



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

September 16, 2020

Ms. Jody Becker
Director
Washington Department of Children, Youth and Families
P.O. Box 40970
Olympia, Washington 98504-0970

Dear Ms. Becker:

Thank you for submitting Washington's (WA) title IV-E prevention program five-year plan for fiscal years (FYs) 2020-2024. The title IV-E prevention program is authorized under the Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115-123, which amended titles IV-B and IV-E of the Social Security Act (the Act). The FFPSA is an important tool that, if utilized effectively, will help move child welfare in the United States to a more preventative system that works to strengthen families and reduce unnecessary family disruption.

Plan Approval

WA submitted a title IV-E prevention program five-year plan to the Children's Bureau (CB) Regional Office on December 19, 2019. We completed a review of this submission and identified areas requiring further documentation to support compliance with state plan requirements. On August 3, 2020, WA provided a revised plan that addressed the identified provisions.

We are pleased to notify you that we reviewed WA's title IV-E prevention program five-year plan submitted August 3, 2020 and find it to be in compliance with applicable federal statutory and regulatory requirements. WA's title IV-E prevention program five-year plan for FYs 2020-2024 is approved as outlined below. An amendment must be submitted any time there is a substantial change to information in the approved plan.

The effective date of WA's plan is October 1, 2019. Please refer to the chart below for the specific dates the state may begin claiming for each approved service or program. Please maintain this approval letter as a part of the final, approved plan.

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in

an approved cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative and training costs in accordance with applicable regulations at §95.509(a)(3).

Approval of Services under the Title IV-E Prevention Program

Pursuant to Sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, only services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse or a state's designation based on an independent systematic review approved for transitional payments as part of the title IV-E prevention program five-year plan by the U.S. Department of Health and Human Services (HHS) are permitted. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse). The title IV-E agency must also provide an assurance each program or service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and that the state will use information gleaned from the continuous monitoring efforts to refine and improve practices. CB has approved the following allowable programs and services under this program:

Approved Service/Program	Effective date for claiming under the plan
Functional Family Therapy (FFT) Motivational Interviewing (MI) Multi-Systemic Therapy (MST) Nurse-Family Partnership (NFP) Parents as Teacher (PAT)	October 1, 2019
Homebuilders SafeCare Child-Parent Psychotherapy	April 1, 2020

Approval of Request for Waiver of Evaluation Requirements

Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of Section 471(e)(5)(B)(iii)(II) are met. CB approves WA's request for waiver of the evaluation requirement for the following approved services:

Nurse-Family Partnership (NFP)
Parents as Teacher (PAT)

Data Collection and Reporting Requirements

Pursuant to Section 471(e)(4)(E) of the Act, states electing the title IV-E prevention program are required to collect and report on child-specific data to HHS for each child who receives title IV-E prevention services. WA has provided an assurance that the state will collect and submit information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures. CB will provide additional information on how to report this information in future guidance.

Payer of Last Resort

In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

The title IV-E prevention program is part of the Children's Bureau's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please contact Paula Bentz, Child Welfare Regional Program Manager in Region 10, at (206) 615-3662 or by e-mail at Paula.Bentz@acf.hhs.gov. You also may contact Nadia Nijim, Children and Families Program Specialist, at (206) 615-3682 or by e-mail at Nadia.Nijim@acf.hhs.gov. We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,



Jerry Milner
Associate Commissioner
Children's Bureau

Enclosures

cc: Paula Bentz, Child Welfare Regional Program Manager, CB, Region 10, Seattle, WA
Nadia Nijim, Children and Families Program Specialist, CB, Region 10, Seattle, WA
Janice Davis Caldwell, Director of Family Protection & Resilience Portfolio, ACF Office of Grants Management, Dallas, TX
Margaret Harrell, Grants Management Officer, Western Division, Family Protection & Resilience Portfolio, ACF Office of Grants Management, Chicago, IL



FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN



Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 1, 2020

Approved for distribution by Secretary Ross Hunter



Washington State Department of **CHILDREN, YOUTH & FAMILIES**

CONTENTS

CONTENTS	1
Introduction	3
Department of Children, Youth, and Families.....	3
Prevention Approach	4
Overview of Washington’s Child Welfare System.....	6
Child and Family Eligibility for the Title IV-E Prevention Program	8
Prevention Candidacy.....	9
Evidence-Based Service Description and Oversight	12
Prevention Evidence-Based Practices at DCYF.....	16
Manual-Version for Evidence Based Practices.....	25
Evidentiary Review of Additional Evidence-Based Practices	25
Prevention Pathway Implementation	27
Implementation Considerations.....	30
Evaluation Strategy and Waiver Request	32
<i>Evaluation Strategy for Well-Supported or Supported EBPs</i>	34
<i>Fidelity Monitoring and Continuous Quality Improvement</i>	58
Monitoring Child Safety and Risk.....	66
Consultation and Coordination.....	70
Child welfare workforce support and training.....	72
Prevention caseloads	76
Assurance on prevention program reporting.....	78
Plan Submission Certification	79

October 1, 2020

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As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the

Washington State Department of Children, Youth, and Families

submits here a plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

October 1, 2020

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Introduction

In keeping with the Children's Bureau's vision for changing national child welfare practice, Washington State is committed to ensuring that all Washington families have timely access to community services and supports intended to strengthen families and promote the safety and well-being of children in their own homes and, ultimately, without the need for formal involvement in the child welfare system.

The Washington State Department of Children, Youth, and Families (DCYF) embraces Family First Prevention Services Act (Family First or FFPSA) implementation as an opportunity to expand the choices and support we provide to children, youth and families. Signed into law February 9, 2018, Family First focuses on creating new opportunities for states to receive federal reimbursements for services that aid in preventing children from entering foster care and improving the well-being of children already in the system. Through Family First, DCYF will create a culture of community participation in child safety and family well-being, thereby reducing the stigma of seeking help.

Family First also enhances DCYF's ability to find loving, permanent homes for children and youth who must enter foster care, and it provides guidelines for those who need intensive therapeutic environments. Increasing family-centered and trauma-informed approaches to safety, permanency and well-being are at the core of DCYF's mission to support Washington families and the Department will use Family First resources to further engage communities in growing these critical efforts.

Department of Children, Youth, and Families

The Department of Children, Youth, and Families is a cabinet-level agency focused on the well-being of children. Our vision is to ensure that "Washington State's children and youth grow up safe and healthy—thriving physically, emotionally and academically, nurtured by family and community."

Guiding principles:

- A relentless focus on outcomes for children.
- A commitment to collaboration and transparency.
- A commitment to using data to inform and evaluate reforms, leveraging and aligning existing services with desired child outcomes.
- A focus on supporting staff as they contribute to the agency's goals and outcomes.

We partner with state and local agencies, tribes and other organizations in communities across the State of Washington with a focus on supporting children and families at their most vulnerable points, giving them the tools they need to succeed.

October 1, 2020

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DCYF is Washington’s newest state agency. It oversees all state early learning, child welfare, and juvenile justice services previously offered through the state Department of Social and Health Services (DSHS) and the Department of Early Learning (DEL). These include all child welfare services such as Child Protective Services investigations and Family Assessment Response, licensed foster care, kinship care, and adoption support. Also included are all state early learning services, such as state-funded preschool, the Child Care Subsidy Program, therapeutic child care, and Home Visiting. As of July 2019, DCYF also administers the state juvenile justice programs, including juvenile rehabilitation institutions, community facilities and parole services.

Prevention Approach

DCYF was created in large part to enhance opportunities for prevention all along its continuum of services for children, youth and families. Brain science tells us that laying a strong foundation early in life critically impacts healthy development and that addressing trauma at critical transition points in the lives of youth helps ensure a successful transition into adulthood. DCYF was created to be a comprehensive agency exclusively dedicated to the social, emotional and physical well-being of children, youth and families — an agency that prioritizes prevention and early intervention at critical points along the age continuum from birth through young adulthood.

DCYF’s founding legislation HB 1661, enacted in 2017, is clear about prevention as one priority reason the new agency was created:

Sec 1 (1): “The legislature believes that, to improve service delivery and outcomes, existing services must be restructured into a comprehensive agency dedicated to the safety, development, and well-being of children that **emphasizes prevention**, early childhood development, and early intervention, and supporting parents to be their children’s first and most important teachers.”

Sec. 101 (1)(b): “The department, in partnership with state and local agencies, tribes, and communities, shall protect children and youth from harm and promote healthy development with **effective, high quality prevention**, intervention, and early educational services delivered in an equitable manner.”

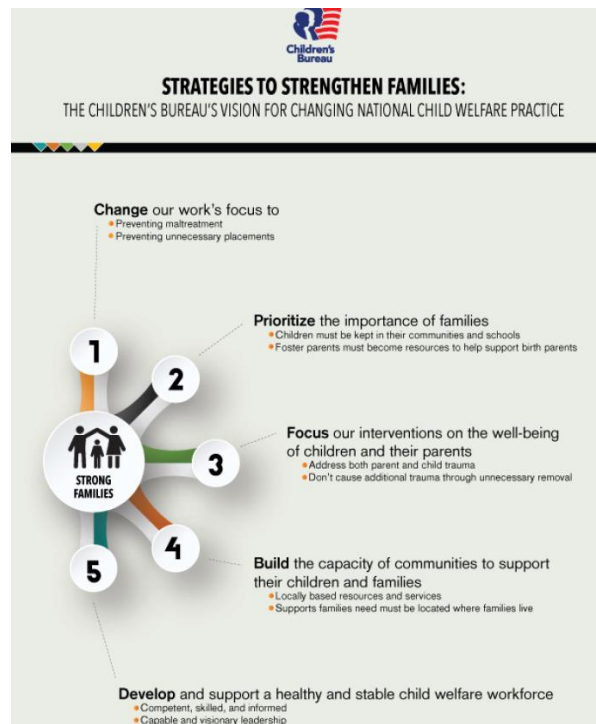
Recognizing the high priority for enhancing and integrating prevention services in the new agency, DCYF established a set of principles in 2018 to guide the agency-wide approach to prevention. DCYF leadership recognizes that FFPSA prevention is an important and substantial opportunity to expand voluntary prevention services for more children, youth and families. The agency also recognizes that expanded voluntary prevention under FFPSA is one component in the agency’s overall prevention portfolio, thus the need for an overarching set of prevention principles to guide the agency in this and other prevention development work. DCYF’s overarching set of Prevention principles are:

October 1, 2020

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- Prevention occurs all along the continuum of DCYF services.
- DCYF offers primary, secondary and tertiary prevention.
- Prevention services are offered both as voluntary and court-ordered services.
- DCYF will develop prevention at multiple levels – individual, family and community.
- DCYF prevention services are informed by the voices of children, youth and families, as well as informed by data and evidence.
- Prevention is an important tool to address disparities and disproportionalities.
- Early learning is one important tool for prevention.
- DCYF endorses the Children’s Bureau’s vision for child welfare: “Strategies to Strengthen Families”

Figure 1. Children’s Bureau Strategies to Strengthen Families



While Washington State expects to expand prevention services offered under FFPSA Prevention for approved candidacy groups, it is important to note that the services funded through FFPSA are just a portion of DCYF’s overall prevention portfolio. As a new agency founded on a commitment to expand prevention opportunities, DCYF expects to substantially expand prevention and early intervention opportunities all along its continuum of services. FFPSA Prevention is one important tool in our toolbox to accomplish this and the agency’s planning takes into account how the FFPSA-funded services for approved candidacy groups will complement other agency prevention efforts.

October 1, 2020

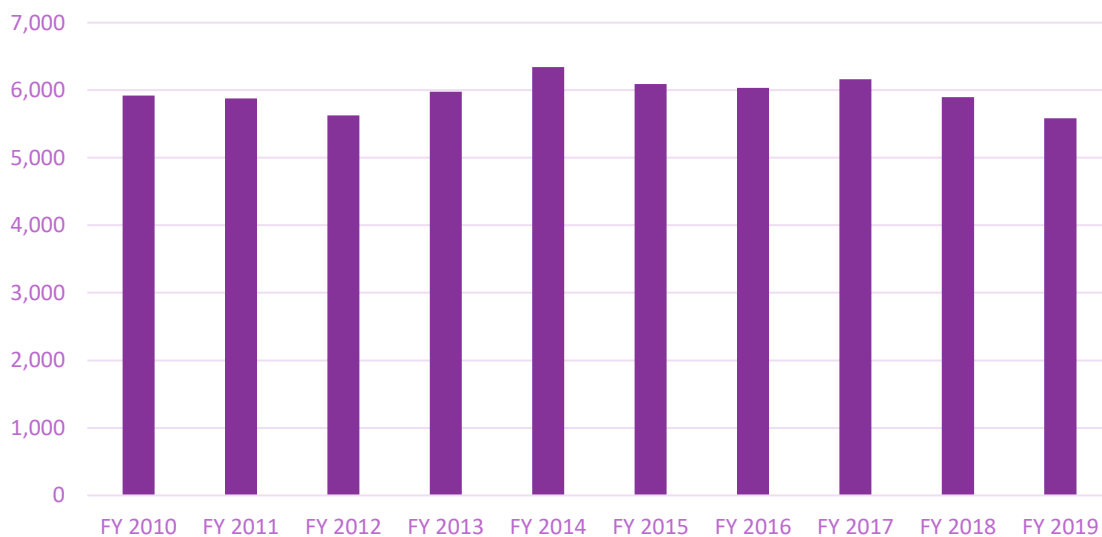
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Overview of Washington's Child Welfare System

Safely Reducing the Number of Children Entering Foster Care

In FY 2019, 5,582 children and youth under the age of 18 entered foster care in Washington. Between FY 2010 and FY 2019, on average 5,951 children and youth under 18 entered foster care each year in Washington. The federal Family First Prevention Services Act (FFPSA) provides an opportunity to expand resources for secondary prevention, targeting children, youth and families at risk for entering or re-entering foster care. Figure 2 below details the number of children under the age of 18 entering foster care in Washington each fiscal year since 2010.

Figure 2. Number of Children <18 years Entering Foster Care in WA, by Fiscal Year



Data Source: InfoFamlink Placement Entries by FY and Age Summary Report

Enacting strategies to safely reduce the number of children in foster care is a necessary priority of DCYF, and this priority can be seen in efforts to improve permanency for youth already in out-of-home care. FFPSA and the expansion of secondary prevention is one important additional tool in reducing the numbers of children in out-of-home care.

Currently, the primary avenue by which children enter Washington's child welfare system is by a report made to the DCYF child abuse hotline. Referrals are screened and supervisors determine whether a Child Protective Services response is required, using state law and agency policy to guide that decision. DCYF may choose to assign the CPS response to the Family Assessment Response (FAR) alternative pathway for lower-risk cases. A recently-released outcome evaluation of FAR shows this pathway is effective at safely and significantly reducing

October 1, 2020

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entry into foster care for eligible children and families.¹ If children cannot be safely maintained at home, DCYF staff may recommend that the court place the child in foster care for the child's protection. Children and youth placed in foster care may return home if safety issues are addressed. In FY 2019, 64% of children exiting foster care were reunified with their families, 25% were adopted, and 9% transitioned to guardianship. The remaining 2% of children exited for other reasons such as aging out. In addition, DCYF oversees family reconciliation services and juvenile rehabilitation services for adolescents, and a portion of those youth enter the state's dependency system as well.

¹ 2019. Final Report Washington State IV-E Waiver Demonstration Project, TriWest.

October 1, 2020

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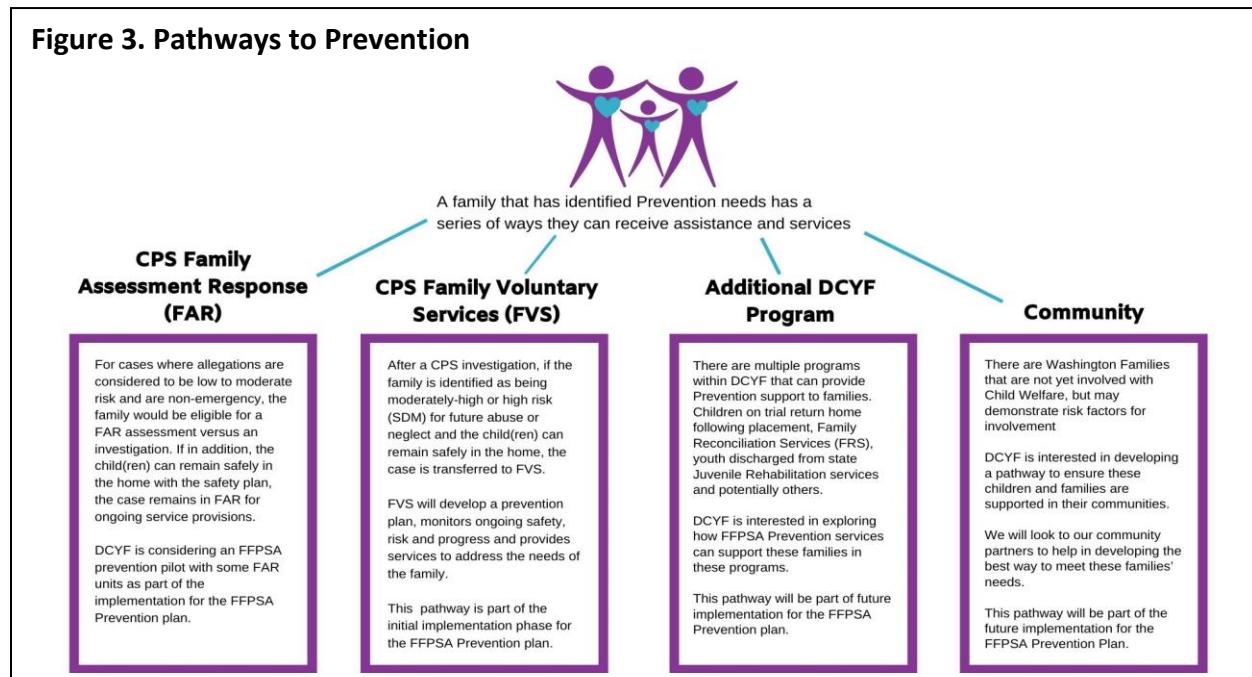
Child and Family Eligibility for the Title IV-E Prevention Program

Pre-print Section 9

What would child welfare look like if we could better support our families before they are in crisis, before children are removed from their homes? One of DCYF's top priorities is to enhance and integrate prevention services for the children, youth and families in Washington to achieve this vision. FFPSA is an integral part of a much larger effort to transform the way we serve our children and families. We are committed to a broader vision of strengthening families by preventing child maltreatment, unnecessary removal of children from their families, preventable incarceration among youth and a range of other destabilizing factors, such as homelessness and economic and food insecurity.

In order to effect true change and improve service delivery and outcomes through high-quality prevention efforts, we must start thinking differently about our services and how to best support our families. Over time and through partnerships with agency stakeholders, tribes, and those we serve, DCYF will take an aggressive approach to prevention candidacy beginning with the candidate groups identified in this plan and progressing to additional candidacy groups for future plan amendments. DCYF will also explore other funding sources to support the agency's broad prevention goals.

DCYF recognizes that there are multiple pathways by which a family can obtain prevention services. Figure 3 illustrates our initial vision of the pathways that exist today and those we intend to build in the future.



October 1, 2020

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Prevention Candidacy

DCYF is designating eight candidacy groups of children, youth and families, eligible for voluntary prevention services under Washington's Title IV-E Prevention Program detailed in Table 1 below. These are groups of children, adolescents, and families known to DCYF, therefore, they are presently touching the DCYF service system now, and the agency and staff have access to them. There are also groups of children and adolescents at imminent risk of entry or re-entry into foster care. These groups were chosen based on federal policy guidance, input from stakeholders and partners, and review of data and evidence.

Table 1. FFPSA Prevention Candidacy Groups, SFY2019		
Candidacy Group	Unduplicated Child/Youth/Pg Women	2-Year Placement Rates
CPS FAR	27,475	6%
CPS Investigation	25,244	15%
CPS Family Voluntary Services	1,125	12%
Trial Return Home	3,436	8%
SUD Pregnant Women	774	26%
Adoption Displacement	1,413	6.2%*
Family Reconciliation Svs.	825	7%
State JR discharge	450	unknown
Pregnant or parenting Foster Youth	20	unknown
Pregnant or parenting JR Youth	70	unknown
Children with developmental disabilities and/or intensive mental health needs	Under development	unknown
TOTAL	60,832	
[^] Rate of re-entry into care within 12 months of exit [*] this is a ratio of the number of adoptions coming into placement to the number of DCYF completed adoptions this year. Strictly speaking, this is not a percentage, since many of the 87 adoptions that resulted in children coming into care did not originate from the 1,413. See further explanation in the text.		

As detailed in Table 1 above, together these candidacy groups included 60,832 children/youth/pregnant women in SFY 2019.

Family Assessment Response (FAR). Established in 2013, FAR is Washington State's alternative response system funded with a Title IV-E waiver that ended September 2019. The final evaluation report for FAR found the implementation safely reduced the placement rate for children served by 17% compared with a traditional investigation for eligible families.² In SFY

² 2019. Final Report Washington State IV-E Waiver Demonstration Project, TriWest
October 1, 2020

2019, 14,932 CPS cases received a FAR response from DCYF. Children served by DCYF in this category have a 6% placement rate in the two years following intake.

CPS Investigation. In SFY 2019, 13,720 cases received a traditional CPS investigation response from DCYF. Children served by DCYF in this category have a 15% placement rate in the two years following intake.

Family Voluntary Services. In SFY 2019, 611 cases were served by DCYF Family Voluntary Services. A family is referred to FVS if, after the CPS investigation, (1) the family is identified as being moderately-high or high risk for future abuse or neglect and (2) the child(ren) can remain safely in the home with a safety plan. Children served in this category have a 12% placement rate in the two years following intake.

Children on trial return home following placement. In SFY 2019, 3,436 children experienced a trial return home. Washington state law currently requires a 6-month trial return for all children reunified following placement. Children reunified with their parents following placement have an 8% placement rate in the 12 months following exit from care.

Adoption Displacement. While adoptions experiencing challenges are notoriously difficult to identify, DCYF has a method to identify and track adoption displacements that result in new foster placements, identifying 87 of these in SFY 2019 from all sources. Not all of these adoptions originate with DCYF, some are out-of-state or international adoptions. Often these displacements are the result of child/youth behavior and lack of family resources to cope with trauma that children have experienced prior to adoption. While DCYF is unable to calculate a rate because so many of these adoptions do not originate with DCYF, we can calculate a ratio of adoption displacements that result in a new foster care placement to the number of total adoptions finalized each year. In SFY2019, that ratio was 6.2 displacements per 100 finalized adoptions. DCYF is collaborating with foster parent groups in Washington to identify needed services and opportunities for intervention to prevent the need for displacement.

Substance using pregnant women. In SFY 2019, DCYF screened out 774 unborn victim referrals for substance abuse. Children served in this category have a 26% placement rate in the two years following intake. It is important to note that substance-using pregnant women referred for child maltreatment, currently does not result in open cases if there is no child present who is in danger. Many of these cases are re-referred at birth and enter the CPS system at that time, in fact, 57% of substance affected infant referrals to CPS have had a previous unborn victim referral during the same pregnancy and 45% of substance affected infants identified at birth are placed.

Pregnant or parenting foster youth and pregnant or parenting juvenile rehabilitation youth. FFPSA allows for prevention services for pregnant or parenting foster youth. In SFY 2019, based on current tracking methods, there were 20 pregnant or parenting youth in foster care and 70 pregnant or parenting juvenile rehabilitation youth. DCYF anticipates that more refined tracking

October 1, 2020

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methods will identify an additional need in this area. Prevention services to or on behalf of the youth will help ensure that the youth is prepared (in the case of pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent so that their unique needs are met and their efforts to transition to adulthood are successful.

Family Reconciliation Services (FRS). FRS is a voluntary program serving high-risk youth and their families. The program targets adolescents between the ages of 12 to 17. The FRS program is intended to resolve crisis situations and prevent unnecessary out-of-home placement. The program is designed to assess and stabilize the family's situation with the goal of returning the family to a pre-crisis state and to work with the family to identify alternative methods of handling similar conflicts. FRS services can be accessed directly through family self-referral or through Washington's At-Risk Youth/Child in Need of Services petition process, whereby DCYF assists the family to prepare a petition to the court. In 2019, more than 3,000 youth had an FRS intake with 825 receiving some kind of service from DCYF staff and 9% receiving EBPs. The FRS population exemplifies clear risk factors for imminent entry into foster care. For example, one-quarter of youth with an FRS intake have had one or more screened-in CPS reports prior to their FRS intake. Youth served by DCYF in this category have a 7% placement rate in the two years following intake.

State Juvenile Rehabilitation (JR) discharge. Twenty-nine point four percent of youth in state JR facilities have had a previous foster care placement in their lifetime, and over 78% have had any child welfare involvement. In addition to youth who are dependent on entry into the state JR system, many of these youth often enter the child welfare dependency system through emergent circumstances, while in crisis when at discharge the family either refuses or is unable to take the youth home safely. While the percentage of youth who are not dependent and who enter dependency following discharged from state JR facilities is not known precisely, in the 30 months between January 2016 and June 2019, 76 youth leaving county detention facilities utilized night-to-night placements in the child welfare system following discharge.

Children with developmental disabilities and/or intensive mental health needs. Youth with intensive mental health needs and developmental disabilities are over-represented in the foster care system. These children and youth's needs can rapidly outpace the skills of their families, especially when their caregivers have needs of their own. In comparing the foster care population in SFY 2016 to the child Medicaid population, 56% of foster youth have a mental health need as opposed to 20% of the Medicaid child population. Twenty-seven percent of youth over the age of 12 have a substance use treatment need as opposed to 5% of the Medicaid child population and 21% have a specific developmental disorder/intellectual disability diagnosis compared to 6%. Children and youth with these high needs are at increased risk for placement when the parent or caregiver has a substance use disorder, mental health issue and/or is experiencing poverty or homelessness of their own. Once in the foster care system, these children and youth can be very difficult to serve and place in quality settings.

October 1, 2020

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Evidence-Based Service Description and Oversight

Pre-print Section 1

The Washington State Department of Children, Youth, and Families will contract through performance-based contracting to provide mental health, substance abuse treatment and prevention, and in-home parent skills-based services to children and parents where these services may safely prevent entry into foster care for those at imminent risk.

DCYF has chosen an initial set of EBPs based in part on contracts DCYF already has in place for prevention, as well as stakeholder and partner feedback and federal guidance. Washington State intends that the list of evidence-based family services available to children and families served under this plan will be more than eight; however, the other services under consideration by DCYF have not yet been reviewed by the Title IV-E Prevention Services Clearinghouse or are currently under review.

Table 2 below lists the initial seven evidence-based family services that DCYF will implement as a part of this Prevention Plan. The FFPSA Clearinghouse for Evidence-Based Practices has reviewed and rated all eight of these practices.

Table 2. DCYF Proposed EBPs for Initial FFPSA Prevention Plan			
	Practice	Type of Service	Title IV-E Clearinghouse Rating
1	Functional Family Therapy (FFT)	mental health	well-supported
2	Motivational Interviewing	mental health substance abuse	well-supported
3	Multi-Systemic Therapy (MST)	mental health substance abuse	well-supported
4	Nurse-Family Partnership (NFP)	parent skill-based	well-supported
5	Parents as Teachers (PAT)	parent skill-based	well-supported
6	Homebuilders	parent skill-based	well-supported
7	SafeCare	parent skill-based	Supported
8	Child-Parent Psychotherapy	Mental health	Promising

While Motivational Interviewing and Multi-systemic therapy are substance abuse interventions, DCYF recognizes that there will be opportunities for further developing substance abuse

October 1, 2020

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prevention services in Washington. To that end, DCYF continues to meet with the Health Care Authority to plan additional substance abuse programs and resources.

The Children's Bureau Program Instruction ACYF-CB-PI-19-06 on Transitional Payments for the Title IV-E Prevention and Family Services and Programs describes the process by which states may review and rate a program or services until the Title IV-E Prevention Services Clearinghouse can review and rate the program or service. The independent systematic reviews of prevention services and programs described in this program instruction represent substantial new (and unanticipated) work for Washington State to complete. Therefore, DCYF will contract with qualified independent reviewer(s) to conduct the evidentiary review described in ACYF-CB-PI-19-06 following submission of this State Prevention Plan, then submit an amendment to the plan with additional reviewed services sometime in mid-2020.

Washington State EBP Environment. In 2012, Washington State enacted House Bill (HB) 2536, requiring that state agencies serving children move toward greater use of Evidence-Based Practices (EBPs) in their service portfolios. The affected state agencies included two of the three DCYF agencies of origin – the former Children's Administration (the former state child welfare agency) and the former Juvenile Rehabilitation Administration (the former state juvenile justice agency). HB 1661, enacted in 2017, brought these two former Administrations together with the Department of Early Learning, to form the current Department of Children, Youth, and Families.

Because of HB 2536, Washington State has a rich tradition of EBPs, including evidentiary review and program evaluation, on which to expand voluntary prevention services. Since 2012 the Washington State Institute for Public Policy (WSIPP) has published updated evidentiary reviews and inventories of practices used by child-serving agencies, both in direct services and in contracts.

Service Ramp Up. DCYF would like to expand voluntary prevention services among the identified candidacy groups. In order to support this increase, the agency will need to invest in additional resources and develop an infrastructure to support expansion. A slow and steady ramp-up in expansion of services, guided by implementation science, is needed to avoid the unintended consequence of displacing existing services for families with children in foster care and to support the necessary focus on state caseworkers, training and fidelity for EBP providers, curation of network providers and program administration

The eight evidence-based prevention practices listed in Table 1 above are all practices for which DCYF already holds contracts, with one exception (Motivational Interviewing). DCYF intends to take an incremental approach with service expansion – with multiple rounds of expanding priority services in targeted geographic areas and onboarding new service providers. Additionally, this plan provides for the substantial additional capacity that the agency will need to build in contract management and monitoring, CQI and evaluation.

October 1, 2020

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DCYF will align oversight of new and expanded EBPs implemented as a part of this plan with nascent efforts in the new agency around outcomes-oriented Performance-Based Contracting (PBC) requirements. State legislation enacted in 2017 that created the new DCYF, requires the new agency to implement outcomes-oriented Performance-Based Contracting for all client service contracts. The intent is to align contracts with priority outcomes for children, youth and families in order to leverage the state's substantial investment in client services as an important tool to drive improvements in outcomes. In 2018, DCYF began intensive work with an initial set of four contract groups and will continue to add three to four contract groups per year to this effort until all client service contracts are converted to performance-based (estimated five to six years in all). Each contract group will go through an initial year of intensive planning, working with consultants and an assigned research/data consultant to closely examine existing data on program effectiveness. Based on analyses of available data, the contract groups choose specific quality and outcome metrics, aligned with the goals of the agency, to begin including in contracts. During the second year of engagement, the contract groups will work with contractors to implement the new contract measures, set up data monitoring and put continuous quality improvement practices in place.

Motivational Interviewing (MI). Motivational Interviewing is the single practice in Table 1 for which the agency does not currently have a contract. MI has emerged as a prominent case management tool in the field of child welfare beyond substance abuse. Research and evaluation to date have highlighted MI as an effective service delivery strategy with both adult and youth populations, making it an ideal fit for DCYF's prevention candidates.

The goal of implementing MI is to assure improved engagement and participation of children, youth and families to support and services offered. Through increased engagement, we anticipate better service matching to the needs of each child and family. MI's client-centered approach will support sustainment of the family's motivation toward progress, so each child and family is able to continue to receive an appropriate dose and level of support and service.

Our goal is to have MI used at each encounter with our families. This will require community-based service providers, caseworkers and supervisors to be trained in the use of MI. Supervisors will provide critical support to caseworkers in using MI in the development and monitoring of the Prevention Plan. Community-based service providers will use MI in developing the assessment and delivering services.

DCYF workers and FFPSA Prevention community-based service providers will practice motivational interviewing with five fundamental principles:

- Express empathy through reflective listening.
 - Empathy involves seeing the work through the families' eyes.
- Develop discrepancy between families' goals or values and their current behavior.

October 1, 2020

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- Motivation for change occurs when people perceive a mismatch between “where they are and where they want to be”.
- Adjust to family resistance rather than opposing it directly.
 - Roll with resistance.
- Support self-efficacy and optimism.
 - Strengths-based approach that believes that families have within themselves the capabilities to change successfully.

DCYF will progressively train DCYF workers and community-based prevention providers in Motivational Interviewing (MI). Motivational Interviewing will be incorporated as a part of a comprehensive DCYF practice model in alignment with utilization of the Child and Adolescent Needs & Strengths – Family Screener (CANS-F Screener) and Child and Adolescent Needs & Strengths – Family (CANS-F). DCYF will employ a phased training approach initially focusing on the prevention workforce. In consultation and collaboration with the University of Washington-Alliance for Child Welfare Excellence, DCYF will train its prevention workforce with MI with fidelity monitoring.

DCYF will consult and partner with its existing provider network and initiate proof of concept projects on a voluntary basis with community-based service providers that already include MI as a part of their practice model. DCYF and the providers then will review and select a most effective framework incorporating MI with the family support service set to be replicated across the state.

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Prevention Evidence-Based Practices at DCYF

Table 3 provides an overview of the selected EBPs, including service category, target population, their rating on the Title IV-E Prevention Clearinghouse, model information, outcomes and fidelity measures. The outcomes specified in Table 3 are those found in published research on these programs, and will not necessarily be measured in DCYF's evaluation of the programs. The Evaluation Strategy section of this plan provides additional information regarding how each service will be evaluated.

Table 3. Prevention Evidence-Based Practices at DCYF						
EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
Nurse-Family Partnership	Nurse-Family Partnership enrolls vulnerable first-time moms to transform their lives and create better futures for themselves and their babies. Research shows that Nurse-Family Partnership succeeds in: keeping children healthy and safe and improving the lives of moms and babies. Nurse-Family Partnership works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, continuing through the child's second birthday. At the same time, new moms develop a relationship with a nurse and is a trusted resource for guidance on everything from safely caring for their child to taking steps to provide a stable, secure future for their new family. Throughout the partnership, the nurse provides	Well-Supported	Parent-skill based	<ul style="list-style-type: none"> • Child Development • Family Economic Self-Sufficiency • Reduced Arrests for Mother • Positive Parenting Practices (Parent-Child Interaction) • Reductions in Child Maltreatment • Reduction in preterm delivery for mothers who smoke 	Currently, NFP services enroll families during the prenatal period until the child turns age two.	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio no more than 1:6 • Caseload limit 1 nurse: 25 clients • Visit completion rate in each phase

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FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Table 3. Prevention Evidence-Based Practices at DCYF						
EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	new moms with confidence and tools to support a healthy start for their babies and to envision a life of stability and opportunities for success for the family.					
Homebuilders	Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting and treatment planning.	Under Review	Parent-skill based	<ul style="list-style-type: none"> • Reduce child abuse and neglect • Reduce family conflict • Reduce child behavior problems • Teach families the skills they need to prevent placement or successfully reunify with their children 	Families with children (birth to 18) at imminent risk of placement into or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals or juvenile rehabilitation facilities	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio • 24-hour availability • Services provided in their natural environment • Caseload limit 1 staff: 18 to 22 families/year • Supervisor availability
Child-Parent Psychotherapy	CPP is a treatment for trauma-exposed children aged birth to 5. Typically, the child is seen with his or her primary caregiver and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's	Under Review	Mental health	Child Domains <ul style="list-style-type: none"> • PTSD symptoms • Comorbid diagnoses, including depression • General behavior problems, including aggression and attentional difficulties 	Children age birth to 5, who have experienced trauma and their caregivers	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent therapeutic content (ex: convey hope, develop an

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Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<p>developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration-related stressors) and respects the family and cultural values. Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.</p> <p>Together, these approaches for Child-Parent Psychotherapy serve</p>			<ul style="list-style-type: none"> Capacity to regulate emotions Cognitive functioning <p>Relational Domains</p> <ul style="list-style-type: none"> Children's perceptions of caregivers and themselves Children's and caregivers' attachment relationships <p>Caregiver Domains</p> <ul style="list-style-type: none"> Caregivers' PTSD symptoms Caregivers' general symptoms Caregivers' empathy towards children Caregivers' ability to interact in positive ways with children 		<p>empathetic relationship with family members, etc.)</p> <ul style="list-style-type: none"> Consistent reflective practice Consistent use of trauma framework

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FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Table 3. Prevention Evidence-Based Practices at DCYF						
EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<p>to support families to reach the following primary goals:</p> <ol style="list-style-type: none"> 1. Restore and protect the child's mental health. 2. Support family strengths and relationships, helping families heal after stressful experiences. 					
				•		•
Functional Family Therapy (FFT)	<p>FFT is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out and substance abuse. While FFT targets youth aged 11 to 18, younger siblings of referred adolescents often become part of the intervention</p>	Well-supported	Mental Health	<ul style="list-style-type: none"> • Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e., school attendance) • Improve family and individual skills 	1 to 18-year-olds with very serious problems such as conduct disorder, violent acting-out and substance abuse	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Rate of meetings/progress notes • Family Self Report (FSR) and Therapist Self Report (TSR) • Rate of staffing and consultations with supervisors • Global Therapist Rating (GTR)

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Table 3. Prevention Evidence-Based Practices at DCYF						
EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<p>process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as outpatient therapy and as a home-based model.</p> <p>The FFT clinical model offers clear identification of specific phases that organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention and therapist skills necessary for success.</p>					<ul style="list-style-type: none"> Family, client and therapist exit survey
Motivational Interviewing	MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to	Well-supported	Mental Health & Substance Abuse	<ul style="list-style-type: none"> Enhance internal motivation to change Reinforce this motivation 	Caregivers of children referred to the child welfare system. Has been used with adolescents	<ul style="list-style-type: none"> Staff successful completion of required model training: initial and booster

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Table 3. Prevention Evidence-Based Practices at DCYF						
EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.			<ul style="list-style-type: none"> Develop a plan to achieve change 		<ul style="list-style-type: none"> Case documentation: Frequency and consistency Case review: thorough and adequate Counselor competence/model adherence: collaboration, evocation and autonomy Counselor skill demonstration: empathy
Multi-Systemic Therapy (MST)	Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically-based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts;	Well-supported	Mental Health & Substance Abuse	<ul style="list-style-type: none"> Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) Empower parents with the skills and resources needed to: Independently address the inevitable difficulties that 	Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system (some other restrictions exist,	<ul style="list-style-type: none"> Staff qualifications Staff successful completion of required model training 24-hour availability Services provided in the family's home or other places convenient to the family Services are intensive, with intervention sessions being

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FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Table 3. Prevention Evidence-Based Practices at DCYF						
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	(b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.			<p>arise in raising children and adolescents</p> <ul style="list-style-type: none"> Empower youth to cope with family, peer, school, and neighborhood problems 	see the Essential Components section for more details)	<p>conducted from once per week to daily</p> <ul style="list-style-type: none"> Caseload: Maximum 6 families/year per therapist Case length: 3 to 5 months
Parents as Teachers (PAT)	<p>There are four dynamic components to the Parents as Teachers model:</p> <ul style="list-style-type: none"> Personal visits (home visits) Group connections Resource network (referrals and connections to services) Child screening (and caregiver screening) <p>Together, these four components form a cohesive package of services with four primary goals:</p> <ol style="list-style-type: none"> Increase parent knowledge of early childhood development and improve parent practices. 	Well-supported	Parent-skill based	<ul style="list-style-type: none"> Child Development and School Readiness Family Economic Self-Sufficiency Positive Parenting Practices (Parent-Child Interaction) Reductions in Child Maltreatment 	Currently, PAT service enrolls families from pregnancy until Kindergarten entry.	<ul style="list-style-type: none"> Staff qualifications Staff successful completion of required model training Reflective supervision Staff: supervisor ratio not more than 1:12 Consistent use of family-centered assessment Consistent documentation of parent goals Consistent use of standard curriculum and visit plans

October 1, 2020

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Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
	<p>2. Provide early detection of developmental delays and health issues.</p> <p>3. Prevent child abuse and neglect.</p> <p>4. Increase children's school readiness and success.</p> <p>The PAT model for providing services to families with children from the prenatal period to kindergarten. Affiliates follow the essential requirements of the model, which provide minimum expectations for program design, infrastructure and service delivery. PAT provides support for affiliates to meet those requirements as well as further quality standards that represent best practices in the field.</p> <p>The PAT model book/manual is proprietary and available to trained and approved affiliates. There is only one Tribal specific local program currently funded with an approved adaptation, all other programs are implementing the program as designed.</p>					<ul style="list-style-type: none"> • Visit completion rate • Caseload limit FT staff no more than 48 visits/month in first year and no more than 60 visits/month thereafter

October 1, 2020

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Table 3. Prevention Evidence-Based Practices at DCYF

EBP Intervention	Model Information	Prevention Clearinghouse Rating	Service Category	Outcomes	Target Population	Fidelity Measures
SafeCare	SafeCare ® is an in-home parent training program that targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas: (1) how to interact in a positive manner with their children, to plan activities and respond appropriately to challenging child behaviors, (2) to recognize hazards in the home in order to improve the home environment and (3) to recognize and respond to symptoms of illness and injury, in addition to keeping good health records.	Under Review	Parent-skill based	<ul style="list-style-type: none"> • Reduce future incidents of child maltreatment • Increase positive parent-child interaction • Improve how parents care for their children's health • Enhance home safety and parent supervision 	Parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent use of parent-infant/child interaction assessment and training • Consistent use of home safety assessment and training • Consistent use of child health assessment and training
				•		•

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Manual-Version for Evidence Based Practices

Table 4. Manual-Version for Evidence Based Practices

Functional Family Therapy (FFT)	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i> . Washington, D.C.: American Psychological Association.
Motivational Interviewing	Miller, W.R. & Rollnick, S. (2012). <i>Motivational Interviewing, Third Edition: Helping People Change</i> . Guilford Press.
Multi-Systemic Therapy (MST)	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). <i>Multisystemic Therapy for Antisocial Behavior in Children and Adolescents</i> (2 nd ed.). New York: The Guilford Press.
Nurse Family Partnership (NFP)	Visit-to-Visit guidelines and other materials are available to those who attend the NFP trainings.
Parents as Teachers (PAT)	PAT Foundational Curriculum to support families prenatal to 3. AND PAT Foundational 2 Curriculum to support families 3 through Kindergarten.
Child-Parent Psychotherapy	Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). <i>Don't hit my mommy: A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma, Second Edition</i> . Washington, DC: Zero to Three.
Homebuilders	Kinney, J., Haapala, D. A., & Booth, C. (1991). <i>Keeping Families Together: The HOMEBUILDERS Model</i> . New York, NY: Taylor Francis.
SafeCare	Lutzker, J.R. (2016). <i>Provider Manual</i> , version 4.1.1.

Evidentiary Review of Additional Evidence-Based Practices

In planning for implementation of FFPSA prevention services, DCYF has identified a number of additional evidence-based practices that have not yet been reviewed by the FFPSA Clearinghouse but have substantial evidence to support their effectiveness and the agency believes would help to meet the needs of Washington's diverse candidacy populations. Thus, following submission of this plan, Washington intends to proceed with evidentiary review of these additional practices under Program Instruction ACYF-CB-PI-19-06. If the evidentiary review finds that those additional practices meet criteria for inclusion in the FFPSA Prevention Plan, Washington will submit an amendment to this plan to include additional EBPs. DCYF has already engaged in discussions with the Washington State Institute for Public Policy (WSIPP), to contract to conduct a number of these reviews in early 2020. WSIPP is the state entity designated by the Washington legislature to conduct an evidentiary review and determine the level of evidence for child-serving state agencies. While the standards WSIPP uses for Washington State reviews are somewhat different, they have expressed confidence in their ability to apply the required Clearinghouse standards to the review requested by DCYF.

October 1, 2020

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In addition, in planning for expansion of prevention services for approved candidacy groups under this Prevention Plan, DCYF has engaged in consultation with the federally recognized tribes who serve as sovereign nations. DCYF views engagement of our tribal partners in prevention as an essential element in the success of our Prevention Plan, given that American Indians/Alaska Natives in Washington are disproportionately represented in the state's child welfare system. DCYF staff engaged in extensive discussion during two dedicated Tribal Policy Advisory Committee meetings throughout our planning year (in December 2018 and August 2019). In addition, the DCYF Director of Tribal Relations conducted a survey of Washington tribes in March 2019 to inquire about prevention practices embraced in tribal communities, that tribal communities find effective and that they would like DCYF to consider; including in its state Prevention Plan. Those discussions and the survey resulted in four prevention practices (Family Spirit, Positive Indian Parenting, Healing of the Canoe and Healing Circles) that the tribes requested DCYF consider and they additionally requested that the agency work with an AI/AN researcher to conduct the evidentiary reviews. In response, DCYF has investigated the evidence on the identified four practices and has located a qualified AI/AN researcher at the University of Washington who is interested and available to conduct the evidentiary reviews according to the FFPSA Clearinghouse standards and the Program Instruction ACYF-CB-PI-19-06. DCYF intends to contract for this review in early 2020 and is prepared to add the qualifying practices to our Prevention Plan in a subsequent amendment to address the racial disproportionality and disparity experienced by tribal populations in child welfare.

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Prevention Pathway Implementation

We see the implementation of FFPSA as a multi-year, multi-phased initiative that will focus on building various pathways for prevention. Changes to processes, procedures, policies, as well as technical changes, will be necessary in order to successfully comply with FFPSA requirements.

FFPSA has several **requirements** that prevention cases must implement, regardless of the pathway. FFPSA requires that a child who is eligible for prevention services must have a **written prevention plan**. The written prevention plan must identify the foster care prevention strategy for the child so that the child may remain safely at home. Additionally, the prevention plan must **list the services** to be provided to or on behalf of the child to ensure the success of that prevention strategy. The prevention plan for pregnant or parenting foster youth must also be included in their care case-plan and describe the foster care prevention strategy for any child born to the youth. In addition to the written prevention plan, prevention cases must monitor and oversee safety, and conduct periodic risk assessments for each child with a prevention plan. There is also required data to be tracked and submitted to the federal government on a six-month basis. The section “Monitoring Child Safety and Risk” details how safety and risk are monitored throughout the life of the prevention case.

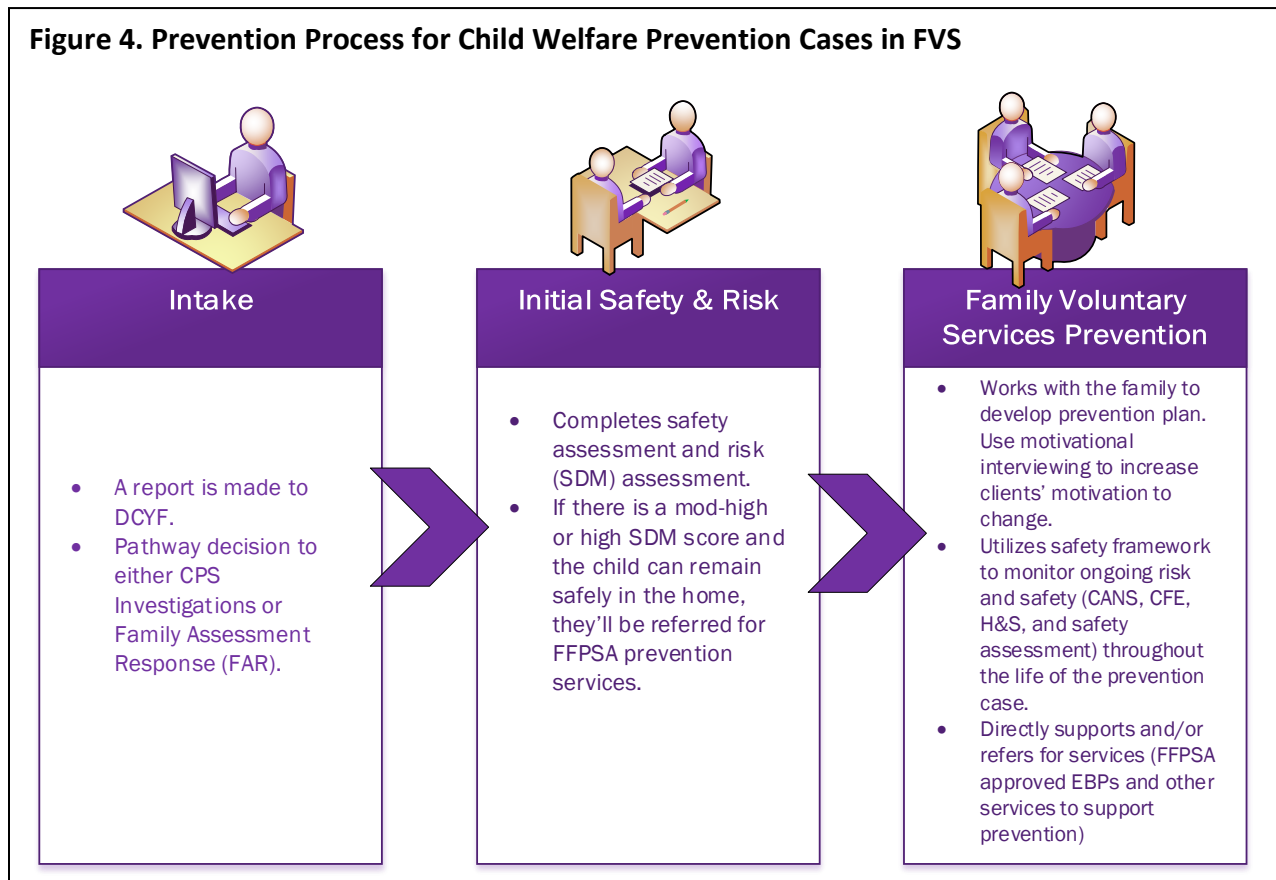
Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention. FAR works with families to support them when they are in crisis and help them connect with their communities without finding parents responsible for child abuse or neglect.

Currently, FAR cases that provide services remain open no more than 120-days. An FFPSA Prevention case can remain open for up to 12 months and require additional monitoring and case management than what is currently required by caseworkers. In order to better understand the workload impacts of adding additional tasks in order to meet the FFPSA requirements (i.e. development of a prevention plan, offering and tracking services for up to 12 months, monthly health and safety, periodic risk assessments) on FAR caseloads, DCYF is interested in conducting FFPSA pilots with several FAR units throughout Washington State. The pilot information will be critical to understanding the impact on caseloads and to identifying strategies needed to align with FFPSA.

Family Voluntary Services (FVS) allows parents to choose to participate in services to meet their children’s safety, health and well-being needs. The goal of FVS is to keep children safe and meet their needs while strengthening and keeping families together. A family is referred to FVS if, after the CPS investigation: (1) the family is identified as being moderately-high or high risk (based on the Structured Decision Making risk score) for future abuse or neglect and (2) the child(ren) can remain safely in the home with a safety plan.

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Figure 4. Prevention Process for Child Welfare Prevention Cases in FVS

Changes to the FVS program will be required in order to implement FFPSA requirements for Prevention cases. As part of the initial implementation to meet FFPSA requirements, DCYF's FVS workers will work with families to develop a prevention plan, which will identify prevention strategies to keep children safe and make sure children, youth and families have the services they need.

The prevention plan is developed with input from the assessments, risk and needs screening and Family Team Decision Making (FTDM) meeting. Updated risk/needs assessments may be used to inform the plan review. FVS teams will routinely reexamine prevention plans to help monitor and track the child and parent or guardian progress during the provision of services. If a child's risk of entering foster care does not improve at a reasonable rate during or following the provision of services, the prevention plan will be re-assessed and changed as needed.

Washington is including two groups of adolescents on its candidacy list – those engaged with the agency's **Family Reconciliation Services** and **youth exiting the state's Juvenile Rehabilitation** system. High-risk adolescents in these categories are at risk of entering or re-entering the foster care system and present similar needs for behavioral health and parent engagement supports. Many of these youth would benefit from the evidence-based practices on the Washington list to prevent entry/re-entry into foster care such as Family Functional

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Therapy (FFT), Multi-Systemic Therapy (MST) and others. In April 2019, DCYF released a policy report entitled *Families and Youth in Crisis*³, in response to legislative concern about these high-need youth. In that report, the agency identified best practices for service delivery to similar youth and their families in Washington, in other states and internationally.

A pathway for substance-abusing pregnant women, **Washington's Plan of Safe Care Initiative** involves an interdisciplinary approach to providing support during and after pregnancy to mothers and their infants who are at risk of substance use and substance exposure. This initiative is sponsored by DCYF in collaboration with the Washington State Department of Health, the Washington Health Care Authority and the National Center on Substance Abuse and Child Welfare. The Plan of Safe Care is designed to take a highly collaborative, proactive and preventive approach to help keep families together, safe and healthy.

In early December 2019, the sponsors of Plan of Safe Care held an event to discuss strategy for implementing Plans of Safe Care in Washington. Participants included stakeholders involved with families in pregnancy, birth and early childhood to inform efforts including medical and public health, substance use treatment, medication assisted treatment, early intervention, child welfare and court professionals. As part of this work, collaborating agencies will plan prevention services to the FFPSA candidacy group: screened out pregnant women with substance use disorder.

A future community pathway is through **Washington's Kinship Navigator (KN) program**, managed by the Department of Social and Health Services Aging and Long Term Support Administration (AL TSA). The Kinship Navigator program currently serves 30 of 39 counties, seven tribes and supports kinship navigators in connecting relatives and unrelated kin raising children with federal, state and community resources. Kinship navigators provide information and referral services, which address specific needs and support greater stability, self-sufficiency and permanency. The KN program connects to a legislatively-mandated committee, the Kinship Care Oversight Committee (KCOC). KCOC links state agencies that serve kin with local groups and agencies that assist the same population, promoting coordination and seamless services for families. These collaborative working relationships enhance service delivery for kinship care families.

In order to access Title IV-E funds, the programs must meet the minimum evidence-based standards defined by the Title IV-E Prevention Services Clearinghouse. Currently, there are no Kinship Navigator programs that meet the required evidence-based standards. Washington State's KN program is uniquely situated for evaluation and DCYF partnered with AL TSA to hire the University of Washington's Partners for Our Children (POC) to complete the program evaluation.

³ 2019. Families and Youth in Crisis. DCYF

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The Kinship Navigator program is currently under evaluation and anticipates that the program could submit the required evaluation reports and elements to the Administration for Family and Children and the Title IV-E Prevention Services Clearinghouse in late 2022. When this program is approved and rated by the Clearinghouse, we will submit an amended plan to include this evidence-based practice in our FFPSA Prevention plan.

Implementation Considerations

Implementation of FFPSA Prevention in Washington State is a huge transformation effort that will take multiple years to fully implement. Establishing an infrastructure that will properly support this ongoing work will be critical to our success.

DCYF will use **formal program and agile project management** methodologies to support this initiative. Following project management best practices will keep work focused and on task. Additionally, project management will provide visibility to the ongoing work and allow for alignment with other initiatives occurring in the department.

Extensive **Change management** support will also be essential to supporting FFPSA Prevention implementation. Integrating formal change management principles into the implementation work will be critical for supporting our staff and external partners through the changes. DCYF's enterprise change management office is a resource to assist with this transformational change. DCYF has trained staff in Prosci Change Management practices and tools.

Several **technical changes** are required to meet FFPSA requirements. To ensure tracking of prevention services for appropriate Title IV-E claiming, information technology (IT) staff are an integral part of preparation for Family First implementation. System enhancements for candidacy identification, EBP selection, prevention plan identification and plan outcomes, and billing processes will need to occur to support DCYF staff and providers. Through the DCYF IT prioritization process, these changes will be prioritized along with all change requests for FamLink. We are working closely with technology services to identify timelines and resources needed to implement these technical changes.

Ongoing engagement and communication is critical to the success of FFPSA Prevention. In order to ensure ongoing collaboration, DCYF will **continue to partner closely with** internal staff, tribes, community providers, constituents, external partners and stakeholders and different groups that represent the youth and families with whom we work. DCYF will also make use of its website and other communication channels to provide up-to-date information.

Focusing on **business readiness** will be at the forefront of the implementation work. There will be a significant amount of work to ensure DCYF staff are trained and supported - streamlining processes, training on new tools, incorporating motivational interviewing in the practice model, and more. Ensuring agency staff has the proper training, coaching and ongoing support is vital.

October 1, 2020

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There are significant **resource needs** in order to implement FFPSA requirements. Family prevention services are time-consuming and take connection and engagement to families. Prevention cases can remain open for up to 12 months and require additional tasks and with already high workloads, it will be important that we consider the impact on caseloads. Additional staffing requirements will be determined as DCYF begins implementation planning in the coming months.

State Regulatory, Statutory, and Policy changes are outlined in Attachment B State Plan for Title IV-E of the Social Security Act: Prevention Services and Programs. We have outlined the policies changes that will occur, prior to implementation, of the candidacy groups in Family Assessment Response (FAR) and Family Voluntary Services (FVS).

As we described, DCYF plans to take a phased approach to implementation for each candidacy group. As we begin implementation for each group, we will review all of the policies and procedures and make updates per our established processes.

DCYF has an established process for making changes to our policies. The policy owner works closely with the DCYF Rules and Policy Administrator and Policy Team to identify internal and external stakeholders, applicable federal or state laws, and administrative and program policies and Washington Administrative Codes (WAC) that may be impacted by the development or revision. Additionally, any forms, publications, or other documents such as guides, manuals, cheat sheets, matrixes, etc., that need to be developed or revised will be identified and must be updated as part of the policy review process. The policy owner and policy team work together to develop action steps and timeline to resolve the impacts. There is also an intensive review process required, with both internal and external partners to review and make edits prior to a policy being finalized: Adolescent Program Manager, Assistant Attorney General, Legislative liaison, Field Operations, Field Advisory Board, Information Technology, Interstate Compact for Placement of Children, Foster Parents Association of Washington State, Racial Equity Administrator, Office of Tribal Relations, HR Labor Relations, Internal Auditor, IV-E Funding Program Manager, Licensing Division, Quality Assurance Administrator, and other impacted DCYF internal divisions. All Child Welfare policy changes require final review and approval by the agency's Deputy Secretary before implementation.

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Evaluation Strategy and Waiver Request

Pre-Print Section 2

DCYF will implement the evaluation strategy described here to ensure approved services that are not granted waivers are analyzed through a rigorous, robust, and well-designed research methodology. This plan calls for evaluations to use FFPSA-approved evidence-based practices. The practices and evaluations will serve to inform internal and external stakeholders on the progress being made by DCYF in improving the lives of children, youth, and families in Washington State. Furthermore, this work will build upon previous and concurrent practice and evaluation studies being conducted by DCYF and help guide the agency toward being data-driven and outcomes-focused in its programmatic decisions. This goal supports the vision that was established for DCYF through the enactment of House Bill 1661 (2017) by the Washington State legislature and governor. FFPSA offers DCYF the opportunity to continue the developments already being made by the agency: focusing on outcomes, providing appropriate services to clients, and enhancing delivery best practices.

In addition to Washington's history of promoting the use of evidence-based practices in child-serving agencies,⁴ DCYF is implementing outcomes-oriented performance-based contracting reform for all contracted client services in an effort to analyze and improve these services, their qualities, and their outcomes. The evidence-based practices included in Table 1, with the exception of Motivational Interviewing, are already under contract with DCYF; additionally, there now exists some level of service capacity around the state. The majority of the existing contracts for these services were part of DCYF's inaugural performance-based contracting cohort, which began in 2018. While these efforts are in their early stages, all existing providers of these services have worked for more than a year to identify appropriate quality and outcome metrics that align with the agency's identified outcomes for children, youth, and families.

DCYF has established a workgroup within the Office of Innovation, Alignment, and Accountability (OIAA) to oversee the design and implementation of the evaluations. The OIAA is designated in the DCYF's founding legislation⁵ as the research unit within the agency and is comprised of researchers and analysts as well as the data warehouse and reporting units.

The OIAA also established an Evidence, Data, and Evaluation (EDE) workgroup consisting of DCYF employees:

- All Members of the PhD research team (currently six)
- Director of the OIAA
- Administrator for the OIAA Evaluation and Research Unit
- Administrator for the OIAA Performance-Based Contracting Unit

⁴ HB 2536, 62nd Leg., Reg. Sess. (Wash. 2012).

⁵ HB 1661, § 104, 65th Leg., 3rd Spec. Sess. (Wash. 2017).

October 1, 2020

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The members of this workgroup have demonstrated leadership in government systems and methodology and have implemented continuous quality improvement as well as process and outcome evaluations using qualitative, quantitative, and community-based participatory research methodologies.

The EDE workgroup will ensure that all evaluations of approved evidence-based programs will use a rigorous methodology; comply with federal requirements; and deliver timely results by determining the order of program evaluations, assigning internal evaluations, identifying and contracting with external evaluators when necessary, and monitoring and consulting with both internal and contracted evaluators. In addition to reviewing and approving evaluation design and implementation, the EDE workgroup will provide ongoing review and consultation throughout the evaluation period to ensure the appropriate methodology is utilized. In this way, OIAA intends to operationalize a community of practice among evaluators and analysts who can support and learn from one another as well as engage in multistate communities of practice for continued learning.

In order to support the significant increase in demand for program evaluations, DCYF will expand its research and analysis positions or OIAA researchers will oversee qualified external researchers who will conduct contracted evaluations. The OIAA director will assign the principal evaluator for each evaluation, and this decision will be informed by staff availability and content expertise.

Many of the practices that DCYF will evaluate, although well-supported, have not been studied or tested with a child welfare population to determine whether the results produce the primary child welfare outcome of interest in this plan—to prevent the entry of children into foster care. DCYF will evaluate the remaining practices to ensure that the overall portfolio of evidence-based practices will meet the needs of the state’s diverse population. Washington State has chosen to evaluate these programs in order to gain an understanding of what works for the children, youth, and families that DCYF serves. DCYF is committed to producing positive outcomes with these services as implemented, and to do so, the agency must be able to determine and then monitor the extent to which this implementation of prevention services is able to safely prevent entry into foster care.

Table 7 describes DCYF’s theory of change for the evidence-based practices it will implement under this Prevention Plan

October 1, 2020

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Table 5: Washington State Prevention Plan Theory of Change

Target Population	Intervention	Proximal Outcomes	Outcomes
<p>Identify, assess and engage families in approved candidacy groups with children at risk of entry or re-entry into foster care.</p> <p>Child protective services (CPS) with screened-in referrals to both the Families in Family Assessment Response (FAR) and the CPS Investigation response</p> <p>Families requesting CPS Family Voluntary Services</p> <p>Children/families on trial return home following placement</p> <p>Screened out CPS referrals for pregnant women with substance use disorder.</p> <p>Adoptions experiencing challenges</p> <p>Pregnant/parenting youth in foster care and those in state JR institutions</p> <p>Youth referred for Family Reconciliation Services (FRS)</p> <p>Youth/families discharged from Juvenile Rehabilitation</p>	<p>Deliver high fidelity evidence-based practices that align with the specific needs and characteristics of each family in the target population.</p> <ul style="list-style-type: none"> • Child-Parent Psychotherapy • Homebuilders • Incredible Years • Functional Family Therapy • Motivational Interviewing • Multi-Systemic Therapy • Nurse-Family Partnership • Parents as Teachers • SafeCare • Triple P 	<p>Parent, child, and family functioning improves by achieving the desired outcomes of each intervention as demonstrated by (but not limited to)</p> <ul style="list-style-type: none"> • Engagement in agreed upon services • Improved parenting skills/behaviors to support child development • Improved parent-child interaction • Increases in family connections to community resources • Increased parental capacity to meet the needs of their children. • Increased family communication • Increased family/child/youth protective factors 	<p>Child maltreatment declines</p> <ul style="list-style-type: none"> • Reduced foster care entry • Reduced foster care re-entry • Reduced foster care census

Evaluation Strategy for Well-Supported or Supported EBPs

The researchers involved in the evaluation process of evidence-based practices (EBPs) are trained and possess the necessary scientific expertise in evaluation design and methodology. The primary responsibility for program evaluation will be assigned to researchers in the OIAA and qualified contracted evaluators with doctoral degrees. Fidelity monitoring reporting systems have been or will be established by DCYF programs for each practice, and management of contracts with provisions requiring fidelity monitoring and continuous quality improvement within DCYF's approved outcomes-oriented framework for performance-based contracting will be the responsibility of program staff.

DCYF will conduct, either directly or by contract, fidelity monitoring and outcome evaluation for well-supported or supported EBPs that are approved in the Washington State FFPSA Prevention Plan. The well-supported or supported EBPs have fidelity metrics identified by developers that must be monitored to ensure the practices are being implemented as intended. Additionally, fidelity indicators are important sources of information that can be used to inform continuous quality improvement efforts and fidelity metrics are important indicators of quality. Thus, DCYF will work with implementing agencies to establish fidelity monitoring, if none exists, and will include this information in the evaluation of well-supported or supported EBPs. DCYF will continuously monitor fidelity indicators of all well-supported or supported EBPs to ensure fidelity to the practice model, to determine the role of fidelity in producing desired outcomes,

October 1, 2020

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and to inform a continuous quality improvement cycle that will perpetually refine and improve practices.

The OIAA team will collaborate and coordinate with relevant stakeholders of each program to develop a comprehensive plan to determine the timeline, data collection process, research questions, outcome metrics, operationalization of outcome measures from the child welfare data source system, analytical procedures, limitations, responsibilities, and evaluation dissemination. In addition, each plan will include the methods for assessing outcomes and the appropriate statistical design control for child, family, community factors, and comparison groups. The evaluation strategy for well-supported and supported EBPs will be conducted through quantitative analysis using quasi-experimental designs with a comparison group whenever feasible. DCYF is also interested in the extent to which each EBP impacts the parent and child intermediate outcomes noted in the theory of change as indicated in Table 7 of this report. Thus, each EBP will be examined to determine whether the research supports its relationship to the intermediate outcomes, and the identified EBP-appropriate intermediate outcomes will become part of the evaluation implemented to the extent that data are available.

Motivational Interviewing

Motivational Interviewing (MI) is a client engagement approach used with youth and adults to improve client motivation for behavior change and to increase engagement rates with available services. Unlike the other EBPs included in this plan, the MI intervention will be implemented primarily with DCYF child welfare caseworkers with the possibility of moving the intervention to community-based providers following the establishment of the intervention. This service will be incorporated into the DCYF evaluation plan as indicated by Table 6. Month 1 indicates the month of implementation of the MI model using FFPSA funding.

Table 6. Motivational Interviewing (MI) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X	X	X							
Plan for Performance Monitoring	X	X	X	X							
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis									X	X	X
Implement Key Performance Metrics Data Display										X	X

October 1, 2020

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Dissemination of Evaluation											X
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Research Questions

- 1) Did the implementation of MI by caseworkers or community-based providers lead to increases in the initiation of EBPs by the clients over time?
- 2) Did the implementation of MI by caseworkers or community-based providers lead to substantial increases in the dosage of EBPs received by clients over time?
- 3) Did the implementation of MI by caseworkers or community based providers lead to substantial increases in the completion of EBPs by clients over time?

Data Collection Method

DCYF has not implemented the MI model yet, and the researcher assigned to this EBP will collaborate with relevant stakeholders to establish a systematic approach for the data collection procedure, quality assurance process, and quality control monitoring. This process will be a pertinent aspect of MI because this will allow an assessment of the program's effectiveness while lessening the likelihood of statistical inaccuracies.

Since this intervention is expected to be delivered primarily by DCYF staff members, the evaluation will rely on administrative data. Caseworkers will enter MI delivery data, including utilization metrics, into the DCYF FamLink case management system. The researcher will work with program and IT staff to plan and implement data collection within the existing FamLink system, so that sufficient data are available to conduct the evaluation. The dataset will include information regarding DCYF services received, client characteristics, demographics, and outcomes.

Outcomes of Interest

The FFPSA Clearinghouse for EBPs has reviewed and rated MI as a well-supported practice. Research has found that MI was an effective case management tool for improving engagement with support programs and services. There are 4 levels of engagement that are of interest for this evaluation: initial referrals to identified services, initial engagement with services, level of dosage and completion with services, and family engagement in other community services and supports. The initial referrals will examine how MI impacted client service selection, initial engagement measurement will examine whether clients had at least one visit with the service provider, level of dosage or completion with services will analyze whether there was significant increase in the dosage and completion of services by clients following the MI intervention, and family engagement in other community services and supports will provide insight into the families building natural community-based support systems.

Statistical Techniques and Quasi-Experimental Methodology

Because DCYF has not implemented this intervention yet, this proposed evaluation methodology is preliminary and may change once MI is implemented and the data collection

October 1, 2020

Approved for distribution by Secretary Ross Hunter

process commences. The target and study population for the evaluation will be all eligible individuals from the approved candidacy groups involved in the child welfare system. DCYF divides Washington State into six geographic regions and prior evaluations have found that geography has a significant effect on program participation rates. DCYF will use a geographically based phased-in approach for the training and application of MI at local offices because providing simultaneous statewide MI training will be an intensive process.

The researcher will implement an office-based readiness assessment tool in order to determine the phased-in process for MI. The research design will use the regional or area implementation of this EBP to create a statistical comparison for the intervention by matching regions or offices on variables like implementation readiness, case mix, and urban-rural classification. The researcher use this information to conduct match-paired stratified randomization to select initial intervention offices, with delayed implementation of MI in the comparison offices. For example, the researcher will select 10 local offices statewide and place them into 5 pairs based on similar characteristics. Once the groups have been formulated, one office will be randomly assigned to the treatment group (MI implementation) while the other office will be the comparison group (no MI implementation).

The researcher will obtain the covariates used for the paired matching and inferential multivariate regression analyses from the child welfare source system and the MI data collection process in order to control for heterogeneous characteristics known to impact engagement and outcomes. To the extent that data are available, covariates may include family poverty level, age, parental education level, child educational experience, race, ethnicity, parental employment status, child welfare history, contractor fidelity, and community poverty level.

If the researcher determines that match-paired stratified randomization is not feasible, they may use another quasi-experimental methodology such as difference-in-differences, multivariate Cox regression, regression discontinuity design, or instrumental variable estimation.

Research Limitations

The process of training caseworkers and community-based providers with the MI technique is imperative but providing the proper match for services during the assessment phase could optimize the advantages of MI. The mismatching of clients to the appropriate services is a limitation that will lead to problematic outcomes, incorrect dosage measurements, or lack of participation in the services by the families. Therefore, the implementation process of MI will need to include assessment training to ensure that caseworkers and community-based providers have adequate service matching tools and skills.

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates

October 1, 2020

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selection bias and results can be attributed to the intervention being evaluated. The outlined research design, stratified matched-pairs randomization, is considered a close approximation to a randomized controlled design while also reducing the risk of sampling bias when a limited number of sites can be targeted with an intervention.⁶ However, this research method will require additional effort to implement and monitor, which will reduce the number of offices that can be included in the initial analysis.

Additionally, while the researcher will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of MI because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Functional Family Therapy and Multi-Systemic Therapy

Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST) are two intervention programs aimed at addressing disruptive behaviors in adolescents, with MST generally reserved for youth with the most disruptive behaviors. Therefore, the evaluation strategy for these two services will be similar in terms of research questions, identified outcomes, and data collection methods. DCYF currently has established contracts for FFT and MST, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA.

Functional Family Therapy

Table 7 provides the anticipated timeline of the FFT evaluation strategy. Month 1 indicates the month of implementation of the FFT using FFPSA funding.

Table 7. Functional Family Therapy (FFT) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X

⁶ Shadish, W., Cook, T., & Campbell, D. (2002). *Experimental and quasi-experimental designs for generalized causal inferences*. Houghton Mifflin Company.

October 1, 2020

Approved for distribution by Secretary Ross Hunter

FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received FFT less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, FFT service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to FFT participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of FFT client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

October 1, 2020

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- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness (because of the great concern among policymakers about youth from the public child welfare system entering homelessness) and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the FFT service for the purposes of performance-based contracting. After consulting with model developers, trainers, and FFT service providers, DCYF measures service engagement as the case receiving at least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 8 treatment sessions; and full completion of service is defined as the case receiving 10 or more treatment sessions.

October 1, 2020

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The longer-term outcomes of interest for FFT will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse. If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasi-experimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity

October 1, 2020

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score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as non-experimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of FFT because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Multi-Systemic Therapy

Table 8 provides the anticipated timeline of the MST evaluation strategy. Month 1 indicates the month of implementation of the MST using FFPSA funding.

Table 8. Multi-Systemic Therapy (MST) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						

October 1, 2020

Approved for distribution by Secretary Ross Hunter

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Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received MST less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, MST service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to MST participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of MST client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

October 1, 2020

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- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness (because of the great concern among policymakers about youth from the public child welfare system entering homelessness) and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. Working in collaboration with service providers program experts, trainers, and model developers, MST program staff will determine thresholds for engagement, minimal service completion, and full completion of service during the implementation phase. The decisions previously made for FFT will be used as an informative reference, but MST engagement metrics may not be exactly the same since this is a more intensive intervention.

October 1, 2020

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The longer-term outcomes of interest for MST will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasi-experimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity

October 1, 2020

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score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as non-experimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of MST because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Homebuilders

Homebuilders is an intensive family preservation service for children from birth to 18 years old. DCYF currently has established contracts for Homebuilders, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA. Table 9 provides the anticipated timeline of the Homebuilders evaluation strategy. Month 1 indicates the month of implementation of the Homebuilders model using FFPSA funding.

Table 9. Homebuilders Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									

October 1, 2020

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FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received Homebuilders less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, Homebuilders service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to Homebuilders participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of Homebuilders client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments

October 1, 2020

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- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the Homebuilders service for the purposes of performance-based contracting. After consulting with model developers, trainers, and Homebuilders service providers, service engagement is measured as the case receiving at

October 1, 2020

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least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 10 or more hours of treatment sessions; and full completion of service is defined as the case receiving approximately 40 hours of treatment sessions.

The longer-term outcomes of interest for Homebuilders will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasi-experimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence

October 1, 2020

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of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as non-experimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of Homebuilders because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

SafeCare and Child–Parent Psychotherapy

SafeCare and Child–Parent Psychotherapy (CPP) are two intervention programs aimed at serving children from birth to 5 years old. Even though SafeCare is rated as a well-supported EBP and CPP is a promising EBP, the evaluation strategy for both of these services will be comparable since the programs serve similar age groups. Therefore, the evaluation strategy for these two services will be similar in terms of research questions, identified outcomes, and data collection methods. DCYF currently has established contracts for SafeCare and CPP, thus service providers are already engaged with the process of data collection, reporting and performance improvement. This evaluation plan will build upon those existing relationships, referral pathways, and data collection systems in order to incorporate the requirements of FFPSA.

October 1, 2020

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SafeCare

Table 10 provides the anticipated timeline of the SafeCare evaluation strategy. Month 1 indicates the month of implementation of SafeCare using FFPSA funding.

Table 10. SafeCare Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X								
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X									
Plan for Performance Monitoring	X										
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis			X	X	X	X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received SafeCare less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, SafeCare service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to SafeCare participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

October 1, 2020

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The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of SafeCare client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

October 1, 2020

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In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. These measures have already been developed for the SafeCare service for the purposes of performance-based contracting. After consulting with model developers, trainers, and SafeCare service providers, service engagement is measured as the case receiving at least 3 treatment sessions and completing a CANS-F Family Plan for Change; minimal service completion is defined as the case receiving at least 12 treatment sessions (two of three modules); and full completion of service is defined as the case receiving 18 or more treatment sessions (three of three modules).

The longer-term outcomes of interest for SafeCare will be whether there was an entry or re-entry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues

October 1, 2020

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discussed below such as sample size and model convergence, they may use another quasi-experimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as non-experimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of SafeCare because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Child-Parent Psychotherapy

October 1, 2020

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Table 11 provides the anticipated timeline of the Child-Parent Psychotherapy (CPP) evaluation strategy. Month 1 indicates the month of implementation of CPP using FFPSA funding.

Table 11. Child–Parent Psychotherapy (CPP) Evaluation Timeline											
Month	1	2	3	4	5	6	7	8	9	10	Continuous
Create Data Collection and Report Plan	X	X	X	X	X						
Create Evaluation Dissemination Plan	X	X									
Establish Fidelity Monitoring	X	X	X	X							
Plan for Performance Monitoring	X	X									
Plan for Data Analysis	X	X	X	X	X						
Conduct Data Analysis						X	X	X	X	X	X
Implement Key Performance Metrics Data Display										X	X
Dissemination of Evaluation											X

Research Questions

- 1) How did family characteristics and risk factors differ for families based on whether they received a service referral, started an EBP, and/or completed the EBP?
- 2) Were families who completed the EBP more likely to connect with additional community resources compared to similar families who did not receive the EBP?
- 3) Were families who completed the EBP less likely to experience a new period of homelessness or housing insecurity compared to similar families who did not receive the EBP?
- 4) Were families who received CPP less likely to have a child enter or reenter care compared to similar families who did not receive the EBP?

Data Collection Method

DCYF contracted researchers at the Research and Data Analysis (RDA) unit of the Washington State Department of Social and Health Services (DSHS) will obtain child-family level data, CPP service data, and referral and treatment session dates and types from the data reports that contracted providers are required to submit to DCYF. The purpose is to have an integrated data collection approach that will provide a comprehensive and nuanced understanding of the services being provided to CPP participants. DCYF and contracted researchers currently have access to sufficient data within the existing data systems to conduct these analyses.

October 1, 2020

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The researcher will extract longitudinal administrative data from the RDA Integrated Client Databases (ICDB) and the DCYF FamLink case management system to generate measures of CPP client characteristics.

The FamLink data from DCYF will contain the following information for the evaluation:

- Current and prior case openings
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child Health and Education Tracking (CHET)

The ICDB data from RDA will use the following information to characterize child and caregiver risk factors:

- Economic stress: receipt of State Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), Diversion Cash Assistance, Basic Food Program, or Consolidated Emergency Assistance Program identified through the Automated Client Eligibility System (ACES), which is the Washington state data system for homeless programs
- Domestic violence: any domestic violence-related charges from Washington State Patrol (WSP)
- Homelessness: any indicator for living in a battered spouse shelter, emergency housing shelter, homeless with housing, homeless without housing, or inappropriate living situation in ACES
- Caregiver criminality: any arrest, conviction, or incarceration at a state juvenile or adult facility
- Caregiver mental illness: mental health diagnosis, inpatient and outpatient services, or prescribed psychotropic medications recorded in medical claims or publicly funded mental health records
- Caregiver substance abuse: alcohol- or drug-related diagnosis, outpatient and inpatient service recorded in medical claims, publicly funded mental health records, and substance-related arrests from WSP

The data for the homelessness indicators will be ascertained from the following:

- Washington State Department of Commerce Homeless Management Information System (HMIS), which contains variables regarding youth and adults who have received any type of housing services like emergency shelter, transitional housing, or rental assistance
- Client living arrangement from the ACES
- Address information in ACES indicating whether a youth or caregiver was homeless

Outcomes of Interest

October 1, 2020

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In addition to the ultimate outcomes of preventing entry and reentry into foster care, DCYF is interested in intermediate outcomes related to homelessness and service utilization related to receipt of other community services as an indication of building community connections. The intermediate outcomes will be measured during a 6-month follow-up period from date of service referral and include service engagement, minimal service completion, and full service completion. Working in collaboration with service providers program experts, trainers, and model developers, CPP program staff will determine thresholds for engagement, minimal service completion, and full completion of service during the implementation phase.

The longer-term outcomes of interest for CPP will be whether there was an entry or reentry into foster care for any child on the case within 6 and 12 months of the last day of service, new connection to community resources (Basic Food Program, Medicaid enrollment, mental health treatment, and/or substance use disorder treatment) within 6 and 12 months of the last day of service, and experience with a new period of homelessness during the 12-month follow-up process. For the new connection to community resources measure, the study population will be limited to families who were not already receiving the same community services in the month that the EBP was initiated.

Statistical Techniques and Quasi-Experimental Methodology

The target and study populations for the evaluations will be all eligible individuals from the approved candidacy groups involved in the child welfare system. Researchers will compile descriptive statistics to compare family risk and case characteristics by service referral, engagement, and completion status. Chi-square analysis will be used to identify significant differences across the sub-groups. Additionally, researchers will use propensity score matching to identify an appropriate comparison population. Multivariate Cox regression models will be used to adjust for any differences in characteristics that may remain between the treatment and comparison cases after the matching procedure. The use of multivariate Cox regression will ensure a more accurate measurement on the magnitude of the treatment effects as compared to using propensity score matching alone.

The matching variables will include family risk factors including economic stress, caregiver mental illness, caregiver substance abuse, caregiver criminality, homelessness, and domestic violence; inception case status, which will indicate whether a family was having their first encounter with Child Protective Services or Child and Family Welfare Services; participant demographics such as race, ethnicity, age, and gender; administrative region; and case management and assessment variables such as intake type, response time, and type of abuse.

If the researcher determines that propensity score matching and multivariate Cox regression models are not feasible or inappropriate methodologies for the evaluations due to issues discussed below such as sample size and model convergence, they may use another quasi-experimental methodology such as difference-in-differences, regression discontinuity design, or instrumental variable estimation.

October 1, 2020

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Research Limitations

In scientific studies, randomized controlled trials are often considered the “gold standard” because the randomization of participants into the treatment or control group eliminates selection bias and results can be attributed to the intervention being evaluated. In the absence of experimental research designs, quasi-experimental methods are considered an appropriate scientific methodology when randomized controlled trials are not feasible. The application of randomized controlled trials to social science research may be problematic because causal effect estimations are arduous and randomized controlled trials can be expensive, unethical, or impractical. Therefore, researchers will use non-experimental research designs, like propensity score analysis, to replicate a scientific experiment when randomization is not used in the selection process.

Despite the ubiquitous use of propensity score analysis and multivariate Cox regression as non-experimental research methodologies, there are several limitations to using these statistical techniques. These methodologies do not include the ability to randomly assign individuals to a treatment or control group and require a large sample size for the evaluation. Propensity score analysis replicates a natural scientific experiment, but the methodology only adjusts for observed confounding covariates and neglects unmeasured variables, which could lead to biased results.

This study may require multiple years of service data in order to construct a sufficient sample size, and the potential of a low sample size or other model convergence problems will prohibit the construction of multivariate models for the EBP. The changes in service referral criteria or capacity over time will affect the pool of an appropriate comparison population. Moreover, in State Fiscal Year 2019, 20% of DCYF cases receiving contracted services received more than one EBP. This could potentially impact the analysis because the study may have to compare separately, exclude those cases that receive more than one EBP, or statistically adjust for multiple EBPs.

Additionally, while researchers will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative data such as a dearth of rigorous quality control method, missing or inaccurate data, timeliness of data entry, and lack of participants leading to a small sample size. These limitations may potentially impact the evaluation of CPP because they could confine the scope of the analysis, prevent the discovery of meaningful correlation, and restrict the generalizability of the study.

Fidelity Monitoring and Continuous Quality Improvement

DCYF is committed to maintaining continuous quality improvement and ensuring the effectiveness of approved well-supported, supported, and promising programs. The agency will align fidelity monitoring and continuous quality improvement of approved EBPs with other agency initiatives, in which outcome measurements, performance metrics, and data feedback loops are already established.

October 1, 2020

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DCYF will support the continuous quality improvement related to implementation of the approved prevention services by developing and implementing program monitoring dashboards to surveil quality, fidelity, and outcomes. Researchers have identified implementation metrics in collaboration with the program teams for each contract group. Researchers rely on published literature, historical data analysis, and any evaluations that are available to help identify appropriate fidelity, quality, and outcome metrics.

Table 12 illustrates fidelity measures for each of the EBPs in Table 1. It should be noted that although many of these programs identify numerous fidelity measures in the program manuals, DCYF's implementation of fidelity monitoring and continuous quality improvement will focus on those fidelity indicators (both structural and therapeutic/interpersonal) believed to be key to producing program outcomes.

Table 12. Key Fidelity Measures	
Functional Family Therapy (FFT)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Rate of meetings/progress notes • Family Self Report (FSR) and Therapist Self Report (TSR) • Rate of staffing and consultations with supervisors • Global Therapist Rating (GTR) • Family, client, and therapist exit survey
Motivational Interviewing (MI)	<ul style="list-style-type: none"> • Staff successful completion of required model training: Initial and booster • Case documentation: frequency and consistency • Case review: thorough and adequate • Counselor competence/model adherence: collaboration, evocation, and autonomy • Counselor skill demonstration: empathy
Multi-Systemic Therapy (MST)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • 24-hour availability • Services provided in family's home or other places convenient to the family • Services are intensive, with intervention sessions being conducted from once per week to daily • Caseload limit: maximum six families/year per therapist • Case length: three to five months
Nurse–Family Partnership (NFP)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio no more than 1:8 • Caseload limit: one nurse to 25 clients

October 1, 2020

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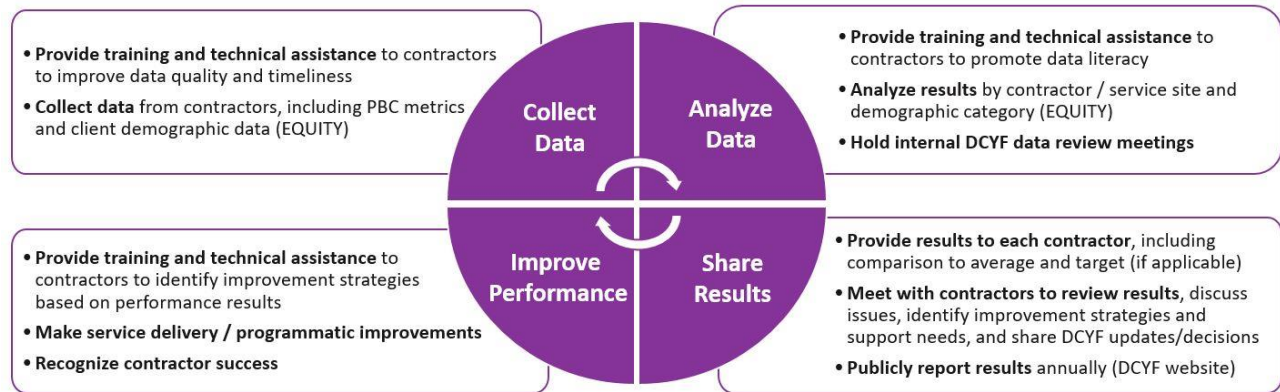
FAMILY FIRST PREVENTION SERVICES: PREVENTION PLAN

Parents as Teachers (PAT)	<ul style="list-style-type: none"> • Use of reflective supervision • Staff qualifications • Staff successful completion of required model training • Reflective supervision • Staff: supervisor ratio not more than 1:12 • Consistent use of family-centered assessment • Consistent documentation of parent goals • Consistent use of standard curriculum and visit plans • Visit completion rate • Caseload limits full-time staff to no more than 48 visits/month in first year and no more than 60 visits/month thereafter
Child–Parent Psychotherapy (CPP)	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent therapeutic content (e.g., convey hope, develop empathetic relationship with family members, etc.) • Consistent reflective practice • Consistent use of trauma framework
Homebuilders	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Staff: supervisor ratio improvement • 24-hour availability • Services provided in natural environment • Caseload limit: 1 staff member to 18-22 families/year • Supervisor availability
SafeCare	<ul style="list-style-type: none"> • Staff qualifications • Staff successful completion of required model training • Consistent use of parent–infant/child interaction assessment and training • Consistent use of home safety assessment and training • Consistent use of child health assessment and training

DCYF will implement a continuous quality improvement process, as illustrated in Figure 5, to promote fidelity, accountability, and improvement. This process will be informed through collecting data, analyzing data, sharing results, and improving performance.

October 1, 2020

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Figure 5. Fidelity Monitoring and Continuous Quality Improvement

The first phase of the continuous quality improvement process will involve collecting data from contractors while providing training and technical assistance to enhance data reporting quality. Contractors will also identify the data storage capacity, collection mechanism, and report process. During the second phase of the process, DCYF will analyze the collected data, conduct internal data review meetings, and provide additional training to contractors to encourage data literacy. DCYF will meet and share the results from the data analysis with contractors during the third phase of the process. Additionally, the agency will make the data analysis report available to the public through the DCYF website. The last step of the continuous quality improvement process will provide training to contractors to identify improvement strategies based on the results of the data analysis. This step will allow DCYF and providers to work collaboratively to validate model fidelity, determine if outcomes were achieved, recognize successes, and refine practices if necessary.

DCYF principles of effective continuous quality improvement include clear ownership, shared accountability, and transparent and inclusive processes for service improvement. The principle of clear ownership identifies the responsible parties for each step of the fidelity monitoring and continuous improvement process. Shared accountability actively engages multiple stakeholders in using data to improve services. Transparent and inclusive processes for service improvements involve regularly scheduled meetings to review outcome metrics data to understand performance and guide implementation action steps.

Waiver Request

DCYF is seeking an evaluation waiver for two well-supported practices: Nurse–Family Partnership (NFP) and Parents as Teachers (PAT). The evidence of effectiveness for these practices is compelling, and both were designated as “well-supported” by the FFPSA Clearinghouse in 2019. DCYF has contracts in place for NFP and PAT, with already established continuous quality improvement requirements with regard to practice for these two evidence-based practices. See Attachment II.

October 1, 2020

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Compelling Evidence of Effectiveness

NFP is an evidence-based community health program that generally serves low-income women who are pregnant with their first child. Each mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits. This program is designed to help families—and the communities they live in—become stronger while promoting multiple positive long-term child, maternal, and family experiences. NFP is based on rigorous evidence of effectiveness from randomized controlled trials in three locations: Elmira, New York; Memphis, Tennessee; and Denver, Colorado.^{7,8}

Taken together, these studies provide compelling evidence of the links between NFP services and several key outcomes including child safety, child well-being, and adult well-being. Among low-income first-time mothers, NFP has been found to significantly: (1) reduce child maltreatment, (2) improve parental capacity and knowledge about child development, (3) improve the long-term economic security of families, (4) reduce injury hospitalizations among children, (5) improve child development, and (6) reduce justice system involvement of children.

- 1) **Child maltreatment.** NFP has been found to reduce child maltreatment by 31%,^{9, 10} to 46.3%,¹¹ with reductions concentrated at ages 4–15.¹² Based on a review of the published research on this outcome, the Washington State Institute for Public Policy estimates an average effect size reduction of 35% in child maltreatment by age 17 in real-world implementation of NFP.¹³

⁷ Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics*, 110(1), 486–496.

⁸ Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., & Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: Age 9 follow-up of a randomized trial. *Pediatrics*, 120(4), 832–845.

⁹ Eckenrode, J., Campa, M., Luckey, D. W., Henderson, C. R., Cole, R., Kitzman, H., & Olds, D. (2010). Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Archives of Pediatrics & Adolescent Medicine*, 164(1), 9–15.

¹⁰ Miller, T. R. (2015). Projected outcomes of nurse-family partnership home visitation during 1996–2013, USA. *Prevention Science*, 16(6), 765–777.

¹¹ Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M., & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637–643.

¹² Zielinski, D. S. (2009). Child maltreatment and adult socioeconomic well-being. *Child Abuse & Neglect*, 33(10), 666–678.

¹³ 2019. Washington State Institute for Public Policy. Benefit-Cost Results: Nurse Family Partnership. <http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/35/Nurse-Family-Partnership>

October 1, 2020

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- 2) **Parental capacity and knowledge about child development.** NFP intervention is linked to improvement in maternal parenting attitudes on non-abusive and non-neglecting behaviors.^{14,15} This was based on data on home environment and parenting skills collected when the child was 6 months, one year, and two years of age.
 - 3) **Economic security.** Economic security is demonstrated by lower Temporary Assistance for Needy Families (TANF) payments and lower use of Supplemental Nutrition Assistance Program (SNAP). NFP reduces TANF payments by 5.6% for 9–12 years after childbirth and reduces SNAP payments by 9.6% for at least 12 years after birth.^{16,17,18}
 - 4) **Injury hospitalizations.** Through age 2, NFP babies have 32.6% fewer injuries that are treated in emergency departments (EDs) or through admittance to a hospital. There was a 32% reduction in ED visits for all reasons.^{19,20,21}
 - 5) **Child development.** A study by Heckman and coauthors found significant impact of home visiting programs, particularly NFP in children’s development. The positive effects of NFP persist as children grow older. By age 6, NFP participants’ children demonstrated higher cognitive skills compared to children in the control group.
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- ¹⁴ Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., & Bondy, J. (2007). Effects of nurse home visiting on maternal and child functioning: Age 9 follow-up of a randomized trial. *Pediatrics*, 120(4), 832–845.
- ¹⁵ Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M., & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637–643.
- ¹⁶ Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L. M., & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637–643.
- ¹⁷ Olds, D. L., Kitzman, H., Cole, R., Hanks, C., Arcoleo, K., Anson, E., & Stevenson, A. (2010). Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics & Adolescent Medicine*, 164(5), 419–424.
- ¹⁸ Miller, T. R. (2015). Projected outcomes of nurse-family partnership home visitation during 1996–2013, USA. *Prevention Science*, 16(6), 765–777.
- ¹⁹ Olds, D. L., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics*, 77(1), 16–28.
- ²⁰ Kitzman, H., Olds, D. L., Henderson, C. R., Hanks, C., Cole, R., Tatelbaum, R., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. *Journal of the American Medical Association*, 278(8), 644–652.
- ²¹ Sonnier, S. W. (2007). Nurse-Family Partnership-Demonstrating results, Prepared for Baptist Community Ministries. *New Orleans: Tulane University of Infant and Early Childhood Mental Health. (As cited by Miller, 2013).*

October 1, 2020

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Girls displayed stronger early socioemotional skills, including reduced aggression and increased empathy, while boys saw larger effect sizes on cognitive skills. At age 12, years after the intervention had ended, boys continued to demonstrate statistically significant improvements in cognition as well as math and reading achievement test scores. Heckman and coauthors noted that enhanced cognitive skill formation seen in boys resulted from healthier prenatal environments fostered by NFP, ultimately resulting in stronger long-term effects for boys than for girls.²²

- 6) **Justice system involvement.** Children of nurse-visited mothers are 43% less likely to be arrested, and 58% less likely to be convicted, as of age 19. They also experience 57% fewer lifetime arrests and 66% fewer lifetime convictions, as of age 19.²³

Parents as Teachers (PAT) is an evidence-based home visiting program that helps parents develop skills to raise their children and improve their health, education, and development outcomes. PAT serves families with children between 0–5 years of age. PAT entails personal visits by parent educators along with group connections, access to resource network, and screening for children.

More than a dozen outcome studies have been conducted on the effects of PAT on development and educational outcomes of the children served. Taken together, these studies provide compelling evidence of the links between PAT services and several key outcomes including child safety and child well-being. Among families with young children, PAT has been found to significantly: (1) reduce child maltreatment and (2) improve parental capacity and knowledge about child development.

- 1) **Child maltreatment.** PAT participation was related to 50% fewer cases of suspected abuse and/or neglect.^{24,25} Children served by PAT had a 22% decreased likelihood of child maltreatment compared to children not in PAT.²⁶ Based on a review of the published research on this outcome, the Washington State Institute for Public Policy estimates an average effect size of 6.1% reduction in child

²²Heckman, J. J., Holland, M. L., Makino, K. K., Pinto, R., & Rosales-Rueda, M. (2017). *An analysis of the Memphis nurse-family partnership program* (No. w23610). National Bureau of Economic Research.

²³Olds, D. L. (2007). Preventing crime with prenatal and infancy support of parents: The nurse-family partnership. *Victims and Offenders*, 2(2), 205–225.

²⁴Wagner, M., Spiker, D., & Linn, M. I. (2002). The effectiveness of the Parents as Teachers program with low-income parents and children. *Topics in Early Childhood Special Education*, 22(2), 67–81.

²⁵Drazen, S. M., & Haust, M. (1993, August). Raising reading readiness in low-income children by parent education. Paper presented at the annual meeting of the American Psychological Association.

²⁶Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. *Child Abuse & Neglect*, 79(1), 476–484.

October 1, 2020

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maltreatment in real-world implementation of PAT by age 17.²⁷

- 2) **Parental capacity and knowledge about child development.** PAT expands parental knowledge of child development and encourages positive parent–child relationships.²⁸ Children who participated in PAT scored higher on standardized tests of intelligence and social development compared to children who did not.²⁹ The parents enrolled in PAT had better scores on Knowledge of Infant Development Inventory (KIDI) and on scales of parental attitude measurement.³⁰

Continuous Monitoring

In order to implement the Fidelity Monitoring and Continuous Quality Improvement cycle illustrated in Figure 5 for NFP and PAT, DCYF contracts with the Ounce Washington to support contracted providers to achieve model fidelity and program quality. The Ounce Washington operates the statewide Implementation Hub to support a variety of home visiting programs, including the two largest in the state—NFP and PAT. The Ounce Washington Implementation Hub houses NFP and PAT model leads, along with a team of experts in the areas of home visiting, family engagement, program implementation, and implementation science. In addition, developers share data from the model-specific datasets with Washington State monthly, which allows for near real-time analysis of program implementation. The Ounce staff support NFP and PAT using a strengths-based approach and an implementation science lens and work collaboratively with grantees to alleviate programmatic barriers.

The Ounce Implementation Hub provides support to local implementing agencies on model fidelity, training, coaching, CQI, public awareness, and community engagement. It also uses various strategies including one-on-one coaching calls, site visits, group-based community of practices, and webinars to offer training and support.

The Ounce Washington provides DCYF with quarterly reports on fidelity indicators for each contracted NFP and PAT provider. In addition, DCYF receives an annual letter from the respective model developers for NFP and PAT, verifying the extent to which contracted providers have met developer fidelity standards.

²⁷ 2019. Washington State Institute for Public Policy. Benefit-Cost Results: Parents as Teachers.

<http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/118/Parents-as-Teachers>

²⁸ Wagner, M., Spiker, D., & Linn, M. I. (2002). The effectiveness of the Parents as Teachers program with low-income parents and children. *Topics in Early Childhood Special Education*, 22(2), 67–81.

²⁹ Pfannenstiel, J., Lambson, T., & Yarnell, V. (1996). The Parents as Teachers program: Longitudinal follow-up to the second wave study. *Overland Park, KS: Research and Training Associates*.

³⁰ Wagner, M., Clayton, S., Gerlach-Downie, S., & McElroy, M. (1999). An evaluation of the northern California Parents as Teachers demonstration. Menlo Park, CA: SRI International.

October 1, 2020

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Monitoring Child Safety and Risk

Pre-print Section 3

During the time period that prevention services are being offered to Family First prevention-eligible children and their caregivers, DCYF will ensure that each child receives a thorough and accurate assessment of safety and risk on a regular basis utilizing multiple safety and risk mechanisms.

Providing for child safety is part of DCYF's core mission. Decisions on child safety are based on comprehensive information, logical reasoning and analysis (not incident-based or reactionary). A focus on safety and risk must be maintained from the initial assessment through case closure using the required tools to assess, control and manage safety threats. Every caseworker will assess the safety of the child for present or impending danger at all contacts. If present danger exists the worker will take immediate protective action. A decision that a child is unsafe does not mean the child must be removed. This level of intervention is **only** justified when it is clear that child safety cannot be controlled and managed in the home.

For all families, regardless of prevention pathway, DCYF will assess safety and risk at intake. In addition, assigned case workers will assess safety and risk at designated intervals throughout the life of the case utilizing a variety of tools and practices. Tool-based assessment of safety and risk occurs through the use of the **Safety Assessment, Structured Decision Making Risk Assessment** and **Child and Adolescent Needs & Strengths Screening**.

A **Safety Assessment** is based on comprehensive information gathering and is used to identify safety threats and determine when a child is safe or unsafe throughout the life of a case. Child safety will be determined by gathering and assessing comprehensive information about a family's behaviors, functioning and conditions. A Safety Assessment will be completed at key decision points in a case to determine if safety threats exist and whether a safety plan can be developed with families to control or manage the identified threats. These key points for prevention cases include:

- All screened in Child Protective Services (Investigation and FAR) intakes (including new intakes on active cases) no later than 30 calendar days from date of intake.
- Every 90 days from the initial safety assessment on FAR cases that are left open on a Prevention Plan.
- During the completion of the Comprehensive Family Evaluation (Within 45 days of transfer to FVS and every 90 days) .
- When there is a change in household members.
- A visitor resides on the premises more than five calendar days and a child is in the home.

October 1, 2020

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- When considering case closure and new safety and/or risk factors have been identified since the most recent safety assessment was completed

The Structured Decision Making Risk Assessment (SDMRA) is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDMRA and following the Safety Assessment, the worker obtains an objective appraisal of the potential future risk to a child. The SDMRA informs when services may or must be offered.

The DCYF caseworker and community-based service providers also utilize the **Child and Adolescent Needs & Strengths – Family Screener (CANS-F Screener)** and **Child and Adolescent Needs & Strengths – Family (CANS-F)** respectively. These are trauma-informed tools that are based on a collaborative approach toward personal change.

The CANS-F Screener identifies global areas where caregiver and family support and services can increase child safety and reduce risk of abuse or neglect. The CANS-F Screener items align with the DCYF Safety Framework and the SDMRA supporting a unified approach to child safety management. The CANS-F Screener results will directly inform case planning and support case closure decisions.

The CANS-F is a comprehensive treatment planning assessment that identifies caregivers or child barriers to engaging in services and areas of focus for clinical interventions. The CANS-F includes all CANS-F Screener items, increasing alignment of work between the community-based service provider and caseworker. The CANS-F is formally assessed three times across the duration of the Family First Prevention Service: initial treatment planning, transition planning (mid-way through intervention) and end of service.

Tool-based safety and risk assessment occurs periodically throughout the life of a case and is supplemented by other ongoing assessment activities, including monthly **Health and Safety Visits with Children and Caregivers** and **Family Team Decision Making Meetings**.

Face-to-face **Health and Safety Visits with Children and Caregivers**, who have an open prevention case, provide opportunities for ongoing assessments of the health, safety, risk and well-being of those children. Regular visits increase opportunities to monitor child safety, progress with services and prevention goals. **Children that are part of prevention cases will receive private, individual face-to-face health and safety visits every calendar month.** For children age five or younger and residing in the home, two in-home health and safety visits must occur every calendar month. One of the two visits may be conducted by qualified case worker or contracted providers. The health and safety visits must occur in the home where the child resides and all parents or legal guardians must receive face-to-face monthly visits with the majority of these visits occurring in the parent's home.

October 1, 2020

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The following activities must be completed during the health and safety visit:

1. Assess for present danger per the Child Safety policy.
2. Observe all of the following:
 1. How the child or youth appears developmentally, physically, and emotionally.
 2. How the parents or caregivers and the child respond to each other.
 3. The child or youth's attachment to their parents or caregivers.
 4. The home environment, when the visit occurs in the home where the child or youth lives.
 5. The infant's sleeping environment to verify it meets the safe sleep guidelines, per the Infant Safety Education and Intervention policy.
3. Meet with the verbal child or youth in private, separate from the parents or guardians, either in the home or another location where the child or youth is comfortable. For children or youth who:
 1. Are developmentally disabled and able to communicate, but are non-verbal, refer to the DSHS 7.02 Equal Access to Services for Individuals with Disabilities administrative policy.
 2. Speak a language other than English, refer to the Limited English Proficiency policy.
4. Discuss the following:
 1. Whether the child or youth feels safe in the home or placement.
 2. The child or youth's needs, wants, and progress.
 3. How family time and visits with siblings are going.
 4. The child or youth's connection with siblings and other relatives. For youth 16 and above, this includes discussing skills and strategies to:
 1. Safely reconnect with any identified family members.
 2. Provide guidance and services to assist the youth.
 3. Maintain community and cultural connections.
 5. Services and activities needed to support transitioning youth for successful adulthood.
5. Confirm each child or youth is capable of reading, writing, using the telephone, and has a business card with the assigned caseworker's name, office address, and phone number.

A **Family Team Decision Making (FTDM)** meeting brings families and communities together with the people involved in their lives to make decisions about the placement of the child. Family Team Decision Making meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding prevention (DCYF Policy 1720 will be updated to reflect Prevention cases). These meetings provide additional opportunities to assess and plan around safety and risk, that are

October 1, 2020

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inclusive of the family's support system and the family's own expertise in what will work for their family, thus making success more likely.

The DCYF case worker will reassess, document, and make updates to the Prevention plan through-out the life of the Prevention case. The Prevention plan is a tool that the case worker to manage the ongoing case. This plan will be reviewed, at a minimum, once a month but could be more frequent given changes in the case. If at any point in time the safety or risk increases to a level where the child is no longer safe in the home, the case worker will take appropriate action to remove the child. As part of **closing the Prevention case or requesting an extension**, there will be a process for the DCYF field and headquarters leadership to review the case for closure or extension decisions.

October 1, 2020

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Consultation and Coordination

Pre-print Section 4

DCYF is committed to ensuring community engagement and stakeholder input in the implementation and expansion of FFPSA. We value meaningful engagement with our partners and the people we serve because we know we must work together to achieve the best outcomes.

DCYF conducted two rounds of **external stakeholder and partner engagement** related to expanding voluntary prevention services through FFPSA – the first occurred Nov 2018 through Jan 2019 and the second in July 2019. In both rounds of stakeholder engagement, DCYF met with stakeholders, partners and tribes around the state, holding community meetings in the eastern, central and western regions of the state. For stakeholders and partners who were not able to attend in-person meetings, the agency held a statewide webinar at the end of each round of engagement. The statewide webinar sessions, along with feedback received from both rounds of engagement, are posted on the DCYF Prevention webpage.

In order to ensure ongoing collaboration, DCYF **will continue to partner closely with** internal staff, tribes, community providers, constituents, external partners, stakeholders and different groups that represent the youth and families with whom we work. DCYF is committed to working with our existing advisory committees, not only on FFPSA but the broader agency prevention work.

Because DCYF believes that prevention can be an important **tool to address disparities and disproportionalities**, the agency has engaged the two racial/ethnic communities that primarily experience disproportionalities in Washington’s child welfare system – Tribal communities and African American communities. DCYF leaders have met with the DCYF Tribal Advisory Committee several times regarding expanding voluntary prevention through FFPSA and conducted a survey of tribes to learn about prevention practices that are embraced by their communities that DCYF should consider for funding under this opportunity. Similarly, agency leaders met with the DCYF Equity Advisory Committee twice regarding expanding voluntary prevention through FFPSA, as well as meeting with leaders in the African American community suggested by the Equity Advisory Committee. We are in continued dialogue with these two affected communities about prevention support needs and have identified specific prevention practices for evidentiary review as suggested by these two communities to address disparities and disproportionalities seen in the data and described in the lived experiences of tribal families.

DCYF contracts with a number of tribal governments for the provision of preventive services. DCYF anticipates the opportunity to expand those contracts for identified EBPs as noted above. Because the agency anticipates that the expansion of voluntary prevention services is an opportunity to address disproportionalities in Washington’s child welfare system, DCYF has and

October 1, 2020

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continues to work with tribes to seek advice about the specific services that might best meet the needs of tribal communities.

Additionally, DCYF has and continues to work with its **Equity Advisory Committee** to seek advice about the specific services that might best meet the needs of tribal and African American communities.

DCYF is also coordinating with the **Washington State Health Care Authority (HCA)**, our sister agency that provides health care through Apple Health (Medicaid), to ensure coordination of services to the greatest extent possible.

DCYF is also in the process of finalizing a program **performance improvement plan (PIP)** with the Children's Bureau. It is essential that the PIP align with the Child and Family Services Plan (CFSP), a five-year strategic plan for child welfare, as well as the FFPSA Prevention plan. We are working closely to ensure these plans not only align, but also work collectively to strengthen our overall systems. All of the plans include activities to build skills in the workforce for increased engagement with children, youth, families, and stakeholders to improve and enhance safety, permanency, and well-being outcomes. Services provided through FFPSA will increase the array of available EBPs addressing the Child and Family Services Review (CFSR) assessment and interviews that indicated limited resources for addressing mental health and substance abuse and more service availability for individualizing services to meet each child's and family's unique needs. The FFPSA plan, PIP, and CFSP provide an aligned opportunity to develop clear and consistent practice expectations for keeping children safely with their own families and ensuring needed community-based supports and services are available to strengthen families.

October 1, 2020

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Child welfare workforce support and training

Pre-print Section 5 and 6

DCYF is committed to supporting and enhancing a competent, skilled, professional and well-trained workforce and providing state agency supports to our staff throughout the state. Caseworkers receive intensive initial training when hired and ongoing training to enhance their skills. Caseworkers will also receive additional training focused on managing prevention cases.

This section outlines the training that DCYF **currently offers and new training** that will be required in the future to provide support to caseworkers and staff to: develop prevention plans, assess risk, identify needs and connect families with services to meet those needs, know how to access and deliver trauma-informed and evidence-based services and how to support families in their motivation for change.

New training modules and the expansion of existing training offerings across the state will likely require additional staff and potentially contractors, to ensure timely and effective training. Additional staffing requirements will be determined as DCYF begins implementation planning in the coming months.

Professional development for public child welfare workers, including tribal child welfare workers who choose to participate and those caring for children in out-of-home care, is primarily provided by the Alliance for Child Welfare Excellence. The Alliance also provides core training to foster, relative and adoptive caregivers. The Alliance brings together the University of Washington and Eastern Washington University to collaborate on improving the professional expertise of the state's child welfare workers and the skills of those caring for adoptive and foster children.

Currently, new caseworkers complete an **8-week competency-based program**, which utilizes a blended learning methodology that includes: eLearning activities, in-person classes, learning labs and field activities designed to equip caseworkers with the essential knowledge and skills needed to provide quality casework. Over 100 different in-service eLearning's, classroom courses and coaching opportunities are offered to **support skill development in child welfare case practice, trauma-informed care, staff supervision, and managing and leading child welfare programs** (www.allianceforchildwelfare.org/course-catalog). DCYF closely monitors the Alliance training plan through the Annual Progress and Services Report that is submitted to the federal government at the beginning of the state fiscal year.

New employees must complete all classroom sessions and field-based learning in order to complete the regional core training (RCT) and be eligible to carry a full caseload. RCT consists of a cohesive developmental curriculum in which knowledge and skills are broadened and deepened. RCT provides participants with blended learning opportunities, including classroom instruction, transfer of learning activities in the field and 1:1 or small-group coaching.

October 1, 2020

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The Alliance curriculum developers have **integrated trauma-informed principles** in several course curricula for child welfare workers and supervisors' that focus on awareness, prevention, planning and wellness balance. Current and proposed trainings provide foundations for understanding the impacts of trauma, including Adverse Childhood Experiences (ACEs) and skill-building opportunities in our approach to working with staff, parents, children and caregivers. Below are a few references utilized in developing curricula:

- Center for advanced studies in child welfare: School of Social Work, University of Minnesota. (2013) CW360-a comprehensive look at a prevalent child welfare issue: Trauma-informed child welfare practice.
- Childhood trauma: Changing Minds. Gestures that can heal. Retrieved November 21, 2016, <https://changingmindsnow.org/healing>
- Child Welfare Information Gateway. Resources on Trauma-Informed Care for Caseworkers. <https://www.childwelfare.gov/topics/responding/trauma/caseworkers/>
- Hermann, Judith. (1997) *Trauma and recovery: The aftermath of violence-from domestic abuse to political terror.* New York: Basic Books.
- The National Child Traumatic Stress Network. (2013). Birth parents with trauma histories and the child welfare system.
- The National Child Traumatic Stress Network. (2008). Child welfare trauma training toolkit-comprehensive guide-2nd edition.
- The National Child Traumatic Stress Network (2012). The 12 core concepts for understanding traumatic stress responses in children and families.
- Smyth, Nancy. (2017) Trauma informed care: What is it and why should we care? Social worker helper. <https://www.socialworkhelper.com/2017/01/27/trauma-informed-care/>
- CWLA. Birth Parent Trauma and What Child Welfare Workers Need to Know. 5-14-2015. <https://vimeo.com/127943492>

In addition to the required training, as part of implementation, staff and supervisors who manage prevention cases will receive additional required training to cover the new requirements associated with FFPSA Prevention cases. DCYF will provide training and support for caseworkers in **assessing needs, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services and overseeing and tracking the continuing appropriateness of the services.** Additionally, training will be provided on how to develop the formal prevention plan, determine candidacy correctly, how to conduct prevention planning in a high-quality manner and how to use prevention plans in conjunction with the case plan; how to determine which prevention services are needed to address the needs of the family and how all these pieces fit together to best support the families.

In addition to mandatory training, supporting materials to assist workers with managing the Prevention caseloads will also be developed. There is currently a tool which aids cases workers in learning about available services for our families, and we will develop and/or expand training and tools specific to the services available that meet FFPSA requirements.

October 1, 2020

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Ongoing coaching is critical to making and sustaining the Prevention work. We will also work closely with our Continuous Quality Improvement (CQI) staff to ensure that they have the proper training needed to provide ongoing coaching and support.

As discussed in Section 1 of this document, DCYF will progressively **train DCYF workers and Family First Prevention Community-based Service providers in Motivational Interviewing (MI) to develop child-specific Prevention plans**. Family engagement is a key factor to facilitate successful connections and coordinate to provide services. Motivational Interviewing will be incorporated as a part of a comprehensive DCYF practice model in alignment with utilization of the Child and Adolescent Needs & Strengths – Family Screener (CANS-F Screener) and Child and Adolescent Needs & Strengths – Family (CANS-F). DCYF will employ a phased training approach initially focusing on the caseworkers managing FFPSA prevention cases. In consultation and collaboration with the University of Washington-Alliance for Child Welfare Excellence, DCYF will train its prevention workforce with MI with fidelity monitoring.

The principles of **reflective supervision are embedded in child welfare worker and supervisor specific courses** to help workers and supervisors build caseworkers' capacities to interact with families in a trusting and psychologically safe manner (the parallel process).

Reflective supervision is based on relationship, reflection and support. Reflective supervision is defined as the “regular collaborative reflection between a service provider (clinical or other) and supervisor that builds on the supervisee’s use of her thoughts, feelings and values within a service encounter.” The key elements of reflective supervision are:

- Reflection: asking and reflecting on what staff observe, think and feel
- Collaboration: developing the partnership
- Regularity: scheduling meeting times on a regular basis.

In May 2019, the Alliance launched a pilot course for supervisors in Debriefing with Good Judgement, an approach to feedback grounded in reflective supervision. The course itself takes place across several months and includes four components (an eLearning, two classroom sessions and an interactive webinar). The design provides time to practice skills both in the classroom and on the job, to reflect on their experiences and try it again.

Washington recognizes the importance of an effective practice model that is grounded in the values, principles, relationships, approaches and techniques that support timely achievement of safety, permanency and well-being outcomes and provides the foundation to develop a more competent and supported workforce. **Our practice culture will be transforming over the next several years**, and it will be critical that FFPSA and any changes to our practice model are aligned and supportive of the other.

October 1, 2020

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Adoption of a consistent practice model that is trauma-informed, safety-focused, family-centered, culturally-competent and creates consistency and accountability in child welfare practice is foundational to our work. As part of the Child and Family Services Plan (CFSP) and Program Improvement Plan (PIP), DCYF is committed to strengthening support for the current model or identifying and implementing a new practice model. To achieve this, we are hiring a dedicated full-time position to lead the process of reviewing the current practice model and assessing for potential change.

October 1, 2020

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Prevention caseloads

Pre-print Section 7

As Washington transitions towards implementation of Family First, impacts on our caseworkers and their caseloads are very much at the forefront of agency planning for staff readiness. Overseeing caseload size and type is essential. Manageable caseloads and workloads can make a significant difference in caseworkers' ability to spend adequate time with children and families to complete critical case activities and ultimately, have a positive impact on outcomes for children and families.

Currently, DCYF does not have a set ratio of cases by type for frontline caseworkers. Field office supervisors monitor caseloads to ensure that sizes are appropriate. The supervisors use a Workload FTE Summary Report and look at the workers' caseloads in FamLink. Agency policy requires that the supervisors review every case with the caseworkers monthly and provide supervision and guidance. This ensures they are very aware of caseload and can address any issues or concerns quickly.

Prevention caseloads require extensive case planning and on-going management throughout the life of the prevention case. For purposes of this five-year plan, DCYF has identified that all Family Voluntary Services (FVS) workers, and the identified pilot Family Assessment Response (FAR) workers, will have a prevention caseload standard of 1:15 children (max 1:18). As we implement the other candidacy groups, we will reassess the caseload standards and adjust based on appropriate size. For example, some case workers may be holding a mix of prevention and non-prevention cases; therefore, their prevention caseload size would be much smaller.

Starting in 2019, all Intake and Child Protective Service workers were added into the maintenance level forecast process. This forecast was established to maintain current funding levels to ensure adequate funding continues. The technical workgroup determined the stepping off point as a combination of historical averages and static caseload ratios. Intake workers had a historical average of 111 intake calls per intake worker and CPS workers had a historical average of 8.6 screened-in intakes per CPS FTE. This forecast was developed with the expectation that cases turn over at the same speed in the future as they have historically.

Expansion of service delivery would likely impact the forecast for CPS workers generally and FAR workers specifically. The current forecast would not adjust to extended case length, because the only changeable variables are measured in the incoming volume and not the currently held volume. Consequently, there is additional work that needs to occur in order to set a caseload standard for prevention cases. We need to do additional analysis on the data to better understand the impacts on workloads and bargain with the union.

We will continue to monitor and oversee caseload standards through ongoing CQI practices as well as regular agency-wide performance monitoring activities using reports and supervision.

October 1, 2020

Approved for distribution by Secretary Ross Hunter

October 1, 2020

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Assurance on prevention program reporting

Pre-print Section 8

The Department of Children, Youth, and Families provides an assurance in Attachment I that DCYF will report to the Secretary required information and data with respect to the provision of services and programs included in Washington's title IV-E Prevention Plan. This will include data necessary to determine performance measures for the state and compliance. Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019. See Attachment I, State Title IV-E Prevention Program Reporting Assurance.

October 1, 2020

Approved for distribution by Secretary Ross Hunter

Plan Submission Certification

Title IV-E Plan – State of Washington

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I, Secretary Ross Hunter, hereby certify that I am authorized to submit the Title IV-E Plan on behalf of Washington State. I also certify that the Title IV-E Plan was submitted to the governor for his review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date: July 31, 2020



(Signature)

Ross Hunter
Secretary

Washington State Department of Children, Youth, and Families

APPROVAL DATE:

EFFECTIVE DATE:

(Signature, Associate Commissioner, Children's Bureau)

October 1, 2020

Approved for distribution by Secretary Ross Hunter