreatment, risk assessment score changes, percentages of families remaining intact six months post-intervention, and recidivism into the hotline system.

Specific to the case review process, when reviewing cases, a stratified sample will be utilized to account for geographical locations, demographics of the family, and access to services. The sample will be large enough to make statistical inferences and data will be used as the bedrock for determining next steps. Overall programs will be monitored to fidelity with specific caseload data and qualitative interviews to inform the quantitative data housed within our FACES system. Data collected during the case review process will also be shared with our providers during quarterly meetings to allow for continued collaboration. Furthermore, focus groups with individuals ranging from providers to researchers serving on our statewide teams for foster care case management will be consulted annually to see if any trends from foster care case management could inform our prevention work as it pertains to our currently selected programs. Utilizing the collection of data, and continuous improvement feedback loops will be vital to seeing improvement across the child welfare populations. While it is important to collect data, and report, it is vital to share the data with the local program administrators and frontline workforce to make improvements. Through the existing existing structure within the quality assurance unit, data will be shared and utlizied to develop local improvement plans for each measure.
Table 3 highlights our current evaluation plans for the four programs we have selected at the well-supported level from the Clearinghouse including specific outcomes for each program selected

Table 3. Prevention Services with Evaluation Plans for Performance

Program	California Evidence-Based Clearinghouse for Child Welfare (CEBC)	Title IV-E Prevention Services Clearinghouse Rating	Program Specific Evaluation Plan	Data for Continuous Monitoring and FidelityOutcome Improvement	
				Short Term Outcome Improvement	Long Term Outcome Improvement
Brief Strategic Family Therapy (BSFT)	2- Supported by Research Evidence	Well-Supported	BSFT is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors including conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. Program specific evaluation will assess the number and proportion of families referred to services who complete the program. Both qualitative and quantitative data will be collected to evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one year after the initiation of services.[53]	Youth behavior improves including decrease of substance use; Substance use concerns no longer pose a relevant safety concern; Parent skills improve with managing difficult behaviors	Children in the home do not experience a removal or repeat maltreatment.
Functional Family Therapy (FFT)	Title IV-E Prevention Services Clearinghouse, Brief Strategic Family Therapy, 20211- Well-Supported by Research Evidence	Well-Supported	Functional Family Therapy (FFT) is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Program-specific evaluation will assess the number and proportion of families referred to services who complete the program. Both qualitative and quantitative data will be collected to evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one	Youth's behavior improves; Parent skill improve.	Children in the home do not experience a removal or repeat maltreatment.

[53] Title IV-E Prevention Services Clearinghouse, Brief Strategic Family Therapy, 2022

			year after the initiation of services.[54]		
Multisystemic Therapy (MST)	1- Well-Supported by Research Evidence	Well-Supported	MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. Program-specific evaluation will assess the number and proportion of families referred to services who complete the program. Both qualitative and quantitative data will be collected to evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one year after the initiation of Services.[55]	Youth behavior improves; Parent skills improve; Parent and/or child substance use is no longer a releavant safety concern;	Children in the home do not experience a removal or repeat maltreatment.
Parent-Child Interaction Therapy (PCIT)	1- Well-Supported by Research Evidence	Well-Supported	PCIT is a dyadic behavioral intervention for children (ages 2 – 7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. Program specific evaluation will assess the number and proportion of families referred to services who complete the program. Both qualitative and quantitative data will be collected to	Youth behavior improves by improving child social skills; Parents skills at managing behavior improves;	Children in the home do not experience a removal or repeat maltreatment.

[54] Title IV-E Prevention Services Clearinghouse, Functional Family Therapy, 2022
[55] Title IV-E Prevention Services Clearinghouse, Multisystemic Therapy, 2022

			evaluate the effectiveness at meeting these program goals preventing removal of the at-risk child at six months and one year after the initiation of services. [56]		

Section 7: Child Welfare Workforce Training and Support

Ensuring a Trained and Supported Evidence-Based Provider Workforce

The Evidence-Based Provider workforce will consist of contracted agencies and staff. Provider contracts will outline requirements to ensure the workforce is acting in accordance with FFPSA requirements, including being trauma-informed, properly trained, abled, and certified to provide the models they administer. Documentation of compliance with contract requirements will be maintained by Children's Division through contract monitoring including on-site visits and document reviews. Compliance will be ensured through accountability, including personnel requirements, fiscal responsibility, training, programmatic compliance, and service delivery.

Children's Division identifies the importance of being trauma-informed and is continuously working towards various modalities to ensure agencies continue a trauma-informed approach. Children's Division would like to continue to explore opportunities for a trauma conference. Previously, an annual trauma conference was held for home visiting providers for two days of intensive trauma training. This conference began with Children's Division contracted providers and has grown over the last couple of years, leading to partnerships with other state agencies and community providers for increased participation and collaboration. As such, Children's Division has identified the opportunities and benefits to continue holding the conference with partners and stakeholders with a targeted focus on child welfare practice.

In November 2020, Children's Division mandated that all contracted Foster Care Case Management (FCCM) partners attend our pre-service training or use our approved statewide training curriculum to maintain consistency and expectations in case management regardless of service provider. Contracted FCCM partners have not been required to attend Child Abuse and Neglect training since they do not conduct child abuse and neglect investigations.

Training and Supporting the Child Welfare Agency Workforce

Effective implementation of FFPSA and intentional utilization of evidence-based services will

[56] Title IV-E Prevention Services Clearinghouse, Parent-Child Interaction Therapy, 2022

stem from a properly trained and supported workforce. Therefore, Children's Division will ensure cohesive training and support that prepares employees with an initial education and training, while also providing opportunities for continuing training and professional development. Ensuring that the full workforce has been trained and supported in the work, Missouri will do this by looking at the new workforce entering child welfare, the existing workforce, and frontline supervision

New Workforce

Children's Division provides employees with multi-layered, continuous learning opportunities. The beginning of a Children's Service Worker's professional development incorporates a formal classroom component with a Children's Division trainer balanced with on-the-job training provided by a supervisor or specialist. Child Welfare Practice Training (CWPT) initial/pre-service training consists of a 10-week competency based curriculum and computer system class followed by on-the-job training. On-the-job training is an opportunity for new employees to further develop and strengthen skills learned in classroom training, applying acquired knowledge to field experiences via observation of another worker or through hands-on work, as well as deepening of their understanding through conversation and reflection. These specific trainings within a Children's Division worker's respective program lines occur during CWPT, which is the Children's Division's onboarding process. Within 6-12 months of hire, opportunities for in-service training within a Children's Service Worker's respective program line occurs. In-service training opportunities include CA/N Investigations/Assessments, FCS/Intact Families, and Alternative Care. Ongoing training opportunities exist within structured, required courses as well as optional courses. Employees are able to access information for training opportunities and register for available courses through an electronic learning management system called the Employee Learning Center. Employees may also access additional electronic courses on LinkedIn.

Frontline staff pre-service Child Welfare Practice Training consists of the following schedule:

Week 1: Before new team members start classroom training, they are engaged in 40 hours of pre-classroom on-the-job training.

Week 2: This competency-based curriculum introduces new team members to the agency's role in various areas during 20 hours of classroom instruction. This includes response to incidents of CA/N, state and federal statutes and regulations, principles of family-centered strength-based practice, competency around bias and ethics, the components of assessing safety and risk using assessment tools, and how to develop intervention strategies to address safety and risk. Additionally, new team members complete a post learning on-the-job training program the week following classroom activities to support the classroom learning.

Weeks 3 and 4: The third and fourth weeks of classroom training consist of 33 hours of instruction. This material introduces new team members to our agency's practice model. Staff receive training on a well-being framework that helps them see whole families with assets and challenges, not just allegations. Staff also receive training on trauma-informed practice and how a person's experiences with trauma can impact their access to well- being. Staff learn strategies to partner with individuals and families in a trauma-informed way that allows us to address

safety concerns and risk factors. New team members are also introduced to the components of Signs of Safety and how these components allow us to engage with families to assess safety. An explanation around how to develop a Family Risk Assessment map so the family can clearly understand our concerns for safety and the behavior we need to see to be confident that the children can be safe in their home in the long-term.

Week 5: New team members are scheduled for an additional 40 hours of on-the-job training after completing the practice model training and before they begin child abuse and neglect training.

Week 6: This competency-based curriculum provides identification of CA/N, the types of referrals and reports that can be made, the screening process, how to conduct an investigation and assessment. Staff learn the functions, roles, and responsibilities of Children's Division staff in their response to hotlines. This specifically includes how to assess for safety and how to develop safety interventions, from the least restrictive to most restrictive options. Staff learn the concepts of family-centered, strength-based, solution-focused service delivery to intact families and have the opportunity to demonstrate the learned skills through the available assessment tools. Staff are also introduced to the concept of team decision-making during this week of training. This week of training consists of 29 hours of classroom training.

Week 7: New team members are given 40 hours of structured post-classroom on-the-job training that supports the learning that occurred inside the classroom.

Week 8: This competency-based curriculum provides 20 hours of classroom instruction on Family Centered/Prevention case management. New team members are introduced to Family Systems Theory, the stages of change, assessment tools, risk assessment, and strategies to lower risk. The training looks at the generalist intervention model and roles, functions, and responsibilities of Children's Division for each stage of the model.

Week 9: This competency-based curriculum provides 20 classroom hours focused on the knowledge of the impact of out-of-home placement of children and families. Staff explore the family-centered out-of-care process, which includes: Adoption and Safe Families Act; reasonable efforts; permanency goals; developing and utilizing permanency planning; and an understanding of expedited permanency time frames. Staff discuss pre- placement planning, selecting an appropriate home for a child, preparing parties for placement, and managing the impact of placement for all parties through a trauma-informed approach. Specific attention is placed on facilitating family support team meetings, court testimony, and documentation. The session concludes with assessing child safety and risk at the time of case closure.

Computer systems: New team members receive multiple trainings on computer systems, totaling 12 hours of classroom instruction. These classes offer hands-on individual experience in entering, updating, and inquiry of Children's Division software and programs.

Week 10: New team members receive one last structured on-the-job training after the completion of alternative care.

Children's Division, like child welfare practice itself, is ever-evolving and striving to ensure our workforce is supported and provided with effective tools to be successful. We, as a Division, are

constantly moving forward to improve practice and outcomes for children and families. To this end, we are currently redesigning our Child Welfare Practice Training. While still adhering to the same goals and objectives, we are implementing a more targeted approach. The training will utilize new technology and streamline content to ensure we are preparing our staff for their positions, the work they will be doing, and strengthening their skills to be successful.

Although the curriculum is in development and set to be implemented by the beginning of 2023, the format and structure will consist of the following:

Weeks 1 and 2: An introductory module presented through eLearnings and virtual sessions to include: government structure; Children's Division purpose; mission; ethics; professionalism; Children's Division structure and the role of each position; and an introduction to our practice model. This module will also provide an introduction to Child Abuse and Neglect to include legal definitions, mandated reporting, types of abuse, safety vs risk, decision making, and tools to assist workers in their day-to-day work.

Weeks 3 and 4: Our CA/N module will be presented through eLearnings, virtual, and in-person sessions to include simulation technology targeted to investigations and interviews. The content will include training on: safety assessments; legal aspects; safety plans/temporary alternative placement agreements; human trafficking; physical and sexual abuse investigations; neglect investigations; educational neglect investigations; conclusions writing; domestic violence; interviewing alleged perpetrators; interviewing children; and evidence collection.

Week 5: Our Family Centered Services module will consist of eLearnings, virtual, and in-person sessions to include: introduction to prevention casework; Family First Prevention Services Act information; assessing needs; developing service plans with families; identifying resources; verification of services; and continuing assessment.

Weeks 6 and 7: The Alternative Care module will consist of eLearnings, virtual, and in-person sessions broken out into five main sections. The first section, "The First 30 Days," will train on parent engagement; absent-parent search; relative searches; initial family assessment; understanding safety issues; creating a plan for the child and family; team engagement; health and well-being needs of the child; ICWA; ICPC; and required hearings/meetings. Section 2 will discuss maintenance of a case to include engagement with service providers, child and parent needs, stabilizing placements, and articulation of harm. Section 3 will identify permanency planning to establish goals, explain reasonable efforts, types of permanency, etc. Section 4 will train policy and law around licensing of resource providers. Section 5 will provide information pertaining to targeted case management of older youth.

Week 8: The following trainings will provided through eLearnings and virtual format and will rely heavily on the participant's program area, if applicable: trauma informed care; mental health impacts, services, and supports; substance abuse impacts, services, and supports; domestic violence impacts, services, and supports; educational services; licensing 2.0 – support for resource parents, services, and stabilization; subsidy – support for guardians, adoptive families, and stabilization; and accessing DMH/DD services.

Children's Division will embed content into Child Welfare Practice Training pertaining to the development of the prevention plan to ensure staff are supported and properly trained. Employees will be trained on identifying candidacy, developing prevention plans, conducting risk and safety assessments, engagement of families, linking families to appropriate evidence-based services, and oversight and evaluation of the appropriateness of the services. These topics will be embedded into the appropriate corresponding week of Child Welfare Practice Training. In addition to training incoming employees, the above-listed components will also be embedded into further skill-building training for supervisors on the Electronic Learning Center (ELC). Online modules will be developed and available to all staff for educational purposes as well as a resource to review if needed for refresher training opportunities. Children's Division has an existing memorandum informational sharing process in place for changes to policy and/or procedures in which a memorandum draft is sent out to supervisory and managerial staff for a review call to address questions or comments before finalization. Upon final approval, the memorandum is then sent to all staff via email and is made available on the DSS intranet. This same process would be applicable to any policy or practice change regarding the prevention plan. In addition, a frontline training for supervisors will be implemented to support them in their vital role. Supporting education will also be provided to supervisor to further the goals of FPPSA.

Exisiting Workforce and Continuing Education for Staff

Inititally, upon implmenetation Missouri will create three trainings designed to give general education and targeted education for specific teams in Missouri. A generalized one to two hour overview of FFPSA will be added to the online learning center for all staff. Following completion, and in line with the phased in approach outlined earlier, front end staff (hotline staff) and service delivery staff will complete an online, short targeted training on assessment and referral process. Service delivery staff including the Family Centered Service staff will complete a half day training targeting continued assessment, utilizing resources, and working with the providers to deliver approved EBPs.

After intitial implementation, the above trainings will become a required portion of transfer or promotion into those positions. In addition, in-service training opportunities are designed to aid staff in learning beyond the initial pre- service training. While there are several opportunities and trainings offered at the Division as well as Department level, there are "core" in-service trainings required and/or conducted that have become embedded in process and practice.

Currently all staff attend Trauma Toolkit training between six and twelve months of employment. This training is designed to deepen a worker's knowledge of trauma-informed practice beyond the introduction in pre-service. All staff are also required to attend Legal Aspects between six and twelve months of employment. Workers attend trainings geared at case managers and supervisors attend trainings geared at their sphere of influence.

Through our continuous case readings, we are identifying gaps in practice and are creating learning circles to address those gaps. Learning circles are a guided discussion attended by all staff and are facilitated by local staff who feel comfortable and knowledgeable about the identified topic. Central Office staff support these learning circles by developing training material for the local field staff to use through PowerPoint presentations. Attendance in the learning circles is tracked in the Employee Learning Center. While we do not consider these to

be formal trainings, we do believe they are learning opportunities that grow and strengthen our practice.

Workgroups by program area (AC, FCS, and CA/N) also occur on a monthly basis. The workgroups are comprised of all levels from the frontline staff to central office staff collectively speaking into program direction. Workgroups occur for participants to discuss what is going well within the region and local circuits, program areas to improve, and an opportunity to problem solve and discuss potential policy enhancements. Since the inception of these workgroups in 2020, there has been increased statewide collaboration. This collaboration has assisted in seeing how all programs align and support one another.

Training for Supervisors

Children's Division has an experiential curriculum for supervisors which builds their confidence and skills to guide others. The curriculum utilizes Educational, Administrative, Supportive, and Clinical Supervision in a way that embodies our practice model (to include Well-being Orientation, a Trauma Informed Approach, and Framework for Safety) focusing on safety and well-being.

This curriculum is intended to support Supervisors in developing the following core competencies:

- Understand each of their roles and responsibilities as supervisors.
- Have increased ability to build and effectively supervise a team of skilled child welfare practitioners, resulting in increased child safety, permanency and well-being.
- Demonstrate the ability to plan for and conduct supervisory consults in all areas of supervision (administrative, educational, supportive and clinical).
- Create a culture of coaching in which they are responsive to their team's needs, provide meaningful feedback and help supervisees grow their own professional practice.
- Demonstrate the parallel process between a supervisor's relationship with their team and their team member's relationships with families in the areas of:
    - Professionalism
    - Communication
    - Critical thinking
    - Problem solving
    - Coaching
    - Trauma Informed Practice
    - Child/family safety, permanency, and wellbeing outcomes

Module 1: Introduction and the Missouri Practice Model: This will include instruction on how to incorporate each aspect of the practice model, in a parallel process to the supervisory role.

Module 2: Educational Supervision: This will include: professionalism; OJT and their role in it; critical thinking to include Framework for Safety; Adult Learning Theory; ethical decision-

making as it relates to professionalism to include self-assessment and self-awareness; role of values; supervisor techniques relevant to ethical decision-making; critical thinking; and the use of ethical decision-making models for resolution of dilemmas, wrapping up in an educational supervisor consult with self-assessment feedback and coaching.

*Module 3: Administrative Supervision***:** This module will dive into Performance Management. Discussion will include how to use data to assess performance and have coaching conversations to increase worker performance. The module will also include an administrative supervisor consult with self-assessment, feedback and coaching.

Module 4: Supportive Supervision: This will include strategies on how to create a high-performing team through Heart of Coaching[57], assessing and navigating secondary trauma in supervision, along with an overview of management and learning styles. This module will also include a supportive supervisor consult with self-assessment, feedback and coaching.

Module 5: Clinical Supervision: This module will include cultural competence, but the module on Clinical supervision will be about increasing worker skill in specific decision-making points on a case. This includes all of the skills learned so far in the training with a focus on critical thinking, ethical decision making, and data informed decisions, and trauma-informed practice.

Evaluation

After each session of the classroom and at the end of OJT, the new employees are asked to complete an evaluation. The evaluation asks the worker if they learned skills and knowledge necessary to carry out their job duties. This information is utilized to assess if curriculum changes are needed. Workers are asked to identify ways that they can utilize the skills and knowledge from the class in their jobs.

During the first week of initial training for workers, in the OJT section, there is a self-evaluation that asks the worker to evaluate their ability to do the job and how adept they consider themselves for each of the competencies that the training is designed around. The competencies are as follows: interpersonal relationships; adaptability; communication; teamwork; sense of mission, vision and values; personal leadership/motivation; technical productivity; analytical thinking; planning and organization; and organizational skills. They are able to discuss this with their OJT designee. At the end of the training, this same evaluation is filled out again by the worker and the supervisor. The supervisor and worker are able to discuss the evaluation and identify areas that need further work. Goals are set around these areas to help the employee develop their skills regarding their job duties.

As our practice and programs continue to evolve, we are planning to incorporate a focused case review with each new case worker within six months of them completing CWPT. This evaluation piece will offer insight into possible gaps in our training areas, assess if the objectives and competencies were met, and act in tandem with our Division's quality improvement efforts. While this piece is still in planning stages, we anticipate being able to coordinate it by the

[57] Crane, Heart of Coaching, 2012

beginning of 2023.

Section 8: Prevention Caseloads

Children's Division is accredited through the Council on Accreditation (COA).[58] As such, standardized caseload sizes are intended to provide effective case management. The COA standard caseload for FCS is a 1:15 staff-to-families ratio. Children's Division intends for designated FCS prevention workers who carry Family First Prevention Services cases to maintain the same standard caseload ratio of 1:15 families.

In instances of pregnant and parenting youth receiving prevention services, case management will be provided by the assigned alternative care (foster care) worker to ensure continuity. The staff-to-children (and their families) ratio for alternative care workers is 1:15.[59]

It is our belief that prevention services are not just providing and overseeing resources and assistance, but also being able to have the capacity and maintain the quality of those services. To this end, it is a priority to give our team members the ability to develop, maintain, and sustain quality, intensive prevention caseloads. As such, during a piloted, phased-in roll-out, oversight of caseload size will occur with direct supervision under Central Office oversight. This will ensure case workers are providing case management services to no more than 15 families at a given time.

Currently, Children's Service Supervisors oversee the staff caseload sizes through completion of a caseload analysis tool every quarter which is readily accessible as part of a centralized management approach. This tool is intended to ensure caseload sizes are within COA standards and equitably assigned amongst staff. Monthly supervisor consultations occur between the Children's Service Supervisor and Children's Service Worker for each family assigned to their caseload. In addition, a monthly consultation will be implemented between the Children's Service Supervisor and Family First Program Manager to provide ongoing discussion and identify additional supports and/or resources needed. These consultations are designed to discuss safety and risk factors of the family; case progress; any concerns or barriers with case planning; case closure and long-term safety planning; and to ensure the workload is manageable.

While the current caseload analysis is a manual tool, Children's Division is exploring a CCWIS replacement system to update the functionality and capabilities of our current case management system. A significant strength of a new system would be the ability to automatically pull and track a case worker's caseload size at any point in time to ensure fidelity to the standardized caseload sizes. Children's Division is committed to utilizing every tool available and equipping our staff with the means to successfully carry out our mission.

Section 9: Assurance on Prevention Program Reporting

Please see Appendix a – Attachment I for assurance that Missouri Children's Division will report to the Secretary such information and data as the Secretary may require with respect to the Title

[58] Council of Accreditation, Public Agency-Personnel Development and Supervision, 2020
[59] Council of Accreditation, Public Agency-Personnel Development and Supervision, 2020

IV-E prevention and family services and program, including information and data necessary to determine the performance measures.

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Appendices & Attachmnents

Appendix A: Attachment I - State Title IV-E Prevention Program Reporting Assurance
Appendix B: Attachment II – State Request for Waiver of Evaluation Requirement for a Well-Supported Practice - Brief Strategic Family Therapy

Appendix C: Attachment II - State Request for Waiver of Evaluation Requirement for a Well-Supported Practice – Functional Family Therapy

Appendix D: Attachment II - State Request for Waiver of Evaluation Requirement for a Well-Supported Practice - Parent-Child Interaction Therapy

Appendix E: Attachment II - State Request for Waiver of Evaluation Requirement for a Well-Supported Practice- Multisystemic Therapy

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

Appendix G: Attachment IV - State Annual Maintenance of Effort Report