DCYF

Rhode Island Department of Children, Youth & Families

Title IV-E Prevention Services Plan

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INTRODUCTION

The Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115-123, authorized new optional Title IV-E funding for time-limited prevention services for mental health, substance abuse, and in-home parent skill-based programs for children or youth who are at-risk of entering foster care, pregnant or parenting youth in foster care, and the parents or relative caregivers of those children and youth.

The Rhode Island Department of Children, Youth and Families (DCYF) is electing to implement the Title IV-E prevention program as authorized by FFPSA. This plan builds upon DCYF's focus and mission of strengthening the capabilities and expanding the capacity of parents and caregivers to effectively care for their children and safely reduce the need for foster care by partnering with families and communities to raise safe and healthy children and youth in a caring environment. Keeping children and youth safe and healthy at home, at school and in the community, requires a family-focused and community inclusive approach.

The intent of this initial Title IV-E Prevention Program Plan (Plan) is to set a basic operational foundation and expand our prevention program, and submit amendments to the Plan, as we build capacity. The prevention service array described in this plan will also be expanded through amendments as additional evidence-based programs (EBPs) are approved through the Title IV-E Prevention Services Clearinghouse or are reviewed and approved through independent systematic reviews and based on the availability and need of services in Rhode Island.

DCYF is a department within Rhode Island's Executive Office of Health and Human Services and is responsible for child welfare and juvenile justice. Additionally, DCYF is charged with children's services and behavioral health along with other Rhode Island departments including: Executive Office of Health and Human Services (EOHHS), Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH), Department of Education (RIDE), Department of Health (RIDOH), and the Office of the Health Insurance Commissioner (OHIC) which collectively are managing the continuum of services and working to improve access and oversight of behavioral health services at the state and local levels.

DCYF was created in 1980 and is statutorily designated as the "principal agency of the state to mobilize the human, physical, and financial resources available to plan, develop, and evaluate a comprehensive and integrated statewide program of services designed to ensure the opportunity for children to reach their full potential. Such services shall include prevention, early intervention, outreach, placement, care and treatment, and aftercare programs. Utilizing a network of comprehensive programs, ranging from community-based services to residential treatment programs, DCYF provides child protection, child welfare, children's behavioral health, preventive services to children at risk of maltreatment, support services for children and families in need, and services for youth requiring community supervision or other juvenile justice programs.

DCYF will be leading the efforts outlined in this prevention plan and will do so with support and partnership with its sister agencies that share responsibility for children's behavioral health.

PREVENTION VISION AND APPROACH

DCYF's child welfare vision is the promotion of child, family, and community well-being among all populations void of race, ethnicity, gender, and socio-economic status disparities, with a focus on eliminating disproportionality and achieving equity. DCYF aims to achieve its vision through a public health model and its accompanying hallmarks of prevention and social determinants of health – the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of

health, functioning, and quality-of-life outcomes and risks such as racism, safe neighborhoods, and access to quality education.[1]

Prevention efforts are generally recognized as occurring along three levels in child welfare: primary prevention directed at the general population, secondary prevention targeted to individuals or families in which maltreatment is more likely, and tertiary prevention targeted toward families in which maltreatment has already occurred. The ideal approach to prevention encompasses all three levels, which results in a comprehensive service framework focused on improving outcomes for children and families. The 2018 Family First Prevention Services Act encourages states to emphasize the importance of primary prevention services in particular.

DCYF recognizes that disparities, and in particular racial disparities, occur at nearly every major decision-making point along the child welfare continuum and that child welfare services and child welfare research have not historically utilized an antiracist approach, nor does it typically include the perspectives of those with lived experience. To fully embrace prevention as a department, we must acknowledge and address racial equity as a part of prevention. As such, we are fundamentally committed to facing these challenges head on and are making the elimination of disproportionality and achievement of racial equity a central theme to this prevention plan which are discussed in greater detail below.

Systemic and Structural Racism and Disproportionality

DCYF leverages the Ecological Model and Pair of Aces framework to promote the values and principles of understanding the larger historical context, a structure of systemic racism and forced marginalization experienced by Black, Indigenous, and People of Color (BIPOC) families. As evidenced in the data below, DCYF continually examines the extent to which racial disparities are observed in Rhode Island to help identify where change is needed.

For over 15 years, DCYF has analyzed data and reported on an array of safety, permanency and well-being outcomes by race and ethnicity. In Rhode Island during FFY20:

- 17 percent of Black, Non-Hispanic children under the age of 18 years were disproportionately indicated for maltreatment compared to their 11.5 percent representation in Rhode Island.
- Nearly 11 percent (10.9 percent) of multiracial children under the age of 18 years are disproportionately indicated for maltreatment compared to their 6.3 percent representation in Rhode Island.

Similar disproportionality is observed in removals. Among a SFY20 entry cohort:

- Black, Non-Hispanic children ages 0-9 years were removed from home close to twice as much in as their representation in the state (age 0-9 years), 20 percent and 12 percent, respectively.
- Multiracial children ages 0-9 years were removed close to three times as much as their representation in Rhode Island (age 0-9 years), 16 percent and 6 percent, respectively.

Similar disproportionality is observed in children ages 10-17 years:

- Among children removed from their homes, 21 percent were Black, Non-Hispanic compared to 12 percent in Rhode Island.
- 16 percent were multiracial compared to 6 percent in Rhode Island, and
- 31 percent were Hispanic compared to 25 percent in Rhode Island.

With the support of EOHHS leadership and its increased focus on race and ethnic disparities, since SFY20, DCYF has seen slight improvements in disproportionality compared to previous years, specifically in the areas of first placement and foster care re-entry. Prior to FY20, Black, Non-Hispanic children had significantly higher odds of being placed in congregate care after controlling for age and prior to FY19, Black, Non-Hispanic children had significantly higher odds of re-entering foster care. DCYF will continue to

[1] https://health.gov/healthypeople/objectives-and-data/social-determinants-health

monitor and measure disproportionality and disparities to inform the development of its strategies to address continued and emerging themes and refine existing programs and practices through continuous quality improvement.

Strategies to Address Disproportionality

DCYF has implemented several strategies to address racial and ethnic disproportionality using rigorous data analyses across an array of indicators and outcomes that focus on children and families' safety, permanency, and well-being. This data is shared monthly in DCYF's divisional Active Department Management meetings (ADMs). Data indicators and outcomes stratified by race and ethnicity are reviewed with each Department division and based on the trends, a deep dive analysis is conducted to better understand the underlying factors associated with the outcomes. The meetings discuss strategies and action steps to address disparate outcomes, implement strategies, and monitor the progress. DCYF also engages in a similar activity called Active Contract Management (ACM) among DCYF and its contracted providers.

DCYF has a Diversity Advisory Committee (DAC) that meets on a regular basis that is comprised of DCYF staff, managers, and administrators. Founded in 2015, the committee's mission is "to recruit, develop, and retain, a diverse, high-performing workforce that draws from all segments of society, who understands the unique challenges of service delivery to Rhode Island families and youth, in a multi-cultural, and culturally competent environment, while valuing fairness, diversity, and inclusion." DAC has helped to develop and monitor the agency's Affirmative Action Plan for each of the past five years. The committee also collaborates across DCYF to provide education and programming that supports topics of cultural competency and humility, engagement with diverse families and communities, and equitable outcomes for the youth and families served by DCYF.

In the wake of the George Floyd murder and the renewed calls for racial justice at the local and national levels, DCYF in summer of 2020 committed to new approaches to address the disproportionalities and disparate outcomes seen across all areas of child welfare, children's behavioral health, and juvenile justice. DCYF formed a race equity team — made up of staff, senior leadership, members of the agency's DAC, and external partners — to develop a strategic direction for this work. As a result, between June of 2020 and May of 2021, DCYF has taken action to address anti-racism and achieve racial and ethnic equity for children and families in Rhode Island through the following endeavors identified in the table below:

DCYF's Racial Equity Focused Actions

- ✓ Provided implicit bias training to nearly 100 percent of its staff.
- ✓ Supported 60 DCYF administrators and other staff to participate in Merciful Conversations on Race, a 10-hour course offered by the Rhode Island State Council of Churches that helped build a common set of values around race equity and address white privilege. The course provides a positive, trusting space to explore why race conversations can be such a struggle; helps to overcome challenges; assists participants to develop common language; helps staff identifying as BIPOC to share their stories, and explores concepts around white fragility.
- ✓ Offered 35 Listening, Learning and Leading sessions that gave staff opportunities to learn from each other and from outside experts about how issues of race and culture affect the lives of both staff as well as the families and communities served by DCYF.
- ✓ Provided professional development training to DCYF staff through a collaborative effort between T-Time Productions and the Division of Juvenile Corrections, Rhode Island Training School – Youth Development Center. The bi-weekly, interdisciplinary sessions focus on culturally relevant teaching and pedagogy that is designed to enhance the resident-students' educational experience.
- ✓ Developed a culture of enhanced engagement with families by defining and embedding equitable family engagement throughout DCYF and its partner agencies.
- ✓ Identified and began integrating new metrics that will help measure racial equity throughout the screening and investigation process and eliminate disproportionality in the rate of removal from home of BIPOC children and youth to achieve permanency.
- ✓ Updated the DCYF SACWIS system, RICHIST, to better track data related to race, ethnicity, as well as preferred and secondary languages. This data set finds that at least one foster parent in 40 percent of all foster homes identified as a race and/or ethnicity other than white/non-Hispanic.
- ✓ Implemented an anonymous Culture and Diversity Questionnaire that is sent to all resource parents. This survey asks resource parents to self-identify in a variety of areas of diversity and express their interests in participating in training and enrichment activities in this area. Results of the survey will provide valuable insight on how DCYF resource families experience their identify and how their identity relates to their involvement in the child welfare system. Nearly 700 responses have been received, to date.

In mid-2021, DCYF launched a multi-phase, multi-year approach to eliminate disproportionality representation and achieve equitable outcomes among all races and ethnicities. To begin, each service division developed a set of strategies to address foundational issues that affect inequity; these strategies will be monitored for progress on the selected outcomes. DCYF's racial equity work is grounded in a model put forth in Annie E. Casey's Racial Equity Action Guide.[2] DCYF and its sister state health and human services agencies continue to work closely with Casey Family Programs to shape its racial equity strategic direction; also, Department leaders have joined a collaborative group through the New England Association of Child Welfare Commissioners and Directors to share innovations.

DCYF will leverage the FFPSA to continue and enhance prevention efforts to mitigate the factors that place families at risk of DCYF involvement with a concerted effort to eliminate racial and ethnic disproportionality in the child welfare system.

[2] https://www.aecf.org/resources/race-equity-and-inclusion-action-guide

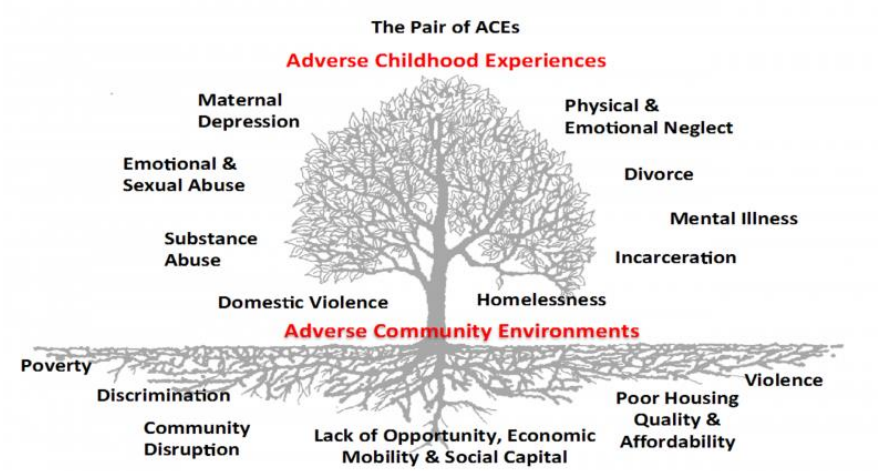
The Public Health Model

The public health model relies on a large multidisciplinary infrastructure to bring evidence-based primary prevention strategies to the public at a whole-of-population scale. At its core is a focus on early and comprehensive engagement aimed at reducing risk factors and enhancing protective factors before problems first emerge. The approach involves defining and measuring the problem, determining the cause or risk factors for the problem, determining how to prevent or ameliorate the problem, and implementing effective strategies on a larger scale and evaluating the impact.[3]

DCYF employs two of the public health's cornerstone frameworks, **the Prevention Framework – Primary, Secondary, and Tertiary Prevention – and an Ecological Model for Prevention** embodying social determinants of health inclusive of racial equity, and their interactive impacts across micro to macro levels. Collectively, these two public health frameworks emphasize and strategically guide child welfare to acknowledge and deploy a system that addresses systemic racism and its destructive effects on upstream social determinants of health – the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks such as racism, safe neighborhoods, and access to quality education.[4] The results can be utilized strategically to target systemic racism and social determinants of health with prevention measures, in particular primary and secondary prevention programs aimed at promoting well-being, reducing the risk of entry into foster care, and mitigating harmful long term impacts.

Illustrative of this public health model is further observed in The Pair of Aces. The tree illustration highlights the potential harmful lifelong impacts that can be associated with a lack of affordable and safe housing, community violence, racism, systemic discrimination, and limited access to social and economic mobility compound one another.

Figure 1. The Pair of Aces



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Application of the Primary and Secondary Prevention Framework

Primary prevention is a universal approach aimed at the general population to increase awareness across all populations and attempt to stop maltreatment before it occurs. Secondary prevention is aimed at populations with one or more risk factors that are deemed high risk, to mitigate the risk of and prevent maltreatment or removal from home through prevention activities and services such as home visiting

[3] https://www.cdc.gov/training/publichealth101/public-health.html
[4] https://health.gov/healthypeople/objectives-and-data/social-determinants-health

programs and parent education programs. This is where the Ecological Model intersects with the Prevention Framework. Communities who may be at increased risk of child welfare involvement often are seeded in systemic racism and systemic marginalization that contributes to a disadvantage and negatively impacts individuals' and families' social determinants of health. (Tertiary prevention is intervention once the event – maltreatment, removal from home - has occurred).

Since 2009, the Department has implemented the Public Health Prevention Framework with a strong shift toward primary and secondary prevention. In 2009, the Department developed a network of prevention-directed providers statewide, the Family Community Care Partnerships. **The DCYF and FCCP collaborative deploy both primary prevention and secondary prevention.**

Primary Prevention

The Department's primary prevention efforts are through the FCCPs and collaboration with the Rhode Island Department of Health.

Primary prevention efforts are achieved through collaborative media campaigns with RIDOH home visiting programs, health providers, and FCCP public service announcements. The public service announcements have addressed a variety of shared aims such as safe sleeping, parenting, and child development. These universal messages provide statewide awareness of these topics as well as where families can receive supports.

Another primary prevention effort is embedded in the FCCP structure itself. The FCCP is a network consisting of community agencies that holistically addresses family functioning and clinical needs as well essential basic needs such as financial, housing, employment, and health care access to support families and mitigate risk of child welfare involvement. Providing these non-traditional child welfare supports aims to provide an array of services and supports to all families in their geographic catchment areas. FCCP supports aim to address the underlying factors that place families at risk, many of which arise from structural racism, such as inadequate housing, education, and employment opportunities.

Secondary Prevention

Secondary prevention is aimed at mitigating the risk for an event to occur such as child maltreatment or the removal of a child from their home. Through FCCP's network structure of basic services and clinical services, the FCCPs secondary prevention efforts include supports and services to families and children who are at high risk for child welfare involvement. These services fall into traditional child welfare services as well as non-traditional upstream prevention efforts such as addressing housing, education, employment, and social injustices affecting communities of color, and communities with less social capital.

FCCPs accept referrals from both the community and DCYF. Families who have come to the attention of DCYF's child protective services unit can make direct referrals of families who are determined safe yet demonstrate risk factors of removal. FCCPs engage the family using a Wraparound model, timely assess the family and work with families to tailor services to address their needs. All FCCPs enter data on families who have consented to FCCP services which allows DCYF to analyze the data for fidelity as well as family outcomes across race, ethnicity, age group and geographic region. Approximately three percent of families discharged from the FCCPs become involved with the Department within six months.

Consistent with secondary prevention initiatives, the Department collaborates with the Rhode Island Department of Health (RIDOH). DCYF and RIDOH collaboration consists of a data sharing agreement and bi-weekly meetings to monitor data on DCYF CPS referrals of children ages 0-3 years indicated for maltreatment to RIDOH home visiting programs. Several of the RIDOH home visiting programs are well-supported Evidence Based Programs. The data analysis and reviews consist of both trends and deep dive analysis. The data includes number of referrals to RIDOH home visiting programs, the percent of home visiting programs that successfully engaged the family, time to engagement, and child \family outcomes. The RIDOH home visiting programs are another cog in the Department's prevention efforts to ensure

upstream community supports are in place, timely assessment of needs and services to prevent unmet needs leading to a family's involvement with the Department and at risk for removal.

A third dimension of the Department's secondary prevention efforts is the Support and Response Unit (SRU) which is embedded within DCYF's Family Service Unit (FSU). The SRU has a referral line from which referrals may come into DCYF from the community or are families referred by DCYF who do not meet the threshold for an investigation yet demonstrate service/support needs. The objective is to assess families and refer them to the FCCP, or other community-based services, or to FSU for in-home services. The FSU unit conducts timely assessments and leverages DCYF's contracted, community-based services to support and maintain families together and prevent removal from home.

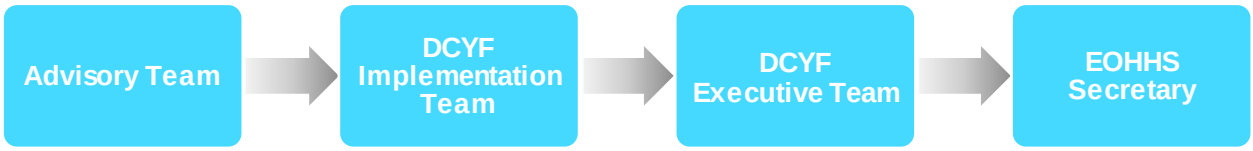
SECTION I: CONSULTATION

Pre-Print Section 4

DCYF is committed to ensuring diverse, community and stakeholder engagement in their work by consulting and coordinating with partner agencies and other stakeholders throughout the development of the Title IV-E Prevention Plan and will continue going forward into implementation. Meaningful and authentic engagement with a broad and representative group of community members, key partners, agencies, and organizations invested in the health and wellbeing of Rhode Island's children and families ensures open dialogue and results in stronger, more thoughtful, and equitable family- and child-centered collaboration.

During planning and development of Rhode Island's five-year Title IV-E Prevention Plan, DCYF established a Family First Advisory Team (Advisory Team) comprised of key stakeholders and partner organizations to consult and advise DCYF throughout the process. The Advisory Team was integrated into a governance framework made up of critical stakeholders throughout DCYF and its parent agency, EOHHS, to guide and shape goals, inform, and approve strategy, and make financially impactful decisions for DCYF and EOHHS. Below is a depiction of Rhode Island's Family First governance framework.

Figure 2. Rhode Island Family First Governance Framework



The Advisory Team kicked off in February 2021 to communicate, advise, and serve as a formal stakeholder in the development and enhancement of the prevention vision for Rhode Island children and families. The Advisory Team is comprised of all relevant units of Rhode Island DCYF, Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH), Department of Education (RIDE), Department of Health (RIDOH), Early Childhood Education, Executive Office of Health and Human Services (EOHHS), Family Court, FCCPs, hospitals, law enforcement agencies, legislators, the Narragansett Indian Tribe, the Office for the Child Advocate, parents, Public Consulting Group, school districts, service providers, and the Trafficking Task Force and is governed by the DCYF Implementation Team.

The Advisory Team meets regularly to provide feedback and advise DCYF on the:

- Selection of potential candidates for Family First prevention services.
- Array of evidence-based Family First prevention services that will meet the needs of the candidate subgroups.

- Current-state business process maps designed to identify policy and practice enhancements needed.
- Family First-related training content, target audiences, and implementation.
- Continuous quality improvement and fiscal infrastructures.

The Advisory Team leverages the collective expertise and experience of the team members to address barriers, identify opportunities, and increase collaboration as Rhode Island implements Family First and enhances its prevention vision.

Going forward, members of the Advisory Team will also be engaged by DCYF in one of three workgroups that will focus on Family First implementation. The workgroups are organized into focus areas that address topics including but not limited to finance, title IV-E claiming, contracting, information technology, CQI, evaluation, training, policy, and practice issues and will help inform and guide the next steps toward achieving Rhode Island's prevention vision.

In addition to the Advisory Team, Rhode Island's Family First planning process has been informed by representatives of the Diversity Advisory Committee (DAC) and the Race Equity Team to address racial equity in all FFPSA related planning.

Consultation efforts informed the development of Rhode Island's Title IV-E Prevention Plan and will continue to guide development of a full continuum of prevention services over the course of the five-year plan period and beyond.

SECTION II: CHILD AND FAMILY ELIGIBILITY FOR THE TITLE IV-E PREVENTION PROGRAM

Pre-Print Section 9

A candidate for prevention services is a child who is at imminent risk of entering or re-entering foster care but able to remain safely at home with the provision of mental health treatment, substance use treatment, or in-home parenting services for the child, parent, or relative caregiver. To be eligible, the child must be identified as a candidate in the child's prevention plan and have an identified need for mental health prevention and treatment, substance use prevention and treatment, or in-home skill-based parenting services to maintain safety, permanency, and/or well-being of the child or to prevent the child from entering foster care.

Pregnant or parenting youth in foster care are also eligible for prevention services when the service is designated in the youth's service plan.

PREVENTION CANDIDATE DEFINITION

Rhode Island defines prevention candidates as children who may be at imminent risk of entering foster care based on circumstances or characteristics of the family (parent(s), child, or relative caregiver). The Rhode Island Family First Implementation Team, comprised of representatives from DCYF, including the Office of Juvenile Probation, identified candidate subpopulations based on analyses of child and family circumstances and characteristics completed by the DCYF Office of Data Analytics, Evaluation, and Continuous Quality Improvement (DPI).[5] The analyses were conducted using a multivariate logistic regression that predicted which children were most at risk for entering foster care. To predict which children are most at risk for entering foster care, the DPI analyzed the following:

[5] Technical assistance support was provided by Chapin Hall consultants working on behalf of the Capacity Building Center for States.

- Prior reports of child maltreatment, including abuse or neglect.
- Children that have been reunified.
- Children in-home that are assigned to the Family Service Unit (FSU).
- Substance use or addiction by the parents or youth.
- Youth that are dealing with homelessness or have runaway.
- Children with complex needs (*e.g.,* Seriously Emotionally Disturbed (SED)).
- Youth at risk for trafficking.
- Children with developmental delays.
- Children that are post-guardianship or post-adoption and are at risk for disruption.
- Children and youth with a sibling in foster care.
- Juvenile Justice involved youth.
- Youth that are pregnant or parenting that are also in foster care.

Once identified, the Family First Implementation Team presented the subpopulations to the DCYF Family First Prevention Advisory Group[6] for discussion and feedback, and to finalize the candidate subpopulation selections. The DCYF Family First Advisory Group used these circumstances and characteristics to identify two candidate population categories and eight candidate subpopulations for Title IV-E- prevention services, presented in Table 1.

Table 1. Candidate Categories and Candidate Populations

Candidate Pathways	Candidate Populations
Children and families that are connected to Family First prevention services through *DCYF*	1. Children & families open to DCYF Family Services Unit (FSU) for in-home services 2. Children & families that have reunified 3. Children or youth engaged in in-home juvenile probation 4. Children in-home with a sibling in foster care 5. Pregnant and parenting youth in foster care (categorically eligible for Family First services)
Children and families that are connected to Family First prevention services through *Family Community Care Partnerships (FCCP)*	6. Children & families that are assessed by the DCYF Support and Response Unit (SRU) but receive services through the FCCPs. 7. Children who are post-guardianship and/or post-adoption at risk for disruption of placement and receive services through the FCCPs. 8. Children & families referred to the Family Community Care Partnerships (FCCP) by another community-based organization or self-referral.

[6] DCYF Advisory group is comprised of representatives from the Rhode Island DCYF, Department of Health (RIDOH), Executive Office of Health and Human Services (EOHHS), FCCPs, Department of Education (RIDE), Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the Narragansett Indian Tribe, law enforcement agencies, school districts, hospitals, service providers, advocacy groups, and parents.

The eight subpopulations consider age, race/ethnicity (including culture-specific and linguistic needs), and targeted needs (child and parent substance abuse, mental health, and parenting skills). DCYF reviewed data from the Rhode Island Children's Information System (RICHIST) and Family Community Care Partnerships (FCCP) data systems, including the Rhode Island Family Information System (RIFIS) and reports from contracted provider programs. Of the children included in these candidate populations, approximately 54 percent of youth and their families have an open case with DCYF, while the other 46 percent are receiving services from FCCPs. Nearly two-thirds (64.4 percent) of the candidate population have identified mental health needs and 66.6 percent of parents and caretakers have identified parenting skills needs. Where available, additional research and data were examined to identify each population's risk of entering/re-entering foster care.

In addition to the identified candidate populations, DCYF is collaborating with RIDOH to expand services to families in need of substance abuse treatment, mental health treatment, or parenting skills through their Office of Family Visiting, First Connection providers and their array of evidence-based programs (*e.g.,* Healthy Families America (HFA), Nurse-Family Partnerships (NFP), and Parents as Teachers (PAT)).

Each candidate population is further described below.

1. All children and families open to DCYF Family Services Unit, In-home and may also include:
    - Children ages 0–17 years,
    - Youth who are experiencing homelessness or have runaway,
    - Children with complex needs (*e.g.,* SED),
    - Pregnant and parenting youth,
    - Youth at risk for trafficking, and
    - Children ages 0–5 years with elevated risk as indicated on their Family Functioning Assessment (FFA).
2. Children and families that have reunified and may also include:
    - Children ages 0–17 years who have reunified with their families after removal from the home by DCYF,
    - Youth who have runaway or are experiencing homeless,
    - Children with complex needs (*e.g.,* SED),
    - Youth who are pregnant and parenting,
    - Youth at risk for trafficking, and
    - Youth ages 12–17 years with elevated risk as indicated on their Ongoing Family Functioning Assessment (OFFA).
3. Youth engaged with in-home juvenile probation typically ranging from ages 12–17 years.
4. Children in-home with a sibling in foster care and may include:
    - Children ages 0–17 years who reside in the home while their sibling/s is in the care and custody of DCYF.
5. Youth who are pregnant or parenting while in foster care are categorically eligible for Title IV-E Prevention Service.

6. Children & families that are assessed by the DCYF Support and Response Unit (SRU) but receive services through the FCCPs may include:
    - Children ages 0–17 years whose families have been assessed following a direct call by the family to the SRU seeking assistance from DCYF
    - Families referred to the SRU following a CPS hotline call where Strategic Decision Making (SDM) did not identify safety factors, but risk is present.
7. Children ages 0-17 years and families who are post-guardianship or post-adoption at risk for disruption of placement and receive services through the FCCPs.
8. Children ages 0-17 years and families referred to the FCCPs by another community-based organization or self-referral.

PREVENTION CANDIDATE DETERMINATION

DCYF prioritizes family-centered, child-focused, and culturally competent in-home prevention services. DCYF and partnering agencies and organizations utilize the risk assessments in Table 2 to inform the candidate determination process for in-home prevention services or foster care. Assessment results are also used to inform the child- and family-specific service plans that detail the services that will be used to best support the needs of the child/youth and their family. Below outlines how the children and families in the different candidate categories will be determined as prevention candidates.

Children and families that are connected to Family First prevention services through DCYF

DCYF has several different divisions that engage children and families:

1. Child Protective Services (CPS): The investigative division that receives, screens, and responds to reports of suspected child maltreatment.
2. Family Service Unit division (FSU): Becomes involved with families after a CPS investigation is conducted and a determination is made that services are needed to address abuse, neglect, or dependency within the family.
3. Office of Juvenile Probation (OJP): Provides supervision to youth who have been adjudicated wayward or delinquent by the Rhode Island Family Court and are sentenced to a term of probation.

Depending on which division is working with the family, the DCYF caseworker in the Child Protective Services Unit (CPS), the Family Services Unit (FSU), or the Office of Juvenile Probation (OJP) will use designated assessment tools presented in Table 2 below and described in detail in the Monitoring and Safety section of this document, to inform candidacy for Family First prevention services or foster care. DCYF caseworkers assess children and families utilizing safety and risk assessment tools to identify a child's risk of entry into foster care and the child and family's needs related to mental health, substance abuse, and/or parenting skills. After a child has been determined to be a candidate, the caseworker will create a child-specific service plan (prevention plan) in RICHIST that outlines the need for services, the types of services that will be provided and the anticipated timeframe for service delivery. When a foster care youth is identified as pregnant or parenting, DCYF will reassess the case and develop a case plan that includes prevention services.

Children and families that are connected to Family First prevention services through Family Community Care Partnerships

Children and families determined to be candidates eligible for Title IV-E prevention services by DCYF will be assessed by the FCCP Family Service Care Coordinator (FSCC) to identify mental health, substance abuse, and/or parenting skills needs. For these children and families that access services and support from

the FCCPs, the FSCC completes an assessment utilizing the Child and Adolescent Needs and Strengths Plus (CANS+) and / or the Functional Assessment and Action Plan (FAAP) and / or the Strengths, Needs and Cultural Discovery (SNCD) assessment tools to determine the child and family's needs and to inform which prevention services will best help the child remain safe at home with their family. The FSCC will complete a service referral form to DCYF outlining the child and families' risk levels, the presentation of the needs of the child and family, description of services needed, and safety concerns, that led to the child being at risk of removal and placement into foster care. Recommendations for candidacy will be submitted by the FSCC to DCYF to make the initial candidacy determination. If the child is still in need of services beyond 12 months and at risk of removal and entry into foster care, the FSCC will submit additional information on risk levels and needs of the child and family and submit to DCYF to reassess candidacy eligibility. DCYF will oversee the FCCP prevention plan through its Active Contract Management (ACM) process. ACM is a high-frequency data-informed collaboration focusing on service provider outcomes.[7] DCYF facilitates monthly ACM meetings with FCCP leadership teams and frequent *ad hoc* working group sessions to address specific issues. The Child Specific Prevention Plan will be integrated into the existing FAAP which must be completed and signed by a licensed clinician within 10 business days of the Agreement to Participate/Agency Open Disposition Date being signed for the primary child.

Risk Assessments

Children and families' service and safety needs are determined by DCYF or FCCP providers in concert with families using comprehensive assessment tools. DCYF and partnering agencies and organizations use the risk assessments in Table 2 to determine whether a child/youth is a candidate for in-home prevention services or foster care. Assessment results are also used by DCYF and FCCP providers to create child- and family-specific service plans detailing which services will be used to best support the needs of the child/youth and their family.

[7] Harvard Kennedy School Government Performance Lab. Active Contract Management: How Governments Can Collaborate More Effectively with Social Service Providers to Achieve Better Results.

Table 2. Candidate Risk Assessment Tools

Family Functioning Assessment (FFA)/ Ongoing Family Functioning Assessment (OFFA)		
Description	**Candidate Subcategory**	**Assessment Administrator**
The FFA assessment tool is completed following a CPS hotline report, or a family's direct call to the SRU for support and services, or upon entry into in-home juvenile probation programming to determine the well-being of a child and youth. This in-person family assessment is conducted to determine whether the child or youth is at an elevated risk for physical abuse, sexual abuse, or neglect if current circumstances do not change. If the results of the FFA indicate that the child is at risk of impending danger, the case will be referred to the FSU or a FCCP and the OFFA or CANS+, respectively, will be used to continuously monitor risk safety. The OFFA is administered within 60 days of a case being referred to the FSU and a progress report is completed every 90 days thereafter. The OFFA assesses ongoing risk and protective capacity. These tools include the following assessments: • ***Caregiver Behavioral Change Assessment*** – identifies caregiver protective capacities that enhance child functioning, caregiver behaviors that demonstrate a need for change, and the needs of children when exhibiting problematic behaviors (as appropriate based on age and level of functioning). • ***Impending Danger Assessment*** – determines living situations that may cause danger to the child. An Impending Danger Safety Plan is created based on the results of the assessment. • ***Safety Reassessment*** – assesses safety elements of impending danger.	• FSU, In-Home • Reunified • Juvenile Probation • SRU • Sibling-In-CarePregnant / Parenting Youth • Post-Adoption or Post-Guardianship	*FFA:* DCYF CPS, SRU caseworkers, and juvenile probation officers *OFFA:* FSU caseworker and juvenile probation officers
Structured Assessment of Violence Risk in Youth (SAVRY)		
Description	**Candidate Subcategory**	**Assessment Administrator**
This tool assesses youth, aged 12–18 years, for violent risk factors and associated severity, risk of future violence and serious delinquency, and the youth's areas of need that contribute to offending behavior. It is administered within the first 30 days after adjudication and is reassessed every six months. These factors collectively are used to determine which services are appropriate for use. Information to complete the tool is obtained from a variety of sources, including an interview with the youth and a review of records (such as police or probation reports). The SAVRY is comprised of six items defining protective factors and 24 items defining risk, divided into historical, individual, and social/contextual categories. Professional evaluators use	Juvenile Probation	Juvenile Probation Officer

judgment to determine the risk rating of high, moderate, or low and whether protective factors are present or absent.[8]		
Child and Adolescents Needs and Strengths Plus (CANS+)		
Description	**Candidate Subcategory**	**Assessment Administrator**
The CANS+ assessment tool is a multi-purpose tool that supports care and service planning, facilitates quality improvement initiatives, and monitors service outcomes. By gathering information on the child/youth's and parents/caregivers' needs and strengths, this tool seeks to facilitate the link between the assessment process and individualized service plans.[9] For families involved with FCCPs, the CANS and CANS+ are proposed for administration as assessments. The CANS+ for stabilization must be completed by the FCCPs and is administered as a comprehensive assessment that is signed and entered in RIFIS by a licensed clinician within 30 days of the Agreement to Participate/Agency Open Disposition Date being signed for the primary child. The CANS+ must be administered by a CANS trained and certified user. The CANS+ will also be administered at the 12-month service mark if the child needs services beyond 12 months. The CANS portion of CANS+ is used as an assessment for case transitions, for families that are open to the FCCPs for at least 60 days beyond the first assessment date a "Transitional Assessment" (CANS) is completed. The CANS is also used to inform discharge planning. Families that are involved with FCCPs that come through a community pathway have their risk monitored through the CANS/CANS+. If there is a safety concern at any time during the 12-month period of service provision by the FCCPs, the FCCP worker is required to contact the DCYF hotline to report their concern.	FCCP	Rhode Island CANS+ certified FCCP worker
Functional Assessment Action Plan (FAAP)		
Description	**Candidate Subcategory**	**Assessment Administrator**
The FAAP is a family-focused, collaborative process of engaging families, collaterals and family supports in providing information about the family's history, functioning, strengths and needs and about how well the safety, permanency and well-being needs are being met for the child. FCCP Supervisors, who are state licensed practitioners, train their bachelor's level FSCC staff on how to complete the FAAP (Proposed Child Specific Prevention Plan). FCCP supervisors review and approve the plan, and electronic signature is required. This information is captured in DCYF's RIFIS with date and time stamp.	FCCP	Family Service Care Coordinator (FCCP workers)

[8] Structured Assessment of Violence Risk in Youth (SAVRY) (Forensic Psychology) - iResearchNet
[9] cans-mhmanual.pdf (magellanprovider.com)

Strengths, Needs, and Culture Discovery Assessment (SNCD)		
Description	**Candidate Subcategory**	**Assessment Administrator**
The SNCD is a comprehensive holistic review of the child and their family that provides essential information used to develop a strengths-based, individualized service plan that respects the unique culture of the child and family. The SNCD is completed and signed by a licensed clinician by day 60 from the Agreement to Participate / Agency Open Disposition Date being signed by the family.	FCCP	Family Service Care Coordinator (FCCP workers)

Reassessments of the child's prevention plan occurs at least once every 12 months and are completed by the respective DCYF caseworker, juvenile probation officer, or FCCP provider partner. Children or youth receiving services in all candidate subpopulations that require the Ongoing Family Functioning Assessment (OFFA), including those assessments within this tool (*e.g.,* Impending Danger Assessment), will be reassessed every three months to monitor risk and safety. The CANS+ is administered at intake and discharge, once the provider deems services are no longer needed.

For FCCP cases, if risk for entering foster care remains high after 12 months of prevention services, if there is a safety concern, the FCCP will contact the DCYF hotline to intervene. Per Rhode Island law RIGL § 40-11-3, all persons in Rhode Island are required to report known or suspected cases of child abuse and/or neglect to the Department of Children, Youth, and Families within 24 hours of becoming aware of such abuse/neglect. Since the inception of the FCCPs, the median length of time a family remains involved with the FCCP is 3 to 4 months with very few children\families remaining involved with the FCCPs 12 months or longer.

SECTION III: SERVICE DESCRIPTION AND OVERSIGHT

Pre-Print Section 1

SERVICE CATEGORIES

DCYF will provide evidence-based services or programs (EBPs) for a child and their parents or relative caregivers when the child, parent, or relative caregiver's needs for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. Categories of prevention services and programs are described below.

Mental Health Prevention and Treatment, Substance Abuse Prevention and Treatment, and In-home Parent Skill-based Programs and Services

As required by FFPSA approved evidence-based mental health prevention and treatment, substance abuse prevention and treatment, and in-home parent skill-based programs and services will be provided by a qualified clinician to a child/youth or to the child/youth's parent or relative caregiver for up to 12 months for each prevention period, beginning on the date the child/youth is identified as a "child/youth who is a candidate for foster care" or a pregnant or parenting youth in a prevention plan, also referred to as a prevention candidate. Services can also be provided for an additional 12-month period following a redetermination of candidacy.

EVIDENCE-BASED SERVICES AND PROGRAMS

Services and Selection Process

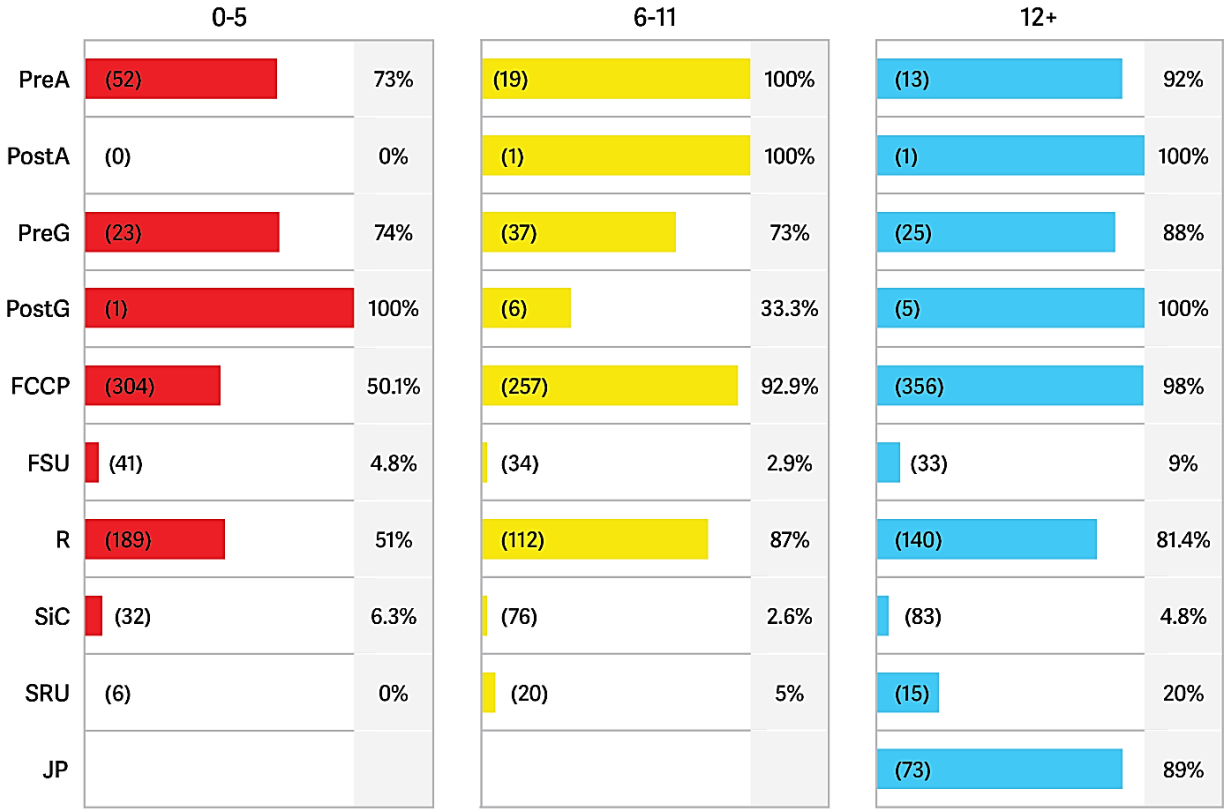
To select evidence-based services/programs for the initial five-year Title IV-E prevention plan, DCYF analyzed both the demographics, and the child and family population needs, of each candidate subgroup. DCYF also conducted an analysis of their service array to better understand Rhode Island's current capacity to provide EBPs and to identify any gaps in service.

Target Population Needs

DCYF identified eight subpopulations of candidates for prevention services based on their likelihood for entering foster care using analyses completed by the DCYF DPI unit of child and family circumstances and characteristics. The analyses were conducted using a multivariate logistic regression that predicted which youth were most at risk for entering foster care based on the identification of factors that were statistically significant. Additional analyses were completed by the DCYF DPI unit to determine the specific needs of the candidate subpopulations as they pertain to mental health and parenting skills. Substance use data was not readily available to DCYF DPI independent of mental health data for this analysis. DCYF DPI will work to revise the current assessment to specifically isolate substance abuse needs, separate from the mental health items. Demographic data on the candidate subpopulations, including gender, age, race/ethnicity, and language(s) spoken, were also analyzed as a part of this process. The figures below show the needs identified in the analyses completed for each subpopulation:

Mental Health Needs

Figure 3. Youth Mental Health Needs by Age by Candidate Subpopulation



PreA = Pre-Adoption

PostA = Post-Adoption

PreG = Pre-Guardianship

PostG = Post-Guardianship

FCCP = Family Care Community Partnerships

FSU = Family Services Unit

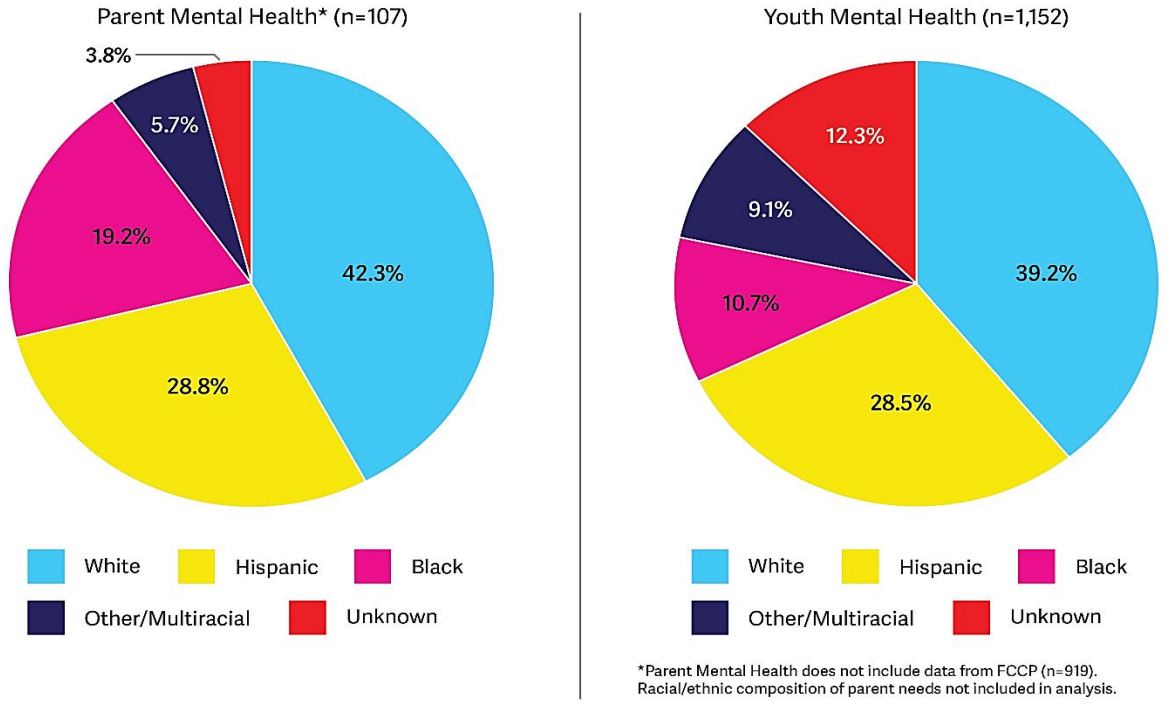
R = Re-Unified

SiC = Sibling in Care

SRU = Support and Response Unit

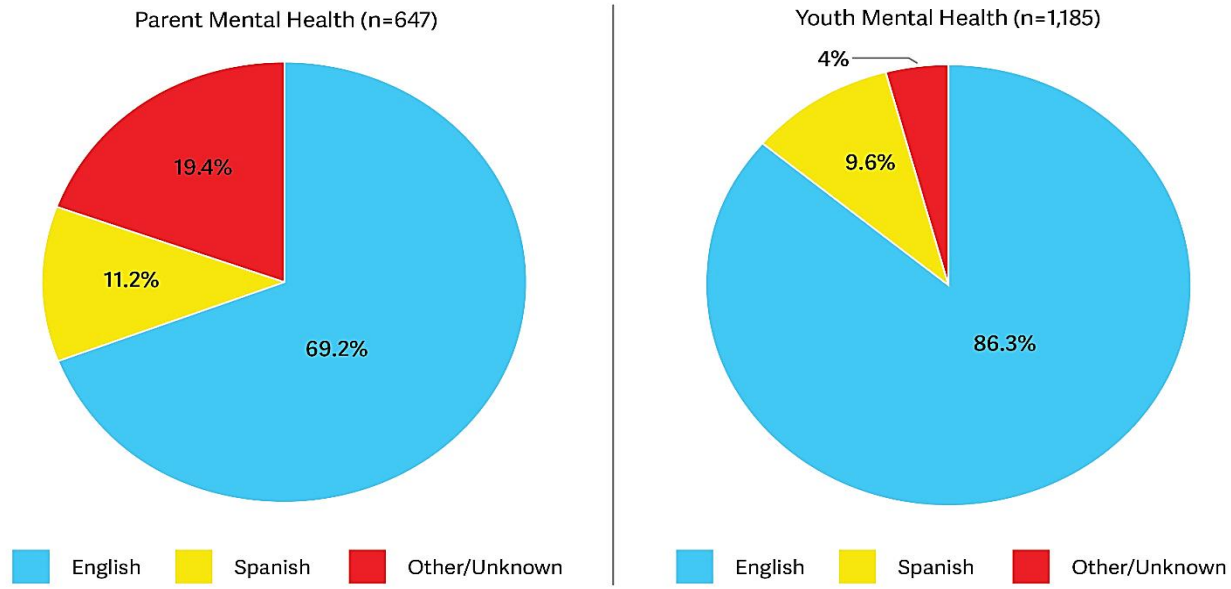
JP = Juvenile Probation

Figure 4. Racial and Ethnic Composition of Parents/Caregivers and Youth with Mental Health Needs



*Parent Mental Health does not include data from FCCP (n=919). Racial/ethnic composition of parent needs not included in analysis.

Figure 5. Linguistic Composition of Parents/Caregivers and Youth with Mental Health Needs



Parenting Skills Needs

Figure 6. Parenting Skills Needs by Youth Age and Candidate Subpopulation

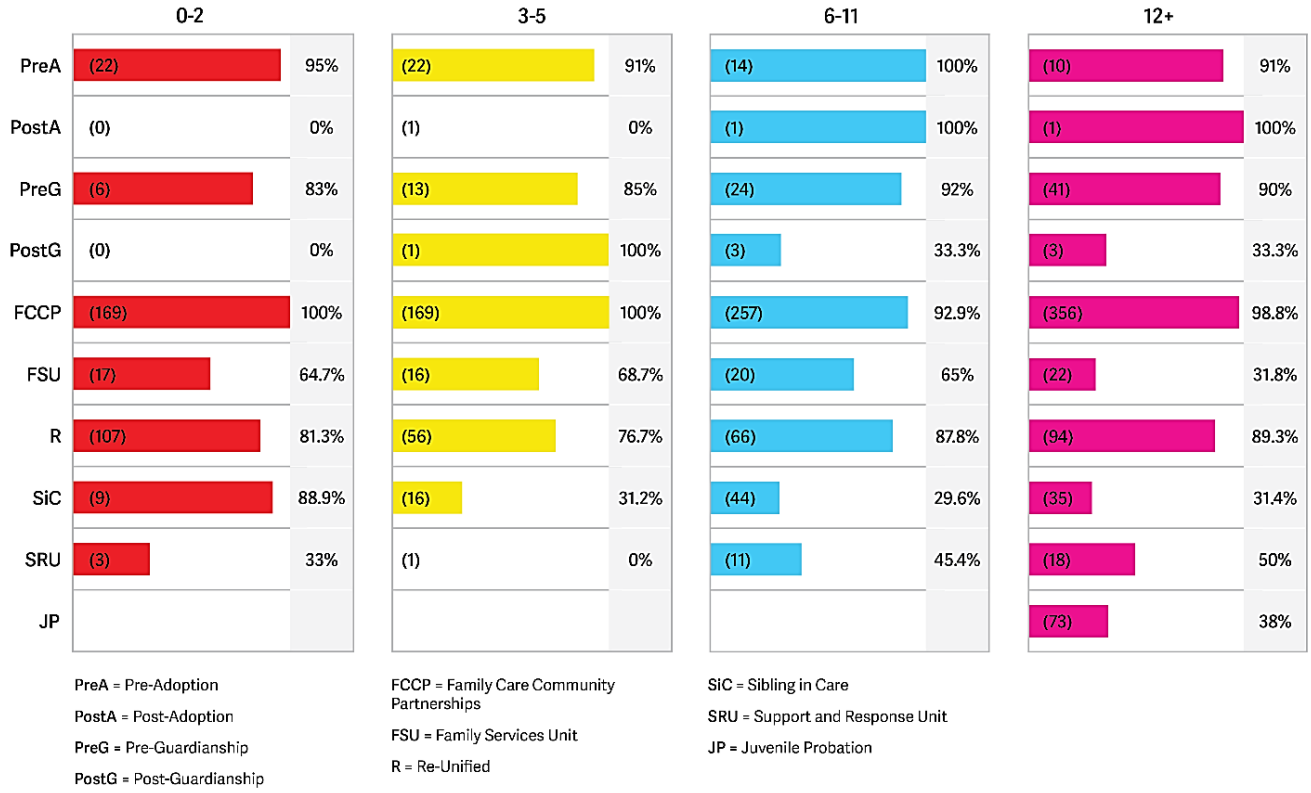


Figure 7. Linguistic Composition of Parents/Caregivers and Youth with Parenting Skills Needs

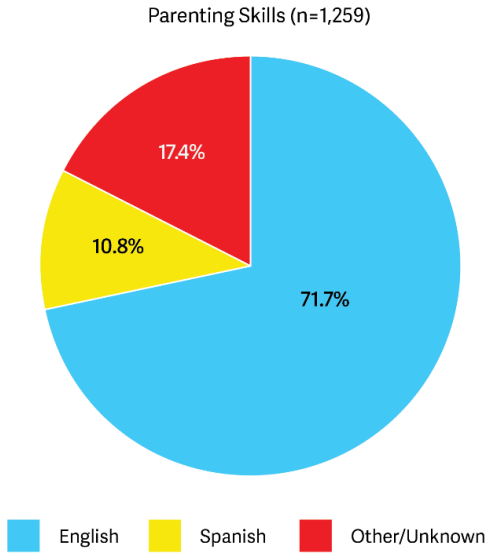
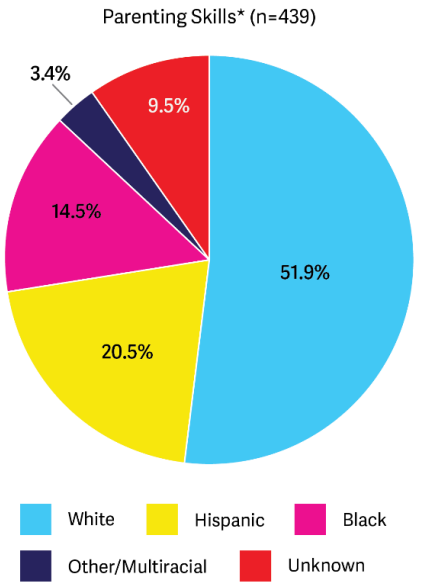


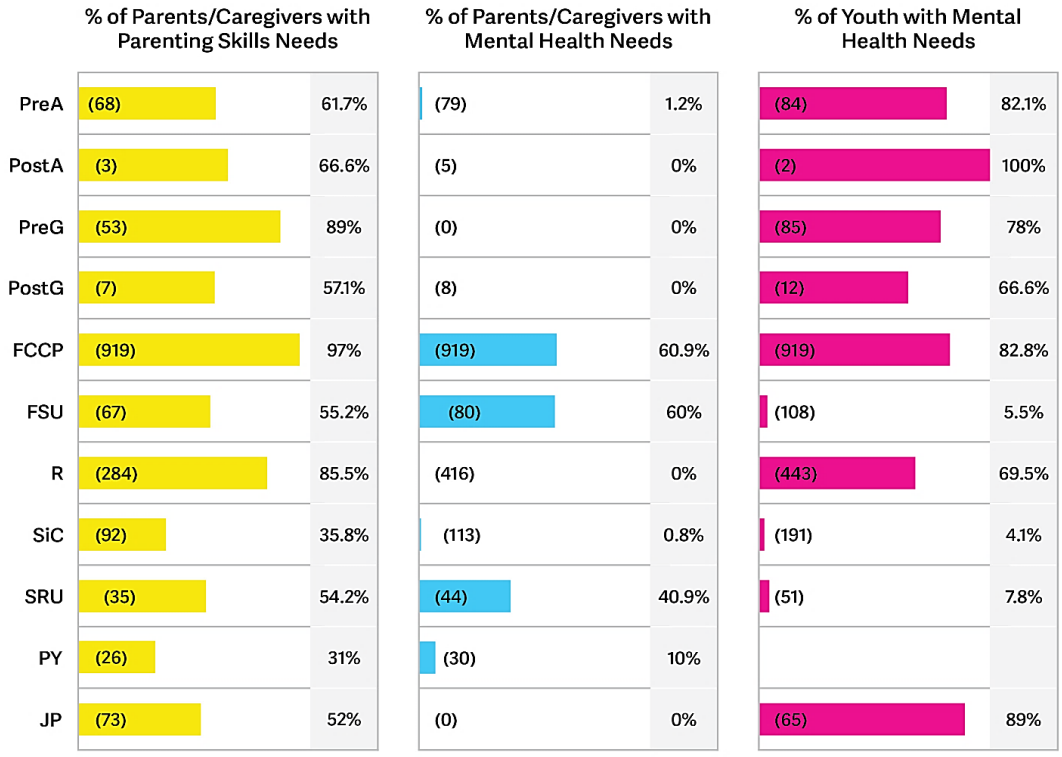
Figure 8. Racial and Ethnic Composition of Parents/Caregivers and Youth with Parenting Skills Needs



*Parent Mental Health does not include data from FCCP (n=919).
Racial/ethnic composition of parent needs not included in analysis.

Needs by Candidate Subpopulation

Figure 9. Parent/Caregiver and Youth Needs by Candidate Subpopulation



PreA = Pre-Adoption
PostA = Post-Adoption
PreG = Pre-Guardianship
PostG = Post-Guardianship

FCCP = Family Care Community Partnerships
FSU = Family Services Unit
R = Re-Unified
SiC = Sibling in Care

SRU = Support and Response Unit
PY = Pregnant/Parenting Youth
JP = Juvenile Probation

Evidence-Based Services and Programs

After analyzing the needs of the target population, DCYF looked at how many service providers currently provide each EBP in DCYF's service array, and how often the service is provided, to better understand Rhode Island's existing capacity to provide each EBP. DCYF considered the following factors:

- Number of service providers that offer each prevention service type,
- Provider capacity to provide services,
- Number of children/families receiving each service annually,
- Potential for service expansion,
- Title IV-E Clearinghouse rating for each service, and
- Funding source for each service.

In addition, the DCYF Family First Implementation Team completed a gap analysis to determine what disparities exist between the current service array in Rhode Island and capacity, and the needs identified in the candidate subpopulations. DCYF reviewed EBPs that are not currently provided in Rhode Island to understand implementation requirements and how to build capacity to offer a new service that will meet the needs of families whose children are at risk of removal.

Upon completion of the candidate subpopulations' needs, service array, and gap analyses, three stakeholder workgroups[10] convened during the week of April 19–23, 2021 to review the results and use them to make data-informed prevention service and program selections. The workgroups were organized into three categories, 1) mental health, 2) substance use, and 3) parenting skills, and focused on current prevention services that meet the cultural and linguistic needs of each candidate subpopulation. The evidence-based services and programs selected for Rhode Island's five-year Title IV-E Prevention Plan are listed in Table 3. Evidence Based Services and Programs Detailed. Following approval of the Rhode Island Plan, DCYF intends to claim reimbursement for Title IV-E allowable services and/or administrative costs for the following prevention evidence-based programs.

Table 3. Evidence Based Services and Programs Detailed

Functional Family Therapy (FFT)	
Service Description	FFT is a short-term, high-quality intervention with an average of 12 to 14 sessions over three to five months. FFT works primarily with youth ages 11–18 who have been referred for behavioral or emotional problems by the juvenile probation, mental health, school, the child welfare agency, or other child welfare partners. FFT is a strength-based model built on a foundation of acceptance and respect.[11] At its core is a focus on assessment and intervention to address risk and protective factors within and outside of the family that impact the adolescent and his or her adaptive development. There are five major components of FFT: engagement, motivation, relational assessment, behavior change and generalization.[12]

[10] EBP workgroups were comprised of representatives from the Department of Education, FCCPs, FSU, the Office of Juvenile Probation, RIDOH, the Trafficked Youth Task Force, child advocates, local schools, parents / caregivers, and service providers.

[11] Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Need, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association.

[12] https://www.fftllc.com/about-fft-training/clinical-model.html

Level of Evidence (promising, support, well-supported)	Well-Supported
Service Category	Mental Health
Version of Book or Manual	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for Adolescent Behavioral Problems*. Washington, D.C.: American Psychological Association.
Outcomes Expected to Improve	Data from the provider are expected to disclose the following outcomes: • Increase percent of youth in school/working. • Reduce percent of youth with no intensification of referral problem. • Increase competency in managing common child behavior problems and developmental issues. • Decrease behavioral problems for children. Data from DCYF's case management system, RICHIST, will be used to monitor the outcome measures below: • Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •
Target Population and How the Service Will Meet Their Needs	The target group for this service is youth ages 11–17 years who have been referred for behavioral or emotional problems by juvenile probation, mental health, school, or child welfare partners. FFT was selected because it is a family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive making it ideal for adolescent and teenage target group.[13] DCYF's target population for this service include the following candidate groups: • FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.
CQI and Fidelity Monitoring	Service providers will submit program fidelity data to program proprietors on a regular, pre-determined basis. The proprietor will issue quarterly reports to DCYF highlighting fidelity, program outcomes, practice

[13] https://youth.gov/content/functional-family-therapy-fft#:~:text=Functional%20Family%20Therapy%20(FFT)%20is,flexibly%20structured%20and%20culturally%20sensitive.

	strengths, and areas of improvement. DCYF leadership, including representatives from the DPI Unit, and service provider contractors will meet quarterly to monitor program outcome trends, identify the root causes of issues, and develop strategies for improvement. DCYF will develop tools to collect fidelity data that are not routinely collected by the proprietor. DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice. More information about CQI and fidelity monitoring can be found in the Evaluation Strategy section of this document.
Plan to Implement	FFT has been implemented in Rhode Island and is an existing service offering through DCYF. Currently DCYF has the capacity to provide this service to all candidate subpopulations as needed. Expansion of service will be considered if needed to meet the needs of children and families.
Parent Child Interaction Therapy (PCIT)	
Service Description	PCIT is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patters. Children and their caregivers are seen together in PCIT. PCIT uses a didactic approach to working with families. Parents are initially taught relationship enhancement or discipline skills that they are going to be practicing in session and at home with their child. In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a "bug-in-the-ear" system for communicating to the parents as they play with their child.[14]
Level of Evidence	Well-supported
Service Category	Mental Health
Version of Book or Manual	Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy* protocol: 2011. PCIT International, Inc.
Outcomes Expected to Improve	DCYF expects providers to measure the following outcomes: • Increase competency in managing common child behavior problems and developmental issues. • Decrease behavioral problems for children. DCYF will use data from RICHIST to measure the following outcomes: • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •

[14] http://www.pcit.org/what-is-pcit-for-professionals.html

Target Population and How the Service Will Meet Their Needs	► Children aged 2–7 years with behavior and parent/caregiver-child relationship problems. ► Parents of children ages 2–7 years with behavior and parent/caregiver-child relationship problems. PCIT was selected because it addresses the negative parent-child interaction patterns that contribute to the disruptive behavior of young children. Through PCIT, parents learn to bond with their children and develop more effective parenting styles that better meet their children's behavioral and mental health needs. DCYF's target population for this service include the following candidate groups: • FSU in-home • Re-unified • SRU • Sibling in Care • Post Guardianship or Post Adoption • Youth that are pregnant or parenting • FCCP
Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.
CQI and Fidelity Monitoring	Once a provider is contracted to implement this service, the DPI unit will work with the provider and PCIT International to determine the best strategy to monitor fidelity and outcomes, either referring to analysis and reporting completed by the PCIT model proprietor or expanding its internal fidelity and outcome monitoring to include this evidence-based program. DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice. More information about CQI and fidelity monitoring can be found in the *Evaluation Strategy* section of this document.
Plan to Implement	A contract for PCIT services will be awarded by DCYF through a competitive procurement process in FFY2022.
Homebuilders	
Service Description	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.[15]
Level of Evidence	Well-supported
Service Category	In-Home Parenting Skills
Version of Book or Manual	Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.
Outcomes Expected to Improve	DCYF expects the providers will collect data to monitor the following outcomes: • Increase the percentage of families that show progress on goal attainment ratings for at least one goal at service closure. • Increase ratings in client and referent satisfaction regarding service delivery. • Increase client utilization of new skills learned during services. • Increase competency in managing common child behavior problems and developmental issues. • Decrease behavioral problems for children. Data from DCYF's RICHIST will be used to measure the following outcomes: • Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •
Target Population and How the Service Will Meet Their Needs	► Children and youth aged 0–18 years ► Families with children 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. Homebuilders was selected because it seeks to remove the risk of harm to a child rather than removing the child from their home. Families learn new behaviors and make better choices for their children, while ensuring child safety. Homebuilders also works with youths and their families to address issues that lead to delinquency while allowing them to remain in the community. The program also addresses school attendance, adherence to curfews, complying with courts, and teaches anger management and conflict resolution skills to avoid getting into trouble.[16] DCYF's target population for this service include the following candidate groups: • FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • Youth that are pregnant or parenting

[15] https://www.cebc4cw.org/program/homebuilders/
[16] https://crimesolutions.ojp.gov/ratedprograms/210

Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of Homebuilders, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.
CQI and Fidelity Monitoring	Service providers will submit program fidelity data to program proprietors on a regular, pre-determined basis. The proprietor will issue quarterly reports highlighting fidelity, program outcomes, practice strengths, and areas of improvement to DCYF. DCYF leadership, including representatives from the DPI Unit, and service provider contractors will meet quarterly to monitor program outcome trends, identify the root causes of issues root causes, and to develop strategies for improvement. DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice. More information about CQI and fidelity monitoring can be found in the Evaluation Strategy section of this document.
Plan to Implement	Homebuilders has been implemented in Rhode Island and is an existing service offering through DCYF. Currently DCYF has the capacity to provide this service to all candidate subpopulations as needed. Expansion of service will be considered if needed to meet the needs of children and families.
Multisystemic Therapy (MST)	
Service Description	MST is an intensive family- and community-based treatment program that addresses all environments that impact high risk youth-home and families, schools and teachers, neighborhoods, and friends. MST clinicians travel to youth for service provision and are on call 24 hours/day, seven days/week, they work intensively to empower parents and caregivers, work with caregivers to focus on youth on school and gaining job skills and introduce youth to recreational activities as an alternative to hanging out with anti-social peers.[17]
Level of Evidence	Well-supported
Service Category	Mental health and Substance Use
Version of Book or Manual	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). New York: The Guilford Press.
Outcomes Expected to Improve	DCYF will request providers to report data on the following outcomes: • Increase parenting skills. • Increase family network of informal social supports in the community. • Increase involvement between youth and prosocial peers and activities.

[17] https://www.mstservices.com/faq-mst

	• Increase in school attendance, vocational training, or employment (if youth is of the legally appropriate age to not attend school). • Increase competency in managing common child behavior problems and developmental issues. • Decrease behavioral problems for children. Data from DCYF's RICHIST will be used to measure the following outcomes: • Percent of youth with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •
Target Population and How the Service Will Meet Their Needs	► Youth ages 12–17 years MST was selected because it aims to uncover and assess the functional origins of adolescent behavioral problems through intense involvement and contact with the family. It works to alter the youth's ecology in a manner that promotes prosocial conduct while decreasing problem and delinquent behavior. This program effectively supports youth with mental health, substance use, and parenting skills needs. DCYF's target population for this service include the following candidate groups: • FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • Youth that are pregnant or parenting • FCCP
Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of MST, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.
CQI and Fidelity Monitoring	DCYF will work with MST Services to collect data providers submit to document program fidelity data and progress in achieving outcomes on an ongoing basis, as well as post-discharge surveys administered to clients to the program proprietor. The proprietor will issue quarterly reports to DCYF highlighting fidelity, program outcomes, practice strengths, and areas of improvement. DCYF leadership, including representatives from the DPI Unit, and service provider contractors will meet quarterly to monitor program outcome trends, identify the root cause of issues, and to develop strategies for improvement. DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice.

	More information about CQI and fidelity monitoring can be found in the *Evaluation Strategy* section of this document.
Plan to Implement	MST has been implemented in Rhode Island and is an existing service offering through DCYF. Currently DCYF has the capacity to provide this service to all candidate subpopulations as needed. Expansion of service will be considered if needed to meet the needs of children and families.
Motivational Interviewing (MI)	
Service Description	MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen person motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. Key qualities include: • MI is a guiding style of communication, that sits between following (good listening) and directing (giving information and advice). • MI is designed to empower people to change by drawing out their own meaning, importance, and capacity for change. • MI is based on a respectful and curious way of being with people that facilitates the natural process of change and honors client autonomy.[18]
Level of Evidence	Well-supported
Service Category	Mental health, substance use prevention, in-home parenting skills
Version of Book or Manual	Miller, W.R. & Rollnick, S. (2012). Motivational Interviewing, Third Edition: Helping People Change. Guilford Press.
Outcomes Expected to Improve	Data from DCYF's RICHIST will be used to measure the following outcomes: • Percent of youth with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •
Target Population and How the Service Will Meet Their Needs	• Adolescents age 12+ years • Parents/caregivers of children aged 0-17 years MI was selected because it engages individuals and assists them in exploring and resolving their ambivalence about change. It can be used in many contexts and addresses mental health, substance use, and parenting skills needs through identification of a path to behavioral change using the individual's own motivations.[19] DCYF's target population for this technique include candidate populations 1-5: • Children & families open to DCYF Family Services Unit (FSU) for in-home services • Children & families that have reunified • Children or youth engaged in in-home juvenile probation • Children in-home with a sibling in foster care

[18] https://motivationalinterviewing.org/understanding-motivational-interviewing
[19] https://youth.gov/content/motivational-interviewing-juvenile-substance-abuse

	• Pregnant and parenting youth in foster care (categorically eligible for Family First services) •
Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of MI, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.
CQI and Fidelity Monitoring	DCYF has selected the Behavior Change Counseling Index (BECCI) instrument to conduct fidelity monitoring. The DCYF DPI Unit will collaborate with Motivational Interviewing training leads, in conjunction with the Motivational Interviewing Network of Trainings (MINT) to develop a strategy for monitoring fidelity and measuring outcomes. DCYF will select a statistically valid sample of cases for which MI was employed for supervisors to complete the BECCI quarterly. DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice. More information about CQI and fidelity monitoring can be found in the *Evaluation Strategy* section of this document.
Plan to Implement	DCYF intends to use MI as a core component of case management[20], embedded within the Safety Assessment Family Evaluation (SAFE) model that will be provided by its probation officers and FSU caseworkers. MI has emerged as a prominent case management tool in the field of child welfare and research has highlighted MI as an effective service delivery strategy with both adult and youth populations making it a strong choice for DCYF and the candidate subpopulations. DCYF probation officers have been trained in MI and DCYF FSU caseworkers and supervisors are currently being trained in the use of MI to incorporate the service into regular interactions with families. Supervision will provide critical support to caseworkers using MI in the development and monitoring of families' Prevention Plans. Incorporating MI as a common practice, workers will be better able to partner with families to set goals within a child's individual prevention plan, develop strategies to reach those goals, and enhance motivation and internal resolve to follow-through. MI will be used throughout the prevention case plan to promote services, including other EBPs, ensure service completion, and increase child-specific child prevention plan attainment, including individualized case goals related to improved parenting skills and mental health and reductions in substance use similar to the approach that will be utilized in Washington D.C. as it is outlined in their approved Title IV-E Prevention Plan.[21] DCYF workers will follow the five fundamental principles of MI:

[20] Motivational Interviewing – Child Welfare Monitor
[21] DC Title IV-E Prevention Program Five-Year Plan_Amended 9.8.20.pdf

	1) Express empathy through reflective listening. 2) Develop discrepancy between families' goals or values and their current behavior. 3) Avoid argument and direct confrontation. 4) Adjust to family resistance rather than opposing directly. 5) Support self-efficacy and optimism. Motivational Interviewing Implementation Steps: • Training: ○ All current DCYF probation officers have been trained in Motivational Interviewing through a train-the-trainer program informed by the Motivational Interviewing Network of Trainers (MINT) ○ Motivational Interviewing is integrated into DCYF's SAFE model of case practice which has been incorporated into new Juvenile Probation and FSU caseworker training curriculum starting April 2022 ○ Training for seasoned FSU caseworkers is scheduled for the Fall of 2022 • Fidelity Monitoring: ○ DCYF has selected the Behavioral Change Counseling Index (BECCI) instrument as its MI fidelity monitoring tool. BECCI is an instrument designed for trainers to score practitioners' use of Behavior Change Counseling in consultations (either real or simulated) ○ DCYF is working with program developers to determine an appropriate training program for DCYF supervisors to administer the BECCI ○ Once identified, DCYF will provide required training for DCYF supervisors ○ DCYF will develop a procedure for using the BECCI instrument including frequency of use and documentation requirements ○ Documentation of use of the BECCI will be stored in RICHIST for fidelity monitoring and CQI
Familias Unidas	
Service Description	Familias Unidas is a family-centered drug use and sexual risk behavior prevention intervention for Hispanic youth and their families. The program was designed specifically for Hispanic people. It helps empower parents to speak with their adolescents about how to prevent drug use and sexual risk behaviors. Familias Unidas is a multilevel intervention that targets risk (*e.g.,* poor adolescent communication) and protective factors (*e.g.,* parental involvement) at the family, peer, and school level. Familias Unidas has been adapted for use on the Internet and is currently being tested for obesity prevention, and delivery in primary care settings.[22]
Level of Evidence	Familias Unidas is currently under review in the Title IV-E Clearinghouse as a "well-supported" practice. The California Clearinghouse has rated Familias Unidas as "Well-Supported by Research Evidence."
Service Category	Mental Health, Substance Use Prevention, and In-home Parenting Skills

[22] https://www.cebc4cw.org/program/familias-unidas/

Version of Book or Manual	Estrada, Y., Pantin, H. M., Prado, G., Tapia, M. I., & Velazquez, M. R. (2020). UM-Familias Unidas Program: For the families of Hispanic adolescents: Intervention manual. University of Miami.
Outcomes Expected to Improve	Data from the provider(s) will be used to measure the following outcomes: • Improve family functioning. • Increase school attendance. • Increase competency in managing common child behavior problems and developmental issues. • Decrease behavioral problems for children. Data from RICHIST will be used to measure additional outcomes: • Percent of youth with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months •
Target Population and How the Service Will Meet Their Needs	► Youth ages 12–16 years ► Parents of Hispanic adolescents between ages 12–16 years Familias Unidas was selected because it promotes positive parenting, involvement, and support. The program aims to increase parental involvement with their child's peers and school and improve family bonding and cohesion. It also focuses on building supportive relationships amongst Hispanic immigrant parents, to integrate them into the greater community and reduce feelings of social isolation. By providing parents with additional knowledge and tools to raise health children, the intervention aims to prevent or reduce illicit drug use, antisocial behavior, and risky sexual behavior.[23] Analyses show that approximately 10 percent of candidate subpopulations are children and families that speak Spanish. DCYF's target population for this service are Spanish speaking children and families in any of the following candidate groups: • FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • Youth that are pregnant or parenting • FCCP
Assurance for Trauma Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service-Delivery.
How Evaluated	DCYF is requesting a waiver for evaluation of Familias Unidas, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." DCYF will follow established procedures to monitor, compile, assess and report fidelity and outcomes as part of the ongoing effort to monitor the effectiveness of the intervention.

[23] https://youth.gov/content/familias-unidas#:~:text=Familias%20Unidas%20works%20to%20promote%20positive%20parenting%2C%20involvement%2C%20and%20support.&text=It%20focuses%20on%20adolescent%20youth,risk%20factors%20for%20problem%20behavior.

CQI and Fidelity Monitoring	DCYF will administer a continuous quality improvement process to measure fidelity. Data submitted by the provider to the University of Miami will be reviewed quarterly, along with the report received following the annual onsite review of the trainer. DCYF will develop and administer additional tools to collect data that are needed to monitor fidelity.
Plan to Implement	Familias Unidas has been implemented in Rhode Island and is an existing service offering through DCYF. Currently DCYF has the capacity to provide this service to all candidate subpopulations as needed. Expansion of service will be considered if needed to meet the needs of children and families.

The EBPs selected for prevention intervention have shown positive outcomes with children and families of color. Each program provides materials in at least one language in addition to English. Table 4 identifies populations for which outcomes have been beneficial, based on studies cited in the Title IV-E Clearinghouse and the California Evidence-Based Clearinghouse for Child Welfare.

Table 4. EBP Outcomes for Children & Families of Color

Rhode Island Selected Family First Intervention	Service Area	Age Range	Positive Outcomes with Children & Families of Color[24]	Materials Available in Languages in addition to English[25]
Familias Unidas	Substance Abuse	12-16	Latinx	Spanish
Functional Family Therapy (FFT)	Mental Health	11-18	Black and Latinx	Spanish, Dutch, Swedish
Homebuilders	Parenting Skills	0-18	Black	Some documents and tools available in Spanish
Motivational Interviewing (MI)	Substance Abuse*	Adolescents and caregivers	American Indian/Alaska Native, Black, Latinx	Spanish, Chinese, Japanese, Korean, Bulgarian, Czech, Danish, Dutch, Estonian, French, German, Greek, Hebrew, Italian, Portuguese, Romanian, Swedish, Turkish
Multisystemic Therapy (MST)	Mental Health; Substance Abuse	12-17	Black and Latinx	Spanish, Norwegian, several other European languages

[24] https://preventionservices.abtsites.com/
[25] CEBC » Search (cebc4cw.org)

Rhode Island Selected Family First Intervention	Service Area	Age Range	Positive Outcomes with Children & Families of Color[24]	Materials Available in Languages in addition to English[25]
Parent-Child Interaction Therapy (PCIT)	Mental Health	2-7	American Indian/Alaska Native, Asian, Black, Latinx	Spanish

SECTION IV: EVALUATION STRATEGY AND WAIVER REQUEST

Pre-Print Section 2

EVALUATION SUMMARY

The Family First Services and Prevention Act requires that each program listed in a State's Five-Year Title IV-E Prevention Plan have a well-designed and rigorous evaluation strategy unless a waiver is granted from HHS. HHS may waive the evaluation requirement if they deem the evidence of the effectiveness of the evidence-based practice to be profound and the state is compliant in meeting the continuous quality improvement standard regarding the practice.[26]

DCYF is implementing several evidence-based programs that have been rated by the Title IV-E Prevention Services Clearinghouse as "well-supported." Therefore, Rhode Island is requesting a waiver for conducting a rigorous evaluation for those services. However, DCYF will integrate fidelity and outcome monitoring of those programs and services into its current continuous quality improvement (CQI) programming.

Table 5. Summary of Evidence-based Program Evaluation Strategy

Intervention	Category	Title IV-E Clearinghouse Rating	CQI (Evaluation Waiver)
Motivational Interviewing	Mental Health, Substance Use, Parenting	Well-supported	✓
Functional Family Therapy	Mental Health	Well-supported	✓
Multisystemic Therapy	Mental Health	Well-supported	✓
Parent-Child Interaction Therapy	Mental Health	Well-supported	✓
Homebuilders	Parenting	Well-supported	✓
Familias Unidas	Mental Health, Substance Use, Parenting	Well-supported	✓

[26] ACYF-CB-IM-18-02: http://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf

Division of Performance Improvement

Rhode Island DCYF has a robust research, program planning, and evaluation and CQI infrastructure as part of the Division of Performance Improvement (DPI). Program evaluations will be conducted under the guidance and oversight of the DPI, while the DPI will carry out contract monitoring and measure fidelity and outcomes achieved for evidence-based programs and services granted a waiver. The Division will also conduct contract and fidelity monitoring for the evidence-based programs and services for which a waiver is not being requested.

DCYF's DPI Administrator, holds a doctoral degree in public health and is an epidemiologist and researcher. She has overseen the Division for 16 years. The DPI Administrator also holds an academic position of Assistant Professor of Practicing Epidemiology in the School of Public Health, Epidemiology Department at Brown University and is a consultant with The Center for States specializing in research, evaluation, and data analytics as it pertains to enhancing data analytic capacity and CQI. The DPI Administrator is supported by the Data Analytics, Research and Evaluation Unit that consists of five Master's-level Public Health epidemiologists who are skilled in research design, research implementation, data collection, data analysis, data driven strategic planning and program evaluation and CQI. Each epidemiologist has primary areas of focus and collaborate with other DCYF divisions and external stakeholders on a monthly basis to review data analysis; evaluate child, family, and system outcomes; and use data to inform program planning, implementation, and evaluation. Meetings are held routinely with the Department's Active Division Management (ADM) and Active Contract Management (ACM) staff. The ADM meetings involve the DPI epidemiologist embedded with a DCYF division/ programmatic staff to engage in data-driven meetings and monitor workplans. The ACM meetings involve a DPI epidemiologist embedded with a DCYF division and a DCYF Contracts representative to meet with the contracted providers to engage in data-driven meetings.

WAIVER REQUEST

DCYF is submitting Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice, for the following well-supported services for which the evidence of effectiveness of the practice is compelling. Documentation of that evidence is also provided below. DCYF's signed Request for Waiver for Evaluation Requirements for a Well-Supported Practice documents have been submitted to the Children's Bureau as separate attachments.

Motivational Interviewing (MI)

The effectiveness of Motivational Interviewing (MI) has been demonstrated through at least 30 studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DCYF to conclude that the program's effectiveness is compelling for Rhode Island's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from two studies that were eligible for review. It is also supported by the California Evidence-Based Clearinghouse for Child Welfare Office, by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice, and by the Pew's Results First Clearinghouse. The review by Pew's Results First Clearinghouse found favorable outcomes in areas of safety, targeting caregivers of children referred to the child welfare system and in use with adolescents.[27]

MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen a person's motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. Given MI's broad applicability beyond using it to support individuals with a substance use disorder, Rhode Island will expand MI to include mental health and parent skilled-based training services. As documented

[27] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database.

in Oregon's approved Prevention Plan, MI has demonstrated efficacy in addressing an array of behaviors and underlying conditions from evoking cognitive and behavioral change among domestic violence offenders[28]) to improving self-management behaviors for patients with type II diabetes.[29] Furthermore, a 2018 literature review of MI used in child welfare found evidence in 12 studies that MI effectively improved a variety of outcomes, including parenting skills, parent/child mental health, retention in services, substance use and child welfare recidivism.[30]

DCYF in-home services caseworkers will be trained on using MI to engage parents and caregivers to motivate behavioral change, ensure service completion, and increase child-specific child prevention plan attainment, including individualized case goals related to improved parenting skills and mental health and reductions in substance use similar to the approach that will be utilized in Washington D.C. as it is outlined in their approved Title IV-E Prevention Plan.[31]

Table 6. Motivational Interviewing Summary of Findings: Title IV-E Prevention Services Clearinghouse Review

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Substance use	-0.01 0	5 (33)	1,634	Favorable: 0 No Effect:33 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.00 0	3 (5)	1,464	Favorable: 0 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver substance use	0.16 6	15 (109)	6,066	Favorable: 16 No Effect: 91 Unfavorable: 2
Adult well-being: Parent/caregiver criminal behavior	-0.01 0	2 (7)	1,610	Favorable: 0 No Effect: 7 Unfavorable: 0
Adult well-being: Family functioning	0.10 4	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver physical health	0.00 0	4 (10)	2,158	Favorable: 0 No Effect: 10 Unfavorable: 0
Adult well-being: Economic and housing stability	-0.02 0	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

[28] Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence and victims*, *23*(5), 558–570.
[29] Song, D., Xu, T. Z., & Sun, Q. H. (2014). Effect of motivational interviewing on self-management in patients with type 2 diabetes mellitus: A meta-analysis. *International Journal of Nursing Sciences*, *1*(3), 291–297.
[30] Shah, A., Jeffries, S., Cheatham, L. P., Hasenbein, W., Creel, M., Nelson-Gardell, D., & White-Chapman, N. (2019). Partnering with parents: Reviewing the evidence for motivational interviewing in child welfare. *Families in Society*, *100*(1), 52–67.
[31] DC Title IV-E Prevention Program Five-Year Plan_Amended 9.8.20.pdf

The California Evidence-Based Clearinghouse for Child Welfare rated MI as having well-supported research evidence with medium relevance for child welfare in the categories of motivation and engagement programs and substance use treatment for adults.[32]

In addition, OJJDP works to prevent juvenile delinquency, improve the juvenile justice system, and protect children, employing MI as a Model Program with no effects. OJJDP stated, "This is a person-centered counseling method designed to foster motivation for change in youth who abuse alcohol and marijuana." The summary of its rating goes on to describe participants as showing "a statistically significant reduction in likelihood to exhibit negative treatment engagement and drive under the influence of alcohol, compared with control youth; however, there were no significant differences in other outcomes such as positive treatment engagement or driving under the influence of marijuana.[33]

Finally, the Pew Foundation Results First Clearinghouse,[34] which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for MI, citing the California Clearinghouse as the source of information. This source indicated that outcome areas for MI include safety, targeting caregivers of children referred to the child welfare system and used with adolescents.[35]

Table 7. EBP Alignment with Outcomes and/or Target Populations: Motivational Interviewing

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months • Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Program Information	• Target Population: MI can be used to promote behavior change with a range of target populations and for a variety of problem areas • Dose: Typically delivered over 1-3 sessions, each lasting 30-50 minutes ○ Typically conducted in community agencies, clinical office settings, care facilities, or hospitals
Evidence	• Source: Motivational Interviewing: A Primer for Child Welfare Professionals • Source: Brief intervention for heavy-drinking college students: 4-year follow-up and natural history ▶ Baer, J. S., Kivlahan, D. R., Blume, A. W., McKnight, P., & Marlatt, G. A. (2001). Brief intervention for heavy-drinking college students: 4-year follow-up and natural history. American Journal of Public Health, 91(8), 1310-1316. doi:10.2105/ajph.91.8.1310 • Sample: All students at the University of Washington who were under 19 years of age were mailed a questionnaire, of which 2041 completed the

[32] https://www.cebc4cw.org/program/motivational-interviewing/
[33] https://ojjdp.ojp.gov/model-programs-guide/all-mpg-programs
[34] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
[35] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

EBP Alignment with Outcomes and/or Target Populations	
	questionnaire. Of the completed questionnaires, 508 individuals were identified as "high risk" according to the following criteria: ○ Drinking at least once a month and consuming 5-6 drinks on at least 1 occasion in the last month, or ○ Experiencing at least 3 negative consequences from drinking on 3-5 different occasions in the previous 3 years ▶ A normative sample was selected randomly from the pool of respondents (n = 151), including 33 persons who were high risk, to track the natural history of changes in drinking behavior • Participants identified as being high risk were randomly assigned to either the high-risk prevention group (intervention group) or the high-risk control group. At baseline, no significant differences were observed between the groups for alcohol consumption, related consequences, or demographic and individual difference factors • At baseline, trained interviewers administered the alcohol dependence questions from the Diagnostic Interview Schedule, questions on drinking patterns and consequences from the Brief Drinker Profile, and interview sections to assess family history of conduct problems • Participants assigned to the intervention group were scheduled for an individualized feedback session • Findings: ○ No significant difference were observed between prevention and control conditions for alcohol consumption, related consequences, or demographic and individual difference factors ○ Drinking problems declined significantly over time, and the preventive intervention produced significant differences in alcohol use and related problems over 4 years ○ Differences in the magnitude of change between the high-risk prevention and high-risk control groups from baseline to 1-year follow-up were evident for frequency and negative consequences ▪ Prevention program appears to have its primary effect between baseline and 1-year assessments • Source: Brief motivational interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care ▶ D'Amico, E. J., Parast, L., Shadel, W. G., Meredith, L. S., Seelam, R., & Stein, B. D. (2018). Brief motivational interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care. Journal of Consulting and Clinical Psychology, 86(9), 775-786. doi:http://dx.doi.org/10.1037/ccp0000332 ○ A randomized controlled trial in 4 primary care settings to determine whether a 15-minute brief motivational interviewing and other drug use intervention, delivered in primary care, reduced alcohol and marijuana use and consequences ○ Adolescents ages 12-18 who came for an appointment during the 2.5-year study were asked to participate ○ Those identified as at risk were randomized to the CHAT intervention or usual care ○ Adolescents completed 4 web-based surveys at baseline and 3, 6, and 12 months postbaseline ○ Results: ▪ Sample: n = 294, 58% female, 66% Hispanic, 17% Black, 12% White, 5% multiethnic or other, with an average age of 16 years

EBP Alignment with Outcomes and/or Target Populations	
	▪ Compared with usual care adolescents, CHAT adolescents reported significantly less perceived peer use of alcohol and marijuana at 3 months and 6 months ▪ CHAT adolescents reported marginally fewer negative alcohol consequences experienced at 6 months ▪ At 12 months, compared to UC, CHAT adolescents reported less perceived peer alcohol and marijuana use and few negative consequences from alcohol and marijuana use • Source: Alcohol interventions among underage drinkers in the ED: A randomized controlled trial ▶ Cunningham, R. M., Chermack, S. T., Ehrlich, P. F., Carter, P. M., Booth, B. M., Blow, F. C., . . . Walton, M. A. (2015). Alcohol interventions among underage drinkers in the ED: A randomized controlled trial. Pediatrics, 136(4), e783-e793. doi:10.1542/peds.2015-1260 ○ Objective: Examined the efficacy of emergency department (ED)-based brief interventions (BIs) delivered by a computer or therapist, with and without a post-ED session, on alcohol consumption and consequences over 12 months ○ Participants: Patients (ages 14-20) screening positive for risky drinking were randomized to BI (n = 277), therapist BI (n = 278) or control (n = 281). After the 3-month follow up, participants were randomized to receive a post-ED BI session or control. ○ BIs incorporated motivational interviewing to address alcohol consumption and consequences, including driving under the influence, and alcohol-related injury, as well as other concomitant drug use ○ Results: ▪ Of the 4389 patients screened, 1054 patients reported risky drinking and 836 were enrolled in the randomized controlled trial ▪ Therapist and computer BIs significantly reduced consumption at 3 months, consequences at 3 and 12 months, and prescription drug use at 12 months ▪ Computer BI reduced the frequency of DUI at 12 months ▪ Therapist BI reduced the frequency of alcohol-related injury at 12 months ▪ The post-ED session reduced alcohol consequences at 6 months, benefiting those who had not received a BI in the ED
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using MI with all of its candidate populations with the goal of achieving four outcomes: reducing recidivism in the juvenile probation population, increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates MI's effectiveness with reduction of risky drinking and associated negative behaviors and consequences from alcohol consumption. DCYF anticipates that using MI to reduce risky behavior, such as alcohol consumption, will lead to improved outcomes for families.

Functional Family Therapy (FFT)

The effectiveness of Functional Family Therapy (FFT) has been demonstrated through multiple studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DCYF to conclude that the program's effectiveness is compelling for Rhode Island's child welfare and juvenile justice

populations. This conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from nine evaluations that were eligible to review. It is also supported by the California Evidence-Based Clearinghouse for Child Welfare Office, by the Office of Juvenile Justice and Delinquency Prevention, and by the Pew's Results First Clearinghouse. The review by the Title IV-E Prevention Services Clearinghouse shows that FFT had favorable[36] effects on child behavioral and emotional functioning, child substance use, child delinquent behavior, and family functioning, which are desired outcomes for the DCYF prevention service array. Unfavorable effects were minimal. These findings are summarized in the table below.[37]

DCYF intends to continue FFT as a short-term intervention to address the service needs of youth ages 11–18 years who have been referred for behavioral or emotional problems by the juvenile probation, mental health, school, the child welfare agency, or other child welfare partners.

Table 8. Functional Family Therapy Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.16 6	4 (26)	390	Favorable: 2 No Effect: 23 Unfavorable: 1
Child well-being: Substance use	0.49 18	1 (18)	52	Favorable: 9 No Effect: 9 Unfavorable: 0
Child well-being: Delinquent behavior	0.05 1	5 (20)	8,636	Favorable: 4 No Effect: 16 Unfavorable: 0
Adult well-being: Positive parenting practices	0.02 0	2 (9)	163	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Family functioning	0.30 11	1 (15)	52	Favorable: 1 No Effect: 14 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated FFT as having supported research evidence with medium relevance for child welfare in the categories of alternatives to long-term care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child and adolescent), and for substance use treatment for adolescents.[38]

In addition, OJJDP identified FFT as a Model Program with an effective rating. OJJDP stated, "This is a family-based prevention and intervention program for dysfunctional youth, ages 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral problems. The program is rated Effective. Program participants showed a statistically significant reduction in general recidivism and

[36] According to the Title IV – E Prevention Services Handbook of Standards and Procedures, impact estimates that are favorable (statistically significant and in the desired direction).
[37] Title IV-E Prevention Services Clearinghouse. Functional Family Therapy. Summary of Findings. Available at https://preventionservices.abtsites.com/programs/108/show
[38] https://www.cebc4cw.org/program/functional-family-therapy/

risky behavior, compared with control group participants. However, there were no differences between groups on felony recidivism or caregiver strengths and needs."[39]

Finally, the Pew Foundation Results First Clearinghouse,[40] which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for FFT, citing the *CrimesSolution.gov* clearinghouse as the source of information. This source indicated that outcome areas for FFT include recidivism, life domain, child behavior emotional needs, child risk behaviors, child strengths, acculturation, caregiver strengths, and caregiver needs.

Table 9. EBP Alignment with Outcomes and/or Target Populations: Functional Family Therapy

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months • Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Program Information	• **Target Population:** 11–18-year-old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems • **Dosage:** Therapists meet weekly with families face-to-face for 60-90 minutes and by phone for up to 30 minutes. Most families complete FFT program in an average of 8-14 sessions over the span of 3-6 months • **Location/Delivery Settings:** Typically, FFT is conducted in clinic and home settings
Evidence	• Source: *Comparison of Family Therapy Outcome with Alcohol-Abusing, Runaway Adolescents* Slesnick, Natasha; Prestopnik, Jillian L. Journal of Marital & Family Therapy. Jul2009, Vol. 35 Issue 3, p255-277. 23p. ○ Target Population: ▪ 12-17 ▪ Use alcohol ○ Three types of therapy ▪ Home-based ecologically based family therapy (EBFT) • Modeled after Homebuilders • Brings family together and addresses the immediate issues associated with a youth's stay at a shelter (runaway) • Therapy is conducted at home • Can require immediate intervention with the school (e.g., if the youth is truant, not doing well, fighting),

[39] https://www.ojjdp.gov/MPG/Topic/Details/79
[40] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

EBP Alignment with Outcomes and/or Target Populations	
	probation officer (e.g., if a court appearance is near), and family (e.g., coping with high emotion, problem solving, and reintegrating the youth back into the home) ▪ Office-based functional family therapy (FFT) • Integrates and conceptually links behavioral and cognitive intervention strategies to the ecological formulation of the family disturbance • Primary focus of sessions is on family interaction and behavior change • This study used office-based interventions • Two phases of therapy: ○ Phase 1: Readiness to change and creating the context in which behavior change can occur (engage the family in therapy, enhance the family's motivation for change, assess the relevant aspects of family functioning to be addressed in therapy) ○ Phase 2: Establishing and maintaining behavior change ▪ Service as usual (SAU) • Informal meetings or therapy provided or arranged by shelter staff ○ This study compared family treatments for shelter-residing runaway youth with primary alcohol problems ○ Method: ▪ Office-based FFT and home-based EBFT were offered for 16, 50-minute sessions ○ Findings: ▪ The impact of family therapy (home and office based) was pronounced on alcohol use (EBFT: 97% decline in alcohol use days and 77% reduction in standard drinks consumed on drinking days, FFT: 83% decline in drinking days, 64% reduction in standard drinks consumed) ▪ All three conditions (EBFT, FFT, and SAU) showed improvements across areas of family functioning (verbal aggression, family cohesion, and conflict), psychological functioning (psychiatric diagnoses, externalizing problems, delinquent behaviors, and days living at home), and substance use ▪ Higher treatment engagement rate with EBFT ▪ Families assigned to either the office- or home-based family therapy showed significant improvements in substance use and family and individual functioning ▪ Office-based FFT had a sharp decline in substance use at 3 months, but leveled off at 15 months (not significantly significant) ▪ FFT showed a significant reduction in males only, and reducing alcohol use in older adolescents • Source: *An outcome evaluation of Functional Family Therapy for court-involved youth* Celinska, Katarzyna; Sung, Hung-En; Kim, Chunrye; Valdimarsdottir, Margret. Journal of Family Therapy. Apr2019, Vol. 41 Issue 2, p251-276. ○ Sample: 155 court-involved youth

EBP Alignment with Outcomes and/or Target Populations	
	○ Outcomes: court-obtained recidivism data and clinical therapeutic data, the Strengths and Needs Assessment (SNA) ○ Findings: ▪ Youth who participated in FFT had lower recidivism rates one year after program completion • FFT treatment group: reduced likelihood of reconvictions for new drug offenses, new property offenses and sanctions for technical violations ▪ Adolescents who were in the FFT interventions were less likely to recidivate as compared to those in the comparison group ▪ Adolescents who completed FFT and exhibited minor drug problems were less likely to commit another drug offense within a year • Source: *The Effectiveness of Functional Family Therapy for Youth with Behavioral Problems in a Community Practice Setting* ○ Sample: ▪ Juvenile offenders who had been adjudicated for a crime and sentenced to probation ▪ Ages 13-17 ○ Findings: ▪ When practiced with model-specific adherence, FFT resulted in a significant reduction in felony and violent crimes and a non-significant reduction in misdemeanor crimes ▪ The high fidelity FFT therapists had more favorable outcomes (less recidivism) than low fidelity therapists regardless of whether the families had high or low levels of risk or protective factors
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using FFT with all of its candidate populations for families with youth aged 11–17 years who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems with the goal of achieving four outcomes: reducing recidivism in the juvenile probation population, increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates FFT's effectiveness improving all areas of family functioning (verbal aggression, family cohesion, and conflict), psychological functioning (psychiatric diagnoses, externalizing problems, delinquent behaviors, and days living at home), and substance use. DCYF anticipates that using FFT to improve family functioning in families with youth aged 11–17 years who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems will lead to outcome achievement. See data sets in Figures 3-9 in Section III *Service Description and Oversight* for additional detail on the target population and their needs.

Multisystemic Therapy (MST)

As noted earlier, Multisystemic Therapy is an intensive family- and community-based treatment program that addresses all environments that impact high risk youth including home and families, schools and teachers, neighborhoods, and friends. The effectiveness of Multisystemic Therapy (MST) has been demonstrated through multiple studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DCYF to conclude that the program's effectiveness is compelling for Rhode Island's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings and is also supported by the California

Evidence-Based Clearinghouse for Child Welfare Office, by the Office of Juvenile Justice and Delinquency Prevention, and by the Pew's Results First Clearinghouse. The review by Pew's Results First Clearinghouse found favorable outcomes in areas of recidivism, re-arrest, incarceration, delinquency, family cohesion, peer aggression, social skills, arrests, peer relations, arrests for new charges, substance use, school/work functioning, home functioning, community, behavior toward others, and moods and emotions."[41]

Table 10. Multisystemic Therapy Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency: Out-of-home placement	0.24 9	3 (5)	1,471	Favorable: 2 No Effect: 3 Unfavorable: 0
Child well-being: Behavioral and emotional functioning	0.22 8	7 (82)	1,415	Favorable: 23 No Effect: 58 Unfavorable: 1
Child well-being: Social functioning	0.03 1	4 (14)	1,002	Favorable: 0 No Effect: 14 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.13 5	1 (3)	486	Favorable: 0 No Effect: 3 Unfavorable: 0
Child well-being: Substance use	0.09 3	2 (14)	610	Favorable: 1 No Effect: 13 Unfavorable: 0
Child well-being: Delinquent behavior	0.27 10	10 (82)	2,467	Favorable: 17 No Effect: 62 Unfavorable: 3
Adult well-being: Positive parenting practices	0.12 4	2 (46)	816	Favorable: 12 No Effect: 34 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.29 11	3 (5)	826	Favorable: 3 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.16 6	4 (21)	912	Favorable: 5 No Effect: 16 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated MST as having well-supported research evidence with medium relevance for child welfare in the categories of alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment for children and adolescents, and substance use treatment for adolescents.[42]

[41] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
[42] https://www.cebc4cw.org/program/multisystemic-therapy/

The California Clearinghouse also rated MST as having supported research evidence with high relevance for child welfare in the category of interventions for abusive behavior[43] as well as having well-supported research evidence with medium relevance for child welfare in the categories of interventions for abusive behavior and sexual behavior problems treatment for adolescents.

The OJJDP identified MST as a Model Program with an effective rating. OJJDP provided this rating for programs that offer a "family and community-based treatment program for adolescent offenders with serious antisocial, delinquent, and other problem behaviors" and those for "adolescents with substance abuse and dependency issues." OJJDP also rated MST as promising for programs that incorporate "management protocols and multisystemic therapy into traditional juvenile drug court services to provide juveniles and families with additional engagement opportunities and support in order to reduce recidivism and substance abuse;" address "family functioning and parental behavior to reduce child abuse, neglect and external placement; serve "adolescents who have committed sexual offenses and demonstrated other problem behaviors; address "externalizing symptoms, suicidal behaviors, and family relations while allowing youth with serious behavioral and psychiatric problems to avoid an inpatient setting and spend more time in school and at home;" and integrate "individual and family services to juvenile offenders who have co-occurring mental health and chemical dependency disorders during their transition from incarceration back into the community."[44]

Finally, the Pew Foundation Results First Clearinghouse,[45] which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported MST as having the highest rating of effectiveness, citing *CrimeSolutions.gov* as the source of information.[46] This source indicated that outcome areas for MST include recidivism, re-arrest, incarceration, delinquency, family cohesion, peer aggression, social skills, arrests, peer relations, arrests for new charges, substance use, school/work functioning, home functioning, community, behavior toward others, and moods and emotions."[47]

Table 11. EBP Alignment with Outcomes and/or Target Populations: Multisystemic Therapy

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months • Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Program Information	• **Target Population:** Youth between the ages of 12 and 17 and their families. This includes youth who are risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement

[43] https://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/
[44] https://ojjdp.ojp.gov/model-programs-guide/all-mpg-programs
[45] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
[46] https://crimesolutions.ojp.gov/ratedprograms/192
[47] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

EBP Alignment with Outcomes and/or Target Populations	
	• **Dosage:** Multiple weekly visits between the therapist and family over an average of 3-5 months • **Location/Delivery Setting:** The program can be delivered in multiple settings, including home, school, and community
Evidence	• Source: Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. ▶ Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65(5), 821-833. ○ Summary: The purpose of the study was to examine the effects of Multisystemic Therapy (MST) in treating violent and chronic juvenile offenders and their families in the absence of certain aspects of the MST quality assurance protocol. Participants were randomly assigned to MST versus usual juvenile justice probation services. Measures utilized include the Global Severity Index of the Brief Symptom Inventory, the Self-Report Delinquency Scale, the Family Adaptability and Cohesion Evaluation Scales, the Missouri Peer Relations Inventory, and Department of Juvenile Justice arrest records. Results indicate MST decreased adolescent externalizing and internalizing symptoms at post treatment, decreased incarceration at a 1.7-year follow-up and decreased recidivism. Analysis of parent, adolescent, and therapist reports of MST treatment adherence (as measured by the MST Treatment Adherence Measure) indicated that outcomes were substantially better in cases where MST treatment fidelity was high. Limitations include possible lack of therapists' adherence to the MST treatment protocol and limited generalizability due to ethnicity and gender of participants. • Source: A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. ▶ Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., & Prins, P. J. M. (2013). A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. Journal of Experimental Criminology, 9(2), 169-187. ○ Sample: 256 adolescents, referred because of conduct problems ○ Results: ▪ MST was more effective than TAU (treatment as usual) in decreasing externalizing behavior, Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) and property offenses, but not for violence ▪ MST showed an improvement in parental sense of competence and a decrease in adolescents' hostility, but no change in self-esteem and an increase in personal failure ▪ MST was effective for positive dimensions of parenting and associations with prosocial peers, but not for relationships with deviant peers ▪ MST was equally effective for adolescents of different ages and with different ethnicities; however, MST showered larger and more positive effects for adolescent cognitions for boys than for girls

EBP Alignment with Outcomes and/or Target Populations	
	• Source: Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. • Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. Journal of Child and Family Studies, 2(4), 283-293. ○ Sample: 84 juvenile offenders at imminent risk of out-of-home placement due to serious criminal activity ○ Family Preservation Service (FPS) models of mental health service delivery emphasize services that are home-based, intensive, goal-oriented and time-limited ○ The goal of FPS is to prevent recidivism and consequent out-of-home placement of children ○ Findings: ▪ Youth who received multisystemic family preservation were less likely to be re-arrested than were youths who had received usual services (at 2.4 years post-referral)
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using MST with all of its candidate populations for youth between the ages of 12 and 17 years and their families with the goal of achieving four outcomes: reducing recidivism in the juvenile probation population, increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates MST's effectiveness reducing recidivism for youth, decreasing externalizing behavior, Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) and property offenses. MST also showed an improvement in parental sense of competence and a decrease in adolescents' hostility. DCYF anticipates that using MST will help to achieve its anticipated outcomes for youth between the ages of 12 and 17 and their families. See data sets in Figures 3-9 in Section III *Service Description and Oversight* for additional detail on the target population and their needs.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) is an evidence-based parent and child behavior training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patters. Children and their caregivers are seen together in PCIT. The program model has been demonstrated to be effective through numerous studies and inclusion as evidence-based in multiple clearinghouses and reports, which, when considered together, led DCYF to conclude that the program's effectiveness is compelling for Rhode Island's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from 21 studies that were eligible to review. PCIT is also supported by the California Evidence-Based Clearinghouse for Child Welfare and the Office of Juvenile Justice and Delinquency Prevention.

The review by the Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable[48] and statistically significant impacts on child behavioral and emotional functioning, positive parenting practices, and parent/caregiver mental or emotional health, which are key outcomes for the DCYF prevention service array. There were no unfavorable effects. These findings are summarized in the table below.[49]

[48] According to the Title IV–E Prevention Services Handbook of Standards and Procedures, impact estimates that are favorable (statistically significant and in the desired direction).
[49] https://preventionservices.abtsites.com/programs/105/show

Table 12. Parent Child Interaction Therapy Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92* 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46* 42	8 (25)	422	Favorable: 20 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.58* 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10 Unfavorable: 0

**Statistically significant*

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated PCIT as having well-supported research evidence with medium relevance for child welfare in the categories of disruptive behavior treatment (child and adolescent), and parent training programs that address behavior problems in child and adolescents.[50] Also, the Pew Foundation Results First Clearinghouse,[51] which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, reported a rating of effective at the highest level for PCIT, citing the California-Evidence Based Clearinghouse as the source for the information.

In addition, OJJDP identified PCIT as a Model Program with an effective rating. OJJDP stated, "The program teaches parents new interaction and discipline skills to reduce child problem behaviors and child abuse by improving relationships and responses to difficult behavior. The program is rated Effective. Program children were more compliant with less behavior problems than the wait list group. The treatment group parents gave more praise and fewer criticisms and improved negative aspects of their parenting. There were fewer rereports of physical abuse."[52]

Table 13. EBP Alignment with Outcomes and/or Target Populations: Parent Child Interaction Therapy

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months

[50] Title IV-E Prevention Services Clearinghouse, Parent Child Interaction Therapy, Summary of Findings. https://www.cebc4cw.org/program/parent-child-interaction-therapy/

[51] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

[52] https://www/ojjdp/gov/MPG/Topic/Details/19

EBP Alignment with Outcomes and/or Target Populations	
	• Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Program Information	• **Target Population:** PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense. • **Dosage:** PCIT is typically delivered over 12-20 weekly hour-long sessions, but the exact treatment length varies based on the needs of the child and family. Treatment is considered complete when a positive parent-child relationship is established, the parent can effectively manage the child's behavior, and the child's behavior is within normal limits on a behavior scale. • **Location/Delivery Setting:** PCIT is usually delivered in playroom settings where therapists can observe behaviors through a one-way mirror. By using the one-way mirror therapists can provide verbal direction and support to the parent using a wireless earphone. Video technology can also be used to deliver the program in other environments such as the home.
Evidence	• Source: Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance ▶ Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance. Journal of Clinical Child Psychology, 27(1), 34-45. ○ Age: 3-6 years ○ Target Population: Families with children referred for conduct disorder ○ At this early age, conduct problem behavior as well as poor parental discipline and negative parent-child interactions are powerful predictors of subsequent delinquency and criminal offenses ○ PCIT is designed to help parents build a warm and responsive relationship with their child and to manage their child's behavior more effectively ○ Findings: ▪ The intervention group showed higher levels of praise and lower levels of criticism in interactions with children ▪ Children's compliance increased ▪ Parental stress scores shifted to normal • Source: Parent-Child Interaction Therapy for Mexican Americans: results of a pilot randomized clinical trial at follow-up. ▶ McCabe, K., Yeh, M., Lau, A., Argote, C. B., McCabe, K., Yeh, M., . . . Argote, C. B. (2012). Parent-Child Interaction Therapy for Mexican Americans: results of a pilot randomized clinical trial at follow-up. Behavior Therapy, 43(3), 606-618. doi:10.1016/j.beth.2011.11.001 ○ The study compared the effectiveness of a culturally modified version of PCIT, called Guaiando a Ninos Activos (GANA), to the effectiveness of standard PCIT and Treatment as Usual ○ Age: 3-7 ○ Families assigned to GANA and PCIT were higher on individual praise, reflection of child speech, and description of child behaviors,

EBP Alignment with Outcomes and/or Target Populations	
	and lower on questions, commands, and criticisms than families assigned to TAU ○ Outcomes were comparable to other trials, this study had more sessions for GANA (18.7) and PCIT (18) compared to 14-session average • Source: Accumulating evidence for Parent-Child Interaction Therapy in the prevention of child maltreatment. ► Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for Parent-Child Interaction Therapy in the prevention of child maltreatment. Child Development, 82(1), 177-192. ○ PCIT focuses on assisting parents to maintain consistent limits, to ignore minor disruptive behaviors, to manage their own emotions during negative interactions, to identify effective time-out strategies, and to implement strategies effectively and judiciously ○ PCIT offers behavior management strategies that focus on positive reinforcement rather that power assertion to reduce child oppositional and disruptive behaviors ○ Two aims of the study: ▪ Examine the effectiveness of standard PCIT with mothers at risk or with a history of maltreating their children ▪ Identify the treatment outcomes that are linked to individual and interactional processes relevant to reducing child abuse ○ Participants: 150 female caregivers and their children (all but three children were between 2.5 and 7 years old) ○ Findings: ▪ PCIT group reported greater improvements by 12 weeks into the program, including reductions in stress due to the child and children's externalizing behaviors ▪ Parents interacted with their children using more positive statements, and more descriptions and reflections ▪ By treatment completion, but not before, parents reported they made more beneficial attributions about their children's behaviors, were less emotionally reactive and distress prone when interacting with their children (i.e., child abuse potential), and they were observed to be more sensitive when interacting with their children ▪ PCIT also was associated with a reduced chance of notification for suspected child abuse – the rate of future notifications was decreased among those families who completed PCIT compared to those who did not complete treatment • When the analysis was limited to only those participants referred from child protection authorities there was still a marginally lower rate of future notification
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using PCIT with six of its candidate populations that include families with children aged 2-7 years with the goal of achieving three outcomes: increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates PCIT's effectiveness in improving parent behavior with higher levels of praise and lower levels of criticism in interactions with children, children's compliance increased, parental stress scores shifted to normal with reductions in stress due to the child and children's externalizing behaviors. Parents interacted with their children using more positive statements, and more descriptions and reflections. By PCIT treatment completion, but

EBP Alignment with Outcomes and/or Target Populations	
	not before, parents reported they made more beneficial attributions about their children's behaviors, were less emotionally reactive and distress prone when interacting with their children (i.e., child abuse potential), and they were observed to be more sensitive when interacting with their children. PCIT is also associated with a reduced chance of notification for suspected child abuse – the rate of future notifications was decreased among those families who completed PCIT compared to those who did not complete treatment. DCYF anticipates that using PCIT will help to achieve its anticipated outcomes in families with children aged 2-7 years. See data sets in Figures 3-9 in Section III *Service Description and Oversight* for additional detail on the target population and their needs.

Homebuilders

The effectiveness of Homebuilders has been demonstrated through multiple studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DCYF to conclude that the program's effectiveness is compelling for Rhode Island's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings and is also supported by the California Evidence-Based Clearinghouse for Child Welfare Office, by the Office of Juvenile Justice and Delinquency Prevention, and by the Pew's Results First Clearinghouse. The review by Pew's Results First Clearinghouse found favorable outcomes in areas of number of reunifications, success of reunifications, days before return home, and placement prevention.[53]

Homebuilders is a home- and community-based intensive family preservation treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program, currently in use by Rhode Island, 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.

Table 14. Homebuilders Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	0.02 0	2 (9)	896	Favorable: 0 No Effect: 9 Unfavorable: 0
Child permanency: Out-of-home placement	0.26 10	2 (18)	905	Favorable: 3 No Effect: 13 Unfavorable: 2
Child permanency: Planned permanent exits	1.07 35	1 (4)	120	Favorable: 4 No Effect: 0 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.19 7	1 (3)	634	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Economic and housing stability	0.06 2	1 (12)	638	Favorable: 1 No Effect: 11 Unfavorable: 0

[53] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

The California Evidence-Based Clearinghouse for Child Welfare rated Homebuilders as having supported research evidence with high relevance for child welfare in the categories of family stabilization programs, interventions for neglect, post-permanency services and reunification programs.[54]

The OJJDP identified Homebuilders as a Model Program with an effective rating. OJJDP found, "The treatment group had a statistically significant greater number of reunifications and reduced rates of out-of-home placement, compared with the control group. However, there were no significant differences between groups in successful reunification (*i.e.,* whether the children returned to foster care)."[55]

Finally, the Pew Foundation Results First Clearinghouse,[56] which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported Homebuilders as having the highest rating of effectiveness, citing *CrimeSolutions.gov* as the source of information.[57] This source indicated that outcome areas for Homebuilders include number of reunifications, success of reunifications, days before return home, and placement prevention.[58]

Table 15. EBP Alignment with Outcomes and/or Target Populations: Homebuilders

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months • Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • FCCP
Program Information	• **Target Population:** Families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services • **Dosage:** 40+ hours of face-to-face services over 4-6 weeks • **Location/Delivery Setting:** Primarily in the client's home
Evidence	• Source: *In-home family-focused reunification: An experimental study.* ▶ Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. Child Welfare, 72(5), 473-487. ○ To test the effectiveness of employing family preservation services to reunify families with their children, 57 families that received in-home, family-based services was compared with a group of families (n=53)

[54] https://www.cebc4cw.org/program/homebuilders/
[55] https://ojjdp.ojp.gov/model-programs-guide/all-mpg-programs
[56] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
[57] https://crimesolutions.ojp.gov/ratedprograms/210
[58] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

EBP Alignment with Outcomes and/or Target Populations	
	that received routine reunification services as a component of an overall out-of-home plan. ○ List of families included those children who met the following criteria: ▪ The child had been in placement for more than 30 days ▪ The child would not have returned home without services ▪ Reunification was part of an overarching case plan ▪ The child was able to be returned home ○ Services ▪ In-home, family-centered ▪ Practice principles: • Client-caseworker relationships should be built through client-centered case planning and active listening • Primary needs should be addressed by making concrete services available • The entire family should be treated • Families should be helped to access resources and to build a supportive network • Learning new skills for parenting, household management, and relationships should be emphasized ▪ Limited to a 90-day period, at least 3 visits per week per family, home-based, oriented toward the provision of concrete services, and focused on skills training ○ Findings: ▪ Treatment was effective in returning children to their homes and in keeping them there ▪ Treatment children spent significantly more time (number of days) living at home during the 90-day period and the follow-up period • Treatment appeared to be successful in returning children to their homes, but not all children stayed there ○ Intensive family preservation services are more commonly used for the prevention of unnecessary out-of-home placement. • Source: In-home family-focused reunification: A six-year follow-up of a successful experiment. ► Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. Social Work Research, 22(4), 205-214. doi:10.1093/swr/22.4.205 ○ Intensive family-based services caseworkers make increased efforts to identify informal, as well as formal, resources to help families access a network of ongoing services that remain in place after the intensive services terminate ○ Results: ▪ Children who received the experimental treatment required less DCFS supervision time, lived at home longer, and were in less-restrictive placements than those in the control group ▪ Almost two-thirds of the families in the experimental group were classified as “stabilized”, compared with approximately one-third for the control group

EBP Alignment with Outcomes and/or Target Populations	
	▪ One-eighth of the experimental families were classified as "separated" at the end of the period, compared with one-fourth of the control families. o California Clearinghouse Summary: Summary: (To include basic study design, measures, results, and notable limitations) o Note: This study uses sample from Fraser, et al. (1996), with the addition of 10 young adults who turned 18 during the intervention in that study. The follow-up examined placement and welfare service histories for children included in the original trial. The authors compared the intervention group [now called Homebuilders®] to the control group on total days of public agency involvement during the 6 years, total number of referrals to the Department of Children and Family Services (DCFS), public agency involvement after DCFS case closure, and reason for discontinuing services. Groups did not differ on days of DCFS involvement and number of referrals. Groups were also equal in the extent to which they received extensive involvement with services, defined as placement in a foster home, corrections facility, or facility of the Department of Mental Retardation. Experimental families received more services overall, which authors attribute as possibly being a result of the intervention's focus on networking families with services. Finally, a greater number of intervention families were classified as having discontinued services due to the family situation being stabilized. Limitations include generalizability due to ethnicity and also limited to former and current participants in the foster care system. • Source: Evaluation of Family Preservation and Reunification Programs: Final Report o Homebuilders Model: Homebuilders, a foster care placement prevention program developed in 1974 in Tacoma, Washington, calls for short-term, time-limited services provided to the entire family in the home. (4) The program is based, in part, on crisis intervention theory. This theory holds that families experiencing a crisis that is, about to have a child placed in foster care will be more amenable to receiving services and learning new behaviors. Social learning theory also plays a part in defining the Homebuilders model. Social learning theory rejects the belief that changes in thinking and feeling must precede changes in behavior. Instead, behavior, beliefs, and expectations influence each other in a reciprocal manner. Key program characteristics include: ▪ Contact with the family within 24 hours of the crisis ▪ Caseload sizes of one or two families per worker ▪ Service duration of 4-6 weeks ▪ Provision of concrete services and counseling ▪ The family receiving up to 20 hours of service/week o Evaluation Design: ▪ Families were randomly assigned to a family preservation program (experimental group) or to other regular services of the child welfare system (control group) o Target Group: Families in which at least one child was "in imminent risk of placement" o Findings: ▪ Children in both groups were primarily in their homes, and family preservation did not result in lower incidence of maltreatment compared with children in the control group

EBP Alignment with Outcomes and/or Target Populations	
	▪ For those with single mothers in the experimental group (in NJ), it was less likely to have subsequent substantial allegation than those in the control group ▪ Family Functioning: families in the experimental group appeared to be doing better at the end of services; however, differences were not maintained. ○ Implications: Relatively intensive and relatively short-term services such as those provided by family preservation programs are one source of help. In this respect, family preservation programs can be thought of as an important part of the continuum of child welfare services.
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using Homebuilders with all of its candidate populations for families who have children at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services with the goal of achieving four outcomes: reduced recidivism in the juvenile probation population, increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates Homebuilder's effectiveness in returning children to their homes and in keeping them there. Children who received Homebuilders required less DCFS supervision time, lived at home longer, and were in less-restrictive placements than those in the control group. DCYF anticipates that using Homebuilders will help to achieve its anticipated outcomes in families who have children at imminent risk of out-of-home placement. See data sets in Figures 3-9 in Section III *Service Description and Oversight* for additional detail on the target population and their needs.

Familias Unidas

Familias Unidas is a family-centered intervention that aims to prevent substance use and risky sexual behavior among Hispanic adolescents. Familias Unidas aims to empower parents by increasing their support network, teaching them about protective and risk factors, improving parenting skills, enhancing parent-adolescent communication, and facilitating parental involvement and investment in adolescents' lives.

Familias Unidas is rated as a well-supported practice by the Title IV-E Prevention Services Clearinghouse because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.[59]

Table 16. Familias Unidas Summary of Findings Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	-0.020	2 (5)	910	Favorable: 1 No Effect: 4 Unfavorable: 0

[59] https://www.cebc4cw.org/program/familias-unidas/

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Substance use	0.3112	2 (11)	445	Favorable: 4 No Effect: 7 Unfavorable: 0
Adult well-being: Positive parenting practices	0.2710	2 (5)	444	Favorable: 1 No Effect: 4 Unfavorable: 0
Adult well-being: Family Functioning	0.2811	2 (7)	909	Favorable: 4 No Effect: 3 Unfavorable: 0

The California Evidence-Based Clearinghouse for Child Welfare rated Familias Unidas as having well-supported research evidence with high relevance for child welfare in the areas of substance use prevention in adolescents, improved family functioning, improved parent-adolescent communication, and improved parenting skills.[60]

Table 17. EBP Alignment with Outcomes and/or Target Populations: Familias Unidas

EBP Alignment with Outcomes and/or Target Populations	
Measures	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months • Percent of children necessitating hospitalization for injuries at 12 and 24 months
Population	• FSU in-home • Re-unified • Juvenile Probation • SRU • Sibling in Care • Post Guardianship or Post Adoption • Youth that are pregnant or parenting • FCCP
Program Information	• **Target Population:** Hispanic adolescents ages 12 to 16 and their families • **Dosage:** Typically delivered over the course of 12 weeks. ○ Eight parent support network group sessions and four individual family visit sessions, with one session per week ○ Each parent support network group session lasts 2 hours and each individual family visit session lasts one hour • **Location:** Home, School
Evidence	• **Source:** A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems ▶ Pantin, H., Prado, G., Lopez, B., Huang, S., Tapia, M. I., Schwartz, S. J., Sabillon, E., Brown, C. H., & Branchini, J. (2009). A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems. Psychosomatic Medicine, 71(9), 987-995. https://doi.org/10.1097/PSY.0b013e3181bb2913

[60] https://www.cebc4cw.org/program/familias-unidas/

EBP Alignment with Outcomes and/or Target Populations	
	○ Population: ▪ Age: Children: 13.8 (Mean), Adults: 40 (Mean) ▪ Race/Ethnicity: 100% Hispanic ▪ Gender: Children: 136 Male and 77 Female, Adults: 186 Female and 27 Male ▪ Status: Participants were 8th-grade Hispanic adolescents with behavior problems and their primary caregivers ○ Summary: ▪ Objective: Evaluated the efficacy of Familias Unidas in preventing/reducing adolescent substance use, unsafe sexual behavior, and externalizing disorders ▪ Results: • Familias Unidas was efficacious in reducing substance use, sexual risk behaviors, and externalizing disorders in this at-risk population • The effects of the intervention were partially mediated by improvements in family functioning • Substance use increases in the Community Control condition were substantially greater than those in Familias Unidas • Incidence of externalizing disorders was substantially greater for youth in Community Control than for youth in Familias Unidas • **Source:** Parent-centered prevention of risky behaviors among hispanic youths in Florida ▶ Estrada, Y., Lee, T. K., Huang, S., Tapia, M. I., Velazquez, M.-R., Martinez, M. J., Pantin, H., Ocasio, M. A., Vidot, D. C., Molleda, L., Villamar, J., Stepanenko, B. A., Brown, C. H., & Prado, G. (2017). Parent-centered prevention of risky behaviors among hispanic youths in Florida. American Journal of Public Health, 107(4), 607-613. https://doi.org/10.2105/AJPH.2017.303653 ○ Population: ▪ Age: Children: 12-16 years, Adults: Mean = 41 ▪ Race/Ethnicity: 100% Hispanic ▪ Gender: Children: 52% Male, Adults: 83% Female ▪ Status: Participants were middle school Latino students and their families ○ Summary: ▪ The study examined the efficacy of Familias Unidas in preventing substance use (alcohol, illicit drugs) and risky sexual behavior among Hispanic adolescents. ▪ Results indicated that Familias Unidas was effective in preventing drug use from increasing and prevented greater increases in risky sexual behavior 30 months after baseline, relative to prevention as usual ▪ Familias Unidas had a positive impact on family functioning and parental monitoring of peers at 6 months after baseline • **Source:** An application of the complier average causal effect analysis to examine the effects of a family intervention in reducing illicit drug use among high-risk Hispanic adolescents ▶ Huang, S., Cordova, D., Estrada, Y., Brincks, A. M., Asfour, L. S., & Prado, G. (2014). An application of the complier average causal effect analysis to examine the effects of a family intervention in reducing illicit

EBP Alignment with Outcomes and/or Target Populations	
	drug use among high-risk Hispanic adolescents. Family Process, 53(2), 336-347. https://doi.org/10.1111/famp.12068 ○ Population: 242 high-risk Hispanic youth aged 12-17 and their primary caregivers were randomized to either Familias Unidas or Community Practice and assessed at baseline, 6 months, and 12 months postbaseline ▪ High-risk: having been arrested or as having committed at least one "Level III Behavior Problem" described by Miami-Dade County Public Schools (MDCP-S) as assault/threat against a non-staff member, breaking and entering/burglary, fighting (serious), hazing, possession, or use of alcohol and/or controlled substances, possession of simulated weapons, trespassing, and vandalism ○ Objective: To provide an applied demonstration of the Complier Average Causal Effect (CACE) analytic approach to evaluate the relative effects of a family-based prevention intervention, Familias Unidas, in preventing / reducing illicit drug use for those participants who received the intended dosage ○ Study Conditions: ▪ Familias Unidas: Guided by ecodevelopmental theory, which posits that adolescents are situated within a network of overlapping and mutually interacting systems • Administered over a 21-week period, eight 2-hour sessions are delivered to parents in a group format that focuses on (a) building parental investment in the adolescent's worlds; (b) enhancing communication skills; (c) improving family support; (d) increasing parental investment in the school world; (e) increasing monitoring of the peer world; (f) preventing and reducing adolescent substance use by enhancing communication skills around drug use; (g) preventing and reducing adolescent risky sexual behavior by enhancing communication skills around risky sexual behavior; (h) prevention as a continuous and ongoing process. In addition, four 1-hour family sessions allow for parents to practice with their adolescent the skills they learned in the group sessions ▪ Community Practice: Participants were offered referrals for standard care services provided y the Department of Juvenile Justice or community-based organizations in Miami-Dade County. • Services: individual and family therapy aimed at preventing and reducing substance use and sexual risk behaviors in adolescents and their families ○ Results: ▪ CACE analytic approach yielded stronger intervention effects among both initially engaged and overall engaged participants ▪ Participants who were classified as initially or overall engaged benefited the most from the effects of a family-based preventive intervention on past 90-day drug use • **Source:** Reducing the risk of internalizing symptoms among high-risk Hispanic youth through a family intervention: A randomized controlled trial.

EBP Alignment with Outcomes and/or Target Populations	
	► Perrino, T., Pantin, H., Huang, S., Brincks, A., Brown, C. H., & Prado, G. (2016). Reducing the risk of internalizing symptoms among high-risk Hispanic youth through a family intervention: A randomized controlled trial. Family Process, 55(1), 91-106. https://doi.org/10.1111/famp.12132 ○ Objective: Studies the effects of Familias Unidas on internalizing symptoms among high-risk youth, as well as the role of family level factors in the intervention's effects ○ Participants: ▪ N = 242 ▪ 12-17-year-old Hispanic Youth with a history of delinquency and their primary caregivers were recruited from the school and juvenile justice systems, and randomly assigned to the Familias Unidas intervention or community practice control. ○ Reducing the risk of internalizing symptoms is important given the multiple barriers to quality mental health treatment services, especially for vulnerable populations such as racial and ethnic minority groups ▪ Interventions that reduce the risk of mental, emotional, and behavioral problems during the key developmental period of adolescence also have the potential to reduce substantial human suffering and costs related to these health outcomes once these problems or disorders have already developed ○ Family-based preventative interventions that aim to strengthen family protective factors, for instance positive parenting behaviors and family functioning, have demonstrated beneficial results on multiple youth outcomes, including substance use, sexual risk and internalizing symptoms ○ Results: ▪ Familias Unidas intervention was more efficacious than control in reducing youth internalizing symptoms ▪ Changes in parent-adolescent communication mediated the intervention's effects on internalizing symptoms, showing stronger intervention effects for youth starting with poorer communication ▪ Familias Unidas can reduce internalizing symptoms among high-risk Hispanic youth, and that improving parent-youth communication, a protective family factor, may be one of the mechanisms by which the intervention influences youth internalizing symptoms
Evidence alignment with DCYF's anticipated outcomes and/or target population/s	Rhode Island is using Familias Unidas with all of its candidate populations for families who have adolescent children that identify as Hispanic, ages 12 to 16, with the goal of achieving four outcomes: reduced recidivism in the juvenile probation population, increased percentage of youth maintaining in the home at 12 and 24 months, reduced subsequent maltreatment reports at 12 and 24 months, and reduced hospital utilization also at 12 and 24 months. The evidence cited in this table demonstrates Familias Unidas' effectiveness in preventing drug use from increasing and prevented greater increases in risky sexual behavior 30 months after baseline. Familias Unidas also had a positive impact on family functioning and parental monitoring of peers and was more efficacious than control in reducing youth internalizing symptoms. Familias Unidas can reduce internalizing symptoms among high-risk Hispanic youth, and that improving parent-youth communication, a protective family factor, may be one of the mechanisms by which the intervention influences youth internalizing symptoms. DCYF anticipates that Familias Unidas will help to achieve its anticipated outcomes in families who have adolescent children that identify as Hispanic, ages 12 to 16. See data sets in Figures

EBP Alignment with Outcomes and/or Target Populations	
	3-9 in Section III *Service Description and Oversight* for additional detail on the target population and their needs.

Continuous Quality Improvement (CQI)

In addition, with each request for a waiver of an evaluation, DCYF has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(iii)(II), including 1) how the state plans to implement the services or programs, 2) how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved, and 3) how information learned from the monitoring will be used to refine and improve practice.

DCYF is committed to continuous quality improvement through contract monitoring and measuring implementation fidelity and outcomes of evidence-based programs and services rated as "well-supported" as well as those rated as "supported" or "promising." On a periodic or ongoing basis, many of Rhode Island's contracted evidence-based providers submit data to their program proprietors to report fidelity to the model, ensuring programs are implemented as defined by policy guidance, and outcomes are positively achieved. Those programs include Multisystemic Therapy, Homebuilders, Familias Unidas, and Family Functional Therapy, each of which is rated as "well-supported. Using data reported to the proprietors on an ongoing basis, reports are transmitted quarterly to the providers from the proprietors, if not more frequently, highlighting fidelity and client outcomes, as well as practice strengths and areas needing improvement.

DCYF intends to supplement that process by retrieving a data extract from the proprietors, where appropriate, and developing tools to collect data that are not reported through ongoing reporting tools. The intent of the fidelity component is to assess if providers have trained capacity to provide the program, if the program is reaching those it is intended to benefit and within reasonable time frames, and if providers are adhering to program manual guidance. The fidelity reviews will also examine the extent to which referred families enroll in the program, if they complete the program as intended and why they might exit before completion. DPI will work with the contracted evaluator to develop a tool to collect data that are not contained within reports to the purveyors or purveyor data systems, tailoring the tool for each evidence-based program based on the program's requirements and data collection needs. DCYF assumes a tool will be developed to collect agency capacity, e.g., education, training and/or certification requirements, from each of its evidence-based providers as often that information is not routinely transmitted to the national purveyor and an additional tool to facilitate monitoring of program reach and process fidelity for Familias Unidas program which does not have a data system that is commonly used to track and transmit client level data for the program purveyor. DCYF will collect the data monthly or quarterly that programs submit to the purveyors and assist to administer the data collection tools developed by the contracted evaluator periodically.

DCYF will implement feedback loops inclusive of quarterly and/or semi-annual meetings with the providers and DCYF leadership to review the aggregated fidelity data for each EBP, identify areas for further exploration and develop strategies, where needed, to make mid-course corrections. DCYF will require providers with gaps in fidelity to prepare and submit a Program Improvement Plan that describes corrective action steps and a timeline to complete those steps. DCYF will assess the extent to which families and children for whom the programs are intended are being referred to the respective programs. A description of the CQI activities Rhode Island will implement are highlighted below. To guide the work of developing DCYF's Plan and development of a CQI strategy, the Advisory Team, Implementation Team, and Executive Team created a logic model to outline the intended inputs, outputs, activities, and impact of the Plan. This helped to clarify goals and objectives and help stakeholders and program staff see how program inputs will lead to the overall prevention vision and inform the plan for continuous quality improvement.

Table 18. DCYF Family First Prevention Services Logic Model.

	Inputs	Outputs	Outcomes	Impact
Infrastructure	• CQI Infrastructure • Active Divisional Management (ADM) • FCCP • Behavioral Health Central • SRU • FSU • CPS • Office of Juvenile Probation • RICHIST enhancements	• Active Division Management (ADM) provides capacity to evaluate implementation and effectiveness. • Allows access to accurate and comprehensive data. • Allows for data collection enhancements to adequately capture racial and ethnic equity indicators • Coordination of services. • Clear procedures and standards.	• Align policy and practice, and regularly review data metrics to continually improve performance.	• Increase in the number of children and families safely sustained at home and in their community. • Improve parental capacity to care for and sustain their family (build their network of support). • Decreased number of children engaged with juvenile justice and decreased length of time for those involved. • Increased array of prevention services. • Increase equity of services available for children/families ensuring culturally appropriate options are available. • Greater collaboration and coordination across public and private
Practice Supports	• Safe Practice Model & FFA/OFFA • Statewide Stakeholder Engagement efforts • Staff training and engagements focusing on racial equity (e.g., listening and learning sessions, workgroups, DAC) • SDM • SRU • CANS+	• Accurate assessment of safety, risk and family strengths and needs. • Connecting children and families to appropriate EBPs, particularly with EBPs showing positive outcomes with children and families of color. Consistent engagement and partnership with families and community resources.	• Retain a professional workforce that is prepared, supported, and effective and is supported with the right tools. • Reduce maltreatment, removal, and recidivism rates for children and families of color.	
Collaboration & Coordination	• Weekly Implementation Team meetings • Monthly or quarterly Advisory Team meetings • RI Coalition of Service Providers • Interstate Child Serving Agencies	• Ownership and support from staff, stakeholders, partners, and community members. • Improved information sharing between agencies and providers.	• Share a vision and plan for Family First and the coordination between DCYF and stakeholders on casework, service delivery, and evaluation.	

	Inputs	Outputs	Outcomes	Impact
Services/ Interventions	• FFT • MST • Familias Unidas • Homebuilders • MI	• Preventive service array with greater evidence base and alignment with service needs. • Expanded service capacity • Improved access to prevention services for children and families of color • Fidelity monitoring	• Consistently achieve the goals of EBPs in which vulnerable children and families participate, including improved mental health and trauma symptoms, reduced problematic substance use, and improved parenting capacity. • Empower parents with skills and resources.	departments /agencies across Rhode Island.

The following summarizes the activities that DCYF will take to monitor fidelity and outcomes of programs for which a waiver to conduct a rigorous evaluation has been granted. Examples of the process and outcome measures to evaluate follow.

Motivational Interviewing: DCYF staff are being trained by DCYF-credentialed trainers to conduct Motivational Interviewing in the fall of 2022. DPI and its training leads will identify components of Motivational Interviewing which are essential to determining if caseworkers are employing the model as intended. DPI will periodically conduct CQI of the evidence-based practice and identify its strengths and areas where improvement is needed.

Rhode Island will seek support from the Motivational Interviewing Network of Trainings (MINT) to develop a CQI strategy. The DPI will implement the Behavior Change Counselling Index (BECCI) instrument to increase the skills of caseworkers in the practice of MI and monitor fidelity.

Family Functional Therapy: DPI will work directly with the national proprietor to receive a copy of the quarterly report for each provider. DPI will also request a copy of data from the proprietor's database semi-annually to complete a more detailed analysis of fidelity measures, where needed.

Multisystemic Therapy: Rhode Island's MST providers routinely submit data to the national proprietor to enable ongoing fidelity and outcome reporting. DPI will work directly with the national proprietor to receive a copy of the quarterly report for each provider. Data from the follow-up activities with clients 30-, 60- and 90-days post-discharge will also be used by DPI to measure outcomes. DPI will also request a copy of data from the proprietor's database semi-annually to complete a more detailed analysis of fidelity measures, where needed.

Parent Child Interaction Therapy: DPI will work in concert with its contracted evaluator to develop a data collection tool that will enable its PCIT providers to report compliance with specific indicators. The data collection tool will enable providers to report data at the client level, to the extent needed, and generate an automated report that measures compliance with key indicators.

Homebuilders: DPI will work directly with the national proprietor to receive a copy of the ongoing reporting sent to providers. DPI will also request a copy of data from the proprietor's database semi-annually to complete a more detailed analysis of fidelity measures, where needed.

Familias Unidas: DPI will work with the provider to receive a copy of the Process and Adherence forms which are used by the trainer to assess a facilitator's fidelity to the program manual. Additionally, DPI will

work with its contracted evaluator to develop a data collection tool that will enable the provider to report compliance with other key program measures.

The table below provides examples of the fidelity and outcome measures that will be reviewed on an ongoing basis. Fidelity measures will range from training and staffing requirements to adherence to program requirements. Outcome measures will include those that programs use to assess changes in behavior as well as those that DCYF uses to examine safety and permanency of children in their care. Data from RICHIST will be used to measure outcomes 12- and 24-months post discharge from the evidence-based program to inform the outcome measures. DCYF will hold quarterly meetings with the providers and DCYF leaderships to review the aggregated outcome measures identified in the table below, identify areas for further exploration and develop strategies, where needed, for improved outcomes. Racial and ethnic disparity or equity will be considered on an ongoing basis for both fidelity and outcome monitoring.

Table 19: Outcome Measures and Instrument and/or Data Sources for Rhode Island's Evidence-based Programs

Key Outcome Measures		
Program	**Measures**	**Instrument and/or *Data Source***
Functional Family Therapy	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*
Parent Child Interaction Therapy	• Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*
Homebuilders	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*
Multisystemic Therapy	• Percent of youth with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*
Motivational Interviewing	• Percent of families that obtain their case plan goals • Percent of youth with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*

Key Outcome Measures		
Program	**Measures**	**Instrument and/or *Data Source***
Familias Unidas	• Percent of youth on juvenile probation with decreased recidivism • Percent of youth living at home at 12 and 24 months • Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months	*Source: RICHIST*

Table 20. Fidelity Measures for Rhode Island's Evidence-based Programs

Key Process (*Fidelity*) Measures		
Program	**Measures**	**Instrument and/or *Data Source***
Functional Family Therapy	• Therapists will meet the model developer required staff qualifications • Therapist will complete the required certified model training prior to serving clients • Therapists will carry the recommended caseload of 10-12 families at any given time • Therapists will meet the model developer's standards for dosage (number and duration) of client contacts • Therapist will meet the supervision/consultation program model requirements • Providers delivering the model will be site affiliates as required by the model developer • Providers will meet the model developer metrics requirements for fidelity and quality assurance • Cases will be completed within the model developer's recommended timeframe of 3 to 4 months	• Weekly Supervision Checklist • Global Therapist Ratings • Provider Records *Source:* • *Functional Family Therapy – Clinical Services System* • *Provider records*
Parent Child Interaction Therapy	• Clinicians satisfy the program's education requirements • Clinicians are trained to apply the PCIT model • Clinicians are certified to apply the PCIT model • Families receive at least one 60-minute session weekly • Clinicians complete the ECBI assessment at each session • Clinicians complete the pre-CDI Phase DPICS assessment	*Source: Provider records*

Key Process (*Fidelity*) Measures		
Program	**Measures**	**Instrument and/or *Data Source***
	• Clinicians complete hte pre-PDI Phase DPICS assessment	
Homebuilders	• Therapists and supervisors meet Homebuilders employment criteria. • Therapists, supervisors and program managers participate in required Homebuilders training and QUEST activities • Families receive their first face-to-face visit within 24 hours of referral • Families receive their first face-to-face visit no later than the end of the day after the referral • Therapists live within an hour's drive of 80% of clients served • Clients have 24/7 availability to therapists • Sessions occur in the family's home or natural environment • Therapists work with 2 families at a time • Therapists meet with families at least 3 times per week • In-person team consultation meetings occur at least once a week • Team members are rated as achieving fidelity on the *Homebuilders Consultation Review* forms • Therapists develop a plan for families to maintain intervention progress	• Provider Agency Report • Online Data Manager System • Quality Enhancement System (QUEST) *Source: Homebuilders Online Data Manager (ODM) System*
Multisystemic Therapy	• Therapist Adherence Measure score • Supervisor Adherence Measure score • Therapists meet the model developer required staff qualifications • Therapists complete the required certified model training prior to serving clients • Therapists serve a maximum of 6 families per year • Therapists meet the model developer's standards for dosage (number and duration) of client contacts • Therapists meet the supervision/consultation program model requirements • Providers delivering the model are site affiliates as required by the model developer • Providers meet the model developer metrics requirements for fidelity and quality assurance	• Therapist Adherence Measure – Revised (TAM-R) • Supervisor Adherence Measure (SAM) • Consultant Adherence Measure (CAM) *Source:* • *MST Institute* • *Provider records*

Key Process (*Fidelity*) Measures		
Program	**Measures**	**Instrument and/or *Data Source***
	• Cases are completed within the model developer's recommended timeframe of 4 to 6 months • Clients are from the target population • Number of clients served	
Motivational Interviewing	• Caseworkers complete program training • Caseworkers implement the program with quality and fidelity using the Behavioral Change Counseling Index (BECCI)	*Source:* • *DCYF records* • *BECCI*
Familias Unidas	• Facilitators are Spanish-speaking and bicultural • Facilitators meet the educational requirements of the program • Facilitators meet the experience requirements of the program • Facilitators complete certification training • Facilitators engage families to actively participate • Facilitators convey importance of key family functioning elements • Facilitators support parents in improving family functioning	*Source:* • *Provider records* • *Adherence Form: Familias Unidas* • *Family Visit Process Form: Familias Unidas*

For all EBPs, DCYF Research, Data Analytics, Evaluation, and CQI Unit, program managers and Contracts meet with providers quarterly or semi-annually to monitor trend data, conduct data analytics to identify and better understand the root cause and underlying factors contributing to outcomes, examine race and ethnic disproportionality, plan and implement strategies and evaluate child and family outcomes, including by demographic characteristic to identify where programming changes are needed to better support children and families of color. Additionally, qualitative research is conducted and discussions involving barriers and successes are identified and integrated into program planning. These discussions will be changed to a quarterly cadence and be expanded to address providers' fidelity to the program manuals and action steps to address challenges, where appropriate, using data from the proprietor's ongoing fidelity monitoring reports. The DPI also meets with DCYF divisions to share the results of its outcome analyses and conversations with providers to identify strategies to make informed practice changes that are intended to improve programming and inform policy decision-making.

In addition to this ongoing support, DPI will conduct implementation reviews as part of its ongoing case review process to verify implementation fidelity at the provider level and review outcome measures and trends annually. As cases are selected into the sample for the annual Child and Family Services Review, Program Improvement Plan monitoring review, case reviewers will identify if and which evidence-based programs or services are being provided to candidates selected into the sample.

During the reviews, providers, DPI staff and family stakeholders will identify areas of strength and needs; a collaborative quality improvement plan will then be developed for providers, where needed. These reviews occur on an annual or more frequent basis according to need.

DCYF will measure outcomes using two data sources. First, using data from RICHIST along with enrollment and discharge data collected from service providers, DCYF will measure safety and permanency outcomes 12- and 24-months following discharge for each evidence-based program by using data from RICHIST. The outcome measures using data from RICHIST include:

- Percent of youth on juvenile probation with decreased recidivism
- Percent of youth living at home at 12 and 24 months
- Percent of youth with no subsequent indicated maltreatment reports at 12 and 24 months
- Percent of children necessitating hospitalization for injuries at 12 and 24 months

When working with the national proprietors to receive ongoing reports of implementation fidelity, DPI will also develop a strategy to receive the results of outcomes the proprietors use on an ongoing basis to measure the providers' success, such as change over time in improved parenting skills, decreased behavioral health problems or increased family interaction. While most of these outcomes will report change from time to enrollment to time of discharge, DPI will work with the proprietors to collect post-discharge data for programs that collect data following discharge from an evidence-based program.

SECTION V: MONITORING CHILD SAFETY

Pre-Print Section 3

The mission of DCYF is to "partner with families and communities to raise safe and healthy children and youth in a caring environment."[61] Children must also be protected from the compounding trauma of separation from their families when they can be safely maintained in their homes or that of a relative. DCYF uses a family-centered, strengths-based approach to case planning and management by engaging family members throughout the case to ensure services are administered to best address the family's strengths and needs.[62] Adherence to monitoring safety is a critical component of the prevention work outlined in Rhode Island's Title IV-E prevention plan. It is an ongoing process throughout the entire in-home, prevention services case and is facilitated primarily using risk and safety assessment instruments that are rated as best practice, as well as obtaining ongoing recommendations from family members regarding services that will be most beneficial in achieving expected service outcomes.

RISK AND SAFETY ASSESSMENTS

The comprehensive assessment and prevention service planning process identifies, considers, and weighs factors (*e.g.,* present, or impending danger, maltreatment, child and adult functioning, parenting, and discipline) that affect child safety, permanency, and wellbeing. This process recognizes patterns in behavior over time and examines family strengths and protective factors to identify resources to support the family's ability to protect their children. A child is considered safe when evaluation of all available information leads to the conclusion that the child is not in present or impending danger of harm in their current living arrangement and no interventions are necessary to ensure the child's safety. Safety interventions are responsive to the present and imminent danger of harm to the child and are not expected to impact identified risks of future harm. Safety concerns require immediate interventions to ensure that children are protected, while risk assessments address the likelihood of future harm and is addressed over time with services that result in long-term positive behavioral changes.

DCYF, including its Juvenile Probation Unit and FCCP provider partners, uses a comprehensive assessment and prevention service planning process for each child and family from the initial point of contact through to case closure. This process is guided by principles of family-centered, culturally competent practice and uses standardized tools at various points throughout DCYF or the FCCP's

[61] Home - Rhode Island - Department of Children, Youth & Families (ri.gov)
[62] Family-Centered Case Planning and Case Management - Child Welfare Information Gateway

involvement with the family. DCYF and FCCPs use a variety of tools and practices to assess and monitor the risk and safety of children receiving prevention services. Risk and safety assessment tools described in detail in Table 2 are used to assess and monitor the risk and safety of children and families. Risk and Safety Assessments are used to:

- Help determine which families are appropriate for prevention services,
- Assist with the development of safety and prevention plans,
- Identify the level of intensity needed for intervention with a family, including how frequently the family needs to be seen, and
- Determine when it is appropriate to recommend closing an in-home, prevention services case.

Structured Decision Making (SDM)

Structured Decision Making is the first tool that the DCYF CPS unit uses to screen and respond to CPS hotline calls reporting suspected child maltreatment. SDM is a well-known approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered in developing and monitoring progress toward a case plan.[63] SDM targets agency services to children and families at high risk of future child welfare system involvement and helps ensure that service plans reflect the strengths and needs of families identified. 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.[64]

Family Functional Assessment (FFA) and Ongoing Family Functional Assessment (OFFA)

The FFA assessment tool is used following a CPS hotline report or a family's direct call to the SRU for support and services to determine the well-being of a child and youth. This in-person family assessment is conducted to determine whether the child or youth is at an elevated risk for physical abuse, sexual abuse, or neglect if current circumstances do not change. If it is determined that the child is at risk of impending danger, the case will be referred to the FSU or a FCCP and the OFFA or CANS+, respectively, will be used to continuously monitor risk and safety.

The OFFA is administered within 60 days of a case being referred to the FSU and a progress report is completed every 90 days thereafter to continually assess safety and develop a change strategy and amended case plan for the child or family if needed. The FFA and OFFA use the following assessments to coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family, and provide prevention, intervention, and treatment services without compromising safety:

- ***Caregiver Behavioral Change Assessment –*** identifies caregiver protective capacities that enhance child functioning, caregiver behaviors that demonstrate a need for change, and the needs of children when exhibiting problematic behaviors (as appropriate based on age and level of functioning).
- ***Impending Danger Assessment –*** determines living situations that may cause danger to the child. An Impending Danger Safety Plan may be created based on the results of the assessment.

[63] https://www.childwelfare.gov/topics/systemwide/assessment/approaches/structured-decision-making /
[64] https://www.cebc4cw.org/program/structured-decision-making/

- ***Safety Reassessment –*** assesses safety elements of impending danger.

Structured Assessment of Violence Risk in Youth (SAVRY)

This tool assesses youth aged 12–18 years for violent risk factors and associated severity, risk of future violence and serious delinquency, and the youth's areas of need that contribute to offending behavior. These factors collectively are used to determine which services are appropriate for use. Information to complete the tool is obtained from a variety of sources, including an interview with the youth and a review of records (such as police or probation reports). The SAVRY is comprised of six items defining protective factors and 24 items defining risk, divided into historical, individual, and social/contextual categories. Professional evaluators use judgment to determine the risk rating of high, moderate, or low and whether protective factors are present or absent.

Child and Adolescents Needs and Strengths Plus (CANS+)

The CANS+ assessment tool is a multi-purpose tool that supports care and service planning, facilitates quality improvement initiatives, and monitors service outcomes. By gathering information on the child/youth's and parents/caregiver's needs and strengths, this tool seeks to facilitate the link between the assessment process and individualized service plans.[65] The CANS+ is administered at intake, discharge, once the provider deems services are no longer needed, and at 12 months for families that receive services beyond one year.

Functional Assessment Action Plan (FAAP)

The FAAP is a family-focused, collaborative process of engaging families, collaterals and family supports in providing information about the family's history, functioning, strengths and needs and about how well the safety, permanency and well-being needs are being met for the child.

FCCP Supervisors, who are state licensed practitioners, train their bachelor's level FSCC staff on how to complete the FAAP. FCCP supervisors review and approve the plan, and electronic signature is required. This information is captured in DCYF's RIFIS with date and time stamp. The FAAP will serve as the Child Specific Prevention Plan for the FCCP candidate populations and will incorporate the necessary data elements to meet the criteria for a Child Specific Prevention Plan.

Strengths, Needs, and Culture Discovery Assessment (SNCD)

The SNCD is a comprehensive holistic review of the child and their family that provides essential information used to develop a strengths-based, individualized service plan that respects the unique culture of the child and family.

The SNCD is completed and signed by a licensed clinician by day 60 from the Agreement to Participate / Agency Open Disposition Date being signed by the family.

Reassessment of Risk and Safety

Reassessments of the child's prevention plan will occur at least once every 12 months and will be completed by the respective DCYF caseworker, juvenile probation officer, or FCCP provider partner. Children and youth receiving services in all candidate subpopulations that require the Ongoing Family Functioning Assessment, including those assessments within this tool (*e.g.,* Impending Danger Assessment), will be reassessed every three months to monitor risk and safety. If a child's risk for entering foster care remains high at the end of the 12-month period as determined by reassessment, FSU, Juvenile Probation, or FCCP case management will continue and a new, Child Specific Prevention Plan will be developed for continued services. If risk and safety reassessment indicate need, the child could be considered for placement outside of their home.

[65] cans-mhmanual.pdf (magellanprovider.com)

Integrating Racial Equity Into Child Protective Services Risk and Safety Work

Child Protective Services has been collecting data about the disposition of reports to the CPS Hot Line involving families of color versus white families (reports Screened-In for investigation vs. Screened-Out). The disposition of these investigations and the rate at which children are removed from their families is also tracked for families of color versus their white counterparts. For those children who are removed from their home, CPS reviews the rates at which each group are placed with relative caregivers, non-relative foster homes, or other settings. In addition, CPS also tracks allegation types by race and the role of the reporter in each case (e.g., law enforcement, medical professional, family member). As part of our evaluation of progress toward fidelity to the SAFE Practice model, which was implemented in November of 2019, our partners at Action for Child Protection completed an initial fidelity review in August 2021. The data from a randomly selected sample of 185 CPS investigations found disparities in the application of the model in specific areas of practice. Each supervisor has met with the consultant to discuss the findings for their individual supervisory unit.

CPS also partners with Evident Change to review the use of SDM practice for screening CPS reports and have held a series of community stakeholder workshops to engage community members and solicit their feedback. The findings from these workshops are being applied to on-going work groups which are addressing policy and practice improvement of the CPS Hot Line.

Supervision is critical to accountability for improving racial equity. New supervisory training for CPS staff will be conducted by DCYF, based on findings from fidelity reviews, to address inequity in the rates of reports from professional reporters. These findings are also shared through CPS community presentations to school staff and other child facing service providers.

At the management level of DCYF, weekly Active Division Management meetings focus on disproportionality through case reviews that are conducted with an outside consultant, group of CPS supervisors, Practice Review Unit and Division of Program Improvement. All identifying information including race, ethnicity, and address are redacted. Findings from these reviews are also incorporated into practice improvement planning.

DCYF AND CHILD AND FAMILY CONTACT

Regular contact between a DCYF worker, Juvenile Probation officer, or FCCP provider and the child and family is required by DCYF policy and is used in conjunction with risk and safety assessments to monitor the child's safety on an ongoing basis. In-person contact with a child and family can occur in the office or in the family's home; however, face-to-face contact in the family home is preferred because interactions are more relaxed and natural, which provides the most accurate depiction of the family's functioning and their environment. Below are the guidelines for DCYF contact with children and families:

1. Initial contact must occur within five working days of case assignment to the worker and should take place in the home of the family if possible.

2. For the first month that a case is active within the FSU, and each subsequent month, the worker must have face-to-face contact with all children and other associated family members. The frequency of contact is determined upon consultation between the worker and supervisor, based on the risk, safety, or needs assessment.

3. For the first month that a case is active with Juvenile Probation, and each subsequent month, probation officers must have contact with a youth a minimum of once per month if the youth is assessed as "low risk," twice per month if the youth is assessed as "moderate risk," and three times per month or more if the youth is assessed as "high risk."

4. The worker/probation officer and supervisor shall discuss the worker/client contact and risk/need assessment regularly to decide on a visitation schedule. Visits between worker and child occur weekly.
5. A decision can be made by the worker and supervisor to increase or decrease worker/client contact based on risk, safety, or needs assessment but visits between the worker and child requires a minimum of no less than monthly visits.
6. Decisions made regarding worker/client contact must be documented in a Case Activity Note in RICHIST or RIFIS.

Telephone contact is also used as a supplement to formal assessment and in-person contact to facilitate regular communication with children and families when monitoring risk and safety. Family, including members of extended family if appropriate, are encouraged to have frequent telephone contact with the DCYF worker. All children in the family, if appropriate age, are provided with the DCYF worker's office address and telephone number to use as needed.

Below are the guidelines for FCCP contact with children and families receiving wraparound services:

1. Within the first 30 days, all families will be engaged and assigned a Family Service Care Coordinator (FSCC) and receive FCCP services. All intake shall be complete, and a functional action plan shall be created within ten days.
2. The family will receive face-to-face contact from an FSCC or Family Support Partner (FSP) at least once a week.
3. FSCCs will complete an assessment(s) specified by DCYF with all families at intake in a timeframe determined by DCYF and at the end of services for families who have worked with the FCCP for a specified minimum length of time.
4. For families that receive services for more than 30 days, the FCCP will identify and record a behavioral health diagnosis for the child, complete the Strengths, Needs and Cultural Diversity with families, develop a team for each family that includes all relevant family members, community members and professionals, support the team to develop a written care plan, and facilitate wraparound team meetings at least once every two months.
5. DCYF tracks FCCPs' timeliness of the first contact and first face-to-face contact with a family and the frequency of family contact with the FCCP.

SECTION VI: COORDINATION

Pre-Print Section 4

DCYF values coordination of care and services for children and families. Coordination and collaboration enable planning and service delivery that is holistic, incorporating the strengths and addressing the multifaceted needs of children and families.

Rhode Island DCYF partnered with families, stakeholders, provider partners, and sister agencies under the Rhode Island Executive Office of Health and Human Services to develop and grow an integrated family and community system of care for families and children who are at risk of abuse and neglect. FCCPs were the first phase of Rhode Island's system of care development and provide a formal collaborative structure for joint planning and decision-making through which community partners take collective responsibility for development and implementation of the Wraparound service process. FCCPs provide an integrated service system that is youth-guided, family-driven, culturally and linguistically competent, and community-based. DCYF's commitment to engagement with stakeholders and coordination of services is exemplified in its

system of care and will continue to coordinate services moving forward and throughout Family First implementation and operation.

DCYF has a strong, established contractual relationship with FCCPs to provide high-fidelity wraparound services and link children and families to the home and community-based services that they need. Additionally, as a part of the contractual agreement, FCCPs are responsible for overseeing service provider partners and build partnerships with an array of provider agencies including pediatric and primary care practices, families, youth, and the community to ensure that enrolled children and families have access to a comprehensive array of services and supports across all life domains. Work completed by FCCPs and their sub-contracted, provider partners is entered into their IT system, RIFIS, which is maintained by DCYF. This gives DCYF easy, direct access to case management data for oversight, planning, safety monitoring, CQI, and ongoing coordination.

COORDINATION WITH TITLE IV-B IN-HOME PARENTING AND MENTAL HEALTH AND SUBSTANCE USE PREVENTION PROGRAMMING

RI Department of Health receives federal funding to implement Parents As Teachers, Healthy Families America, and Nurse-Family Partnership home-visiting program models. DCYF did not include these prevention programs in the title IV-E prevention plan to avoid duplication of services. Instead, DCYF and RIDOH will continue to work together to determine how best to leverage existing funds in conjunction with title IV-E prevention programming. DCYF and RIDOH collaboration consists of a data sharing agreement and bi-weekly meetings to monitor data on DCYF CPS referrals of children ages 0-3 years indicated for maltreatment to RIDOH home visiting programs. Several of the RIDOH home visiting programs are well-supported Evidence Based Programs. The data analysis and reviews consist of both trends and deep dive analysis. The data includes number of referrals to RIDOH home visiting programs, the percent of home visiting programs that successfully engaged the family, time to engagement, and child \family outcomes. The RIDOH home visiting programs are another part of the Department's prevention efforts to ensure upstream community supports are in place, timely assessment of needs and services to prevent unmet needs leading to a family's involvement with the Department and at risk for removal.

DCYF contracts with service providers throughout the state that offer an array of mental health and substance use prevention services that are funded through Medicaid and approved as well-supported services through the Title IV-E Clearinghouse. These services include MST and FFT. Through the payer of last resort requirement, Medicaid will continue to fund these programs. DCYF coordinates care with the Executive Office of Health and Human Services for Medicaid service provision to ensure coordination of services to the greatest extent possible.

SECTION VII: CHILD WELFARE WORKFORCE SUPPORT AND TRAINING

Pre-Print Sections 5 & 6

DCYF WORKFORCE SUPPORT AND TRAINING

DCYF is committed to employing a well-trained staff dedicated to providing quality services to children, youth, and families throughout the state. Through the support of DCYF leadership, including senior staff members, division chiefs, and supervisors, employees are provided with training opportunities at the onset of and throughout their career. DCYF training focuses on the following training programs:

- ***New Worker Training Program:*** Frontline staff members in Child Protective Services, Family Services, and Juvenile Probation must complete an intensive 26-week core training and remain compliant with state legislation.

- ***Ongoing Training Program:*** Per state legislation, DCYF is required to have all staff complete a minimum of 20 hours of training each calendar year.[66]
- ***Supervisory/Administrative Training Program:*** This training is for existing supervisors and administrators, and those staff members who are looking for professional development.

The DCYF Workforce Development Unit implements a non-biased, third-party evaluation program for all trainings provided (curricula, content, and instruction) as well as an annual audit (needs assessment survey) and review of each training program to ensure that DCYF's training activities meet the needs of employees and the families served.

The training administrator within the Workforce Development Unit is responsible for developing curricula, ensuring employees participate in training that is appropriate to their respective job functions, following the Safety Assessment Family Evaluation (SAFE) practice model approach to safety assessment and management, and for recording training participation within DCYF's designated database. SAFE is considered the first comprehensive safety decision-making model and intervention framework. The SAFE model is strengths-based, family-centered, and trauma-informed to guide child welfare agency decision-making, and it recognizes that issues concerned with child safety change as the child protective services intervention proceeds.[67] Motivational Interviewing has recently been embedded within DCYF's SAFE practice model which is included in all new worker training programming.

DCYF also understands that many staff members are considered Subject Matter Experts (SMEs) on specific topics and practices. To capitalize on this internal knowledge, the Workforce Development Unit collaborates with agency SMEs to create course content, and, whenever possible, have the SME co-train or lead the training they assist in developing. This allows each staff member the opportunity to work on their own professional development.

New Working Training Program

The New Worker Training Program uses a three-prong training approach for new frontline child protective investigators, social caseworker II, and juvenile probation officers. This 26-week core curriculum course orients workers to DCYF and their roles and responsibilities.

- ***Classroom Course Training:*** This training is conducted either in the form of in-person sessions or by way of interactive virtual classroom-learning. New Workers will take part in over 60 courses ranging from topics related to DCYF procedure and protocols, comprehensive assessment, service planning, understanding safety, risk and protective capacity, family engagement, and building healthy relationships. New workers will also gain knowledge of key factors that impact DCYF services, including racial and cultural matters, mental health, substance use disorders, and sexual abuse matters.
- ***Transfer of Learning Program:*** This training contains a structured field program that requires new workers and their supervisors to formally address the classroom knowledge (competencies, values, and policy) to specifically defined events in the field, which concludes with written summations and supervision on each activity.
- ***Graduated Caseload Assignment Plan:*** New workers are paired with either senior staff or their supervisor to share case assignments. This allows new workers to begin experiencing casework with support, direction, and oversight. As training progresses, new staff are gradually assigned more cases that are a mixture of new openings and transfer cases. Supervisors individualize caseloads based on new workers' skills, abilities, and progression.

[66] RIGL 42-72-5(b)(10)
[67] https://action4cp.org/our-services/practice-model/

Throughout core training, supervisors are required to provide intensive supervision focusing on assisting new workers with navigating DCYF practices, making connections between coursework and field experiences, and helping workers with exposure to secondary traumatic stress. Following core training, the transition into regular supervision begins with workers and supervisors maintaining a weekly one-on-one supervision meeting and participating in a monthly unit meeting. Once a new worker completes the New Worker Training Program, supervisors are responsible for ensuring that each employee receives appropriate ongoing training. This is completed through a periodic review of the employee's training needs, such as the worker's employment and educational history relative to the current needs of DCYF.

Ongoing Training Program

All DCYF staff are required to complete 20 hours of training each calendar year. To meet these requirements, the Workforce Development Unit has created a variety of virtual, online, and ongoing training opportunities for all staff. Ongoing trainings are predominately created by the Workforce Development Unit as well as staff with subject matter expertise from divisions throughout DCYF. Training is traditionally offered in person but opportunities for virtual workshops, conferences and webinars have expanded in the past year due to the COVID-19 global pandemic to compliment in-person trainings.

Ongoing training topics may include but are not limited to functional requirements, such as new policy, tools and practices, field enhancement, working with LGBTQIA+ youth, Motivational Interviewing, substance use, implicit bias, and family engagement. Ongoing Training opportunities also include self-help programs, such as secondary trauma, Youth Mental Health First Aid, and Merciful Conversations on Race. DCYF also encourages staff to take part in continuing education through sources outside of the department such as college courses, workshops, and conferences.

Supervisory/Administrative Training Program

DCYF believes that to be successful, the department needs well trained, well informed, and competent supervisors and administrative staff members. As a practice, all new initiatives, training topics, and practices are first implemented within the supervisory and administrative ranks. Each new program is built on a sustainability plan for day-to-day operations and ongoing staff training. The Workforce Development Unit also implements Training of Trainers (TOT) opportunities whenever practical to expand the array of trainings the department can offer to staff. Supervisors and administrators are also required to take part in group and individual training programs to advance their individual skills. DCYF currently use modules from the NCWII Leadership Academy for Supervisors (LAS) and the Leadership Academy for Middle Management (LAMM).

Prevention and Delivery of Trauma-Informed Evidence-Based Services Training Programming

Training for DCYF workers specific to the topics of assessment of family's needs, connection to and delivery of trauma-informed and evidence-based services, oversight of appropriate prevention plan development, implementation and review of plans at 12 months will be offered at every level of DCYF's training program including new worker training, ongoing training for case workers, and supervisory training. FFPSA specific topics will be built upon in the existing training curricula that DCYF has developed in its' prevention-focused system of care.

DCYF prevention training is focused on development of service plans based on assessment of individual child and family needs and is continuing to grow and enhance prevention training offerings. DCYF is currently adding to its prevention training array with the rollout of Motivational Interviewing training, a well-supported EBP, to the Family Services Unit. The Workforce Development Unit has recruited staff to take part in a three-day train-the-trainer Motivational Interviewing program which is included in the new worker training program, followed by an eight-week Motivational Interviewing coaching session. Following successful completion of this course, these trainers will join an already existing team of Motivational

Interviewing trainers to provide training for all staff levels. Going forward, DCYF will continue enhancing its prevention-specific training to DCYF staff by developing and enhancing courses specific to:

- Identifying prevention services candidates and creating child-specific prevention plans,
- Conducting risk and safety assessments,
- Engaging families in assessments of strengths, needs, and the identification of appropriate services,
- Connecting families with appropriate trauma-informed, evidence-based services to mitigate risk and promote family stability and well-being, and
- Oversight, evaluation, and determination of continued appropriateness of services.

The DCYF Workforce Development Unit implements a non-biased, third-party evaluation program for all trainings provided (curricula, content, and instruction) as well as an annual audit (needs assessment survey) and review of each training program to ensure that DCYF's training activities meet the needs of employees and the families served.

The training administrator within the Workforce Development Unit is responsible for developing curricula, ensuring employees participate in training that is appropriate to their respective job functions, following the Safety Assessment Family Evaluation (SAFE) practice model approach to safety assessment and management, and for recording training participation within DCYF's designated database. SAFE is considered the first comprehensive safety decision-making model and intervention framework. The SAFE model is strengths-based, family-centered, and trauma-informed to guide child welfare agency decision-making, and it recognizes that issues concerned with child safety change as the child protective services intervention proceeds.[68]

Racial Equity Training

In addition to the extensive list of training described in the vision of this prevention plan, DCYF is also working on other training programs to support DCYF staff in understanding racial equity and how they can contribute to the goal of creating racial equity in services and programming within DCYF.

Authentic Family Engagement is a training program developed by DCYF in collaboration with consultants from Ann E. Casey that focuses on better understanding the lived experience of BIPOC and their perception of child welfare. The goal of this program is to improve the relationship between DCYF and the children and families served. A pilot program was launched in the summer of 2021 with plans for expansion to all DCYF staff.

Moving forward, DCYF is continuing to expand its racial equity training offerings with new programs rolling out later in 2021 and 2022:

1. Cultural Humility Workshop – This two-hour training offers DCYF staff the opportunity to discuss current issues related to racial and cultural topics.
2. Diversity in Supervision – Formulated after a series of focus groups with front-line DCYF staff and supervisors, the DCYF Workforce Development Unit is working with Rhode Island College faculty on creating a series of discussions/forums that will take place within each region of the state.
3. Internship to Employment – Though not a specific training, DCYF/WFD has partnered with Rhode Island College School of Social Worker to offering a comprehensive Internship Program to students who come from diverse racial, cultural, and economic backgrounds with the goal of creating the departments next pool of front-line candidates.

[68] https://action4cp.org/our-services/practice-model/

DCYF is also expanding training to resource families. DCYF provides pre-service and in-service training for all resource families. These trainings are presented through a racial equity lens with a focus on diversity, equity, and inclusion. DCYF is gauging feedback from foster families on how they can share their lived experience to promote cultural competency and humility in foster care. Additionally, DCYF is currently procuring an unlimited license for Foster Care College, which offers a comprehensive catalog of on demand trainings in both English and Spanish and has course offerings related to parenting strategies for supporting children from other cultures. Learning opportunities are required as part of the foster family experience, but additional enrichment is also strongly encouraged.

FCCP WORKFORCE SUPPORT AND TRAINING

Since 2009, DCYF has contracted with FCCPs to provide high-fidelity, Wraparound services and link children and families to the home- and community-based services that they need. FCCPs coordinate and manage subcontracted service providers that deliver home- and community-based services aimed at strengthening families, addressing behavioral health needs, and reducing risk factors to prevent the occurrence of child maltreatment, DCYF involvement, including the Juvenile Probation Office, and psychiatric hospitalization.

DCYF solicited its current array of FCCP providers based on a Request for Information (RFI), comprehensive assessment of relevant research and prevention programs in other states, and lessons learned from previous contracting engagements. In 2017 DCYF issued a Request for Proposal (RFP) for FCCP providers. As a part of DCYF's contracts with FCCPs, they are responsible for management of their sub-contracted service providers while DCYF has direct access to case management data for oversight, planning, safety monitoring, and CQI. Currently DCYF contracts with five FCCP vendors that are contracted with the department through December 2021. DCYF is determining whether to extend the current FCCP contracts through 2023 or issue a new RFP.

DCYF and FCCPs are engaged partners, practicing Active Contract Management (ACM), a high-frequency data-informed collaboration focusing on service provider outcomes.[69] DCYF facilitates monthly ACM meetings with FCCP leadership teams and frequent *ad hoc* working group sessions to address specific issues.

To ensure FCCPs are meeting specified performance outcomes, DCYF requires FCCPs to submit quarterly performance outcome reports; these include descriptive data of the number of referrals received by the FCCP, number of DCYF referrals, number of Youth Diversion Program (YDP)/wayward disobedient (WD) referrals and cases opened, number of families opened to the FCCP, number of families opened that have never been previously opened to FCCP services, number of families closed to the FCCP, and average caseload per Family Service Care Coordinator (FSCC). FCCPs must also report to DCYF on activities including community outreach relationships, program activities (*e.g.,* Wraparound service completion, secured housing, referrals for service), expenditures, barriers, staff trainings that are offered (including the training topics, and frequency), specification of Wraparound-certified staff (including staff who completed the training), staff certified and re-certified in evidence-based programs, and outcomes. FCCPs also submit a staffing grid that includes the title of each staff member included in the contract budget, the name of the employee serving in that role, and any position vacancies.

FCCP outcome and program data, including data from partnering service providers, is recorded in the RIFIS system, which is merged into DCYF's RICHIST system. This allows the DCYF DPI Unit to assess outcomes, such as subsequent investigations, subsequent indicated investigations, in-home cases open to FSU, and children removed from home. This information is reviewed in bi-monthly meetings among DCYF leadership and during EOHHS PULSE meetings.

[69] Harvard Kennedy School Government Performance Lab. Active Contract Management: How Governments Can Collaborate More Effectively with Social Service Providers to Achieve Better Results.

FCCP staff should be diverse and are required to have foundational skills in cultural and linguistic competence, with competencies in language, culture, religion, and sexual and gender orientation to reflect the population served. FCCP staffing structure includes a Program Manager who oversees the administration of programs, Supervisors who provide ongoing clinical and program supervision and coaching to a maximum of six direct service staff, FSCCs who are wraparound facilitators, Family Support Partners (FSPs) who provide family support by empowering the family towards self-efficacy, Housing Navigators, and staff responsible for community outreach and engagement. FCCPs enter all staff qualifications and certifications in RIFIS, which is verified through audits.

FCCPs provide internal Team-Based Wraparound Service training to all staff members using interactive activities amongst staff (*e.g.,* brainstorming and partner exercises). This training was developed through a collaborative effort between DCYF, FCCPs, Seet Consultants, Inc., The Rhode Island Child Welfare Institute, and Yale Consultation Center & Data Systems of Placement Solutions. Training provides staff with an understanding of the Wraparound model, focusing on individualized needs planning that are youth centered, family focused, and community based. Wraparound training topics include youth and family engagement, crisis stabilization (specifically understanding safety, risk, and protective capacity), cultural competencies, assessments, as well as service, crisis, and transition planning. Following Team Based Wraparound training, staff demonstrating all identified competencies will become certified Wraparound service providers. Each FCCP staff member also receives a two-day, DCYF-led RIFIS training.

FCCPs are continuously responsible for upholding core Wraparound principles and staff certification. Each FCCP is responsible for providing Wraparound training to their staff as needed. Depending on the Wraparound principle and staff members' individual needs, training frequency can range from daily through individual supervision to weekly or quarterly group meetings.

FCCP staff receive regular wraparound services training including wraparound certification and re-certifications every 1-2 years. Additionally, FCCP staff complete initial training of the CANS/CANS+ online and through trainings administered via PowerPoint. Re-certification for CANS/CANS+ is completed yearly as required. The CANS/CANS+ is used in part to inform the completion of the FAAP (Proposed Child Specific Prevention Plan). All trainings are required, administered on an ongoing basis and as needed except the supervision which occurs weekly. RIFIS training occurs when onboarding new employees and as refreshers are needed. Other trainings are measured across quarters by the agencies and reported to DCYF on the FCCP Quarterly Reports. Below is a table of trainings that FCCP Family Care Coordinators are required to complete the training programs listed in the table below.

Table 21. Family Community Care Partnerships Training Programs

Training Program / Topic	Staff Role	Frequency of Training
RIFIS	Family Service Care Coordinators (FCCP)	Upon hire, ongoing
FAAP	Family Service Care Coordinators (FCCP)	Upon hire
CANS/CANS+ (training and recertification)	Family Service Care Coordinators (FCCP)	1-2 years
Wraparound	Family Service Care Coordinators (FCCP)	Ongoing
Individual and Group Supervision facilitated by an Independently Licensed Clinician	Family Service Care Coordinators (FCCP)	Weekly, ongoing

Training Program / Topic	Staff Role	Frequency of Training
Crisis intervention techniques and strategies, mental health trainings, housing navigation, Department of Human services benefits, etc.	Family Service Care Coordinators (FCCP)	Ad-hoc, ongoing
New Worker Training Program*	Frontline staff in CPS, FSU, Juvenile Probation (DCYF)	Upon hire, 26-weeks
Ongoing Training Program*	All staff (DCYF)	Annually, 20 hours ongoing (minimum)
Supervisory/Administrative Training Program*	All supervisors and administrators (DCYF)	Annually, ongoing
Motivational Interviewing*	Juvenile Probation, FSU (DCYF)	3 days of training, 8 weeks of coaching, ongoing as needed
Cultural Humility Workshop*	All staff (DCYF)	2 hours, ongoing
Diversity in Supervision Series of Focus Groups*	Front-line staff and supervisors (DCYF)	Ongoing

All FCCP staff are either certified or working toward Wraparound service certification. DCYF receives quarterly updates from FCCPs on Wraparound progress.

DCYF is collaborating with the FCCPs to continue to develop training materials focusing on identifying a prevention candidate, documenting eligibility, creating child-specific prevention plans, identifying services needed, educating, and informing families of EBP programming and availability of services to prevention candidates and ongoing case monitoring. When a child, youth, or family begins services with an FCCP, the Family Service Care Coordinator (FSCC) at the FCCP completes the Functional Assessment Action Plan that helps determine what resources are available to the family and what services and supports are needed to keep the child/youth safely at home. The Functional Assessment Action Plan is due to DCYF within 10 business days of the family signing the Agreement to Participate form, for review and approval. If the child, youth, or family remains open to the FCCPs after the initial stabilization period then by Day 60 a Family Service Plan is developed.

FCCP Supervisor who are state licensed practitioners train their bachelor's level FSCC staff on how to complete the FAAP (Proposed Child Specific Prevention Plan). FCCP supervisors review, approval, and electronic signature are required for each FAAP and provides ongoing monitoring and supervision. This information is captured in RIFIS with date and time stamp. Also, for each EBP identified in the Title IV-E Prevention Plan, DCFY and its service providers will follow the specific, purveyor indicated training criteria and modules and will provide oversight of training through various contracting and reporting mechanisms to ensure that providers have the skills to deliver the EBPs selected.

SECTION VIII: PREVENTION CASELOADS

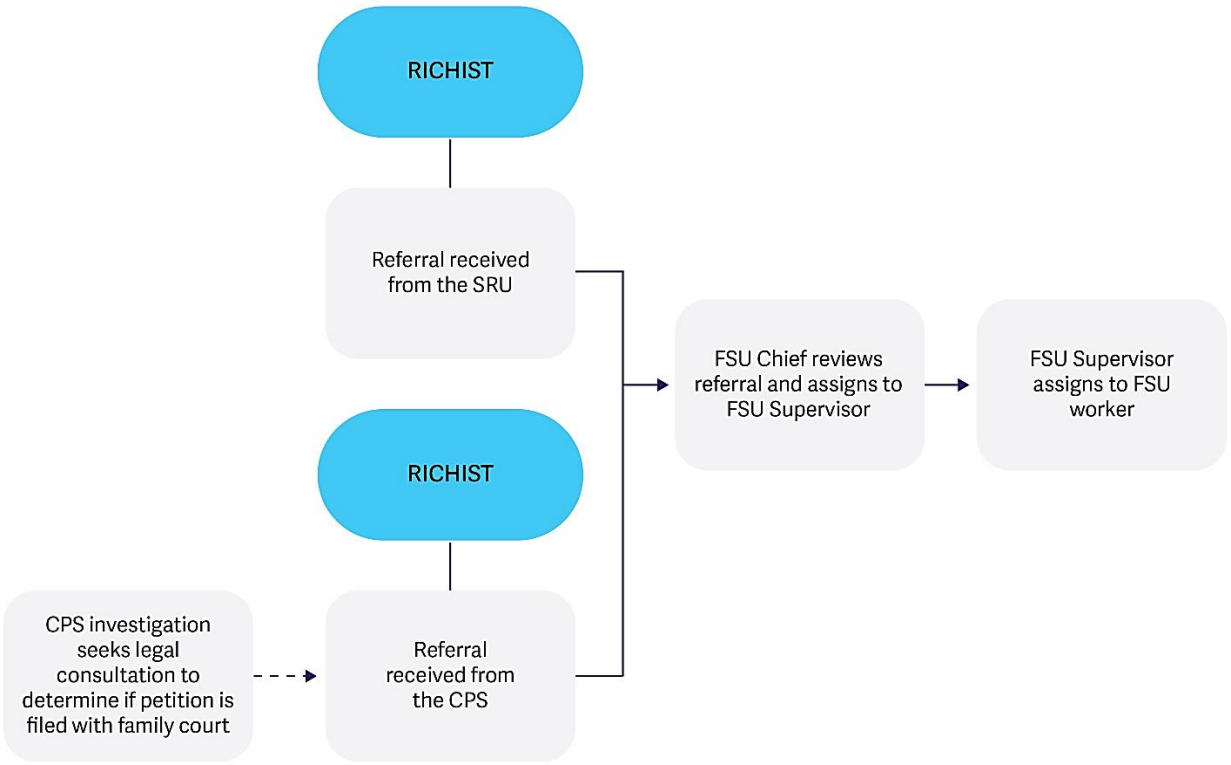
Pre-Print Section 7

DCYF, including the Juvenile Probation Unit, and the FCCPs have established processes to determine, manage, and oversee prevention caseworker caseloads. Caseloads are defined as either a family or child depending on the candidate subpopulation.

CHILDREN AND FAMILIES CONNECTED TO FAMILY FIRST PREVENTION SERVICES THROUGH DCYF

The DCYF CPS unit and the SRU refer cases to the FSU that are deemed in need of in-home prevention service or out-of-home placement services. Once the referral is reviewed by the FSU Chief, the case is assigned to a supervisor and worker. An FSU caseworker may be assigned prevention cases and in-home placement cases. Figure 9 shows the process in which a case is referred to and assigned within the FSU.

Figure 9. DCYF FSU Case Assignment Process



Factors that supervisors consider when assigning in-home prevention cases and out-of-home placement cases include the worker's workload, skill level, in-home and out-of-home placement caseload ratio, and the complexity of the case. The target caseload, including prevention and in-home cases, for each full-time worker is 14:1. New workers nearing the end of training and on probation are assigned between 10 and 14 cases.

All DCYF units enter worker caseload data into RICHIST. This data is used to create a daily caseload dashboard for each caseworker including each worker's caseload, separated by in-home and out-of-home placements, with detailed case information such as race and ethnicity and case plan goals. This dashboard assists supervisors in monitoring the types of cases each caseworker is assigned and the workload. Additionally, caseload data in RICHIST is analyzed monthly to determine the number of cases and children

each worker oversees, the number of assigned open cases with no active children, and workers who are assigned more than 14 families or more than 28 children. A caseload report is created and available to all staff. This report is reviewed at monthly FSU Active Division meetings to analyze caseload data trends. Information within the report is used to inform human resources for hiring purposes, FSU leadership for caseload management, and executive leadership for labor management workload/caseload meetings.

The DCYF Juvenile Probation Unit caseloads are managed separately from the FSU. Probation workers' caseloads include both youth in-home and out-of-home. Although there is not a target caseload standard for the in-home probation candidate population, on average, caseworkers are assigned 20 cases, of which approximately 15 cases serve the youth in-home probation population. Cases are assigned based on geographic location, current caseload size, and other factors, such as SAVRY and OFFA assessment outcomes, and court ordered services. The process in which cases are assigned is in Youth risk levels determine the frequency of contact the probation worker has with the youth and their parents or caregiver.

Figure 10. Juvenile Probation Case Assignment Process

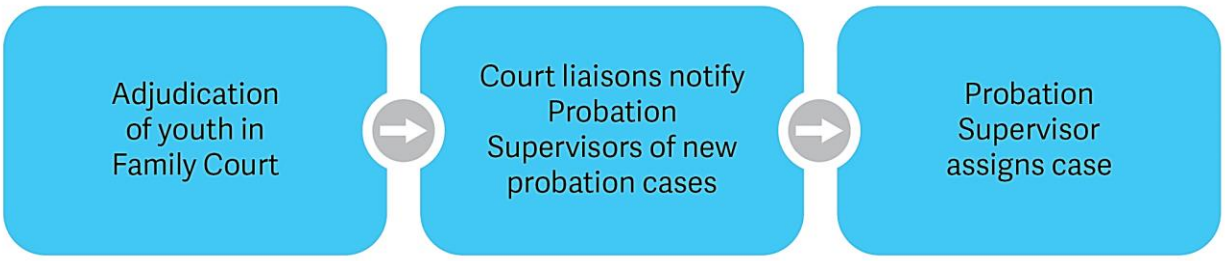


Table 22. DCYF Prevention Caseload Standards

Candidate Subpopulation	DCYF Caseload Standard*
1) Children and families open to DCYF Family Services Unit, In-Home	14:1
2) Children and Families that have reunified	14:1
3) In-home juvenile probation	Average of 20 cases per probation officer (15 in-home)
4) Children and Families in the Support and Response Unit	14:1
5) Children in-home with a sibling in foster care	14:1
6) Children that are post-guardianship or post-adoption and at risk for disruption of placement	14:1
7) Pregnant and parenting youth in foster care	14:1

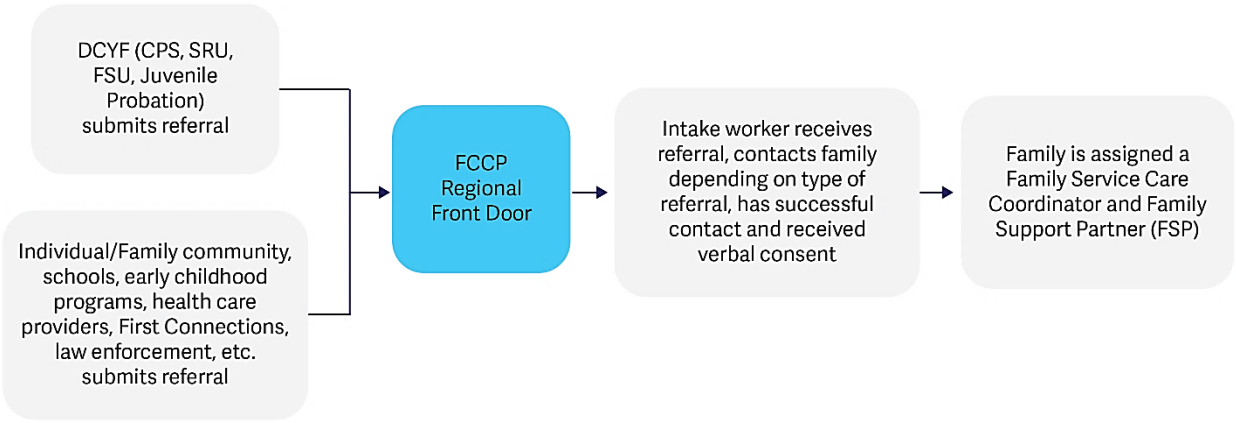
**DCYF FSU workers' caseload standard includes in-home and out-of-home placements.*

CHILDREN AND FAMILIES CONNECTED TO FAMILY FIRST PREVENTION SERVICES THROUGH FCCPS

Family Community Care Partnerships

FCCP cases are defined as one primary child and their family. Families receiving services are assigned a team, which is comprised of a supervisor, Family Service Care Coordinator (FSCC) and Family Support Partner who offers peer support. Figure 11 depicts how FCCP cases are assigned to team members.

Figure 11. FCCP Case Assignment Process



When assigning prevention cases to the FSCCs, the Supervisor will consider the FSCC's workload, strengths and weakness, and the complexity of other assigned cases. Supervisors use the RIFIS to track FSCC caseloads and inform decision making. The FSCC target prevention caseload is 12:1.

Table 23. Family Community Care Partnerships Prevention Caseload Standard

Candidate Subpopulation	FCCP Caseload Standard*
6. Children & families that are assessed by the DCYF Support and Response Unit (SRU) but receive services through the FCCPs. 7. Children who are post-guardianship and/or post-adoption at risk for disruption of placement and receive services through the FCCPs. 8. Children & families referred to the Family Community Care Partnerships (FCCP) by another community-based organization or self-referral.	12:1

DCYF and FCCPs are engaged partners, practicing Active Contract Management (ACM), a high-frequency data-informed collaboration focusing on service provider outcomes.[70] DCYF facilitates bi-monthly ACM meetings with FCCP leadership teams and bi-weekly working group sessions to address specific issues and provide oversight. A detailed structure has been developed to support and oversee prevention caseloads which are documented in the contracts between DCYF and FCCPs. ACM meetings are held at

[70] Harvard Kennedy School Government Performance Lab. Active Contract Management: How Governments Can Collaborate More Effectively with Social Service Providers to Achieve Better Results.

regular intervals and involve a multidisciplinary team from DCYF including, but not limited to, DCYF Contracts, DCYF Performance Improvement, and DCYF Behavioral Health, where he DCYF members meet with the contracted FCCP providers to engage in data-driven meetings. During ACM meetings staff review FCCP data dashboards, populated with data from the RIFIS system, to track progress and monitor trends. Timelines for FCCP reporting to DCYF are broken down in table C.

To ensure FCCPs are meeting specified performance outcomes, DCYF requires FCCPs to submit quarterly performance outcome reports; these include descriptive data of the number of referrals received by the FCCP, number of DCYF referrals, number of Youth Diversion Program (YDP)/wayward disobedient (WD) referrals and cases opened, number of families opened to the FCCP, number of families opened that have never been previously opened to FCCP services, number of families closed to the FCCP, and average caseload per Family Service Care Coordinator (FSCC). FCCPs must also report to DCYF on activities including community outreach relationships, program activities (e.g., Wraparound service completion, secured housing, referrals for service), expenditures, barriers, staff trainings that are offered (including the training topics, and frequency), specification of Wraparound-certified staff (including staff who completed the training), staff certified and re-certified in evidence-based programs, and outcomes. FCCPs also submit a staffing grid that includes the title of each staff member included in the contract budget, the name of the employee serving in that role, and any position vacancies.

FCCP outcome and program data, including data from partnering service providers, is recorded in the RIFIS system, which is an independent data capture system from DCYF's RICHIST System. This data can be merged with DCYF RICHIST data and allows for the DCYF DPI unit to assess outcomes, such as subsequent investigations, subsequent indicated investigations, in-home cases open to FSU, and children removed from their homes. This information is reviewed periodically among DCYF leadership, EOHHS leadership, and other key stakeholders.

SECTION IX: ASSURANCE ON PREVENTION PROGRAM REPORTING

Pre-Print Section 8

DCYF provides an assurance in Attachment I, submitted to the Children's Bureau as a separate attachment, that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs included in Rhode Island's Title IV-E Prevention Plan, including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7). Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019.