

**NEBRASKA**

Good Life. Great Mission.



# **Nebraska's Five-Year Title IV-E Prevention Program Plan 2019**



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## ACRONYMS & TERMS

BH	Division of Behavioral Health
Case Manager	CFS Child & Family Services Specialist (CFSS)
CEBC	California Evidence-Based Clearinghouse <sup>1</sup>
CFS or Division	Division of Children & Family Services
CFSP	Child & Family Services Plan <sup>2</sup>
CQI	Continuous Quality Improvement
Department	Nebraska Department of Health & Human Services
EBP	Evidence-Based Practice
FCT	Family Centered Treatment
Family First or FFPSA	Family First Prevention Services Act
Federal Clearinghouse	Title IV-E Prevention Services Clearinghouse <sup>3</sup>
FFT	Functional Family Therapy
HFA	Healthy Families America
MIECHV	Maternal, Infant & Early Childhood Home Visiting <sup>4</sup>
MST	Multisystemic Therapy
PCIT	Parent & Child Interaction Therapy
PH	Division of Public Health
Plan	Nebraska's Five-Year Title IV-E Prevention Program Plan
PPI	Provider Performance Improvement
RFP	Request for Proposal
RFQ	Request for Qualifications
SDM	Structured Decision Making
SOP	Safety Organized Practice
SACWIS	State Automated Child Welfare Information System
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

<sup>1</sup> <https://www.cebc4cw.org/>

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

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

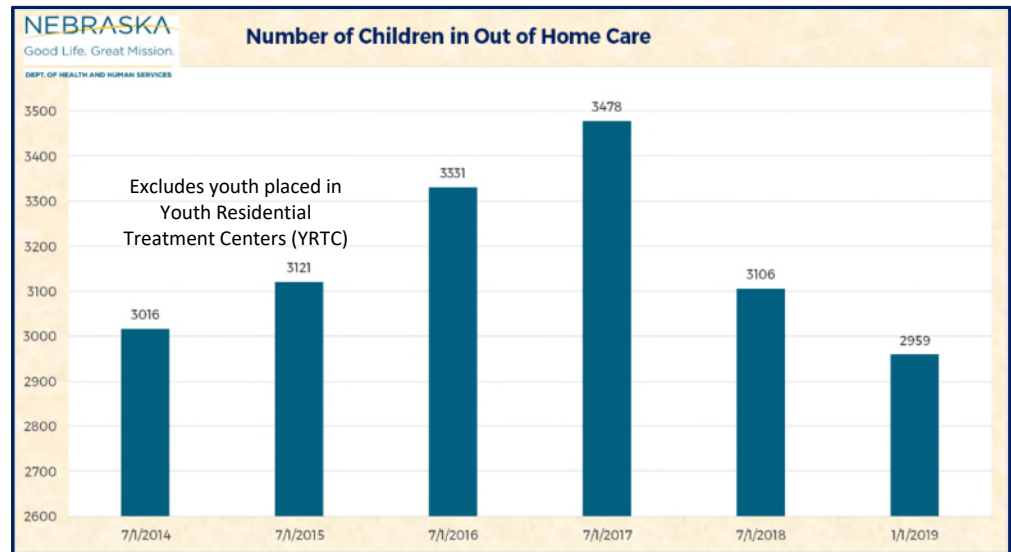
<sup>4</sup> <https://www.acf.hhs.gov/ecd/home-visiting>

## FORWARD

The Nebraska Department of Health and Human Service's (DHHS) mission is to "Help people live better lives."

To help people live better lives, the DHHS Division of Children and Family Services (CFS) will employ the Family First Prevention Services Act (FFPSA) to grow and improve prevention services for families, providing more comprehensive, evidence-based services to children in their own homes, with their family, with reduced levels of secondary trauma.

Over the past several years, CFS has committed to a cultural shift that focuses on serving families through *prevention* rather than *intervention*. From 2017-2019, CFS safely reduced the number of children in out-of-home care by 15%. Further, for children in out-of-



home care since 2014, CFS has increased use of relative/kinship resource homes by 12% and decreased congregate care placements by almost 3%. Implementation of FFPSA will help further the Nebraska's efforts to serve more families in the home with improved preventative, evidenced-based programs.

Implementation of FFPSA aligns with Nebraska's *Performance Improvement Plan (PIP) Goal #5*, which is to enhance current service array to ensure appropriate and individualized services are accessible. As noted in the Nebraska PIP, *Item 29: Array of Services*, families in rural and frontier areas of the state face a lack of social service resources. Access to substance abuse and specialized mental health services are notable challenges. Nebraska expects implementing this Plan will not only improve in-home service quality and array of available services, but will reduce the demand for foster care services that are often not readily available, particularly in the rural Nebraska.

The Division is working to ensure that execution of Family First supports and encourages innovation. FFPSA is a monumental opportunity through which federal funding will help support existing and new prevention efforts and drive improved outcomes for the families CFS

serves. This new opportunity requires a commitment by Nebraska's child welfare system to embrace an improved way of working with families.

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## SERVICE DESCRIPTION AND OVERSIGHT

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### Nebraska's Landscape

Program and population data from CFS shows:

- Approximately 22,845 children are involved in an investigation; 11,246 children receive services and 2,454 children enter foster care (based upon 2016 data, as identified in the Performance Improvement Plan).
- The majority of children enter foster care due to neglect.
- From 2015-2017, of all accepted intakes for abuse/neglect, 37% included a child age 0-5 years.
- From 2015-2017, 45% of children removed from the home were ages 0-5 years.
  - In 2017, of the total children ages 0-5 who entered out-of-home care, 47% were age 1 or younger.
- Approximately 46% of children who enter out-of-home care ages 0-5 have at least one parent who was previously in the state's custody.
- In July 2018, 40% of all the children involved in an ongoing services case had a parent who was also involved with CFS as a child.
- Parental substance abuse is a contributing factor for approximately 50% or more of children who enter out-of-home care.
- As of January 2019, approximately 60% of all children served are in out-of-home care and 40% are in-home.

Re-entry into foster care after adoption or guardianship dissolution was recently studied by the Nebraska Foster Care Review Office.<sup>5</sup> This study included analysis of point-in-time data from December 31, 2018. On this date, of the 4,200 children in out-of-home care, 226 were previously state wards who had exited state care to "permanent" homes through either adoption or guardianship. Analysis of this sample showed:

- 4.3% of the child welfare population were previously placed in permanent homes, and many of these homes are no longer a permanent option.

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<sup>5</sup> The Nebraska Foster Care Review Office Quarterly Report; March 1, 2019; [www.fcro.nebraska.gov](http://www.fcro.nebraska.gov)

- For dually-involved youth in care, 14.5% were previously adopted or placed in a guardianship, which is substantially higher than the proportion of kids solely involved with child welfare or juvenile justice. Dually-involved youth have both an active child welfare and juvenile justice case.
- Nearly all children who re-entered care did so during the early teenage years.

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

## Definition of Candidacy

Developing a clear scope for Nebraska’s children and families in need of Family First prevention services is a critical task for CFS, its partners and stakeholders. Nebraska’s approach to candidacy – meaning who is eligible for Family First services – is to define the families currently served by CFS who meet the requirements of FFPSA.

### Nebraska’s Definition of Candidacy:

*Children and youth at imminent risk of entering foster care, as defined by Nebraska Revised Statute 71-1901, but who can remain safely in the child’s home or kinship/relative home as long as Title IV-E prevention services necessary to prevent entry into the foster care system are provided. This includes but is not limited to those children and youth who are:*

1. *residing in a family home accepted for assessment, or with an ongoing services case including non-court and court involved families where the child may be a state ward;*
2. *reunified with their following an out-of-home placement;*
3. *the subject of a case filed in juvenile court and is mentally ill and dangerous, as defined by Nebraska Revised Statute 43-247 (3);*
4. *pre- or post-natal infants and/or children of an eligible pregnant/parenting foster youth in foster care;*
5. *at risk of an adoption or guardianship disruption or dissolution that would result in a foster care placement;*
6. *presenting with extraordinary needs and whose parents/caretakers are unable to secure assistance for them;*
7. *involved with juvenile probation and living in the parental/caretaker home.*

Nebraska’s candidacy definition allows a child to transition between traditional IV-E eligibility and FFPSA IV-E eligibility.

## Assessing Children and their Parents for Eligibility

CFS uses Structured Decision Making (SDM), a comprehensive case management system for child welfare, to guide decision making. SDM is rated as a promising practice per the California Evidence-Based Clearinghouse for Child Welfare (CEBC). SDM assessments are used to guide decision making, including identification of families at high risk of maltreatment, and ensures interventions meet the needs and strengths of families. Families involved in accepted intakes of abuse or neglect receive this initial assessment. A family whose case does not close after the initial assessment receives an ongoing services case. Nebraska will offer FFPSA prevention services to families involved with CFS prior to October 1, 2019, as well as new families, who meet the definition of candidacy and are in need of such services (**Attachment A**).<sup>6</sup>

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

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

## Program Selection

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

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<sup>6</sup> Please see *Attachment A: Standard Work Instruction for Foster Care Prevention Plan*, for regarding the policies and procedures for CFS staff regarding the FFPSA prevention program including determining candidacy and eligibility for FFPSA prevention programs and services.



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

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

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

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

CFS is submitting this initial Plan with the inclusion of six programs that are 1) rated on the federal clearinghouse, 2) currently available in Nebraska, and 3) included in contracts awarded based on the RFQ. CFS is including Family Centered Treatment (FCT), an existing CFS contracted program. Transitional payments for FCT are also requested, as it has not yet been rated by the IV-E Clearinghouse. Given the costs associated with implementing or expanding EBPs, CFS has secured additional funding to assist these efforts. Nebraska intends to submit an amended Plan in the near future requesting transitional payments for additional programs once the requirements outlined in ACYF-CB-19-06 have been received.

Of the ten prevention programs rated by the federal clearinghouse (kinship programs excluded), Nebraska discovered that six of the ten programs are available in the State. Of those

six programs, five are included in this Plan. Of those five programs listed in this Plan, two are Medicaid funded and have specific codes for which they are billed. An additional two programs are Medicaid eligible, meaning Nebraska Medicaid does not have specific billing codes for these EBPs. This is likely due to providers using the EBP and billing with other codes, since providers do not bill by specific EBP. This leaves one program, Healthy Families America (HFA), which is neither Medicaid funded nor eligible. Approximately 80% of all children CFS works with in an ongoing services case have Medicaid insurance.

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

**Nebraska Title IV-E Prevention Services**

	<b>Evidence Based Program</b>	<b>Target Population in Years</b>	<b>Average Length of Service<sup>7</sup></b>	<b>Outcomes (CEBC)<sup>8</sup></b>	<b>Title IV-E Clearinghouse Rating</b>	<b>CEBC Rating</b>	<b>Requesting Transitional Payments<sup>9</sup></b>
<b>In-Home Parenting</b>	1. Healthy Families America	Parents of children 0-5 (must be under 2 at time of referral)	Until child is 3, can be offered until age 5	Increased nurturing parent-child relationships, healthy child development, enhanced family functioning, increased protective factors, reduced risk	Well-supported	Well-supported	n/a
<b>Mental Health</b>	2. Family Centered Treatment	Children 0-17 and their caregivers	6 months	Family stability, increased family functioning in the critical areas contributing to increased risk of family dissolution, increased effective coping, reduced harmful or hurtful behaviors, build upon strengths to sustain changes made	Not yet rated	Promising	yes
	3. Functional Family Therapy	Children 11-18	3 months	Eliminated youth referral problems (e.g., delinquency, oppositional behaviors, violence, substance use), improved prosocial behaviors (e.g., school attendance), improved family and individual skills	Well-supported	Supported	n/a
	4. Multisystemic Therapy	Children 12-17 and their caregivers	3-5 months	Youth: Reduced behavior problems Caregiver: increased ability to address parenting difficulties and empower youth	Well-supported	Well-supported	n/a
	5. Parent and Child Interaction Therapy	Children 2-7 and their caregivers	4-5 months	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem Parent: Increased ability to comfort child, improved behavior management and communication with child	Well-supported	Well-supported	n/a
	6. Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	3-5 months	Improved PTSD, depression, anxiety symptoms; reduced behavior problems; improved adaptive functioning improved parent skills; reduced parent distress	Promising	Well-supported	n/a

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

<sup>8</sup> Outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/>

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

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## In-Home Parenting Skills Programs

### Program 1: *Healthy Families America*

Implementation of Health Families America (HFA), specifically the Child Welfare Adaptation, is a part of the proposed Department's 2019-2020 Business Plan:

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

“One such evidence-based home visiting program in Nebraska is the Healthy Families America model. The HFA model, since its inception, has been focused on the prevention of child abuse and neglect through a voluntary, strengths-based approach. The program best serves families who are high-risk and overburdened, including those who are involved in the child welfare system. HFA is designed to engage families as early as possible, during pregnancy or at the birth of a baby. For child welfare agencies, a challenge arises when families with older infants and toddlers are identified and are unavailable due to the age of a child. To address this existing gap in service, HFA created the Child Welfare Adaptation.”

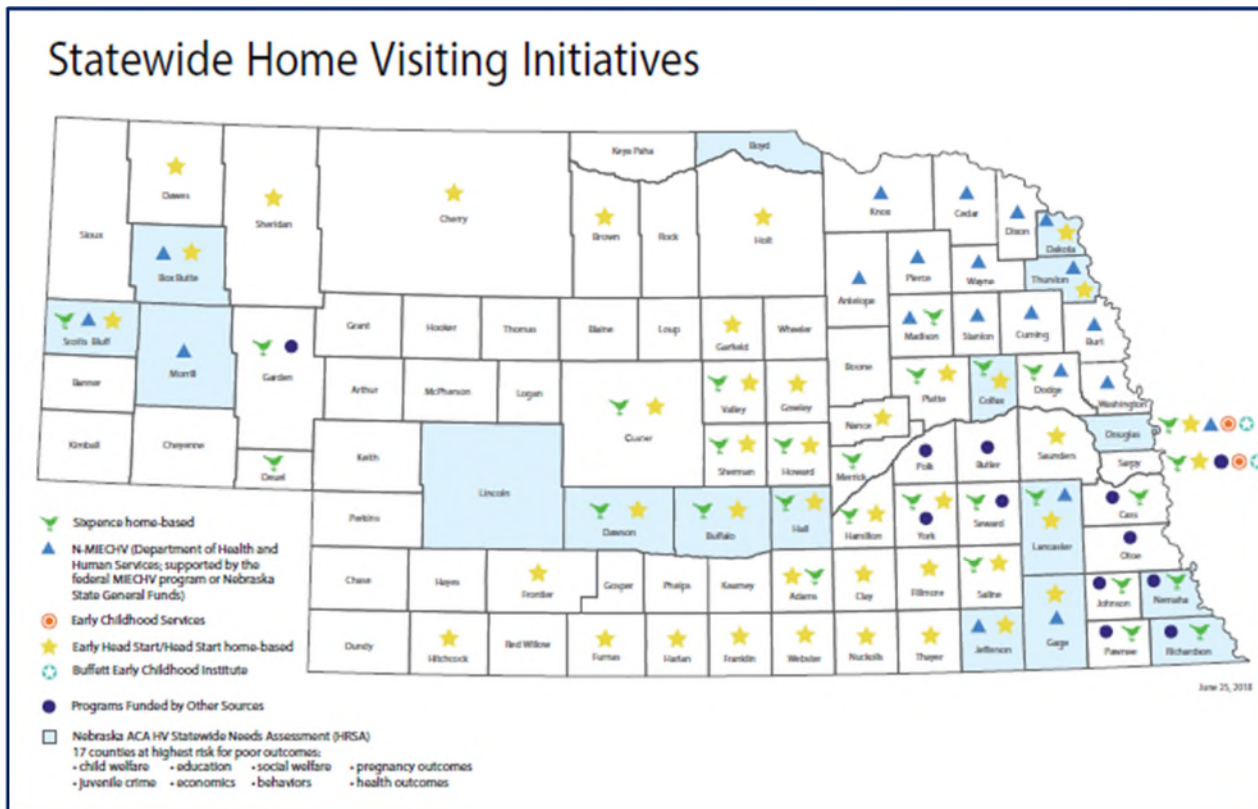
Through the adaptation approach, HFA is available to eligible families with children up to 24 months of age. See **Attachment C** for a description of the HFA Child Welfare Adaptation. Per the federal clearinghouse, HFA was reviewed and rated well-supported with the extended enrollment to age 24 months.

HFA is well aligned with FFPSA and well suited for the State's needs. In Nebraska, 60% of children who enter foster care do so through neglect. Furthermore, almost half of all children who enter foster care are ages 0-5, the majority of which are age 1 or younger.

The DHHS Division of Public Health (PH) receives federal Maternal, Infant & Early Childhood Home Visiting Program (MIECHV)<sup>10</sup> funds to implement the HFA home-visiting model. Through this funding, HFA is currently offered in 21 Nebraska counties. See *Statewide Home Visiting Initiatives* map below. CFS is working with PH to determine how to leverage existing funds and expand services using FFPSA dollars.

<sup>10</sup> Health Resources & Services Administration, Maternal & Child Health, Home Visiting; <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>

In collaboration, CFS and PH are working with one urban and one rural site to begin the Child Welfare Adaptation. The sites were selected based on strong relationships between the local CFS office and the HFA site, as well as service capacity and number of potential referrals. Nebraska expects additional sites will continue to reply to the RFQ and expand the reach of HFA. A site requesting to use the HFA Child Welfare Adaptation has to submit a detailed implementation plan to HFA National for approval.



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

### Program 2: *Family Centered Treatment*

Family Centered Treatment (FCT) is a model of intensive in-home treatment services for youth and families, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children’s well-being through family value changes. The target population for FCT is 1) youth who have been placed out-of-home, have a mental health or serious emotional disturbance diagnosis, and have a permanency plan of reunification; or 2) families with a youth who is at risk of an out-of-home placement due to the youth’s medical necessity for a higher level of care. FCT is rated promising and high for child welfare relevance on the CEBC.

FCT was submitted to the federal clearinghouse for review (**Attachment D**) but has not yet been rated. **Attachment E** includes an executive summary of the research conducted on FCT from 2004-2019. **Attachment F**, *Checklist for Program or Service Designation for HHS Consideration*, as required by ACYF-CB-PI-9-06 for transitional payments, is being reviewed by an independent evaluator. Upon receipt, Attachment F will be sent in to be included in this Plan.

FCT has had successful outcomes in several states and jurisdictions working with families who have had multi-generational system involvement. Instead of addressing the symptoms of a behavior and obtaining compliance with a family plan, FCT treats the systemic trauma a family may have experienced and the underlying cause. This aligns with the CFS goal of being trauma-informed. FCT was recently designated as a Trauma Treatment Practice by the National Child Trauma Stress Network.

CFS worked with the Behavioral Health Region and the Lincoln County Community Collaborative to pilot FCT in the North Platte-Lexington area and surrounding communities. The implementation process for FCT began in spring of 2017 and the first six families began the service in January 2019. To enhance sustainability, CFS worked with system partners in Medicaid and the Behavioral Health Region to create a blended funding model. The treatment services are billed to Medicaid or private insurance and the non-treatment services are paid by one of three organizations. CFS pays for families we are working with and the Behavioral Health Region pays the non-treatment costs for families that are not involved with CFS but do meet income eligibility. The Lincoln County Collaborative also agreed to build funding into their budget to pay for at least one family who may not have insurance coverage, meet behavioral health income criteria, or be involved with child welfare. This allows families to access the service regardless of involvement. CFS is working with another part of the state to increase the number of families served with FCT in the pilot phase. This area was chosen due to lack of available in-home services and a high percentage of youth in out-of-home care.

CFS receives monthly fidelity data reports and meets weekly to discuss referrals with the provider awarded the contract to pilot FCT. FCT will positively impact families through the thorough assessment process and strong family engagement, and by addressing the underlying trauma that has historically led the family to unsafe behaviors.

### **Program 3: Functional Family Therapy**

Per the CEBC, Functional Family Therapy (FFT) is a family intervention program for dysfunctional youth with disruptive, externalizing problems. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out and substance abuse. FFT targets youth aged 11-18. FFT has been rated well-supported by the IV-E Clearinghouse.

**Program 4: *Multisystemic Therapy***

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

**Program 5: *Parent and Child Interaction Therapy***

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

**Program 6: *Trauma-Focused Cognitive Behavioral Therapy***

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

**Improved Outcomes for Children & Families**

Each evidence-based program selected for this plan has intended outcomes (chart on page 11 of this Plan). CFS believes that Family First, along with other current CFS initiatives, will improve outcomes for Nebraska children and families.

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

SOP aligns well with the Division's efforts towards emphasizing a family's voice and choice while involved with the child welfare system. CFS aims to improve its engagement with families served by ensuring their opinion is valued and they are empowered to make decisions for their family. CFS believes that implementing Family First, along with SOP and family voice and choice, will lead to better family engagement, improved workforce retention and better outcomes for families.



## Eastern Service Area Ongoing Case Management Contractor

The Division is transitioning ongoing case management services from PromiseShip to Saint Francis Ministries in Douglas and Sarpy counties, comprising the CFS Eastern Service Area. As part of their contract, Saint Francis will deliver evidence-based models in compliance with FFPSA with at least 50% of all prevention service expenditures on well-supported programs. CFS continues to work closely with both PromiseShip and Saint Francis Ministries during this transition to ensure Family First readiness. More information on the *Eastern Service Area Case Management Transition* can be found [here](#).

## Continuous Quality Improvement

The CFS Continuous Quality Improvement (CQI) team will assess Family First Outcomes. The CQI team was established in 2012 and is comprised of team members with CFS protection and safety case management skills and experience, as well as knowledge of the Statewide Automated Child Welfare Information System (SACWIS) and provider performance. Nebraska's CQI program is designed to enable both a qualitative and quantitative review process, providing support to continually improve case management practices and outcomes. In compliance with ACYF-CB-IM-12-07, the CFS CQI team provides support through a review process.

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# EVALUATION STRATEGY

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## Evaluation Intent and Approach

Evidence-based interventions determined to be supported or promising by the IV-E Clearinghouse will be evaluated by CFS, or contracted vendor with evaluation expertise, with the exception of services that already encompass their own evaluation. An example of such program is Family Centered Treatment, which has an evaluation established through Indiana University, which will provide relevant documentation. Consistent with federal legislation and subsequent HHS guidance, the Department is requesting a waiver of evaluations requirements for its well-supported programs.

## Ability to Conduct an Evaluation of Prevention Programming

The Division recognizes the value of working through communities to strengthen families so children can reach their full potential. In 1997, with input from Nebraskans across the state, CFS used funding from the [Family Preservation and Support Act](#) to support the creation of the

Nebraska Children and Families Foundation (NCFE). Designated to act as the lead agency for the Community Based Child Abuse Prevention Fund, NCFE has managed numerous targeted prevention initiatives across the state through the use braided public and private funds.

Nebraska CFS and NCFE partner with the University of Nebraska to develop and implement evaluations of multiple prevention strategies within communities across Nebraska. Examples of such evaluations conducted through this process can be found [here](#), as well as on the [NCFE website](#). Evaluation is an ever-evolving process. FFPSA offers an opportunity for Nebraska to continue to improve upon alignment of effort, building upon a strong foundation of relationships at both the community and state levels in the collection and analysis of data, implementation of practices and collective work toward identified results.

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## EVALUATION WAIVER

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The Department is requesting a waiver for the following programs and will follow established procedures to monitor, compile, assess and report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions.

- Healthy Families America
- Multisystemic Therapy
- Parent-Child Interaction Therapy
- Functional Family Therapy

These programs are rated as well-supported programs on the federal clearinghouse.

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

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## CONSULTATION AND COORDINATION

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### How CFS Consulted with Other Agencies to Develop Continuum of Care

CFS held an external stakeholder meeting in June of 2018 inviting child welfare stakeholders to participate in an implementation workgroup. The Prevention Services and Programs Plan Committee was established to develop this Plan. Stakeholders include those representing the Nebraska Legislature, legal community, service providers, tribal partners, managed care organizations, various community organizations, and representatives from other DHHS

divisions. CFS co-lead this external workgroup with the Nebraska Children and Families Foundation (NCF). As the Community-Based Child Abuse Prevention agency in Nebraska, NCF is a strong partner in the FFPSA planning given their expertise in community engagement and prevention portfolio. Committee meeting agendas, notes, and workgroup members can be found [here](#).

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

CFS has met with tribal representatives to provide information regarding FFPSA and gain input and insight into how the implementation of FFPSA in Nebraska can support the unique cultural needs of Native families. CFS will continue to partner with the tribes in identifying culturally-relevant evidence-based models relevant for FFPSA.

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

CFS continues to work closely with providers and stakeholders to develop a continuum of care for children, parents and caregivers receiving prevention services.

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

A recent [report](#) by Voices for Children in Nebraska revealed equity issues in the State's child welfare system. Data within this report show that a disproportionately high number of reports to the CFS Abuse and Neglect Hotline involving minority groups are substantiated and/or filed in Juvenile Court. Further, interventions are recommended at a higher rate for minority populations. In order to address this, Nebraska plans to engage with internal and external stakeholders to identify strategies to make the State's child welfare system culturally sensitive and equitable for all families. CFS has begun working with Voices for Children to identify stakeholders for a committee which will develop a plan aimed at reducing the overrepresentation of minority populations within CFS.

## How Family First Prevention Services Will Be Coordinated with Other IV-B Plan Services

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

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

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

[Bring Up Nebraska](#)<sup>11</sup> is a statewide prevention initiative designed to give community partners the ability to develop long-term plans using the latest strategies to prevent life's challenges from becoming a crisis for many Nebraska families and children. The Family First and Bring Up Nebraska initiatives align to create a comprehensive approach to supporting the well-being of children and families.

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## CHILD WELFARE WORKFORCE SUPPORT

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CFS partners with the University of Nebraska, Center for Children, Families and the Law (CCFL) to provide training for our workforce. This training helps to ensure staff are competent, skilled, and professional when working within child welfare. CFS worked to ensure CCFL is knowledgeable and equipped to provide new worker training related to FFPSA. All new staff who attend CFS new worker training are provided with several different trauma-informed trainings.

<sup>11</sup> Bring Up Nebraska: A Community-Based Prevention Strategy; <http://www.bringupnebraska.org/>

A description of these trainings are as follows:

**Training: Introduction to Trauma Informed Care**

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

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

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

**Training: Secondary Trauma**

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

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

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

**Training: Trauma Review and Preparation**

*Topic Area:* Trauma-informed care

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

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

**Training: Trauma Capable**

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

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

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

CFS will assess the need for additional trainings each year as part of the required annual in-services training for staff.

For additional CFS training details, please see the following section.

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## CHILD WELFARE WORKFORCE TRAINING

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CFS and CCFS provide new caseworkers training related to assessing a family's needs for prevention services and accessing identified trauma-informed and evidence-based services. CFS workforce will be trained in Safety Organized Practice (SOP), to enhance family engagement. Training is provided on an ongoing basis for specific trauma-informed and evidenced-based services as they become available to each community.

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

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

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## MONITORING CHILD SAFETY

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

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

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

The SDM Family Strengths and Needs Assessment (FSNA) is completed for each family throughout the life of the case. The SDM FSNA assesses areas of strength and need for the

caregiver and child. Such areas include coping skills, mental health, resource management, substance use and parenting skills. Regular assessment allows case managers to identify needs of the family that should be prioritized in the family's case plan, will improve child safety, and will reduce risk of maltreatment by utilizing protective factors already existing in the family.

SDM Risk Re-Assessments are completed every 90 days for families with children in-home and participating in ongoing case services. The Risk Re-Assessment evaluates a family's progress towards meeting case plan goals and guides decision-making related to case closure. When an ongoing case is considered for case closure based on the Risk Re-Assessment, a new safety assessment will be completed. The CFS Policy Memo regarding these assessments can be found [here](#)<sup>12</sup> and [here](#)<sup>13</sup>.

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

Visits with children should be private face-to-face visits. These monthly visits provide information about the child's safety, permanency and well-being and allow the child an opportunity to share information about what is working well, what are they worried about and what needs to happen next<sup>14</sup>.

CFS staff have monthly face-to-face visits with all parents of all children involved in the case. These visits should occur in the family home at least every other month. During these visits there should be discussion regarding child safety and risk factors, areas of strengths, family needs, and the effectiveness of services being provided to improve the family's safety. A parent is also provided an opportunity to express concerns or input regarding their case. CFS staff will discuss the SOP danger or harm statements identified by CFS and the family. These statements focus on the areas of concern related to safety and risk. These statements clearly identify what the worry is about, what actions needed to mitigate the worry and how long the action needs to be demonstrated.

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

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<sup>12</sup> Division of Children and Family Services, Protection and Safety Procedure #36-2016: *Ongoing Case Management*; effective 9/23/16

<sup>13</sup> Division of Children and Family Services, Protection and Safety Procedure #2-2018: *Initial Assessment*; effective 5/7/18

<sup>14</sup> Academy for Professional Excellence; *Safety Organized Practice*; <https://theacademy.sdsu.edu/programs/cwds/sop/>

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## PREVENTION CASELOADS

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

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

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## ASSURANCE ON PREVENTION PROGRAM REPORTING

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

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## FUTURE PLANNING

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Given the many components involved with implementation of FFPSA, Nebraska decided to focus on what can be successfully accomplished for the initial phase of implementation. Over the course of the next five years, CFS intends to use the information learned from the initial phase of implementation to drive later phases. Some future planning includes the following.



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

In order to better understand the needs of these families, CFS staff are beginning to review child abuse/neglect **intakes that do not meet the standards to be accepted for an assessment**. This process began in June 2019 but will be an informative part in identifying the needs assessment and efforts to work with families in the least intrusive way and not creating a system that forces families into involvement with the CFS in order to receive needed services.

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

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

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

Nebraska is excited to begin implementation of FFPSA on October 1, 2019. FFPSA supports Nebraska's vision for moving the child welfare system to serving families through prevention rather than intervention. The State of Nebraska is proud to be one of the first states to implement Family First and looks forward to the renewed vision it offers for the child welfare system.

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## STATE CONTACT

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402-471-1362

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## ATTACHMENTS

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

Attachment B: Draft Nebraska Evidence-Based Programs

Attachment C: Healthy Families America Child Welfare Adaptation

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

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

Attachment F: Transitional Payment Checklist: Family Centered Treatment (ACYF-CB-PI-19-06 Attachment B)

- *Note: Attachment F will be sent in to be included with this Plan once received from the independent evaluator.*

Attachment G: CFS Standard Work Instruction for Mandatory Monthly Visits

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

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

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

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



# Attachment A

<b>State of Nebraska</b> WORK INSTRUCTION DOCUMENT FOR:	<b>Author:</b> Elizabeth Schropp	<b>Effective Date:</b> October 1, 2019
Foster Care Prevention Plan	<b>Version #:</b> 1	<b>Page:</b> Page 1 of 12

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

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

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

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

**Definitions:** AILA: Approved Informal Living Arrangement

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

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

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

CFS: Child and Family Services

CFSS: Child and Family Services Specialist

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

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Foster Care Prevention Plan		

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

TLP: Transitional Living Plan

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

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

This includes:

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

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Foster Care Prevention Plan		

**Procedure:**

A. Determining a Candidate for Foster Care:

1. A child should be determined to be a Candidate for Foster Care when the following circumstances are met:

Part One-child should meet one of these criteria:

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

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

2. If a youth is determined to be a Candidate for Foster Care, the CFS Specialist should discuss with the family the opportunity to participate in Prevention Services. If the family is in agreement with Prevention Services, a FCPP should be developed with the family *in conjunction* with the Case Plan or Family Plan for Alternative Response cases. The FCPP and the Case Plan/Family Plan may contain similar information, however, they both need to be completed in order to claim IV-E funding.
3. Structured Decision Making assessments required for traditional Initial Assessment, On-Going Case Management or Alternative Response cases remain the same for cases with families also participating in Prevention Services. Expectations for SDM assessments to be completed is outlined in the following Policies and Standard Work Instructions: PSP #34-2016: Ongoing Case Management; Administrative Memo 2-2018: Initial Assessment; Alternative Response Program Manual.

B. Pregnant/Parenting Foster Youth:

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- If the youth or young adult is pregnant, medical confirmation of the pregnancy is necessary for eligibility. This documentation should be provided by a medical professional and should be scanned into the master case in Document Imaging under Casework. Once this has been provided, a FCPP can be created with the youth or young adult. It is not necessary for paternity to be established for a father to be eligible for services.
- If the youth or young adult has qualified for Medicaid services based on a confirmed pregnancy and documentation of the pregnancy confirmation has been provided to Medicaid and displayed on N-FOCUS, a narrative can be entered by the CFS Specialist in the CFS Program Case under Correspondence that a Medicaid narrative confirming the pregnancy; CFS Specialist should provide the date that the narrative was entered.
- If an eligible youth/young adult is in agreement with participating in prevention services, a FCPP should be created with them. These services are voluntary for the youth or young adult and it should not be required of them to participate.
- A FCPP should be developed with the eligible youth/young adult *in conjunction* with the Case Plan or Transitional Living Plan in the case of young adults participating in the Bridge to Independence program. The FCPP and the Case Plan/Transitional Living Plan may contain similar information, however, they both need to be completed.

### C. Foster Care Prevention Plan

1. The FCPP is a written plan describing the goals, strategies and prevention services to be utilized in order to prevent a child from entering foster care. This plan should:
  - Include the date a child was identified as a Candidate for Foster Care; NOTE: this date **must** be prior to the start of prevention services
  - Be created *with* the family and must be tied to the family's Case Plan. If the parent is involved in the Bridge to Independence program, the FCPP can be tied to the parent's Transitional Living Plan. If a family has an open Alternative Response Case, the FCPP should be created on NFOCUS and scanned into Document Imaging, under Casework, with the Family Plan.
2. Every FCPP should be created with the family. The goals and strategies to address needs within the family should be developed and agreed upon with the parent(s)/caregiver(s) as well as the child(ren) in a developmentally appropriate manner whenever possible. The family should be provided a copy of their FCPP and the CFS Specialist should maintain a copy of the FCPP on N-FOCUS. Any changes to the FCPP should be discussed with the family prior to changes being made and an updated copy should be offered to the family after changes have been made.



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

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

Families who are working with CFS prior to the implementation of the FCPP on October 1, 2019, whose child(ren) meet qualifications to be a Candidate for Foster Care **are** eligible for Prevention Services. The CFS Specialist assigned to work with the family should discuss with the family the opportunity to participate in Prevention Services and, if the family is in agreement with Prevention Services, develop a FCPP for their child(ren). A FCPP should be developed with the family *in conjunction* with the Case Plan or Family Plan. The FCPP and the Case Plan/Family Plan may contain similar information, however, they both need to be completed. As a reminder, the FCPP must be created **prior** to a Prevention Service starting.

E. Creating a Foster Care Prevention Plan on NFOCUS

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

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2. To document a FCPP, follow these steps:

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

FCPP icon. 

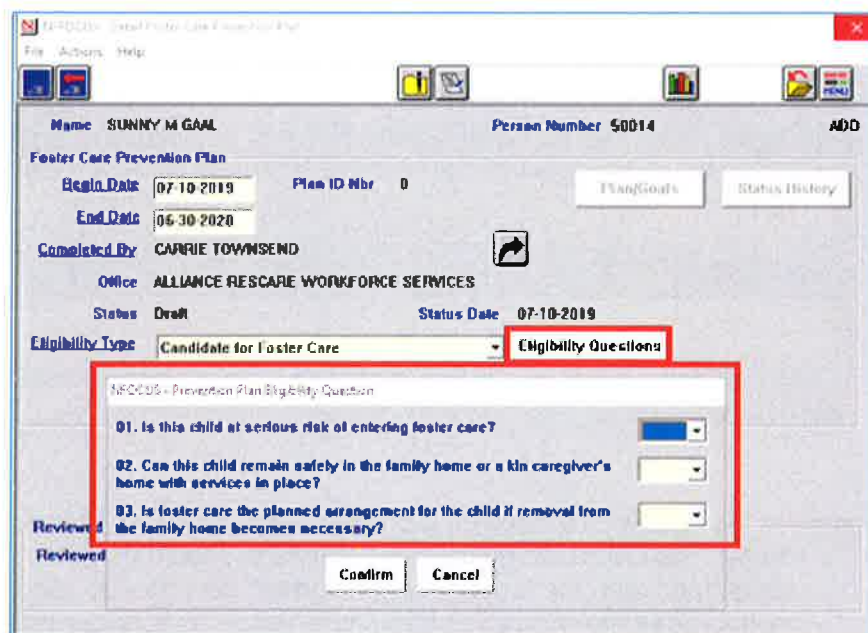


- The Detail FCPP window will display.

- Note:** The Begin Date will be auto-populated with today's date. The End Date will be auto-populated to the last day of the 12<sup>th</sup> month from the Begin Date.
- Enter the "Completed By" field by selecting the Out Select Arrow.

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- The “Search Office Position” window will display. Search for the worker and return to the “Detail Foster Care Prevention Plan” window with the **Blue Select Arrow**.
- Click on the Eligibility Type dropdown list and select the appropriate option.
- Click the Eligibility Questions button and complete the questions.



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

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N-FOCUS - Detail Foster Care Prevention Plan Narrative

File Actions Help

Household Name: MATTHEW PERRY Case Plan ID: 6804772 ADD

Goals:

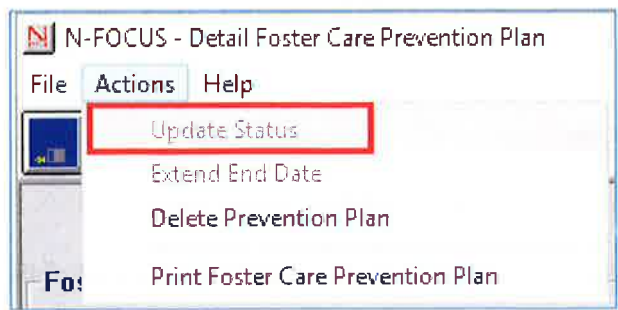
Strategy:

Services:

Progress:


08-0 08-05-2019 12:57

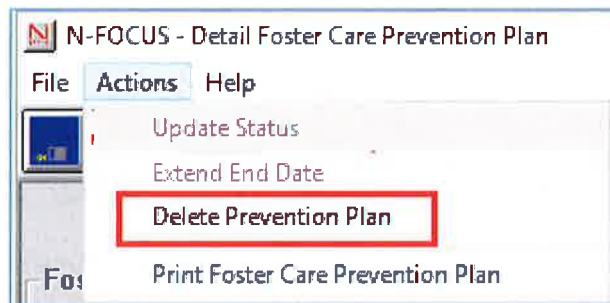
- Complete the “Goals”, “Strategy”, “Services”, and “Progress” fields
  - **Note:** The Goals, Strategies and Services should be reflect what has been developed with the family. The “Progress” field can be used to provide update notes regarding progress or additional goals or services that have been added.
- If the user wants to add an additional goal, click the Save and Next button.
- If the user wants to return to the Detail screen, click Save and Close.
- When there are multiple Plan/Goals, the user can view these in the List
- When ready to change the status to Ready for Review, select Action> Update Status.



F. Deleting a Foster Care Prevention Plan

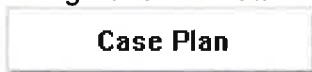
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1. **IMPORTANT:** This function is only available when the Foster Care Prevention Plan is in Draft or Revisions Required status.
2. To delete a FCPP, follow these steps:
  - Navigate to the Detail Program Case window, highlight a child/youth, and click the Foster Care Prevention Plan icon. 
  - The List Foster Care Prevention Plan window will display.
  - Highlight a plan and select Action>Delete Prevention Plan.



G. Tying a FCPP to a Case Plan

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



2. The Detail SDM Case Plan window will display.

Name	Role	Permanency Objective
ROGER SMITH	Primary Caregiver	
BARB SMITH	Secondary Caregiver	
JED STREUBY	Child	Family Preservation
SETH SMITH	Child	Family Preservation
SHARON SMITH	Child	Reunification
ZACH SMITH	Child	Family Preservation

3. Highlight the child/youth from the Persons Involved in the Plan list box.
  - The Tie Foster Care Prevention Plan push button will become active.

**Tie FC Prev Plan**

4. Click the Tie FC Prev Plan button
  - The List FC Prev Plan window will display.
5. Select the appropriate FCPP from the list.
6. Click the Blue Return Arrow.
7. Confirm the correct FCPP was selected.
8. Once tied, the user may view the tied FCPP by clicking on the Foster Care Prevention Plan



icon on the Detail SDM Case Plan window.

9. **Note:** Case Plans cannot be moved from FINAL status to ADMIN REOPEN status when one or more FCPP's are tied. You must untie each FCPP and then change the status of the Case Plan.
  - To untie a FCPP, select the child/youth on the Detail SDM Case Plan window, click Actions>Untie Foster Care Prevention Plan.
  - Follow the instructions above to retie the FCPP's prior to returning the Case Plan to FINAL status.

#### H. Tying a FCPP to a Transitional Living Plan


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

TLP

click the

The Detail Transitional Living Plan window will display.

Name	Begin Date	End Date	Role
SHARON SMITH	08-12-2019		Youth

2. Highlight the child/youth.
3. The Tie FC Prev Plan button will become active.
4. Click the Tie FC Prev Plan button.
  - The List Foster Care Prevention Plan Window displays.
5. Select the appropriate Foster Care Prevention Plan
6. Click the Blue Return Arrow.
7. Confirm the correct Foster Care Prevention Plan was selected.
8. Once tied, you may view the tied Foster Care Prevention Plan by clicking the Foster Care Prevention Plan icon  on the Detail Transitional Living Plan window.

<b>State of Nebraska</b> WORK INSTRUCTION DOCUMENT FOR:  Foster Care Prevention Plan	<b>Author:</b> Elizabeth Schropp	<b>Effective Date:</b> October 1, 2019
	<b>Version #:</b> 1	<b>Page:</b> Page 12 of 12

9. **Note:** TLPs cannot be moved from FINAL status to ADMIN REOPEN status when one or more Foster Care Prevention Plans are tied. You must untie each Foster Care Prevention Plan and then change the status of the TLP.
10. To untie, highlight the child/youth on the Detail Transitional Living Plan window, click Actions, and click Untie Foster Care Prevention Plan.
11. Follow the instructions above to retie the Foster Care Prevention Plans prior to returning the TLP to FINAL status.

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

**References:** PSP #34-2016: Ongoing Case Management  
 Administrative Memo 2-2018: Initial Assessment  
 Alternative Response Program Manual

**Revision History:**

REVISION LEVEL	DESCRIPTION	AUTHOR	APPROVAL DATE	EFFECTIVE DATE
Initial				

**Approval by:** *Jamie Kramer*

**Date:** 9/4/2019



**\*\*SEE KEY ON LAST PAGE**

Type of FFPSA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
In Home Parenting Skill Based Program	3 5 7 Model	The 3-5-7 Model® is a copyrighted strengths-based approach that empowers young people and families to engage in the work of grieving their losses and rebuilding relationships towards the goals of well-being, safety, and permanency. The 3-5-7 Model® incorporates the underpinnings from child development, attachment, separation and loss, trauma, family systems, relationship development, and resiliency theories to provide a directional approach to achieving permanency in relationships. The 3-5-7 Model® uses tools (e.g., lifebooks, loss/life lines) to support work around issues of separation and loss, identity formation, attachment, and building relationships, and it also supports deeper therapeutic work around abuse, abandonment, and neglect experiences. Practice applications can be made throughout ongoing case management services, from intake to child protective to placement services. Along with being a standalone program as described in this entry, the three tasks of the 3-5-7 Model® are designed to be able to be used with other child welfare practice models. The 3-5-7 Model® supports kinship, foster, and adoptive family relationships. The 3-5-7 Model® can also be used an engagement strategy with birth families.	Young people and parents (biological, foster, kinship, and adoptive) receiving services in the child welfare system  For children/adolescents ages: 0 – 21 For parents/caregivers of children ages: 0 – 21	NR	High	Yes		<a href="http://www.cebc4cw.org/program/3-5-7-model/">http://www.cebc4cw.org/program/3-5-7-model/</a>	
Juvenile Justice	Crossover Youth Practice Model (CYPM)	CYPM is for child welfare agencies with youth receiving any level of services) that are at-risk for or have been referred to or become involved with the juvenile justice system and for juvenile justice departments with youth who are subsequently referred to and become involved in the child welfare system because of suspicions of abuse/neglect. CYPM is designed to create a multisystem approach to identification of youth, assessment of needs, collaborative case planning, and ongoing case management. The model is designed to provide a foundation that helps jurisdictions work collaboratively with the goals of improving system functioning and outcomes for youth. The model implements a process that seeks to reduce the number of youth who crossover between the child welfare and juvenile justice systems, the number of youth entering and reentering out-of-home care, the length of stay in out-of-home care, the use of congregate care, and the disproportionate representation of children of color. The CYPM infuses into this work values and standards; manualized practices, policies; and procedures; and quality assurance processes.	A child welfare agency and juvenile justice department serving the same youth or youth at risk of becoming involved in each other's system  For organizations that serve children ages: 11 – 17	3	High	Yes		<a href="http://www.cebc4cw.org/program/crossover-youth-practice-model-cypm/">http://www.cebc4cw.org/program/crossover-youth-practice-model-cypm/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Aggression Replacement Training (ART):	Aggression Replacement Training® is a cognitive-behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents ages 12-17. The program consists of 10 weeks (30 sessions) of intervention training, and is divided into three components—social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition, and reinforce the lessons in the curriculum.	Chronically aggressive children and adolescents ages 12-17  For organizations that serve children ages: 12 – 17	3	Medium	No	Cost: \$1,449 (for youth in state juvenile justice institutions)  Savings: \$4,865 B.C.: \$4.03	<a href="http://www.cebc4cw.org/program/aggression-replacement-training/">http://www.cebc4cw.org/program/aggression-replacement-training/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Alternative Response	NE: A comprehensive assessment of (i) child safety, (ii) the risk of future child abuse or neglect, (iii) family strengths and needs, and (iv) the provision of or referral for necessary services and support that does not include an investigation or formal determination as to whether child abuse or neglect has occurred or the entry of the subject of the report into the central registry of child protection cases maintained pursuant to Neb. Rev. Stat. § 28-718. ( <a href="http://dhhs.ne.gov/children_family_services/AlternativeResponse/Pages/Program.aspx">http://dhhs.ne.gov/children_family_services/AlternativeResponse/Pages/Program.aspx</a> )	NE: Intakes of child abuse/neglect that do not meet any exclusionary criteria and dependent on RED Team criteria review  - NE's program is being evaluated; Minnesota's AR model called Family Assessment Response is a 3 Caregivers who are emotionally or physically aggressive or abusive with their children, children who experience behavioral dysfunction, especially aggression, or trauma-related symptoms secondary to their exposure to physical discipline/abuse, and high conflict families who are at-risk for these problems.	NR-NE; 3- MN	High (MN)	Yes		<a href="http://www.cebc4cw.org/program/family-assessment-response/">http://www.cebc4cw.org/program/family-assessment-response/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)	Alternatives for Families: A Cognitive-Behavioral Therapy (originally named Abuse-Focused Cognitive-Behavioral Therapy) is designed for families who are referred for problems related to the management of anger and/or aggression, which include several behaviors on a continuum reflecting the use of coercion and/or physical force. Specifically, AF-CBT seeks to improve the relationships between children and their parents/caregivers who experience any of the following clinical concerns: anger/emotional abuse, family conflict, child behavior, child physical abuse. AF-CBT is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, developmental victimology, and the psychology of aggression.	For children/adolescents ages: 5 – 17 For parents/caregivers of children ages: 5 – 17	3	High	Yes	N/A (\$1500 per therapist to be trained.)	<a href="http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/">http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/</a>	
In Home Parenting Skill Based Program	Attachment Biobehavioral Catchup	ABC targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children's lead with delight. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child.	Caregivers of infants 6 months to 2 years old who have experienced early adversity	1	High	Yes		<a href="http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/">http://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Celebrating Families	Celebrating Families!™ is a family-inclusive, trauma-informed, skill-building program for families with a parent with a substance addiction that was developed to prevent children's future addiction, mental and physical health problems. The program combines prevention and intervention in order support the healing of families in early recovery, while developing skills to prevent future addiction. The program is available in a Spanish version, ¡Celebrando Familias!, with a minor cultural modifications but the same content.	Adults with a diagnosed substance use disorder, or substance use problems, addiction, dependence, or abuse For children/adolescents ages: 0-17	NR	Medium	No		<a href="http://www.cebc4cw.org/program/celebrating-families/">http://www.cebc4cw.org/program/celebrating-families/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Child Centered Play Therapy	CCPT is a developmentally responsive, play-based mental health intervention for young children ages 3 to 10 who are experiencing social, emotional, behavioral and relational disorders. CCPT utilizes play, the natural language of children, and therapeutic relationship to provide a safe, consistent therapeutic environment in which a child can experience full acceptance, empathy, and understanding from the counselor and process inner experiences and feelings through play and symbols. In CCPT, a child's experience within the counseling relationship is the factor that is most healing and meaningful in creating lasting, positive change. Based on person-centered principles, overarching goal of CCPT is to unleash the child's potential to move toward integration and self-enhancing ways of being. Child outcomes following CCPT include decreased symptomatic behaviors and improvement in overall functioning.	Children ages 3-10 who are experiencing social, emotional, behavioral and relational problems  For children/adolescents ages: 3 – 10	3	Medium	No	N/A	<a href="http://www.cebc4cw.org/programs/child-centered-play-therapy-ccpt/">http://www.cebc4cw.org/programs/child-centered-play-therapy-ccpt/</a>	

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

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

Type of FFP/SA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
Mental Health and Substance Abuse Prevention Treatment Service	Functional Family Therapy	FFT is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.	11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse	2	Medium	Yes	Cost: \$3,134 Savings and B-C: N/A	<a href="http://www.cebc4cw.org/program/functional-family-therapy/">http://www.cebc4cw.org/program/functional-family-therapy/</a>	YES
Mental Health and Substance Abuse Prevention Treatment Service	GenerationPMTO (GROUP delivery format)	Same as Generation PMTO except GROUP delivery format. 10-14 weeks duration	Parents of children 2-18 years of age with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors						
Mental Health and Substance Abuse Prevention Treatment Service	GenerationPMTO (INDIVIDUAL delivery format)	GenerationPMTO was formerly known as Parent Management Training - the Oregon Model (PMTO®). GenerationPMTO (Individual Delivery Format) is a parent training intervention that can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, adoptive parents, and other primary caregivers. This behavioral family systems intervention can be used as a preventative program and a treatment program. It can be delivered through individual family treatment in agencies or home-based and via telephone/video conference delivery, books, audiotapes and video recordings. GenerationPMTO interventions have been tailored for specific child/youth clinical problems, such as externalizing and internalizing problems, school problems, antisocial behavior, conduct problems, deviant peer association, theft, delinquency, substance abuse, and child neglect and abuse. For the group version of GenerationPMTO, please see Parenting Through Change (PTC; GenerationPMTO Group).	Parents of children 2-18 years of age with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors	1	High	Yes	Cost: \$619 Savings: \$5,587 B-C: \$9.50	<a href="http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/">http://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/</a>	
In Home Parenting Skill Based Program	Healthy Families America Home Visiting Program (HFA)	Healthy Families America (HFA) has been rated by the CEBC in both Home Visiting topic areas. Please click here to see the HFA entry and rating in the Home Visiting for Prevention of Child Abuse and Neglect topic area.  HFA is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues. HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby).  HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based, designed to promote positive parent-child relationships and healthy attachment; strengths-based; family-centered; culturally sensitive; and reflective.  The HFA model is based upon 12 Critical Elements. These Critical Elements are operationalized through a series of standards that provide a solid structure for quality, yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities.  HFA's Vision: All children receive nurturing care from their family essential to leading a healthy and productive life.  HFA's Mission: To promote child well-being and prevent the abuse and neglect of our nation's children through home visiting services.	Overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences; families are determined eligible for services once they are screened and/or assessed for the presence of factors that could contribute to increased risk for child maltreatment or other poor childhood outcomes, (e.g., social isolation, substance abuse, mental illness, parental history of abuse in childhood, etc.); home visiting services must be initiated either prenatally or within three months after the birth of the baby  For parents/caregivers of children ages: 0 – 5	1	Medium	Yes	Cost: \$5,071 (2016) Loss: (\$1,840) B-C: \$0.64	<a href="https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/">https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/</a>	YES
Mental Health and Substance Abuse Prevention Treatment Service	Helping Men Recover	HMR is a gender-responsive, trauma-informed treatment program for men. The materials include a facilitator's guide and a participant's workbook. This is the men's version of the women's curriculum, Helping Women Recover, which is highlighted on the CEBC as part of a combined Helping Women Recover & Beyond Trauma (HWR/BT) intervention. HMR addresses what is often missing in prevailing treatment modes: a clear understanding of the impact of male socialization on the recovery process, a consideration of the relational needs of men, and a focus on the issues of abuse and trauma (both experienced and perpetrated). The Helping Men Recover Facilitator's Guide for the 18-session program is a step-by-step manual containing the theory, structure, and content needed for running groups. The participant's workbook allows men to process and record the therapeutic experience. The program model is organized into four modules that emphasize the core areas of men's recovery: Self, Relationships, Sexuality, and Spirituality. The materials are designed to be user-friendly and self-instructive.	Men with addictive disorders	NR	Medium	No		<a href="http://www.cebc4cw.org/program/helping-men-recover-a-program-for-treating-addiction-hmr/">http://www.cebc4cw.org/program/helping-men-recover-a-program-for-treating-addiction-hmr/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Helping Women Recover & Beyond Trauma	HWR/BT is a combination of two manualized curricula, Helping Women Recover (HWR): A Program for Treating Addiction and Beyond Trauma (BT): A Healing Journey for Women, that in order to replicate the research protocol and outcomes, they both need to be used, as this entry details. When used individually, there is not enough research evidence to be able to rate either curricula on the CEBC Scientific Rating Scale.  HWR/BT is a combined intervention of 29 sessions that integrates three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma; and then adds a psychoeducational component that teaches women what trauma is, its process, and its impact. The program model is organized into seven modules. The first four: Self, Relationships, Sexuality, and Spirituality are areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The last three: Violence, Abuse, and Trauma; The Impact of Trauma on Women's Lives; and Healing from Trauma; focus on the trauma with a major emphasis on coping skills, with specific exercises for developing emotional wellness. The program comes with facilitator's manuals, two participant workbooks (A Women's Journal and A Healing Journey), and 3 DVDs. The materials are designed to be user-friendly and self-instructive. A special edition for criminal justice settings has also been developed.  Note: The Beyond Trauma materials were expanded and revised in 2017. The changes include an additional session, expanded sessions, inclusion of information from neuroscience, updated statistics, and resources. These changes have not been reviewed by the CEBC and are not included in the program's Scientific Rating.	Adult women with addictive disorders and a trauma history (e.g., abuse, domestic violence, community violence, etc.)	2	Medium	No	N/A	<a href="https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/">https://www.cebc4cw.org/program/helping-women-recover-beyond-trauma/</a>	

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In Home Parenting Skill Based Program	Homebuilders	Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.	Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities  For children/adolescents ages: 0 – 17 For parents/caregivers of children ages: 0 – 17	2	High	Yes	Cost: \$3,547 (2008) Savings: \$13,005 B-C: \$4.73	<a href="http://www.cebc4cw.org/program/homebuilders/">http://www.cebc4cw.org/program/homebuilders/</a>	
In Home Parenting Skill Based Program	Love & Logic	The Love and Logic Institute, Inc., developed training materials designed to teach educators and parents how to experience less stress while helping young people learn the skills required for success in today's world. This approach is called Love and Logic and is based on the following two assumptions: •That children learn the best lessons when they're given a task and allowed to make their own choices (and fail) when the cost of failure is still small; and •That the children's failures must be coupled with love and empathy from their parents and teachers.  This model has been used by parents and teachers and has been applied to a wide range of situations.	Parents, grandparents, teachers, and other caretakers working with children, children 0-18	NR	Medium	No		<a href="http://www.cebc4cw.org/program/love-and-logic/">http://www.cebc4cw.org/program/love-and-logic/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	Motivational Interviewing	MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.	Caregivers of children referred to the child welfare system, has been used with adolescents	1	Medium	No	Cost: \$263 (2014) Savings: \$5,572 B-C: \$21.95	<a href="http://www.cebc4cw.org/program/motivational-interviewing/">http://www.cebc4cw.org/program/motivational-interviewing/</a>	YES
Mental Health and Substance Abuse Prevention Treatment Service	Multisystemic Therapy (MST)	Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.	Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system (some other restrictions exist, see the Essential Components section for more details)	1	Medium	Yes	Cost: \$7,076 Savings: \$4,824 B-C: \$1.62	<a href="http://www.cebc4cw.org/program/multisystemic-therapy/">http://www.cebc4cw.org/program/multisystemic-therapy/</a>	YES
Mental Health and Substance Abuse Prevention Treatment Service	Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	MST--N63:N66CAN is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. MST-CAN clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of 4 families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between CPS and the family. Empirically-based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, Cognitive Behavioral Therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and Reinforcement Based Therapy for adult substance abuse.	Families who have come to the attention of Child Protective Services within the past 180 days due to the physical abuse and/or neglect of a child in the family between the ages of 6 and 17; where the child is still living with them or is in foster care with the intent of reunifying with the parent(s); other criteria may apply  For children/adolescents ages: 6 – 17 For parents/caregivers of children ages: 6 – 17 First-time, low-income mothers (no previous live births)	2	High			<a href="http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/">http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/</a>	
Pregnant Parenting Youth	Nurse-Family Partnership (NFP)	The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.	For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5	1	Medium	Yes	Cost: \$5,944 (2015) B-C: \$0.81	<a href="http://www.cebc4cw.org/program/nurse-family-partnership/">http://www.cebc4cw.org/program/nurse-family-partnership/</a>	YES
In Home Parenting Skill Based Program	Nurturing Parenting (for Parents and their school-aged children 5-12 years)	The Nurturing Parenting Program for Parents and their School Age Children 5 to 12 Years is a 15-session program that is group-based, and family-centered. Parents and their children attend separate groups that meet concurrently. Each session is scheduled for 2.5 hours with a 20-minute break in which parents and children get together and have fun.  The lessons in the program are based on the known parenting behaviors that contribute to child maltreatment: Inappropriate parental expectations, Parental lack of empathy in meeting the needs of their children, Strong belief in the use of corporal punishment, Reversing parent-child family roles, Oppressing children's power and independence  Assessment (pre, process, and post) of parent's parenting and child rearing beliefs, knowledge, and skills allows the program facilitators to measure the attainment of lesson competencies.	Families who have been reported to the child welfare system for child maltreatment including physical and emotional maltreatment in addition to child neglect; may be used as a court-ordered parenting program	3	High	No	B-C: .87	<a href="http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/">http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/</a>	
In Home Parenting Skill Based Program	On the Way Home Program	OTWH is a 12-month reunification program developed to address the transition needs of middle and high school youths with, or at-risk of, emotional and behavioral disorders who are reintegrating into the home and community school settings following a stay in residential care. The program modifies and integrates three interventions: Check & Connect, Common Sense Parenting, and homework support to address the educational and family-based transition challenges most common for school-aged youths. Services are provided by a trained Family Consultant in the family home, school, and community, and primary objectives are to promote youth home stability and prevent school dropout. On average, families engage in 2 hours of direct service hours per week and consultants carry caseloads of up to 15 families. Training is manualized, service decisions are guided by weekly data analysis, and consultants are supervised by a licensed mental health practitioner (e.g., professional counselor, social worker).	Middle and high school students (12-18) with, or at-risk for, emotional and behavioral disorders transitioning from residential placements back into the home and community school settings and their caregivers  For children/adolescents ages: 12 – 18 For parents/caregivers of children ages: 12 – 18	3	High	Yes		<a href="http://www.cebc4cw.org/program/on-the-way-home-otwh/">http://www.cebc4cw.org/program/on-the-way-home-otwh/</a>	

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

Type of FFPSA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
In Home Parenting Skill Based Program	<b>Structured Decision Making</b>	SDM is a comprehensive case management system for Child Protective Services (CPS). CPS workers employ objective assessment procedures at major case decision points from intake to reunification to improve child welfare decision-making. SDM targets agency services to children and families at high risk of maltreatment and helps ensure that service plans reflect the strengths and needs of families. When effectively implemented, it increases the consistency and validity of case decisions, reduces subsequent child maltreatment, and expedites permanency. The assessments from the model also provide data that help agency managers monitor, plan, and evaluate service delivery operations.	Families referred to and assessed by child protective service (CPS) agencies  For parents/caregivers of children ages: 0 – 17	3	High	Yes		<a href="http://www.cebc4cw.org/program/structured-decision-making/">http://www.cebc4cw.org/program/structured-decision-making/</a>	
In Home Parenting Skill Based Program	<b>Teaching-Family Model (TFM)</b>	TFM is a unique approach to human services characterized by clearly defined goals, integrated support systems, and a set of essential elements. TFM has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. The model uses a married couple or other "teaching parents" to offer a family-like environment in the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers, and other support network to help maintain progress.	Youth who are at-risk, juvenile delinquents, in foster care, mentally retarded/developmentally disabled, or severely emotionally disturbed; families at risk of having children removed 0-17	3	High			<a href="http://www.cebc4cw.org/program/teaching-family-model/">http://www.cebc4cw.org/program/teaching-family-model/</a>	
In Home Parenting Skill Based Program	<b>The Incredible Years</b>	The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.	Parents, teachers, and children For children/adolescents ages: 4 – 8 For parents/caregivers of children ages: 4 – 8	1	Medium	Yes	Cost: \$2,215 (2013) Savings: \$1,039 B-C: 1.79	<a href="http://www.cebc4cw.org/program/the-incredible-years/">http://www.cebc4cw.org/program/the-incredible-years/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>The MANDT System</b>	The Mandt System® is a relationally based program that uses a continuous learning and development approach to prevent, de-escalate, and if necessary, intervene in behavioral interactions that could become aggressive. The context of all behavior is relational.	Child welfare organizations and other human service programs concerned with the physical, psychological, and emotional safety of service recipients and service users	NR	High	Yes		<a href="http://www.cebc4cw.org/program/the-mandt-system/">http://www.cebc4cw.org/program/the-mandt-system/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>Therapeutic Crisis Intervention</b>	At TCI's core lies the principle that successful resolution of a child's crisis depends on the environment's (the care organization) and the individual's (the care worker) therapeutic and developmentally appropriate response. The TCI system teaches and supports strategies for care workers at all levels of the organization to: <ul style="list-style-type: none"><li>•Assess children's aggressive behaviors as expressions of needs.</li><li>•Monitor their own levels of arousal.</li><li>•Use non-coercive, non-aggressive environmental and behavioral strategies and interventions that de-escalate the crisis and that lead to the child's own emotional self-regulation and growth.</li><li>•Use physical interventions only as a safety intervention that contains a child's acute aggression and violence.</li></ul>	Staff working in residential child care organizations	NR	High	No		<a href="http://www.cebc4cw.org/program/therapeutic-crisis-intervention/">http://www.cebc4cw.org/program/therapeutic-crisis-intervention/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>Theraplay</b>	Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive and replicate the natural, healthy interaction between parents and young children. Children have been referred for a wide variety of problems including withdrawn or depressed behavior, overactive-aggressive behavior, temper tantrums, phobias, and difficulty socializing and making friends. Children also are referred for various behavior and interpersonal problems resulting from learning disabilities, developmental delays, and pervasive developmental disorders. Because of its focus on attachment and relationship development, Theraplay has been used for many years with foster and adoptive families.	Children ages 0-18 who exhibit behavioral problems and their caregiver (biological, adoptive, or foster)  For children/adolescents ages: 0 – 18  For parents/caregivers of children ages: 0 – 18	3	Medium	Yes		<a href="http://www.cebc4cw.org/program/theraplay/">http://www.cebc4cw.org/program/theraplay/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>Trauma Systems Therapy (TST)</b>	Trauma Systems Therapy (TST) is a comprehensive, phase-based treatment program for children and adolescents who have experienced traumatic events and/or who live in environments with ongoing stress and/or traumatic reminders. TST is designed to address the complicated needs of a trauma system, which is defined as the combination of a traumatized child/adolescent who, when exposed to trauma reminders, has difficulty regulating his/her emotions and behavior and his/her caregiver/system of care who is not able to adequately protect the youth or help him/her to manage this dysregulation. The most common setting in which TST is implemented is for youth involved with the child welfare system who may be in birth homes, foster care, residential treatment centers, community-based prevention programs, juvenile justice settings, school-based programs, and programs for unaccompanied alien minors.  TST aims to stabilize the child's environment while simultaneously enhancing his/her ability to regulate emotions and behaviors. TST begins by assessing each child and his/her environment. Based on this assessment, the child is placed into one of three treatment phases. A TST priority problem is established, and a TST treatment team is assembled to address this priority problem from multiple perspectives. Different interventions and therapies are indicated within each phase, designed to both help the youth to better regulate survival states, and to help caregivers and providers to become better able to meet the child's needs.	The combination of a traumatized child/adolescent who, when exposed to trauma reminders, has difficulty regulating their emotions and behavior and their caregiver/system of care who is not able to adequately protect the youth or help them to manage these survival in the moment states  For children/adolescents ages: 4 – 21 For parents/caregivers of children ages: 4 – 21	NR	High	Yes		<a href="http://www.cebc4cw.org/program/trauma-systems-therapy-tst/">http://www.cebc4cw.org/program/trauma-systems-therapy-tst/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)</b>	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.	Target Population: Children with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment.  For children/adolescents ages: 3 – 18 For parents/caregivers of children ages: 3 – 18	1	High	Yes	\$1,037 (CBT based models for child trauma)	<a href="http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/">http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/</a>	YES

Type of FFPSA Service	Name of Program	Program Overview (from CEBC if applicable)	Target population (from CEBC if applicable)	CEBC Rating	Child welfare Relevance (from CEBC if applicable)	Home-Based (from CEBC if applicable)	Cost & Cost Savings (per CFP list)	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
Mental Health and Substance Abuse Prevention Treatment Service	<b>Trauma-Focused Coping (Multimodality Trauma Treatment)</b>	TFC targets the internalizing effects of exposure to trauma in children and adolescents, with an emphasis on treating posttraumatic stress disorder (PTSD) and the collateral symptoms of depression, anxiety, anger, and an external locus of control [i.e., tendency to attribute one's experiences to fate, chance, or luck]. The intervention utilizes social learning theory and a skills-oriented cognitive-behavioral approach that is carried out in 14-week sessions of gradual exposure, moving from psycho-education, anxiety management skill building, and cognitive coping training to finally trauma narrative and cognitive restructuring activities.	Children and adolescents in schools who have suffered a traumatic exposure (e.g., disaster, violence, murder, suicide, fire, accidents)  For children/adolescents ages: 9 – 18	3	Medium	No		<a href="http://www.cebc4cw.org/program/trauma-focused-coping/">http://www.cebc4cw.org/program/trauma-focused-coping/</a>	
Mental Health and Substance Abuse Prevention Treatment Service	<b>Triple P - Positive Parenting Program (only Level 4 is on CFP list)</b>	Level 4 Triple P is one of the five levels of the Triple P - Positive Parenting Program® System which is also highlighted on the CEBC. Level 4 Triple P helps parents learn strategies that promote social competence and self-regulation in children as well as decrease problem behavior. Parents are encouraged to develop a parenting plan that makes use of a variety of Level 4 Triple P strategies and tools. Parents are then asked to practice their parenting plan with their children. During the course of the program, parents are encouraged to keep track of their children's behavior, as well as their own behavior, and to reflect on what is working with their parenting plan and what is not working so well. They then work with their practitioner to fine tune their plan. Level 4 Triple P practitioners are trained to work with parents' strengths and to provide a supportive, non-judgmental environment where a parent can continually improve their parenting skills. Level 4 Triple P is offered in several different formats (e.g., individual, group, self-directed, and online). The CEBC evaluated the standard version of Level 4 Triple P as described above and not any other variations (including early teen versions or those for children with developmental delays).	Target Population: For parents and caregivers of children and adolescents from birth to 12 years old with moderate to severe behavioral and/or emotional difficulties or for parents that are motivated to gain a more in-depth understanding of positive parenting  For parents/caregivers of children ages: 0 – 12	1	Medium	Yes		<a href="http://www.cebc4cw.org/program/triple-p-level-3-discussion-group/">http://www.cebc4cw.org/program/triple-p-level-3-discussion-group/</a>	
In Home Parenting Skill Based Program	<b>Trust-Based Relational Intervention (TBRI)</b>	TBRI Online Caregiver Training is a program available via 18 modules on a website that can be accessed in the home or any other location with Internet availability. The training presents the Trust-Based Relational Intervention, a holistic approach that is multidisciplinary, flexible, and attachment-centered. It is a trauma-informed intervention that is specifically designed for children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence, but can be used with all children. TBRI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting Principles. These principles have been used in homes, schools, orphanages, residential treatment centers and other environments. They are designed for use with children and youth of all ages and risk levels. By helping caregivers understand what should have happened in early development, TBRI principles guide children and youth back to their natural developmental trajectory.	Parents (e.g., birth parents, foster parents, kinship parents, adoptive parents, etc.) and caregivers of children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence  For parents/caregivers of children ages: 0 – 17	3	High	Yes		<a href="http://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-online-caregiver-training/">http://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-online-caregiver-training/</a>	
In Home Parenting Skill Based Program	<b>Visit Coaching</b>	Visit Coaching (developed by Marty Beyer, PhD) is fundamentally different from supervised visits because the focus is on the strengths of the family and the needs of the children. Visit Coaching supports families to meet the unique needs of each child during their family time in the community, family homes, visit centers, or offices. Visit Coaching includes: <ul style="list-style-type: none"><li>•Helping parents understand the unique developmental needs of their child and demonstrate that understanding during visits with their child</li><li>•Preparing parents for their children's trauma-related needs and reactions during visits</li><li>•Helping parents give their children their full attention at each visit</li><li>•Building on the parent's strengths in meeting each child's needs</li><li>•Helping parents visit consistently and keep their sadness, anger, and other issues out of the visit</li></ul>	Parents whose child(ren) are living in foster care and see them only during visits	NR	High	Yes		<a href="http://www.cebc4cw.org/program/visit-coaching/">http://www.cebc4cw.org/program/visit-coaching/</a>	
In Home Parenting Skill Based Program	<b>Wraparound</b>	Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed.  The values associated with Wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent and community-based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, Wraparound should be "strengths-based", helping the child and family recognize, utilize, and build talents, assets, and positive capacities.	Designed for children and youth with severe emotional, behavioral, or mental health difficulties and their families where the child/youth is in, or at risk for, out-of-home, institutional, or restrictive placements, and involved in multiple child and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education, etc.)	3	High	Yes	Varies by the study	<a href="http://www.cebc4cw.org/program/wraparound/">http://www.cebc4cw.org/program/wraparound/</a>	
In Home Parenting Skill Based Program	<b>Wyman's Teen Outreach Program (TOP)</b>	The Wyman's Teen Outreach Program® (TOP®) promotes the positive development of adolescents through curriculum-guided, interactive group discussions; positive adult guidance and support; and community service learning. TOP® is focused on key topics related to adolescent health and development, including building social, emotional, and life skills; developing a positive sense of self; and connecting with others. Specific curriculum lesson topics include health and wellness (including sexuality), emotion management, and self-understanding among many others. In addition, the development of supportive relationships with adult facilitators is a crucial part of the model, as are relationships with other peers in the program. TOP® has been adapted to fit the needs of special populations, including youth in foster care, justice involved youth, and LGBTQ youth. Any adaptations need Wyman's prior approval which can be requested through the program representative whose contact information is located at the end of this entry. Please note, the adapted versions have not been reviewed or rated by the CEBC.	Male and female adolescents in grades 6-12 who may come from disadvantaged circumstances  For children/adolescents ages: 11 – 19	3	Medium	No		<a href="http://www.cebc4cw.org/program/wymans-teen-outreach-program/">http://www.cebc4cw.org/program/wymans-teen-outreach-program/</a>	

Casey Family List (11.10.18)	1	Well Supported	*Rows that are mostly yellow or red but Name of Program is green: Casey Family Program list indicates these programs could be classified as well-supported under FFPSA but listed at a lower level on CEBC
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Type of FFPSA Service	Name of Program	Program Overview <i>(from CEBC if applicable)</i>	Target population <i>(from CEBC if applicable)</i>	CEBC Rating	Child welfare Relevance <i>(from CEBC if applicable)</i>	Home-Based <i>(from CEBC if applicable)</i>	Cost & Cost Savings <i>(per CFP list)</i>	Website	Selected for First Round Review by HHS Title IV-E Prevention Services Clearinghouse
	2	Supported	currently						
	3	Promising							

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

Cost & Cost Savings (See KEY tab for description)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### HFA CHILD WELFARE ADAPTATION

The HFA model, since its inception, has been focused on the prevention of child abuse and neglect. In communities throughout the country, child welfare providers have served as a source of referral to HFA for families who could benefit from home visiting. This has resulted in improved parent-child relationships, improved child health and safety, and many families averting further child welfare involvement. HFNY's randomized control study found that mothers with prior CPS reports experienced a reduced rate of confirmed abuse, as well as reduced rate of child welfare services cases opened. The HFA model was designed to engage families as early as possible, during pregnancy or at the birth of a baby. The literature suggests these are significant life events when parents can be more motivated to connect with a home visitor and before poor parenting practices become less amenable to change. For child welfare providers who work on the front lines each day and who recognize the value of connecting families in distress to long-term, intensive home visiting services like HFA, a challenge arises when families with older infants or toddlers are identified and HFA services are unavailable due to the child's age. However, it can be argued the very rationale for enrollment prenatally or at birth is similar to the rationale when serving a child welfare referred population. Parents referred by child welfare can potentially also be more motivated to change.

To address this existing gap in service, HFA has worked closely with state leaders and local implementing agencies to create an optional child welfare adaptation of the HFA model. HFA affiliates (new or existing) whether implementing a child welfare adaptation only or as an add-on to traditional HFA services who work with local child welfare providers, receive referrals from them\*, and who choose to seek a child welfare adaptation, will comply with the following requirements:

- 1) Age at intake - A child welfare adaptation allows target children up to the age of 24 months at time of intake as long as the site maintains documentation to show the initial referral was received from the child welfare system.
- 2) Standard 1 – Initiate services prenatally or at birth. For families enrolled under an approved child welfare adaptation sites will continue to enroll as early as possible, but with an extended enrollment window to age 24 months. Standards, 1-2.C and 1-3.B will remain with the same threshold expectation. Sites are required to demonstrate a minimum of 80% of the adapted portion of the cohort are determined eligible and with a first home visit within twenty-four months of birth (a 2 rating), lest model fidelity be compromised. At least 95% will meet these criteria to demonstrate best practice (a 3 rating). Also, the site will establish and renew annually a formal MOA between the site and the local child welfare office related to referrals and services, sharing of information, including a very clear description of voluntary participation by the family at intake and throughout the course of HFA services (see sample language below, including in the MOA what HFA can and can not do).
- 3) Standard 3 - Voluntary nature of services. HFA remains a voluntary program throughout the family's enrollment, and the worker-parent alliance is maintained vs HFA becoming an "arm" of CPS or the courts. HFA sites utilizing this adaptation may need to further strengthen their creative outreach methods to ensure opportunities to build family trust.
- 4) Standard 4 - Length of services. Services will be offered for a minimum of 3 years (as with traditional HFA) regardless of age at intake (If resources like Family First are used, which are currently slated to provide 12 months of funding for services to families involved in the child welfare system or with characteristics similar to, the site will have to demonstrate access to



other funding streams through blended or braided resources to ensure the site's ability to offer services over the long-term).

- 5) Sites will adhere to all other HFA model expectations as expressed in the HFA Best Practice Standards, including need for signed consent to release information with CPS and the court (unless subpoenaed).
- 6) Data collection - Any site seeking a child welfare adaptation is required to code family data in such a way allowing it to be analyzed and reported separately from traditional HFA families.

\* NOTE: Sites not currently working with their local child welfare office, will establish this relationship first before seeking a child welfare adaptation.

In addition, sites with approval to implement a HFA Child Welfare Adaptation are strongly encouraged to implement the following recommendations (when families become involved with child welfare after already being enrolled in HFA, the site is not required to seek a child welfare adaptation but will want to consider how to implement these recommendations to support staff):

- 7) Standard 8 - Maintain smaller caseloads due to the higher risk of families served (HFA recommends. 10-12 families maximum when at the most intense level of service, 16-20 families maximum when at a variety of service levels, and a case weight of 20-24 points maximum). Also, spread child welfare referred families across site staff, rather than concentrating all with one worker, to reduce staff burnout.
- 8) Standard 9 – Consider staff characteristics and capacity at the time of hire to work exclusively with a child welfare population. A minimum of a bachelor's degree in human services or related field for HFA direct service providers is strongly recommended.
- 9) Standard 11 – Staff working with families referred from child welfare will receive ongoing training as is required in the standard, and in particular should include HFA's Facilitating Change or other training on motivational interviewing techniques, as well as training on specific issues impacting child welfare referred families, e.g. understanding of the child welfare system, and specific issues such as opioid use.
- 10) Standard 12 – In addition to required weekly individual supervision, provide monthly reflective consultation groups for direct service staff and supervisors with a skilled Infant Mental Health consultant (see HFA's facilitator requirements in standard 12-1.C for those providing reflective consultation groups). Supervisors should obtain additional training. HFA's Advanced and Reflective supervision courses should be received by supervisors.
- 11) Governance and Administration – strengthen cooperative relationship between HFA site and local CPS (i.e. invite child welfare membership on the site's Advisory Group, convene monthly trainings/in-services, with regular conversations in between, for child welfare staff to increase understanding of HFA as a voluntary program serving in a support role to families, not in a role as child welfare. This is critical, especially with CPS staff turnover, and to support coordination of services for families).
- 12) Remain involved with the family in situations where the target child is removed from the parent's custody when reunification is the plan, and strive for visits as often as possible with both the parent and child, recognizing this may include conducting the HFA visit during supervised visitation (but not with the HFA site responsible for supervision of the visit).
- 13) Sites are encouraged to have a thoughtful plan, describing how this adaptation is integrated into their home visiting services that gives families, staff, community partners and all referral

sources clear expectations regarding who the site's target population is and how Healthy Families services are described to families and agencies connected to child welfare, as well as to families and agencies not involved with child welfare.

With that in mind, sites will include in their implementation plan:

- a) Number of families the site intends to serve with this child welfare adaptation in years 1, 2 and 3 of implementation
- b) Total number of families (child welfare and all others) the site is intending to provide HFA services to
- c) Overall description of target population
- d) Description of how Healthy Families services will be communicated to agency partners, referral sources and all members of the target population

**A site requesting a HFA child welfare model adaptation will submit its request to the HFA National Office, via the assigned Implementation Specialist, providing a written implementation plan of its intentions related to each of the requirements (items 1-6) and recommendations (items 7-13).**

Sample Language to articulate expectations between the HFA site and local Child Welfare office:

**Healthy Families America and Department of Child Welfare  
At-A-Glance**

**Healthy Families** is a voluntary evidence-based home visiting program serving pregnant women and families of infants and young children. HFA is a prevention program dedicated to supporting families in their quest to be the best parents they can be. Program services are designed to strengthen families during the critical first years of a child's life. The child's age at HFA enrollment is prenatal to age 24 months as services are focused primarily on prevention through education and support in the homes of new parents. All HFA Program criteria are based on proven best practice standards. Intensity of services is based on each family's needs, beginning weekly and moving gradually to quarterly home visits as families become more self-sufficient. The Department of Child Welfare contracts with community providers who implement the program in their local communities.

**FAMILY SUPPORT SPECIALISTS** are caring, well-trained home visitors who offer support, encouragement, and services using an evidence-based approach which include the following:

- Providing emotional support and encouragement to parents
- Teaching & supporting appropriate parent-child interaction and discipline
- Providing periodic developmental assessments and referrals if delayed
- Linking families with community services, health care, child care, and housing
- Encouraging self-sufficiency through education and employment
- Providing child development, nutrition, and safety education

**INTAKE INTO THE HFA PROGRAM** consists of the following steps which generally take place in a potential participant's home.



- Parents are to be informed, verbally and in writing, of the voluntary nature of participating in HFA services as early as possible but no later than when families consent to participate in services.
- The Family Resource Specialist reviews the Family Rights and Confidentiality handout, which also indicates the services are voluntary. Families will need to complete the signed document before services can proceed.
- In the event child welfare or the court system attempt to mandate services for a family, HFA staff will ensure that both the agency and the family know services will be offered voluntarily.
- HFA Family Resource Specialist or Family Support Specialist will complete a Parent Survey interview which is a comprehensive psycho-social assessment identifying early childhood trauma, life stresses, coping skills, parenting styles, etc. which will form the basis of each family's HFA Service Plan.
- All intake assessments must occur and the program accepted by the family prior to the target child turning twenty-four months of age.
- Program services to the entire family can continue until the child is five years of age.

#### **HFA WILL PROVIDE THE FOLLOWING TO CHILD WELFARE INVOLVED FAMILIES:**

- Accept referrals from Child Welfare staff and provide a screening and/or assessment for the parent(s) if the parent(s) wishes to determine if they are eligible to receive program services.
- While the child is often in parental custody at the time of HFA intake, situations of newborns removed at birth are appropriate referrals when reunification is intended.
- If a child has medical complications and is in the hospital for a period of time (i.e., the infant is not in the home), the family can be accepted into the program as long as the family retains custody of the child.
- Having an in-home dependency petition does not preclude enrollment in HFA if all other enrollment criteria are met.
- Should Child Welfare file a dependency petition and the child is removed from the parent's custody, there must be a plan for reunification if services are to continue.
- If the parent is involved in multiple services, the HFA Manager may request a staffing with Child Welfare and the parent(s) to determine the services most appropriate to meet the needs of the individual family.
- HFA staff will attend Child Welfare case staffings only with the parent(s) permission and with the parent(s) also in attendance.
- HFA staff are required by the model to report suspected child abuse and neglect, even if the state does not acknowledge them as mandated reporters, and staff will continue to report observations of child abuse and neglect in families in the program or as families are leaving the program.

#### **HFA CAN NOT PROVIDE THE FOLLOWING:**

- Supervision for visits between the child and parent(s) and/or transport to/from supervised visits.
- Progress reports to the Child Welfare staff without the written consent of the parent(s).

- Program records to Child Welfare or other government agencies without specific prior written consent of the parent(s) or the receipt of a court order.
- Joint visits to a family by HFA staff and Child Welfare without the parent(s) consent.
- Testimony in a proceeding without a court order or parent(s) written permission.
- Mandated service for a Child Welfare case plan since program services are voluntary and the parent can terminate services at any time.
- Preference to Child Welfare families. All families are enrolled in services on a first-come first-served basis.
- A waiting list for child welfare involved families. The HFA program does not maintain waiting lists.
- Upon termination of services, HFA will be unable to advise Child Welfare of the parent's status unless the parent gives written consent for HFA staff to talk with Child Welfare.

If you want to make a referral and please contact us.

Local HFA Site Manager: \_\_\_\_\_

Phone Number: \_\_\_\_\_







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July 20, 2018

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

Dear Deputy Assistant Secretary Goldstein,

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

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

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

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

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

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

## Section 2.1

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



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

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

## Section 2.2

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

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

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

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



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

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

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

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

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

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

Other non-published studies of note:

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

Current studies in progress

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

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

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



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

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

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

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

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

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

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



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

Stage of implementation specific tools include:

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

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

Attached:

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

**Components of FCT Trauma Treatment**

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

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

**2.3**



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

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

These studies are attached to this email correspondence.

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

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

## 2.4

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

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

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

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

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



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

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

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

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

### 2.5

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

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

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

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





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

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

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

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

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

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





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

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

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

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

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

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

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

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



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

Sincerely,

*Timothy J Wood, LPC*

Timothy Wood, LPC

Executive Director-Family Centered Treatment Foundation, Inc.



Attachments incorporated for review:

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

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

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

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



## RESEARCH PUBLICATIONS

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

[http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2010/RAND\\_TR750.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR750.pdf)

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

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

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

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

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

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

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

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

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

**Highlights from Findings:**

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

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

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

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

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

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

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

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

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## INDEPENDENT REPORTS

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

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

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

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

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**Bright, C. L. (2017, July). *Adapting juvenile justice interventions to serve youth with trauma histories.* Presented at the International Academy of Law and Mental Health's 35th International Congress on Law and Mental Health, Prague, Czech Republic.**

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

**Preliminary Findings:**

**Theme 1 – trauma awareness**

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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## PUBLISHED ARTICLES

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

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

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

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

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

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

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

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

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

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

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

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



# Attachment G

<b>State of Nebraska</b> WORK INSTRUCTION DOCUMENT FOR:	<b>Author:</b> Elizabeth Schropp	<b>Effective Date:</b> 4-5-19
Mandatory Monthly Visits with Children, Parents and Out of Home Care Providers	<b>Version #:</b> 1	<b>Page:</b> Page 1 of 7

**Purpose:** Provide instructions for DCFS case managers regarding requirements for mandatory monthly contacts with children, parents and out of home care providers.

**Scope:** Division of Children and Family Services Protection and Safety

**Responsibilities:** Child and Family Services Specialist: conduct monthly visits with parents, youth and out of home caregivers as outlined. Documents monthly visits as required. Makes arrangements for other individuals to conduct monthly visits when necessary as outlined.  
Child and Family Services Specialist Supervisor: approve changes to expectations for contact when appropriate as outlined.

**Rescinds:** This Standard Work Instruction rescinds Administrative Memo #28-2017

## Definitions:

Out of Home Care Provider: Any adult providing care for a child other than the parent(s). This can include relatives, kinship placement, foster parents, group home staff, PRTF staff, adult caregiver(s) in an informal living arrangement, etc. If a youth is placed in Independent Living or with a legal parent, they do not have an out of home care provider.

## Procedure:

### 1. Who will Conduct the Visit?

- A. The assigned CFS Specialist or DCFS contractor for case management (hereafter CFS Specialist) will conduct the visit. On rare occasions, a different CFS Specialist, the CFS Supervisor, DCFS contractor for case management or Resource Development worker may conduct the visit.
- B. When multiple children are placed in a facility such as a group home or residential treatment facility, DCFS can designate one or more CFS Specialists to make the monthly visit to a number of children and report individually to each child's CFS Specialist. In all situations, it remains the responsibility of the assigned CFS Specialist to ensure that the visits are made and appropriately documented on N-FOCUS in the Required Contacts narrative.
- C. Wards placed out-of-state may have a person designated in the other state to conduct the visit. Such individuals may be staff of a private agency with a contract with Nebraska for the service or a courtesy case manager assigned by the other state under Interstate Compact for the Placement of Children (ICPC) or Interstate Compact for Juveniles (ICJ).
  1. The CFS Specialist will not visit a child in another state without first notifying the Nebraska ICPC Office in DCFS Central Office to determine if the other state allows Nebraska staff to conduct visits in the other state.

### 2. Visitation with Children:

- A. Placed In-Home: The CFS Specialist will have face-to-face contact with all children in the home, regardless of whether the child is a DHHS ward or Non-ward.

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- B. Placed Out-of-Home: The CFS Specialist will have face-to-face contact with all children placed out of the home as well as any other children remaining in the family home, regardless of whether or not the other children in the family home are DHHS wards or Non-wards.
- C. All children placed in Nebraska under the auspices of the Interstate Compact on Placement of Children (ICPC) or Interstate Compact on Juveniles (ICJ) in non-facility placements.
- D. When a parent chooses to prohibit the CFS Specialist from having contact with the non-ward minor siblings of state wards, the CFS Specialist will document and discuss this with their supervisor. The CFS Specialist and supervisor will discuss alternative ways to engage the parent to allow access.
- E. For a child living outside the Service Area or local office area, a courtesy case manager in the area where the child resides can, upon request, be assigned to conduct the monthly visit.
- F. All visits with children must occur in the home where they reside. When a visit cannot occur in the home, the CFS Specialist must obtain approval from their supervisor and document the approval in Consultation Point narrative.
- G. If the child cannot be located at his or her residence, the CFS Specialist will notify his or her supervisor immediately in writing, by phone or other electronic means. For youth missing from placement, the CFS Specialist will follow the procedure for reporting a youth that is missing from care, as outlined in the program guidance on "Youth Who Cannot Be Located" #29-2017.
- H. The frequency of face-to-face contact is based on the SDM risk levels.
  - 1. In Home Cases
    - a. Low or Moderate Risk – One face-to-face contact per month.
    - b. High or Very High Risk – Two face-to-face contacts per month.
  - 2. Out-of home Cases
    - a. Low or Moderate Risk – One face-to-face contact per month.
    - b. High or Very High Risk – Two face-to-face contacts per month. One of the two contacts may be made by the agency supported foster care worker or Resource Development worker assigned to the specific child.
- I. With supervisory approval, when more than one contact per month is required, one contact can be via SKYPE, phone call, text or other electronic means if an in-person contact cannot occur. CFSS will document in the Required Contact narrative why a face to face contact could not occur and what efforts were made to have face to face contact with the youth.
- J. All visits with children age 18 months and older must be private. Others may be present with children who are less than 18 months old, non-verbal (involving little or no use of words) or have a disability limiting their ability to communicate. This will be considered and documented as a private contact.
- K. All children in out-of-home care will have contact with the CFS Specialist within the first 7 calendar days of any out-of-home placement. This does not apply to youth placed in another state through the Interstate Compact for the Protection of Children (ICPC).
- L. Children placed out-of-state through ICPC, will have contact with their case manager based on the ICPC regulations and laws.
- M. **Topics to be Covered/Focus of the Visit:**
  - 1. Visits should address the following:
    - a. The strengths and needs of the child;

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- b. Evaluation of current services;
  - c. Permanency, establishment and evaluation of goals;
  - d. Assessment of the child's safety in the residence and safety of the community;
  - e. School; and
  - f. Visits with parents and siblings.
2. The following information should be provided and discussed with the child when appropriate, taking into account age, development, mental health concerns, etc.:
    - a. Dates for court hearings and discussion on the child attending and participating;
    - b. Court ordered expectations;
    - c. Requirements of probation or parole;
    - d. Explanation of the Youth Bill of Right and discussion monthly regarding whether those rights have been respected for the youth. If the youth feels their rights have been violated in anyway, CFSS will work with the youth as well as their parents and out of home caregiver when applicable to address those issues.
    - e. Opportunity to ask questions or express concerns.
  3. Discussion about Transitional Living plans for state wards age 14 or older and discussions on Independent Living should occur with every child age 14 or older. This discussion should center on: assessment of the youth's knowledge, skills and abilities; areas needing more education, training, and mentoring; and plans for the future. Discussion should include asking the child for his or her input and hopes for the future as well as how he or she is doing in school; medical issues or concerns. If applicable, discussion of mental health and substance use issues or concerns including discussion of how psychotropic medications are working and any side effects the youth may be experiencing.
  4. For children who are non-verbal due to age or disability, the CFS Specialist must observe and document the child's general growth, progress in meeting developmental milestones, behavior, and any concerns and progress shared by the caregiver. Refer to Program Guidance on "Health Care Coordination and Psychotropic Medication Guidelines".

**3. Visitation with Parents**

- A. The CFS Specialist will have a private face-to-face visit with:
  1. Legal parents and non-custodial parents of all children who are HHS-Wards whose parental rights are not terminated, regardless of the permanency objective
  2. Legal parents and non-custodial parents providing care to a child placed under the auspices of ICPC or ICJ
- B. Visits with custodial and non-custodial parents must be confidential. The parents must be in agreement with any additional individuals being present during the visit. At least every other month the visit must occur in the parent's residence unless otherwise instructed below.
  1. For a parent receiving treatment in a residential facility, monthly face-to-face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face-to-face visit. The barriers identified must be documented in the Required Contact narrative

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2. For a parent who is incarcerated, monthly face-to-face contact is required unless there is a clear barrier to having contact with the parent. When a clear barrier exists, phone contact can replace the face-to-face visit. The barriers identified must be documented in the Required Contact narrative
  3. For a parent living outside the Service Area or local office area, a courtesy case manager in the area where the parent resides may be assigned to conduct the monthly visit
  4. For a parent living out-of-state, monthly contact can be made via phone or other avenues such as letter, e-mail, texting or other forms of communication at the request of the parent
  5. Refusal to meet or appointments that are missed without good cause will be documented in the Required Contact Narrative – Efforts to Contact.
- C. The frequency of contact is based on the risk levels.
1. Low or Moderate Risk – One face-to-face contact per month.
  2. High or Very High Risk – Two face-to-face contacts per month.
- D. When more than one contact per month is required, one contact can be via SKYPE or other electronic means if an in-person contact cannot occur, with supervisory approval.
- E. The CFS Specialist will have a monthly private face-to-face visit with the non-custodial parent in court cases.
- F. Regular efforts to locate and engage the non-custodial parent must be documented in the Required Contacts Narrative – Efforts to Contact.
- G. **Topics to be Covered/Focus of the Visit:**
1. Discussion should include the following:
    - a. Current safety threat(s) identified
    - b. Safety plan
    - c. Risk levels
    - d. Family strengths and needs
    - e. Establishing a permanency objective and case plan
    - f. Ongoing evaluation of the permanency objective and case plan
    - g. Discussion of concurrent planning (when needed); and
    - h. Visitation issues
    - i. Upcoming court hearings such as the Permanency Hearing and the 15 out of 22 Month provisions
  2. Discussion should also include information on the child's:
    - a. Health and treatment needs
    - b. School performance and peer relationships
    - c. For older children, discussion about their skills and abilities towards achieving independence
    - d. Discussion on psychotropic medications being taken by the child and the parent's observations of how psychotropic medications are working and any side effects the youth may be experiencing
    - e. When any child in the home is under the age of 2, the CFS Specialist will have a discussion about Safe Sleep and observe the child's sleeping arrangement utilizing the Nebraska Safe Sleep Environment Checklist as a guide. The CFS Specialist will encourage the parent to address any identified concerns regarding the child's safe



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sleep environment and assist the parent in making any necessary changes, if requested.

**4. Visitation with Out of Home Care Providers**

- A. The CFS Specialist will have monthly contact with the child's out-of-home care provider as follows:
  - 1. Caregiver of each ward in out-of-home care;
  - 2. Caregiver of each child in an Informal Living Arrangement in a non-court involved case; and
  - 3. Caregiver of each child in out-of-home care under the auspices of ICPC and ICJ.
- B. At a minimum every other month the visit must be face-to-face, in the caregiver's home. For caregivers out of state, the visit may be by phone or email. For out of state, contact must be made in addition to contact that may be made by an ICPC Courtesy worker.
- C. If the caregiver refuses or cancels contacts without good cause the CFS Specialist will document this in the Required Contacts – Efforts to Contact and consult with the supervisor to consider whether or not the current placement continues to be suitable and in the child's best interest.
- D. **Topics to be Covered/Focus of the Visit:**
  - 1. Discussion should include the following:
    - a. Child's health status including any recent treatment, unmet medical needs, and current medications, including psychotropic medications
    - b. Child's school performance and educational plan
    - c. Peer relationships or needs
    - d. Behavioral needs
    - e. For children 14 and older discussion of the child's independent living knowledge, skills and abilities should occur with a plan as to what action the foster family or caregiver will do to support teaching, coaching, and mentoring
    - f. Issues around visitation with parents and siblings
    - g. Status of court process
    - h. Any issues, concerns or needs in the caregivers' household should also be discussed.
    - i. When any foster child in the home is under the age of 2, the CFS Specialist will have a discussion about Safe Sleep and observe the foster child's sleeping arrangement utilizing the Nebraska Safe Sleep Environment Checklist as a guide. The CFS Specialist will address any identified concerns regarding the foster child's safe sleep environment and assist the parent in making any necessary changes.
    - j. The CFS Specialist should regularly reassess the caregiver's commitment to the child and willingness to provide continued care including the caregiver's willingness and ability to provide permanency when needed.

**5. Waiver of Case Manager's Contacting Parent in the Parent's Home:**

- A. When the home environment of the parent presents a threat to the safety of a CFS Specialist, a supervisor may waive the requirement for face-to-face contact with the parent in the home. This

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decision must be documented in N-FOCUS. The decision to waive the requirement must be made and reviewed and documented each month.

**6. Documentation of Visits:**

A. Documentation of all monthly contacts (and information about contacts that were attempted and not successful) with children, parents, and caregivers must be documented in the Required Contacts narrative within seven (7) calendar days of the contact. The following information must be included:

1. Location of visit
2. Date of visit
3. Who was present at the visit identified by first and last name
4. If the visit was not private, describe why
5. Observations of the child, parent, and caregivers and interactions noted
6. Assessment of child safety and risk which reflects the child, parent and caregiver's input
7. Issues discussed which reflect the child, parent and caregivers
8. Actions needed by whom and by when

**7. Immediate Alternative:** When a visit cannot occur due to an unforeseen emergency, the supervisor must be notified in advance. The supervisor will make arrangements for alternative coverage. If alternative coverage cannot be arranged a written exception to this requirement must be approved by a CFS Administrator. Exceptions will be documented by the CFS Specialist in the Consultation Narrative within seven (7) calendar days of the decision, and include the name of the administrator approving the decision.

**Expected Results:** CFS Specialists will have more thorough and informative monthly contact with children, parents and out of home care providers. They will have a clear understanding of what should be documented from these contacts and when and documentation will reflect that monthly contacts are being completed in a more comprehensive manner.

**References:** Protection and Safety Procedure on Health Care Coordination and Psychotropic Medication Guidelines.

Protection and Safety Procedure #28-2017; Protection and Safety Procedure #29-2017

Nebraska Safe Sleep Environmental Checklist

**Revision History:**

REVISION LEVEL	DESCRIPTION	AUTHOR	APPROVAL DATE	EFFECTIVE DATE
Initial		Elizabeth Schropp	4-5-19	4-5-19

**Approval by:** *Jamie Kramer*

**Date:** 4-5-19

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**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Nebraska Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Healthy Families America (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10 15 19

(Date)

\_\_\_\_\_  
(CB Approval Date)

Dannette K Smith by EDodson

(Signature and Title)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Nebraska Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Multi-Systemic Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10 15 19  
(Date)

Dannette R Amite M EdD  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Nebraska Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parent/Child Interaction Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10 15 19  
(Date)

\_\_\_\_\_  
(CB Approval Date)

Dannette K Smith by Edna  
(Signature and Title)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Nebraska Department of Health and Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10 15 19  
(Date)

Dannette K Smith M EdD  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)



**State Assurance of Trauma-Informed Service-Delivery**

**Instructions:** This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

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

**Signature:** This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10 15 19  
(Date)

Dannette K Amick, Esq.  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES  
Administration on Children, Youth and Families  
Children's Bureau**

**State Annual Maintenance of Effort (MOE) Report**

<b>State:</b> Nebraska	<b>FFY:</b>
<b>Baseline Year:</b>	2014
<b>Baseline Amount: \$</b>	3,578
<b>Total Expenditures for Most Recent FFY:</b>	N/A

<p><b>This certifies that the information on this form is accurate and true to the best of my knowledge and belief.</b></p> <p><b>This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.</b></p>
<p>Signature, Approving Official:</p> <p><i>Dannette R Smith</i></p>
<p>Typed Name, Title, Agency:</p> <p>Dannette Smith, Chief Executive Officer, Nebraska Department of Health and Human Services</p>
<p>Date: 10 15 15</p>