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DEPARTMENT OF CHILDREN, YOUTH & FAMILIES FAMILY FIRST PREVENTION SERVICES ACT (FFPSA) PREVENTION PLAN



Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Vision for Prevention

The Department of Children, Youth, and Families' (DCYF) 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."

The agency's guiding principles include:

- A relentless focus on exemplary 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 and contracted providers as they contribute to the agency's goals and outcomes.

Legislative Impacts

DCYF's founding legislation, [HB 1661](#), is clear about prevention being one of the priority reasons the DCYF 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, DCYF established a set of principles in 2018 to guide the agencywide approach to prevention.

As a state agency founded on a commitment to expanding prevention opportunities, DCYF expects to substantially expand prevention and early intervention opportunities all along its service continuum. FFPSA Prevention is one important tool in our toolbox to accomplish this – the agency's plans consider how the FFPSA-funded services for approved candidacy groups will complement existing agency prevention efforts.

House Bill 1900: Maximizing federal funding for prevention and family services and programs was passed in 2019 in Washington state to focus on enhancing prevention services for various issues, including mental health and substance abuse. It aimed to improve access to preventive care and support systems, particularly for vulnerable populations. The bill sought to allocate resources more effectively, strengthen community-based programs, and coordinate efforts between different agencies to better address and reduce the prevalence of mental health and substance use issues before they escalate.

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House Bill 1227: In 2021 the Washington state Legislature passed [House Bill 1227](#): Keeping Families Together Act in recognition that children and families are best served when children are cared for by their loved ones in their communities. Significant statutory changes included in the Keeping Families Together Act including raising the legal standard for child removal and balancing the threat to safety versus the harm of removal. Prevention services were defined in state law under RCW 13.34.030:

“Specific mental health prevention and treatment services, substance abuse prevention and treatment services, and in-home parent skill-based programs that qualify for federal funding under the federal Family First Prevention Services Act, P.L. 115-123. Courts must consider whether there are available prevention services or supports that would eliminate the need for removal while the family continues under court jurisdiction, and if the parent agrees to participate in those services, the law requires the court to order that the child return/remain home.”

Building Community-Based Pathways

Part of DCYF’s five-year prevention plan includes creating and delivering Family First prevention services through community-based pathways. A community-based pathway provides families with high-needs who are adjacent to the child welfare system with prevention services, approved within this plan, in their own communities. These are services that improve safety, health, and well-being.

Services through community-based pathways are less coercive, offer services funded by Title IV-E, and allow families to connect with neighborhood resources and supports without requiring system involvement. To increase accessibility, build trust, and ensure relevance within communities, DCYF will leverage partnerships with local community organizations, Family Resource Centers (FRC), and the expanding Plan of Safe Care (POSC) pathway.

In a [July 2023 policy analysis report](#), Chapin Hall explored Washington state’s current policy landscape, identified promising practices from other jurisdictions, compared alternative methods of pursuing community-based pathways, and made recommendations to DCYF in alignment with key decision-making criteria, including cost, implementation timeline, and alignment with other system-change initiatives. DCYF is using this Chapin Hall report, as well as ongoing partnership with Chapin Hall, to design this service delivery type. DCYF community-based pathways will emphasize a voluntary framework for accessing services, reducing perceived coercion, and building trust, and will include eligibility standards based on family risk factors and service needs to make prevention services accessible to a broader range of families who are adjacent to the child welfare system and have high needs.

Community-based pathways present an opportunity for Washington state to positively meet the high-risk needs of children, youth, and families adjacent to the traditional child welfare

service delivery and case management context. Further, DCYF will implement data collection and evaluation mechanisms to evaluate outcomes and refine services over time. The community-based pathways' cost-effectiveness and feasibility will be reviewed regularly to ensure it stays within the DCYF budget and timeline, as recommended by the Chapin Hall report. Further details around community-based pathways are included in additional sections throughout the Five-Year Prevention Plan.

Section 1. Service Description and Oversight

Throughout Washington, communities and the child welfare system have utilized prevention services to prevent and mitigate child maltreatment. Washington state child-serving agencies, including the legacy agencies that formed DCYF in 2018, have long implemented evidence-based practices (EBPs) as a part of their service arrays. In 2012, Washington state enacted [House Bill \(HB\) 2536](#), requiring that state agencies serving children move toward greater use of EBPs in their service portfolios. Since 2012 the Washington State Institute for Public Policy (WSIPP) has published updated evidentiary reviews and inventories of practices used by child-serving agencies in the state, including DCYF, both in direct services and in contracts.

RCW 74.14A.025 informs mental health and disability service provision by articulating focus on services that meet the needs of individuals and families with dignity and respect. The state supports community-based prevention, outcome-based measures to assess progress, and customer service that empowers staff to deliver high-quality, respectful services.

Applying many of the EBPs included in the Five-Year Prevention Plan is not a new concept, but many rural and smaller communities still struggle to get the resources necessary to deploy EBPs at scale. Many EBPs are currently delivered through braided funding from a variety of sources, such as Medicaid, grants, and state and federal funding. This section describes Washington's strategies for the initial and subsequent selection of EBPs to further the implementation of the Title IV-E Prevention Program established through FFPSA.

The selection criteria for an EBP to be included in this Five-Year Prevention Plan was based on current infrastructure within Washington and current or prior implementation. As Washington continues to grow the prevention service array, DCYF will implement a future process for reviewing additional EBPs to be added to the Five-Year Prevention Plan through amendments. DCYF will utilize several criteria to select further EBPs for Washington's population, the target population to include in the prevention state service array, including:

- The extent to which the EBP meets priority needs among approved candidacy groups
- The extent to which the EBP is currently being used by DCYF or within communities throughout Washington
- DCYF capacity for the federally required implementation, evaluation, and Quality Assurance/Continuous Quality Improvement (QA/CQI) supports of the EBP

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- The qualifications of those who would be delivering the EBP
- The eligibility requirements of the EBP
- Whether the EBP was effective at serving eligible populations at greatest risk of maltreatment
- The amount of support provided by the purveyor of the EBP and community partners

In addition, DCYF utilizes the Washington State Institute for Public Policy for data-driven reviews to understand effectiveness of EBPs and assess economic impact and value for investment.

Choosing EBPs by Assessing Needs and Service Gaps

A service array that meets the needs of those served is an essential part of every system of care. The array must include effective, adequate and available services that:

- Assess the strengths and needs of children and families
- Determine other service needs
- Address the needs of families in addition to individual children to create a safe home environment
- Enable children to remain safely with their parents when reasonable
- Help children in foster and adoptive placements achieve permanency

In 2024, DCYF contracted with Public Consulting Group (PCG) to review current services, research best practices, and engage with those affected to understand the existing service framework and identify issues related to access and engagement. This helped create a framework that aligns with DCYF’s goals for service delivery across service lines.

That [report](#) recommends several key actions to enhance services and DCYF is working to develop applicable and actionable strategies to ensure that the services provided will lead to positive outcomes for children and families.

Funding is another key component of choosing and implementing EBPs. DCYF can leverage Title IV-E Prevention funding when other funds do not cover all components of an EBP or when a recipient does not qualify for services through other funding sources. The Title IV-E prevention services funding is the “payer of last resort” as required by FFPSA. Other payers for services may include Medicaid, individual insurance plans or similar safety-net funding sources.

Concrete Goods as Prevention

Loss of income, material hardship, and housing instability are among the most reliable predictors of child welfare systems involvement. In Washington state, RCW 26.44.020 outlines that poverty and experiencing homelessness does not constitute negligent treatment or maltreatment in and of itself. Washington state has made a commitment to address

intergenerational poverty and promote self-sufficiency through the establishment of the [Poverty Reduction Taskforce](#) under [HB 1482 2018 Legislative Session](#).

Concrete supports and services are a well-evidenced child welfare protective factor that are used across DCYF to help alleviate the various financial challenges that contribute to abuse and neglect. For families with an active child welfare case, DCYF assesses the family's capacity to meet basic needs as well as their knowledge of and access to community supports. The agency uses a mandated distribution model to ensure families have access to short-term assistance while assisting with referrals to community-based resources for ongoing support. In the provision of EBPs, DCYF has a long-standing practice of supplementing contracted evidence-based, in-home parenting programs with flexible funds for concrete goods and services. Additionally, DCYF implements community-based concrete goods programming in its Division of Partnership, Prevention, and Services (PPS), distributing economic assistance to thousands of low-income families across Washington through nonprofit organizations.

DCYF will continue to implement concrete supports and services and utilize administrative reimbursement through child-specific allowable activities including, but not limited to, childcare, transportation and peer navigation, to support a family's ability to participate in services and change efforts.

Continuous Quality Improvement

In implementing Quality Assurance (QA)/CQI supports for the approved EBPs contained in this plan (see QA/CQI plan in Appendix A), DCYF will leverage fidelity monitoring and CQI of approved EBPs in which outcome measurements, performance metrics, and data feedback loops are already established. Currently DCYF supports CQI related to implementation of the approved prevention services by:

1. Implementing a provider data dashboard to monitor quality, fidelity, and outcomes.

[Performance-Based Contracting \(PBC\)](#) is the tool DCYF uses to strengthen and improve the quality of contracted services and provide support to programs and providers. DCYF has created an agencywide PBC standard that guides programs to become more data-driven and to focus on the outcomes for the children and families they serve.

To do this, DCYF's Office of Innovation, Alignment and Accountability (OIAA) is developing PBC data dashboards for each contracted service array and service provider. To meet the standard, all contracts for client services must include measurements of provider services, quality, and outcomes:

- Services: Services or products delivered to clients by service providers
- Quality: Services delivered in a way that increases the likelihood of positive outcome achievement for all clients
- Outcomes: Results of high-quality services being delivered to clients by service providers

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DCYF's OIAA is producing PBC data dashboards that will be publicly available and will permit visibility and accountability on services, quality, and outcomes for the two EBP service arrays that contain all the EBPs included in this plan: The Combined In-Home Service Array and the Home Visiting Service Array.

- DCYF's Combined In-Home Services PBC data dashboard allows service providers to use PBC as a tool for continuous improvement for their own monitoring. The dashboard combines service referral, payment, Child and Adolescent Needs Strengths-Family Assessment (CANS-F) assessment, and outcome data to provide insights into the number of services provided, the people who receive them, the completion of required CANS-F assessments, and overall child outcomes. DCYF will be transitioning to the Family Advocacy and Support Tool (FAST).
- DCYF's Home Visiting PBC data dashboard will similarly allow service providers to use PBC as a tool for continuing improvement. The home visiting data dashboard will combine service referral, service delivery, assessment, and outcome data to provide insights into the number of services provided, client information, service dosage, completion of required assessments, and overall child and family outcomes.

2. Maintaining consultant contracts to support EBP fidelity.

EBP fidelity monitoring as well as training and consultation are well established within DCYF through several contracts with model developers, highly skilled and experienced consultants, and certified trainers. These contracts provide the necessary supports for both newly trained and seasoned EBP practitioners to receive ongoing consultation and fidelity oversight to maintain their fidelity status as well as new sites/agencies in their implementation of a new model.

There is also a built-in framework to support providers who are not maintaining fidelity through Quality Assurance plans that are specific to the EBP model, to get them back on track. DCYF believes that a robust infrastructure of high-quality training and fidelity monitoring has a positive impact on the quality of services delivered to children, youth, and families.

3. Establishing an agencywide Quality Assurance & Continuous Quality Improvement Framework.

[This framework](#) was developed by DCYF in July 2023. It defines quality assurance as activities to ensure quality requirements are fulfilled and continuous quality improvement as activities to improve practice and performance.

4. Implementing a prevention data dashboard to support the agency's efforts to prevent child maltreatment.

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The [DCYF Prevention Dashboard](#) consists of aggregated descriptive data requested by Washington Strengthening Families Locally about characteristics and trends of children and families involved in the state's child welfare system to help inform local prevention planning efforts.

5. Implementing an agency performance page that tracks nine population-level outcome goals for DCYF related to the resilience, education, and health of children, youth, and families.

This agency performance page tracks outcome goals and supporting strategic priorities that are essential to the agency's work. Data from five of these outcome goal indicators can be found in Appendix C.

Section 2. Evaluation Strategy and Waiver Request

DCYF will evaluate approved EBPs (including process and outcome measures) except for those that are waived for evaluation based on their well-supported status and waiver submission. Findings from these evaluations will contribute to the evidence base of each respective program while supporting the agency toward being data-driven and outcomes-focused in its programmatic decisions. DCYF will work with program administrators to develop contracts that prioritize adherence to fidelity and data collection.

The primary responsibility for program evaluation will be assigned to a dedicated evaluator in the Office of Innovation, Alignment and Accountability (OIAA), as well as specialized evaluation contractors, if needed, who will collaborate with program managers to determine the timeline, data collection process, implementation process, research questions, outcome metrics, operationalization of outcome measures from the child welfare data source system, analytical procedures, limitations, responsibilities, and evaluation dissemination. The evaluation strategy for these EBPs will be conducted through quantitative analysis using quasi-experimental designs with a comparison group whenever feasible. Evaluation plans for each EBP can be found in the corresponding EBP section (Appendix A).

Each evaluation will measure whether programs contribute to preventing children from entering out-of-home care, which is the primary purpose of this plan and the agency's FFPSA efforts. DCYF will use the opportunity to evaluate each program to determine and then monitor the extent to which the agency's prevention services produce positive outcomes for the children, youth, and families it serves.

DCYF is submitting Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice for the following well-supported services for which the evidence of the effectiveness of the practice is compelling: Nurse Family Partnership, Parents as Teachers,

Functional Family Therapy (FFT) Motivational Interviewing (MI) Multi-Systemic Therapy (MST), Homebuilders, and Parent-Child Interaction therapy (PCIT).

DCYF strives to maintain a high degree of model fidelity for well-supported, evidence-based practices. Quality assurance and continuous quality improvement plans for MI, FFT, Homebuilders®, MST, Nurse Family Partnership, Parents as Teachers, and PCIT can be found in Appendix A.

Section 3. Monitoring Child Safety in Child Welfare

During the period that prevention services are being offered to Family First Prevention eligible children and their caregivers with an open child welfare case, DCYF will provide each child with an assessment of safety and risk utilizing multiple tools at regular intervals throughout the life of the case.

Providing for child safety is core to DCYF’s mission. Decisions regarding child safety are based on comprehensive information, logical reasoning and analysis, and global, rather than incident-based, assessments. The focus remains on safety from the initial assessment through case closure. The agency-approved Safety Framework is used to gather, assess, analyze, and plan for present and impending danger threats as well as to assess for risk of future abuse or neglect.

Every caseworker assesses the safety of the child for present or impending danger at all contacts. If present danger exists, immediate protective action is taken. If a child is experiencing impending danger and identified as unsafe, DCYF caseworkers engage families in safety planning to prevent out-of-home placement. Out-of-home placement is only justified when there is an active safety threat that cannot be controlled or managed with an in-home safety plan.

DCYF utilizes a standardized framework, referred to as the Safety Framework. The Safety Framework includes various assessment-based tools, such as the Safety Assessment or Structured Decision-Making Assessment, that inform and guide caseworkers through the decision-making process.

Child safety is determined by gathering and analyzing comprehensive information on the family, such as their behaviors, conditions and overall functioning. If a child is determined to be unsafe, the Safety Framework will assist the caseworker in determining whether an in-home safety plan can mitigate the threats to child safety, or if an out-of-home plan is necessary.

Assessments of families provide a greater understanding of how their strengths, needs, and protective factors impact child safety, well-being, and permanency. The Structured Decision-Making Risk Assessment (SDMRA) assists the caseworker in obtaining an objective appraisal of the risk to a child and informs when services may be appropriate or required by policy.

The Safety Framework not only informs and guides child-safety related decisions, but it also provides precise language and clear definitions, strengthens child safety assessment and planning, and guides appropriate placement decisions.

Child welfare involved candidacy populations receiving an evidenced based practice will also receive the Child and Adolescent Needs Strengths-Family Assessment (CANS-F) during their service delivery per the contracts. In 2026 DCYF is updating this assessment to the Family Advocacy and Support Tool (FAST). Both tools are part of the Transformational Collaborative Outcomes Management (TCOM) and assess the strengths, needs, safety and risk of families.

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 Shared Planning Meetings, which occur at critical decision points throughout the life of a case and utilize a shared decision-making model.

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 aged five or younger and residing in the home, two in-home health and safety visits must occur every calendar month. Important elements of health and safety visits included but are not limited to ongoing assessment of safety and immediate response to present danger. Caseworkers conduct visits with verbal children in private and in a location where the child or youth feels comfortable. For children or youth who experience a developmental disability impacting their verbal communication, caseworkers refer to the DCYF Administrative Policy 6.03, Access to Services for Individuals with Disabilities. If the child or youth speaks a language other than English, caseworkers make use of the resources described in the DCYF Administrative Policy 6.02, Access to Services for Clients and Caregivers who are Limited English Proficient (LEP).

During health and safety visits, caseworkers will note the child or youth development, physical, and emotional well-being as well as the interactions between the child or youth and their primary caregiver(s). Additionally, caseworkers should assess parent-child relational health, attachment, and attunement as well as the home environment. For infants, caseworkers ensure a safe sleeping environment as identified in the DCYF Infant Safety Education and Intervention Policy.

Discussions during these visits help the caseworker's assessment of the child or youth's perception of safety in the home and evaluation of family and individual strengths and needs. Caseworkers discuss the family's community and meaningful connections, supports for emerging adulthood, and community-based resources like behavioral health treatment and concrete goods, including diaper banks and clothing closets.

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A Family Team Decision Making meeting brings families and their support networks together to make decisions about the placement of child or youth. 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 of out-of-home placement. These meetings provide additional opportunities to assess and plan around safety and risk that are inclusive of the family's support system and the family's own expertise in what will work for their family, increasing the likelihood of success.

The DCYF caseworker will reassess, document, and make updates to the prevention plan throughout the life of the Prevention case. The prevention plan is a tool that the caseworker will use to manage the ongoing case. This plan will be reviewed with the family, at a minimum, once a month but could be more frequently given changes in the case. If at any point in time a child is identified as unsafe with the inability to safety plan, caseworkers will take appropriate action to ensure child safety either through a Voluntary Placement Agreement, a petition requesting the court order in-home services with court oversight or an out-of-home placement, or in collaboration with law enforcement in the event a child is taken into protective custody.

Decision-points for Prevention case closure or extension will be discussed with the family and presented to the court in instances of in-home court ordered Prevention services cases.

Prevention cases can be extended with family agreement and court approval (if applicable) if there is an ongoing need for services.

Community-Based Prevention Pathway

Community-based pathway prevention service providers will assess and monitor child safety and risk through the delivery of the in-home service intervention. The in-home service delivery models that include specific assessment of safety and risk include Nurse Family Partnership, Family Spirit, Parents as Teachers, Homebuilders, Functional Family Therapy, SafeCare and Parent Child Interaction Therapy.

Nurse-Family Partnership (NFP) assesses child safety and risk through a systematic, relationship-based approach using the STAR (Strengths and Risks) Framework, continuous nursing assessment, developmental screenings, and addressing key risk areas (intimate partner violence, substance use, and mental health) in private, all while empowering mothers with education on child development, care, and protective factors, with mandatory reporting protocols in place for serious concerns.

Nurse-Family Partnership (NFP) evaluates child safety and risk through a structured, relationship-based approach that uses the STAR (Strengths and Risks) Framework, ongoing nursing assessments, and regular developmental screenings. Nurses privately address key risk areas, such as intimate partner violence, substance use, and mental health, while also educating mothers about child development, caregiving, and protective factors. Throughout the

program, mandatory reporting protocols guide responses to serious safety concerns, ensuring risks are identified early and families receive the support they need.

Family Spirit assesses child risk and safety through ongoing, culturally-rooted home visits by trained health educators who deliver a strengths-based curriculum, teaching parenting skills, monitoring child development (physical/behavioral), checking in on maternal well-being (stress, substance use), and identifying resources for food/safety, all while building strong family rapport to promote healthy environments and identify concerns early. They use validated tools, observations, and family input to ensure children are safe and developing well, addressing risks like poor nutrition or maternal stress before they escalate. In Washington State each Family Spirit affiliate provides proximate home visiting tailored to the community they serve, and the model developer requires a standardized tool to be utilized in service delivery.

Parents as Teachers (PAT) supports child safety by embedding safety assessment into its core components: personal visits, where parent educators observe and partner with caregivers; annual child screenings that monitor health and development; and a strong resource network that connects families to needed services. Throughout these components, PAT emphasizes early identification of concerns such as potential abuse or neglect and empowers parents to recognize risks, strengthen protective factors, and promote healthy development, ultimately helping families stay safer through knowledge, guidance, and support.

Homebuilders practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment through the use of the North Carolina Family Assessment Scale (NCFAS). Homebuilders practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety.

Functional Family Therapy (FFT) provides ongoing assessment of child risk and safety by closely examining family interactions and understanding the purpose behind behaviors, for example, seeking attention or avoiding conflict. The model builds on family strengths through a phased process that begins with engagement, moves into motivation, and then evaluates specific relational patterns such as communication and conflict. Providers introduce targeted skill-building in areas like parenting and communication and help families apply these skills in real-life situations to make changes sustainable. Throughout the process, FFT continually monitors risk factors such as substance use or delinquency while strengthening protective factors like positive parenting and supportive relationships.

SafeCare delivers ongoing risk assessment through in-home, module-based training that helps parents build practical skills in child health, home safety, and parent-child interaction. Providers

teach caregivers how to recognize and respond to risks such as early signs of illness, household hazards, and low engagement, while monitoring progress through structured skill criteria and hands-on practice to strengthen families’ ability to prevent neglect and abuse.

Parent-Child Interaction Therapy (PCIT) evaluates child risk and safety through live coaching that strengthens positive parent-child interactions. Providers observe warmth, attachment, and appropriate responses during play, use tools such as the Child Abuse Potential Inventory (CAPI), and watch for both protective capacities and signs of maltreatment in real time, often through recorded play sessions. They also assess caregiver stress and mastery of core skills, such as giving effective commands during the parent-directed interaction phase, to ensure safety and support the development of a secure, healthy parent–child bond. The emphasis is not only on identifying danger, but on building strong, positive interaction skills.

The EBP models that do not require a specific risk and safety assessment during the service intervention will be contractually obliged to utilize the Family Advocacy and Support Tool (FAST). FAST is an assessment tool designed to identify strengths, needs, risks and safety factors impacting the family. The FAST is delivered at the beginning of the service intervention and updated periodically whenever a change of circumstances occurs with the family. The tool is updated at the conclusion of service delivery as well to demonstrate progress and goal attainment. The evidenced based practices that will include this tool will include Motivational Interviewing, Promoting First Relationships, Incredible Years, Child Parent Psychotherapy, and Triple P. In addition, these interventions include mandatory reporting protocols that will guide responses to serious safety concerns, ensuring risks are identified early and families receive the support they need.

Multi-Systemic Therapy (MST) is solely delivered to our JR and Juvenile court candidacy populations who already utilize the Integrated Developmental Evaluation and Assessment (IDEA) and the Positive Achievement Change Tool (PACT) respectively to assess and monitor youth safety and risk. MST will not be delivered to our community pathway candidacy population.

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The authority to deliver community-based prevention services is established under RCW 74.13.903 and further defined in RCW 74.13.020, which guide the scope and delivery of services within the prevention pathway. DCYF maintains responsibility for ensuring compliance and fidelity to these requirements throughout the duration of service provision.

Practice Innovation

DCYF is exploring the utilization of the North Carolina Family Assessment Scale-General + Reunification (NCFAS-G+R) for caseworkers managing prevention cases. The NCFAS-G+R is an assessment tool designed to examine family functioning in the domains of:

- Environment
- Parental Capabilities

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- Family Interactions
- Family Safety
- Child Well-Being
- Social/Community Life
- Self-Sufficiency
- Family Health
- Caregiver/Child Ambivalence
- Readiness for Reunification.

The NCFAS-G+R has 70 subscales for these 10 domains. Each of the NCFAS-G+R scales provide an organizing framework for caseworkers to conduct a comprehensive family assessment intended to inform the development of a prevention plan and subsequently document changes in family functioning that happen as a result of services that are provided.

If adopted, the NCFAS-G+R will be completed by the caseworker after gathering information necessary to confidently assign ratings on the level of functioning on each subscale, then assigning a rating to each of the overarching domains that comprise the subscales. Caseworkers will conduct an initial, interim, and closing assessment to compute score changes between pre-intervention and post-intervention levels of functioning. Caseworkers utilize Motivational Interviewing throughout the case. DCYF is piloting the utility of this tool with small groups of caseworkers throughout 2024 and 2025.

Section 4. Consultation and Coordination

DCYF has a structure and environment that supports collaborating, coordinating, and partnering with a wide variety of internal and external partners, Tribes, courts, youth, parents, caregivers and community collaborators. DCYF engages partners in a continuous improvement cycle by encouraging and facilitating ongoing, year-round engagement to successfully implement the provision of prevention services.

Tribal Engagement

Washington state recognizes the distinct heritage and legal status of tribal governments. American Indian tribes are recognized as sovereign nations that have the authority, among other things, to govern their own people and their land, and define their own Tribal membership criteria. To honor this sovereignty, DCYF follows a government-to-government Tribal relationship in seeking consultation and follows the Washington Governor's Office of Indian Affairs [Centennial Accord](#) and the [New Millennium Agreement](#).

Throughout the development of the Prevention Plan, DCYF regularly engaged Tribal Nations by hosting government-to-government Tribal Consultations and utilizing the DCYF Child Welfare Tribal Policy Advisory Committee to solicit input on the development of the Title IV-E

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Prevention Program. The Tribal Policy Advisory Committee convened in the summer of 2024 followed by two Tribal roundtables, an ICW Subcommittee meeting and a Tribal Listening Session. [In these forums](#), DCYF presented on the importance of including Tribal voice and requested feedback on the development of eligibility standards so that items listed within this plan meet the needs of Tribal communities. Further, DCYF attained feedback from Tribal Nations on Tribal specific prevention services, eligibility, the Washington state Indian Child Welfare Act, and Title IV-E agreement opportunities to include within this Five-Year Prevention Plan.

Since the approval of the 2020-2024 Five-Year Prevention Plan, DCYF worked with a Native researcher at the University of Washington Indigenous Wellness Research Center who produced an evidentiary [review](#) on four prevention practices prioritized by Tribal Nations including Positive Indian Parenting, Family Spirit, Healing of the Canoe (Canoe Journey), and Family Circle (Talking Circle or Healing Circle).

This evidentiary review concluded that only one of the four program models evaluated in the report, Family Spirit, had enough evidence available to be rated under the Title IV-E Prevention Clearinghouse. Family Spirit is currently rated as Promising and is included in this plan submission for implementation by DCYF. This Five-Year Prevention Plan expands prevention services opportunities that can be accessed by Tribal Nations with Title IV-E agreements through updated policies issued by the Children's Bureau.

DCYF will continue to collaborate and amend the prevention plan when Tribes opt into Title IV-E agreements and seek to implement a prevention program through FFPSA.

Community Engagement Office

DCYF's Community Engagement team provides oversight and support in working with external community partners and advisory bodies to ensure consistent and effective communication between constituents and the agency. This engagement looks like helping teams involve community partners in the planning and implementation of policies, programs, and services. It is also a continuum of community involvement used to plan and execute, based on the timeline, goals and desired level of partner influence on decision making.

DCYF relies on this consultation to advance strategic goals by building and strengthening relationships with trusted community partners while integrating other system-change efforts that shift agency culture and practice toward proactivity.

Collaboration with Lived Experts & Families

DCYF worked with the University of Washington Evans School consulting team to determine how co-design can be applied to the child welfare system. The agency wanted to know how to center lived experience and align processes with DCYF's strategic priorities. The Evans School

consulting team developed a co-design guide with implementation protocols for making co-design the norm for DCYF.

The guide highlights a framework, definition to set standards, and co-design tools to improve the agency's child welfare system's ability to function in a supportive manner for the families and households interacting with the child welfare system and to better collaborate with families.

Community Collaboration

During the drafting of this Five-Year Prevention Plan, DCYF [hosted a series of community engagement sessions](#) in all six child welfare regions throughout the state to help guide the development of this plan.

Discussions centered around the current gaps and obstacles in Washington regarding prevention services. These themes underscore critical areas of focus, including the urgent need for funding and resource allocation, improved access to services, and community collaboration. Addressing mental health and substance use disorder treatment services, enhancing cultural competence, and ensuring that families receive the support they need are essential for community well-being. Efforts toward prevention, training, and overcoming systemic obstacles will also be vital in fostering a more effective service delivery framework.

Kinship Navigator-Washington Case Management Coordination

The Washington Case Management Model (WCMM) is a specific component of the broader Kinship Navigator Program. Under WCMM guidelines, Navigators provide case management services to families with complex, ongoing needs. It is important to note that only the third level of service, which involves intensive case management, is covered by the WCMM. The first and second levels of service, which include short-term information and assistance/referral (I&A/I&R) and minimal case coordination, are part of the broader, Kinship Navigator Program but not guided by the WCMM.

Service Coordination and Eligibility for Reimbursement

While the broader Kinship Navigator Program provides various levels of support, only families receiving services at the third level (within WCMM) are eligible for Title IV-E reimbursement. This distinction ensures that families with the most complex needs receive necessary, long-term case management, while families requiring less intensive support continue to benefit from the broader Kinship Navigator Program support.

Plans to implement

The WCMM program connects caregivers with trained Kinship Navigators who provide tailored services based on the caregiver's self-identified needs. Using WCMM guidelines, the Kinship

Navigators help families apply for state and federal benefits and provide information and referrals for services to meet identified specific needs. Overall, the WCOMM program aims to help kinship care families achieve greater stability and self-sufficiency and keep children out of the foster care system. It also supports families involved in the child welfare system, promoting placement stability and increased permanency.

Cross Agency Coordination

Prevention of childhood abuse and neglect extends outside of the child welfare agency. DCYF acknowledges that the DCYF vision for prevention cannot be realized through the work of DCYF alone.

As Washington is working to implement Family First as a broad system transformation, the effort spans multiple state and local agencies within Washington. To reach children and families as early as possible and before a report of abuse or neglect is made, a holistic approach is necessary to coordinate services with the following: Department of Health, Department of Social and Health Services, Washington's Health Care Authority, Department of Commerce, and the Washington Office of Superintendent of Public Instruction.

Mitigating Risks of Child Abuse and Neglect, Together

Even though these departments do not oversee traditional child welfare services, they often serve the same families that DCYF may support, including a broad range of programs from food assistance, health coverage, Temporary Assistance for Needy Families (TANF), employment development programs and housing support, all of which can help mitigate the risk of child abuse and neglect. By utilizing a public health lens focused on social determinants of health, the prevention identifiers listed below can inform the variety of services that the departments provide directly and the coordination across the agencies. With a wide array of supportive services in Washington and with the implementation of Family First, the implementation can begin to address the root causes of crisis.

Supporting Individuals with Disabilities

DCYF has established an Americans with Disabilities Act Accessibility Program to ensure that individuals with disabilities, including parents, guardians, and children, have full access to DCYF programs and services. DCYF and Developmental Disabilities Administration (DDA) work collaboratively and across agency while utilizing staff under the Integrated Health Services team to provide education, assistance, and liaise across organizations and systems to ensure children, youth, and caregivers with Mental Health and Disability support and service needs are met. Additionally, DDA works directly with DCYF involved families providing services to support individuals with developmental disabilities living in family homes, as well as children and youth with complex behavioral needs staying in their homes, using a wraparound care model.

Infant and Early Childhood Programs

DCYF's 2022 Family First Needs Assessment identified that three-quarters of all children in foster care placement are under age 11, and one-third are infants. Both DCYF's assessment data and the Washington Health Care Authority's (HCA) data show that many welfare-involved young children under age 5 are healthy overall; while they are likely to develop significant health or behavioral health challenges as they get older.

DCYF currently provides Nurse Family Partnership, Parents as Teachers, SafeCare, Promoting First Relationships, Parent-Child Interaction Therapy, and Incredible Years. These services capture these important years of development, promote healthy childhood outcomes, promote healthy caregiver mental health, and identify and address the needs of young children which can help link families to needed services, and ultimately prevent children from being placed in out-of-home care.

Additionally, DCYF has worked with other agencies such as Department of Health, Washington State Hospital Association, and birthing hospitals to support birthing parents with substance use disorder. Several statewide partner meetings occurred to identify "must-haves" including a public health approach and meeting communities where they are at. This consultation and coordination resulted in the implementation of a community-based pathway detailed in Section 5 and 6.

Providers & Partners Delivering Prevention Services

DCYF recognizes the need for a variety of community-based approaches implemented to address needs across Washington state. DCYF intends to design contracts in partnership with community stakeholders to determine the provision of prevention services for families accessing prevention services in the community. This will include:

- Identifying and utilizing existing safety monitoring and risk assessments that are currently being used by community providers (or are embedded in EBPs)
- Developing protocol and training whereby community-based providers can address increased risk and safety concerns with additional supports and services
- Reexamining the prevention plan should the risk of entering foster care remain high despite the provision of services
- Training and supporting community-based providers as mandated reporters when conditions exist such that the provider must make a report of child abuse/neglect through the statewide intake hotline for further system intervention
- Recognizing, honoring, and strengthening community-based providers in trauma-informed practice, family engagement, assessment, child safety and risk, and planning in prevention cases

DCYF is working to grow and expand from established community-based pathways that are being designed and implemented through a phased approach. Some examples of current efforts in Washington include:

Plan of Safe Care (POSC) is a family-centered prevention plan designed to promote the safety and well-being of pregnant women using substances as well as infants with prenatal substance exposure and their birthing parents. POSC policies and practices are required by DCYF by federal statute, (Public Law 114-198), which DCYF has implemented in collaboration with the Washington state Department of Health, Hospital Association, and Health Care Authority.

When infants with prenatal substance exposure do not meet criteria for mandated reporting, providers can voluntarily connect gestational parents/caregivers of substance-exposed newborns and infants to voluntary services and supports through an online referral to Help Me Grow. Help Me Grow connects families with a warm handoff to statewide level benefits, infant developmental screening, recovery resources, evidence-based home visiting programs and other needs. Any intake received on a pregnant woman using substances with no other children or safety concerns is screened out by statute (no child present in the home). In select counties across the state these families are referred to Help Me Grow for voluntary service navigation and care coordination. POSC as part of the community-based pathway is designed to take a highly collaborative, proactive, and preventative approach to accessing wrap-around services and long-term supports to keep families together, increase protective factors, and improve stability and family well-being.

Family Resource Centers (FRCs) are place-based organizations that provide a single point of entry to a range of services for anyone in the community according to RCW 74.14C.010. FRCs provide information, assess needs, make referrals to family services, and provide direct delivery of family services via FRC staff or contracted providers. FRCs are welcoming and strengths-based and are designed to meet the needs, cultures, and interests of the communities served. Families and staff work in partnership to develop and pursue families' goals in increasing self-reliance and self-sufficiency.

DCYF is partnering with Family Resource Centers statewide to plan for implementation of an FRC-based community pathway in high-need communities around the state. DCYF is designing, sequencing, and managing implementation of community-based pathways and ensuring that community-based providers are adequately prepared to provide Family First prevention services. DCYF has currently been partnering with nine FRCs in communities across the state to build capacity to meet family and community needs. While each center is unique and rooted in its community, FRCs have a lot in common in how they approach their work and support families and their communities. To create a robust continuum of care for families, DCYF will also partner and coordinate with other state agencies for the administration of programs.

Family Reconciliation Services (FRS) are voluntary services serving youth and adolescents in conflict with their families in the absence of abuse/neglect. The program targets adolescents between the ages of 12 through 17 with services to resolve crisis situations and prevent unnecessary out-of-home placement. While currently a child welfare program, a community-based pathway model was co-designed and the [2024 annual report](#) details additional information about the model.

FRS will use a “stepped care” model of intervention. In this model, youth are assessed and triaged into one of five paths: no need, low need, moderate need, high need, and suspected abuse/neglect. Each path specifies a set of appropriate services given the level of need and evidence-based approaches to reduce risk, increase stability and promote development. At each level of care, families would be assessed to determine whether the level intervention services are appropriate, with families moving up or down the hierarchy of intensity as indicated.

For DCYF there is potential crossover of the referral, assessment and service planning protocols between FRS and the prevention pathways outlined in this plan. Washington’s community pathways have commonalities to FRS in that they aim to serve families before child welfare involvement and commonalities with Title IV-E Agency Pathway in that the children and families served may be at a higher risk than the general public and there is an involvement with a DCYF contracted social worker.

Section 5. and 6. Child Welfare Workforce Support and Training

Family Practice Model

The Family Practice Model (FPM) is responsive to the DCYF Strategic Initiative to Improve the Quality and Intention of Practice. The FPM framework is an organizing structure that outlines the agency’s commitment to apply values equally to child welfare case management practice and to workforce development.

The framework represents a methodical and reliable way to resource, prepare, and support child welfare staff to adapt to practice changes and promote a best practice standard for case work. The FPM establishes a system to operationalize agency values through case practice in a way that promotes consistency of how workers engage, assess, and coordinate services with/for families. The mission of FPM is to prepare and support field operations staff by clarifying value-driven practice standards and commit to enhancing the professional environment for staff. The FPM includes a cohesive effort to launch guidance on policy, practice guidance, Family Practice Profiles, workforce development, and quality assurance.

This co-design process is part of the agency’s goal of using the voice of the workforce to guide the development of practice profiles. Through co-design sessions, workers operationalized

DCYF values in case management practice, organized by how workers engage, assess, and plan with families. The best practice case management standards developed in partnership with child welfare workers ensures alignment with practical application of the standards and provides workers with a sense of ownership in decisions and tools that structure their practice. By implementing a values-based FPM, staff are affirmed and supported so they can serve families through engagement, so families feel seen, heard, and understood.

The FPM further ensures that staff have the knowledge and tools necessary to consistently interact with families using value-based case management through workforce development. This is the second pillar of the FPM, which is the agency and leadership's commitment to ensure staff are resourced, prepared and supported for success in their professional role within DCYF.

Trauma-Informed and Healing-Centered Practice

Trauma-informed and healing-centered approaches are essential to protecting the health and well-being of families and children receiving services as well as the staff that serve them. DCYF has made investments in trauma-informed and healing-centered approaches, including establishing a Staff Peer Support Administrator and Staff Peer Support Specialists, providing training in Trauma-Informed Care and Crisis Response, and incorporating relevant strategies into some existing trainings.

The Washington state Legislature's 2021 passage of the Fair Start for Kids Act (FSKA) in [Senate Bill 5237](#) provides an opportunity to build on the efforts of trauma-informed and healing-centered champions across DCYF areas of operation. DCYF has made the assurance of being a trauma informed agency.

Workforce Professional Development

Professional development for public child welfare workers, Tribal child welfare workers, foster caregivers and judicial partners is primarily provided by the [Alliance for Professional Development, Training, and Caregiver Excellence](#) (Alliance). The Alliance consists of a partnership with DCYF, the University of Washington, the University of Washington-Tacoma, Eastern Washington University, and Partners for Our Children. The Alliance has been supporting child welfare in Washington state since 2010 with evolving curriculum and coaching to ensure best practices.

The Alliance provides training created to optimize knowledge, values, and skills for child welfare workers and leaders. Foundational level learning is designed to prepare the new worker with the knowledge and skills to understand their roles and begin to engage in casework. Continued learning opportunities are designed to provide a deeper dive into specific topics and additional program specific instruction. Both foundational and continued learning courses include training on developing appropriate case plans and conducting ongoing risk and safety assessments. The Alliance also provides supervisor and leadership development to support the organizational

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transformations that lead to better outcomes for families and coaching for skills development to all levels of the organization.

While the Alliance provides foundational training and professional development for child welfare workers, DCYF recognizes the opportunity to provide additional training, and workforce supports for key areas of practice as it relates to Family First. As DCYF has been implementing aspects of the 2020-2024 Prevention Plan, the Family First QA/CQI team is completing FFPSA baseline office assessments to engage child welfare field offices in their readiness to meet practice-related requirements for Title IV-E prevention fund claiming, and to provide leadership and decision-makers with office-level data regarding the availability/utilization of contracted and community-based therapeutic services.

Baseline office assessments are used to inform the training program for each child welfare field office. Training is provided to the DCYF child welfare workforce and community prevention partners. Training includes a variety of topics as described below and tailored through separate tracks to meet the needs of different audiences. These topics and their delivery to specific audiences will ensure that those working with families eligible for prevention services have a common knowledge and value-base regarding prevention work and the specific knowledge and skills for their role. The spirit of MI and trauma-informed cares will be infused throughout all topics.

The training topics will be offered in various formats. Additionally, there will be a variety of training resources such as micro learnings, tip sheets, resource guides, Frequently Asked Questions, etc. to support training and application.

All the training topics are relevant to both the DCYF workforce and community prevention partners. However, several of the topics will require adaptation to meet the unique training needs of the audience. In these instances, there will be two training tracks developed, one for the DCYF workforce and one for community prevention partners. For example, the DCYF workforce and community prevention partners both need to know about creating child-specific prevention plans, but what each audience does with that information within their role will differ. The DCYF workforce is primarily responsible for completing child-specific prevention plans for youth and families involved in child welfare, whereas community prevention providers will be responsible for creating these plans when families are accessing services through a community pathway. Community prevention providers may also be referencing child-specific prevention plans that were created by a DCYF caseworker when providing services to a family. Below is a description of topic areas that will be covered in Family First Implementation trainings and whether two distinct tracks will be designed for the topic areas.

DCYF FFPSA PREVENTION PLAN

| Topic | Foundational/Skills | Tracks |
|--|---------------------|------------------------------|
| Overview of FFPSA and Washington’s five-year prevention plan. <i>Also available in on-demand format for the public.</i> | Foundational | Single Track |
| Developing a prevention mindset and the prevention framework at DCYF. This topic will provide information on how Washington’s FFPSA Prevention Plan fits within the larger DCYF prevention portfolio and why FFPSA matters. | Foundational | Single Track |
| Technical procedures necessary for the administration of Family First include determining eligibility by assessing what children and families need; connecting to the families served; developing child-specific prevention plans collaboratively with families; matching services to the family’s identified needs; accessing and delivering trauma-informed and evidence-based services; completing ongoing risk assessments; and evaluating the continuing appropriateness of the services. | Skills | Dual Track |
| EBPs included in Washington’s Family First Prevention Plan. The information provided will include the age range of children; location of service; standard length of service; access to concrete funds within service; what family situation and need would this service be appropriate or inappropriate for; and method of service delivery. | Foundational | Single Track |
| Overview of Washington’s community pathways through Family First. Referral pathways for youth and families will be included in the content curriculum, as well as an emphasis on why upstream prevention without child welfare involvement or least intrusive involvement is crucial. | Foundational | Dual Track |
| Supporting staff through change. The primary audience for this module will be supervisors and others in leadership positions within DCYF. Strategies that DCYF already uses such as Learner Centered Coaching and the ADKAR model, will be incorporated. <i>This training will not be required for community prevention partners but will be made available to them on demand as a resource.</i> | Skills | Single Track (DCYF staff) |

In addition to the training outlined above, Family First program consultants will have scheduled office hours to support the workforce in each region regarding serving families through prevention cases. As Family First Prevention Services becomes more embedded in practice, DCYF will collaborate with the Alliance to add the training elements outlined above into their curriculum to ensure consistency of information and availability for all new child welfare staff. Guides and tools will also be developed to support the workforce’s application of Family First learning in their efforts to serve families. A few of those guides and tools will include:

- EBP Overview to include those in the Family First Prevention Plan and all EBPs available within DCYF’s service array
- Implementation Guide for Field Agencies that includes federal Family First requirements
- “How to Guide” for referrals and service matching

Training and professional development is an ongoing process and will utilize the CQI process to identify ongoing training needs as it relates to the Family First foundation and skill training topics. Child welfare professionals who provide direct services also participate in identification, design, and implementation of CQI processes and procedures, improvement strategies, and recommend areas for practice and resource allocation to support QA/CQI in coordination with leadership. These efforts ensure that the workforce is skilled and competent to provide high quality services and case management to families.

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DCYF offers trainings to support workforce development around disability awareness and etiquette as well as disability rights. DCYF also makes available educational materials to staff related to effectively engaging with parents with a cognitive disability while acknowledging that each case and each person is unique and they must tailor services to meet their individual needs.

Additional resources are available to caseworkers related to tailoring psychological evaluation referrals to assess the client's potential disability and evaluate how behaviors related to this disability affect the parent's ability to parent. The guidance emphasizes the referral should use clear, objective language, focusing on observable behaviors that pose a risk of harm and encourages caseworkers to consider the current risks the client's behavior poses to the child.

The guidance is clear that the evaluation reports may not fully predict the parent's response to all potential risks or how their ability to parent may change over time. Staff within the Integrated Health Systems team also conduct 1:1 case consultation with staff, supervisors, and Assistant Attorney General's around how to meet the individual needs of our parents with disabilities.

Contracted Service Provider Training and Support

DCYF has a contract in place to train DCYF service providers on the CANS-F assessment and treatment planning. In 2026 DCYF is updating this assessment to the Family Advocacy and Support Tool (FAST). Service providers have access to guides that help them understand their roles and responsibilities within the service framework by offering clear guidelines and procedures for the provision of prevention services. These aims to ensure consistent and effective service delivery, enhance communication between providers and community partners, and improve family engagement in support processes. Guides can outline referral processes, service expectations, reporting requirements, and billing protocols, designed to enhance the quality of care for families.

Providers are also supported by the Service Array Team to lead in identifying, developing, implementing, and managing services and providers that match the needs of Washington families. This team supports the contractor community in their ability to work within contract requirements and supports staff in maintaining relationships with DCYF contractors.

Additionally, this team conducts statewide provider meetings to support engagement, consistency of practice, and recommendations for contract changes to improve performance and alignment with practice and supports.

Section 7. Prevention Caseloads

Prevention caseloads require working in partnership with families, extensive case planning, and on-going case management throughout the life of the prevention case. DCYF caseworkers who

carry prevention cases currently identified as all Family Voluntary Services (FVS) and Family Assessment Response (FAR) will have a prevention caseload standard of 1:15 cases (max 1:18). As we implement additional candidacy groups, caseload standards may be reassessed and adjusted as needed. For example, some caseworkers may be holding a mix of prevention and non-prevention cases; therefore, their prevention caseload size would be much smaller.

Additionally, DCYF is undertaking redesign of assessments used in child welfare, looking at tools, improving the statewide service continuum to increase availability of appropriate prevention services, and strengthening case planning on FAR and FVS cases. Current projects are anticipated to inform decisions related to prevention caseload standards and ensure caseworkers' ability to spend time planning with families, completing critical case activities, and connecting families to services and resources to build protective factors, improve child and family well-being and ultimately, ensure child safety in the long-term.

Section 8. Assurance on Prevention Program Reporting

DCYF will use a combination of manual data collection and electronic data collection to ensure that data will be reported as specified in Technical Bulletins #1 and #2. *See Attachment I: State Title IV-E Prevention Program Reporting Assurance.*

Section 9. Child and Family Eligibility for the Title IV-E Prevention Program

DCYF utilizes the Social Security Act definition to determine eligibility for prevention service reimbursement: "A child who is identified in a prevention plan under section 471(e)(4)(A) as being at imminent risk of entering foster care but who can remain safely in the child's home or in a kinship placement as long as services or programs specified in section 471(e)(1) that are necessary to prevent the entry of the child into foster care are provided." DCYF is additionally utilizing the flexibility given by the Children's Bureau to define eligibility for Title IV-E prevention services within this plan.

Relative and kin caregivers are individuals connected to a child through blood, marriage, or adoption, as well as extended family members and may receive prevention services within this plan when there is an eligible child within the home. This definition also includes those who share an emotionally significant bond with the child, fictive kin, and individuals recognized as relatives or kin based on Tribal customs.

Circumstances or characteristics of the child, parent, or kin caregiver that could put children at risk of entering foster care may include:

- The child has been abused or neglected, and the child's health, safety, and welfare is seriously endangered as a result

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- There is no parent capable of meeting the child's needs such that the child is in circumstances that are a serious danger to the child's development
- The child is otherwise at imminent risk of physical harm

The following children are currently eligible for Title IV-E prevention programs in our plan based upon an individual assessment and determination that the child can remain safely in the home as long as allowable mental health, substance use, and/or in-home parent skill-based program services are provided.

- Children involved in a DCYF program with in-home intervention or court ordered services. Examples include the following:
 - Family Assessment Response (FAR)
 - Child Protective Services (CPS) Investigation
 - Family Voluntary Services (FVS)
 - Children on trial return home following placement
 - Adoption displacement
 - Family Reconciliation Services (FRS) – also part of the community-based pathway
 - State Juvenile Rehabilitation (JR) residential release
 - Pregnant or Parenting DCYF involved youth
- Children involved in a county juvenile court probation program and residential release
- As defined by a Tribal Nation

Family First Community-Based Pathway Eligibility

Through community collaboration, DCYF is dedicated to ensuring that more families can access vital support services designed to prevent the need for out-of-home placement or before child welfare involvement becomes necessary. Identifying child-specific eligibility for prevention services funded through the community-based pathway is accessed outside of being involved with the Title IV-E agency. Recognizing the variety of challenges that families face, DCYF will implement prevention identifiers as part of its eligibility criteria. The existence of these characteristics does not, in and of themselves mean that they are likely to enter an out-of-home placement.

To be considered eligible for Title IV-E prevention services, an assessment would seek to understand current circumstances that may exacerbate the impact of such characteristics and increase the likelihood that, without intervention, placement may be needed. In these situations, when there is a recommendation that a prevention service may provide supports and interventions that mitigate such safety threats or risks, DCYF will make a determination for eligibility.

Other examples of circumstances may include but are not limited to:

- Current or recent (within 12 months) family involvement with the child welfare agency

- Change in family relationships characterized by frequent conflict or violence
- Recent increase in substance use that impacts daily functioning and ability to care for the child or youth
- Recent incident in which a parent or guardian made a plausible threat to cause serious physical harm to a child or youth
- Incarceration of the caregiver
- Child or youth participated in criminal activity
- Other recent or current circumstances that may cause family instability or a threat to the child/youth's safety or well-being

Pregnant and Parenting in Foster Care

To improve outcomes for older youth, pregnant and parenting foster youth are eligible for receiving Title IV-E funded prevention services included in the state's five-year prevention plan. There is no requirement in the Act that children of expectant or parenting foster youth be determined to be at imminent risk of foster care to participate in services. Youth can voluntarily engage in the design of their case plans to include supportive services that meet their individualized needs and the needs of their child(ren).

Within DCYF's existing framework for practice, appropriate and relevant Title IV-E funded services provided to pregnant and parenting foster youth under the state's five-year prevention plan will be added to the youth's existing case plan and the youth will be eligible to receive services for a 12-month period. Continuous 12-month periods of services can be provided if the youth is assessed to have a continued need for the services.

Active Efforts and Washington Indian Child Welfare Act

Washington is committed to meeting the unique needs of American Indian/Alaska Native (AI/AN) children and families by ensuring that services are provided in a manner consistent with the Washington Indian Child Welfare Act (RCW 13.38) and the Indian Child Welfare Act of 1978 (25 U.S.C. Sec. 1901 et seq.) AI/AN children may be provided prevention services either by a Tribal Title IV-E Prevention Program or by the DCYF Title IV-E Prevention Program. In the DCYF Title IV-E prevention service pathway, prevention services to an AI/AN child under the program is closely intertwined with the requirement to provide Active Efforts under WICWA and ICWA to maintain an Indian child with their family.

The purpose of the [DCYF Active Efforts and Tribal Collaboration policy](#) is to provide guidance on how to, when there is reason to know children are or may be Indian:

- Provide active efforts to prevent the children's removal or promote the timely reunification of Indian families.

- Understand the Indian Child Welfare Act (ICWA) active efforts requirement, which is distinct from requirements to make reasonable efforts in that it requires both a higher level of engagement and culturally responsive services.
- Contact and partner with known Tribes throughout the life of a child welfare case.

When there is reason to know children are or may be Indian children, caseworkers must throughout the life of the case:

1. Provide ongoing active efforts to prevent the children’s removal or promote the timely reunification of Indian families.

Active efforts:

- a. Are required even if parents, guardians, or Indian custodians do not participate or participate inconsistently in the [case plan](#).
 - b. Are required regardless of whether a Tribe is identified or participating in a case.
 - c. Are tailored to the facts and circumstances of the case as well as the specific needs of the parents, guardians, or Indian custodians, children, and the family.
 - d. Are provided in a manner consistent with the prevailing social and cultural traditions, culture and way of life of the Indian child's Tribes.
 - e. Include access to culturally responsive services, to the maximum extent possible.
 - f. Include meaningful efforts, beyond simply providing referrals, to initiate engagement and maintain a partnership with parents, guardians, or Indian custodians in the creation and implementation of a case plan to support reunification.
2. Collaborate with known Tribes the children may be affiliated with.
 3. Prioritize the best interests of Indian children.
 4. Aim to keep children connected to their Tribes, community, and culture.
 5. Contact the [Office of Tribal Relations](#) (OTR) when:
 - a. There are no known Tribes, and the caseworker is unsure of how to provide active efforts to prevent the children’s removal or promote the timely reunification of the family.
 - b. There are known Tribes, but the caseworker is unsure about:
 - i. How to provide active efforts to prevent the removal or promote the timely reunification of the family.
 - ii. What cultural considerations to consider when providing active efforts.

Title IV-E Agency Pathway

The Title IV-E Agency Pathway (DCYF) for prevention services allows DCYF’s Child Welfare and Juvenile Rehabilitation divisions, Tribes with Title IV-E agreements, and local county juvenile courts with Title IV-E agreements that are collaborating with children and families to: identify, assess, and directly support families with prevention services.

Tribes operating under a Title IV-E agreement with the state pursuant to 472(a)(2)(B)(ii) of the Act may opt to directly provide Title IV-E prevention services that are both culturally responsive and rooted in tradition. In Washington state, the Lummi, Quinault, and Makah Tribes all have existing Title IV-E agreements with DCYF. The state has been actively working to enter into consultation with all Tribes to determine how the IV-E prevention program can be incorporated into their existing Title IV-E agreements and Tribes without Title IV-E agreements that may wish to initiate an agreement in the future. Future state plan amendments will include more details about those agreements and attach individual Tribal Prevention Plans.

County Juvenile Courts who opt into providing Title IV-E prevention services will use a data system to allow for the secure exchange for all case documentation, including eligibility determinations, ongoing risk and needs assessments through the Juvenile Court Assessment Tool (JCAT), and fiscal reporting. DCYF will continue to oversee the training, consultation, quality assurance, and continuous quality improvement of the programs that qualify as Title IV-E prevention services. This will ensure that prevention cases overseen by probation departments conform with the state's prevention plan and are aligned with all model fidelity and continuous monitoring processes as required.

Family First Community-Based Pathways

To make the prevention continuum effective, it's essential to ensure that services and supports are available to all children, youth, and families. Many struggling families, especially in low-income neighborhoods, are already reaching out for help from local community agencies like faith-based groups, schools, libraries, sports clubs, after-school programs, and scouting organizations. Strengthening the connections between these groups and local service providers who understand the community's needs — such as community-based organizations (CBOs), Family Resource Centers (FRCs), behavioral health agencies, and public health offices — is already happening and is key to enhancing prevention efforts.

DCYF implements two ways to access community-based Title IV-E approved prevention services. Both prioritize the family's autonomy and choice in seeking the support they need. In both, families always choose whether to voluntarily participate in community-based services.

- DCYF-referred families can be directed to a community-based pathway when their needs can be safely met outside the agency. This may be recommended at any point of involvement with DCYF when the child is in the home including intake, CPS, Family Voluntary Services, or at the dismissal of a dependency.
- Similarly, community-referred families may also access support on their own terms, i.e. they are identified by local community agencies working with DCYF on Title IV-E compliant services on Title IV-E compliant services.

Referral, Intake, and Assessment

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Community-based pathways are a means by which children, youth and families can receive early intervention services at the earliest point possible to minimize the stigma of working directly with the child welfare agency. Through a community-based pathway, families can self-refer or be referred by a public or private entity under agreement with DCYF for a community pathway. Families may also be referred to a community-based pathway by the Title IV-E agency (DCYF) that determines a family is eligible for prevention services based on the prevention identifiers or following a case being closed. Note: a child protective services case will not be opened.

These referrals help identify families for the local service provider contracted by DCYF for prevention services. DCYF will conduct an intake assessment of the family's strengths and needs. During the intake process, the agency will assess the circumstances of the child and family. If the assessment determines a need for mental health, substance abuse, and/or in-home parenting skill-based services to strengthen the family, the child may be identified as potentially eligible for Title IV-E prevention services.

Eligibility Determination

If the contracted local service provider contracted with DCYF to provide a community pathway identifies a child they believe may be an eligible candidate for Title IV-E prevention services and can provide a prevention service to mitigate the family's risk and safety concerns, they can submit their recommendation to the Title IV-E agency (DCYF) for review to make a determination, with appropriate consent from the family. DCYF will make all determinations as to eligibility.

Prevention Planning, Coordination of Delivery of Services

Upon notification of a prevention service eligibility determination, the local service provider will begin prevention planning with the family and, if applicable, in partnership with the child's Tribe(s). If more than one service is to be provided, the contracted service provider and DCYF will determine the roles of care coordination and how the agencies ensure that community-based prevention services are provided to support the family's unique needs. The local service provider, in partnership with the child's Tribe(s), determines how case management and coordination of services will be conducted. The contracted local service provider will be required to deliver EBP services to model fidelity standards and coordinate with other service providers under the monitoring and oversight of DCYF.

Oversight of Community Pathways, Safety Monitoring and Risk Assessments

Prevention service providers are responsible for oversight and monitoring of child safety and risk using service delivery interventions, consistent engagement practices, and safety planning. The frequencies of interventions and meetings will be based on the family's needs and documented in the child's written prevention plan.

Elements of this oversight may include:

- Prevention service providers trained to assess and monitor safety, risk, and needs of families when appropriate.
- Required safety monitoring and periodic risk assessment when services are being provided to the child and family and assessed at a minimum to ensure services are appropriate throughout a 12-month period.
- DCYF ensures, through the development of guidance, that regular, ongoing safety monitoring and periodic risk assessments are included in the service providers' contract.
- Re-determination for eligibility shall be updated no less than every six months or as a new change occurs, any time a safety or new risk factor is identified, and/or any time services are not having the intended result as reported by the prevention service provider or the family.
- The service provider's responsibility for updating the child and families' written prevention plan, including engagement efforts and ongoing safety and risk monitoring, as well as communicating with DCYF on any eligibility re-determinations.
- Updates documented in a future data management system by the service provider.
- The service providers use of traditional mandated reporter processes to seek support from DCYF, if an incident occurs where safety cannot be mitigated with planning, intervention or services provided to the family.

DCYF is responsible for overseeing its contractors to ensure all Title IV-E administrative activities are performed in compliance with federal and state requirements. The Agency receives and reviews periodic reports to support their effective oversight of contracted service providers. Service providers will be required to track data for each child deemed eligible for Title IV-E prevention services and share this information with DCYF. Information within the reports may include safety and risk monitoring, adherence to model fidelity standards, length, and completion of services. Reporting will ensure safety is being monitored as well as information on services outcomes and adherence to model fidelity.

DCYF, as a part of continuous monitoring, will address any concerns with the service provider over observed systemic issues in care coordination. If DCYF identifies a problem through their review of periodic reports or other performance monitoring activities, they will follow up with their contracted entities to address it immediately. These requirements and conditions for the provision of Title IV-E prevention services are outlined in the Provider Agreement. Authority to provide community-based services has been established by [RCW 74.13.903](#) and defined [RCW 74.13.020](#).

Conclusion

Children do best in a strong family, and families do best with support from their communities. Through Family First, DCYF is dedicated to a shift in culture, policies, and programs to ensure all Washington families and communities can thrive.

DCYF is prioritizing the enhancement and integration of prevention services for the children, youth, and families of Washington state. FFPSA is an integral part of a much larger effort to transform the way we serve Washington children and families that began with the creation of DCYF as a new agency in 2018. We are committed to a broader vision that strengthens families by preventing child maltreatment, unnecessary removal of children from their families, incarceration among youth and a range of other destabilizing factors, such as homelessness and economic and food insecurity. We strive to establish and implement prevention approaches that avoid causing further harm, while empowering children, youth, families and their communities to identify and provide the resource needs for safety, connection, healing, and the prevention of future harm.

To create true change and improve service delivery and outcomes through high-quality prevention efforts, the agency must think differently about their services and how to best support families before crisis occurs. Through collaborative partnerships with internal and external agencies, Tribal Nations, and the children, youth, and families served, DCYF will take a holistic approach to preventing the conditions that enable child maltreatment and family separation. DCYF will also continue to explore other funding sources to support the agency's broad prevention goals.

Appendix A: Evidence Based Services

The Table below lists the 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 twelve of these practices.

DCYF Approved EBPs for Initial FFPSA Prevention Plan

| | Practice | Type of Service | Title IV-E Clearinghouse Rating |
|----|--|----------------------------------|---------------------------------|
| 1 | Nurse-Family Partnership (NFP) | Parent Skill-Based | Well Supported |
| 2 | Parents as Teachers (PAT) | Parent Skill-Based | Well Supported |
| 3 | Homebuilders® | Parent Skill-Based | Well Supported |
| 4 | Functional Family Therapy (FFT) | Mental Health | Well Supported |
| 5 | Multi-Systemic Therapy (MST) | Mental Health Substance Abuse | Well Supported |
| 6 | Parent-Child Interaction Therapy (PCIT) | Mental Health | Well-Supported |
| 7 | Motivational Interviewing | Mental Health Substance Abuse | Well Supported |
| 8 | Promoting First Relationships (PFR) | Parent Skill-Based | Supported |
| 9 | SafeCare | Parent Skill-Based | Supported |
| 10 | Family Spirit | Parent Skill-Based | Promising |
| 11 | Incredible Years (school age & toddler) (IY) | Parent Skill-Based | Promising |
| 12 | Child-Parent Psychotherapy | Mental Health | Promising |
| 13 | Triple P | Parent Skill-Based | Promising |
| | | | |

The following section outlines the components the EBP will address. This includes program selection and outcomes, service description and training, implementation, target population, fidelity monitoring, continuous quality improvement (CQI), request for evaluation waiver, as appropriate, workforce support and training, any necessary supports, and prevention caseloads.

Nurse Family Partnership (NFP)

Rated: Well-Supported

Service Type: In-Home Parent-Skill Based

Manual: Nurse Family Partnership. (2020). *Visit-to-visit guidelines*.

Program Selection and Outcomes

Nurse Family Partnership (NFP) is currently part of DCYF's Home Visiting services. Home visiting programs are voluntary, family-focused services offered to expectant parents and families with new babies and young children to support their physical, social and emotional health. DCYF's selection of NFP is informed by existing prevention contracts, direct feedback from community partners, and federal guidance that emphasizes evidence-based interventions.

NFP outcomes include improved child development, family economic self-sufficiency, parent-child interaction, healthy birthweight and reductions in child maltreatment.

Service Description and Training

Nurse-Family Partnership (NFP) is a home-visiting program delivered by trained registered nurses. It supports young, first-time, low-income mothers from early pregnancy through their child's second birthday.

The program aims to improve maternal and child health, strengthen relationships, and promote economic self-sufficiency. Nurses provide individualized support in areas such as goal setting, preventive health, parenting skills, and education and career planning. Program content is tailored to meet each mother's unique needs and preferences.

Implementation

Providers enter into contracts designed to uphold fidelity to the agency's home visiting model. These contracts include expectations for enrollment, retention, service dosage, and the content of home visits. They also outline requirements for staffing plans, enrollment targets, priority populations, and defined service areas. Paired with data reporting, technical assistance, and continuous quality improvement, these elements help ensure high-quality services for children and families.

Providers are expected to meet or exceed requirements set by DCYF, the State of Washington, and relevant federal agencies. This includes active participation in meetings, continuous quality improvement efforts, technical assistance activities, and data collection. Programs are subject to annual site visits from their assigned DCYF Program Specialist, who may be accompanied by other DCYF team members.

Target Population

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NFP is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. Home Visiting in Washington prioritizes families with certain risk factors including homelessness, and families with multiple young children between birth to age 5 not connected to early learning resources. DCYF service delivery for this EBP will focus claiming on individuals who meet FFPSA candidacy eligibility. A child cannot meet the definition of a candidate for foster care prior to being born for purposes of IV-E reimbursement.

Fidelity Monitoring

Providers are expected to implement Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) in accordance with each program's model requirements. Start Early Washington offers technical assistance to support implementation and ensure fidelity to those models.

To verify fidelity, DCYF requires providers to submit documentation typically a letter of fidelity status issued by the national model office or, if none exists, by Start Early Washington's technical assistance provider. For both NFP and PAT, the DCYF Home Visiting Services team works in formal partnership with Start Early Washington Model Leads and the national model offices to facilitate consistent communication regarding each provider's implementation progress.

Fidelity indicators will be established, reported, and monitored in alignment with DCYF's performance-based contracting (PBC) requirements.

Continuous Quality Improvement

Washington State continues to strengthen and expand its continuous quality improvement (CQI) strategy, led by the Department of Children, Youth, and Families (DCYF) in collaboration with Start Early Washington's Implementation Hub and the Washington State Department of Health, which oversees HVSA Data and Evaluation. Through coaching and technical assistance, providers are supported in implementing local CQI projects and reporting outcomes via quarterly progress reports.

CQI promotes the intentional use of data, tools, and rapid-cycle improvement strategies to guide decision-making and enhance practice. It is deeply embedded across Hub processes, with Start Early's Manager of Quality Improvement and Innovation offering specialized support for targeted process improvement projects within home visiting programs and the broader system. Hub staff provide customized coaching to CQI teams, guiding them through project implementation and Plan-Do-Study-Act (PDSA) cycles. The Hub also curates and shares tools, resources, and insights from across the field to elevate quality and impact.

Washington's CQI approach combines reflective practice with data-driven decision-making and centers the expertise of home visiting staff and families. Through well-designed projects,

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providers refine program delivery, test innovative solutions, share best practices, and improve overall efficiency and effectiveness.

Request for Evaluation Waiver

DCYF is seeking an evaluation waiver for NFP, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather formal evaluation.

NFP is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 10 studies qualifying as eligible for review by the Clearinghouse.

Workforce Support and Training

Start Early Washington is the technical assistance partner for DCYF Home Visiting services. Start Early Washington supports new and experienced home visiting programs with training and professional development opportunities that support the delivery of high-quality home visiting and family support services, with the intent to produce desired impacts and improved outcomes for children and families. Across all home visiting programs, consistent practices must be in place to ensure the implementation of high-quality programs that create confident, competent home visitors and supervisors and effectively support families in achieving their goals.

Necessary supports include:

- **Technical Assistance:** regular, personalized support to help programs implement best practices through a mutual goal-setting process and supports that are customized to the program's specific priorities, including consultation, resource connection, reflective supports or observation and coaching.
- **Peer Learning:** collaborative environments for home visiting professionals to participate in open-ended discussions centered around brainstorming, reflection and communities of support.
- **Training and Professional Development:** skill building fundamentals for home visiting assessments such as developmental screenings, mental health screenings and parent child interaction.
- **Continuous Quality Improvement (CQI):** access to tools and resources that measurably improve program goals and ensure high quality service delivery. CQI supports include customized, individual coaching through a specific project, with review of emerging lessons learned across programs. Integrating CQI tools and frameworks improves quality and outcomes over time.

Home visiting programs of all models receive individualized supports for the following topics:

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- Staff hiring, onboarding & retention
- Best practices in family engagement
- Family recruitment & enrollment
- Data collection to inform decision making
- Building referral relationships & early childhood system connections
- Supportive organizational policies & procedures
- Technical & adaptive skills in staff supervision, reflective practice & team culture

Programs implementing Nurse-Family Partnership, Parents as Teachers, and Parent Child+ also receive specific supports on implementing their program with fidelity to model requirements.

Prevention Caseloads

The NFP model allows for a full-time nurse home visitor to carry a caseload of 21-25 enrolled families.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for NFP, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather formal evaluation. See Attachment II.

The Prevention Services Clearinghouse has rated Nurse Family Partnership as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Clearinghouse identified 10 studies eligible for review, two of which achieved a high rating, and five others which achieved a moderate rating. Outcomes of interest for NFP were related to child safety and well-being and adult well-being.

NFP has also been rated as well-supported by the California Evidence-Based Clearinghouse (CEBC) with a medium child welfare relevance for the topic areas of home visiting programs for child well-being, home visiting programs for prevention of child abuse and neglect, prevention of child abuse and neglect programs, and teen pregnancy services. CEBC reviews showed NFP's effectiveness in reducing reports of child abuse and neglect, improved parent-child interactions, and better parent well-being outcomes related to mental health. Numerous studies highlighted positive long-term effects of NFP on children whose mothers participated, up to twenty years from program completion.

In Washington state specifically, NFP has found significant success with participants. [State-level data from](#) CY 2023 shows that, among NFP participants, 90% of babies were born full term, 96% of mothers-initiated breastfeeding, 87% of babies received all immunizations by 24 months, and 49% of clients over the age of 18 were employed at 24 months.

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Parents As Teachers

Rated: Well-Supported

Service Type: In-Home Parent Skill-Based Programs and Services

Manual: Depending on the ages of children in the families served, the Foundational Curriculum is available to support families prenatal to age 3 and the Foundational 2 Curriculum is available to support families with children aged 3 through kindergarten. The manuals may be used separately, concurrently, or sequentially.

Parents as Teachers National Center, Inc. (2016). *Foundational curriculum*.

Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten*.

Program Selection and Outcomes

Parents as Teachers (PAT) is currently part of DCYF's Home Visiting services. Home visiting programs are voluntary, family-focused services offered to expectant parents and families with new babies and young children to support their physical, social and emotional health. DCYF's selection of PAT is informed by existing prevention contracts, direct feedback from community partners, and federal guidance that emphasizes evidence-based interventions.

PAT outcomes include improved child development, school readiness, improved family economic self-sufficiency, parent-child interaction, healthy birthweight and reductions in child maltreatment.

Service Description and Training

PAT is a home-visiting parent education program designed to support new and expectant parents develop skills intended to promote positive child development and prevent child maltreatment. Through personalized guidance, PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of health issues and developmental delays, prevent child abuse and neglect, and increase school readiness and success.

PAT follows a comprehensive model built around four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT's program is designed to serve families from various backgrounds and needs, particularly those with specific risk factors. Participation can begin during pregnancy and continue until the child enters kindergarten. Home visiting services last about one hour and offered biweekly or monthly basis, depending on family needs. Sessions can be held in the family's home, schools, childcare centers, or other community spaces.

Parent educators must have a high school degree or GED and at least two or more years of experience working with children and parents. To become certified, educators must complete a three-day foundational training, and a two-day model implementation training on strategies used to implement PAT. The PAT National Center also offers ongoing technical assistance and certification renewal sessions.

Implementation

Providers enter into contracts designed to uphold fidelity to the agency's home visiting model. These contracts include expectations for enrollment, retention, service dosage, and the content of home visits. They also outline requirements for staffing plans, enrollment targets, priority populations, and defined service areas. Paired with data reporting, technical assistance, and continuous quality improvement, these elements help ensure high-quality services for children and families.

Providers are expected to meet or exceed requirements set by DCYF, the State of Washington, and relevant federal agencies. This includes active participation in meetings, continuous quality improvement efforts, technical assistance activities, and data collection. Programs are subject to annual site visits from their assigned DCYF Program Specialist, who may be accompanied by other DCYF team members.

Target Population

PAT offers services to new and expectant parents from the prenatal stage through their child's entry into kindergarten. Designed for use in any community and with families of all backgrounds, PAT promotes health development during the critical early childhood years.

While PAT can benefit any family, many programs focus on families facing high-risk factors including teen parenthood, low income, limited parental educational, history of substance abuse in the household, and chronic health conditions. DCYF service delivery for this EBP will focus claiming on individuals who meet FFPSA candidacy eligibility. A child cannot meet the definition of a candidate for foster care prior to being born for purposes of IV-E reimbursement.

Fidelity Monitoring

Providers are expected to implement Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) in accordance with each program's model requirements. Start Early Washington offers technical assistance to support implementation and ensure fidelity to those models.

To verify fidelity, DCYF requires providers to submit documentation typically a letter of fidelity status issued by the national model office or, if none exists, by Start Early Washington's technical assistance provider. For both NFP and PAT, the DCYF Home Visiting Services team works in formal partnership with Start Early Washington Model Leads and the national model

offices to facilitate consistent communication regarding each provider’s implementation progress.

Fidelity indicators will be established, reported, and monitored in alignment with DCYF’s performance-based contracting (PBC) requirements.

Continuous Quality Improvement

Washington State continues to strengthen and expand its continuous quality improvement (CQI) strategy, led by the Department of Children, Youth, and Families (DCYF) in collaboration with Start Early Washington’s Implementation Hub and the Washington State Department of Health, which oversees HVSA Data and Evaluation. Through coaching and technical assistance, providers are supported in implementing local CQI projects and reporting outcomes via quarterly progress reports.

CQI promotes the intentional use of data, tools, and rapid-cycle improvement strategies to guide decision-making and enhance practice. It is deeply embedded across Hub processes, with Start Early’s Manager of Quality Improvement and Innovation offering specialized support for targeted process improvement projects within home visiting programs and the broader system. Hub staff provide customized coaching to CQI teams, guiding them through project implementation and Plan-Do-Study-Act (PDSA) cycles. The Hub also curates and shares tools, resources, and insights from across the field to elevate quality and impact.

Washington’s CQI approach combines reflective practice with data-driven decision-making and centers the expertise of home visiting staff and families. Through well-designed projects, providers refine program delivery, test innovative solutions, share best practices, and improve overall efficiency and effectiveness.

Workforce Support and Training

Start Early Washington is the technical assistance partner for DCYF Home Visiting services. Start Early Washington supports new and experienced home visiting programs with training and professional development opportunities that support the delivery of high-quality home visiting and family support services, with the intent to produce desired impacts and improved outcomes for children and families.

Across all home visiting programs, consistent practices must be in place to ensure the implementation of high-quality programs that create confident, competent home visitors and supervisors and effectively support families in achieving their goals.

Necessary supports include:

- **Technical Assistance:** regular, personalized support to help programs implement best practices through a mutual goal-setting process and supports that are customized to the

program's specific priorities, including consultation, resource connection, reflective supports or observation and coaching.

- Peer Learning: collaborative environments for home visiting professionals to participate in open-ended discussions centered around brainstorming, reflection and communities of support.
- Training and Professional Development: skill building fundamentals for home visiting assessments such as developmental screenings, mental health screenings and parent child interaction.
- Continuous Quality Improvement (CQI): access to tools and resources that measurably improve program goals and ensure high quality service delivery. CQI supports include customized, individual coaching through a specific project, with review of emerging lessons learned across programs. Integrating CQI tools and frameworks improves quality and outcomes over time.

Home visiting programs of all models receive individualized supports for the following topics:

- Staff hiring, onboarding & retention
- Best practices in family engagement
- Family recruitment & enrollment
- Data collection to inform decision making
- Building referral relationships & early childhood system connections
- Supportive organizational policies & procedures
- Technical & adaptive skills in staff supervision, reflective practice & team culture

Programs implementing Nurse-Family Partnership, Parents as Teachers, and Parent Child+ also receive specific supports on implementing their program with fidelity to model requirements.

Prevention Caseloads

To maintain program quality and ensure meaningful engagement, caseload limits for full-time staff are defined as follows:

Year 1: No more than 48 visits per month

Subsequent Years: Up to 60 visits per month

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for PAT, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather formal evaluation. See Attachment II.

The Prevention Services Clearinghouse has rated Parents as Teachers as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study

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designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Prevention Clearinghouse identified 13 studies eligible for review, two of which achieved a high rating, and one other achieved a moderate rating. Outcomes of interest for PAT were related to child safety, permanency, and well-being and adult well-being.

PAT has also been rated as promising by the Prevention Clearinghouse with a medium child welfare relevance for the topic areas of home visiting programs for child well-being and prevention of child abuse and neglect programs. According to studies evaluated by the CEBC, PAT significantly reduced child welfare involvement for participating families, including reduced rates of CPS reports, substantiations, out-of-home placements, and abuse-related injury.

In a 2023 [meta-analysis](#) of program effects, the Washington State Institute for Public Policy (WSIPP) found that Washington state families who participated in PAT had increased preschool test scores and reduced child abuse and neglect according to adjusted effect sizes.

Homebuilders®

Rated: Well-Supported

Service Type: In-Home Parent Skill-Based Programs and Services

Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together: The HOMEBUILDERS® model*. Taylor Francis.

Kinney, J. M., Haapala, D. A., & Booth, C. (2004). *Keeping families together: The Homebuilder® Model*. New Brunswick, New Jersey. Aldine Transaction.

The developer of Homebuilders® has updated the manual that was reviewed and approved by the Clearinghouse when it assigned the rating. DCYF will be implementing the service as approved by the Prevention Clearinghouse.

Program Selection and Outcomes

DCYF has selected Homebuilders® based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

Homebuilders® outcomes include reduced child abuse and neglect, reduced family conflict, reduced child behavior problems, and teaching families the skills they need to prevent placement or successfully reunify with their children.

Service Description and Training

Homebuilders® provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services.

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Homebuilders® practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and obstacles to goal attainment. Homebuilders® practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety.

Homebuilders® utilizes research-based intervention strategies including Motivational Interviewing, a variety of cognitive and behavioral strategies, and teaching methods intended to teach new skills and facilitate behavior change. Practitioners support families by providing concrete goods and services related to the intervention goals, collaborating with formal and informal community supports and systems, and teaching family members to speak for themselves.

Homebuilders® services are concentrated during a period of four to six weeks with the goal of preventing out-of-home placements and achieving reunifications.

Homebuilders® therapists typically have small caseloads of two families at a time. Families typically receive 40 or more hours of direct face-to-face services. The family's therapist is available to family members 24 hours per day, seven days per week. Treatment services primarily take place in the client's home.

Homebuilders® practitioners are required to have a master's or bachelor's degree in psychology, social work, counseling, or a closely related field. Practitioners with a bachelor's degree are also required to have at least two years of related experience working with children and families.

Supervisors and program managers are also required to have a master's or bachelor's degree in social work, psychology, counseling or a closely related field. Those with a master's must have at least two years of experience working with children and families. Those with a bachelor's degree must have at least four years of experience as a Homebuilders® practitioner. If they do not have prior Homebuilders® experience, supervisors must complete at least six Homebuilders® interventions during their first year.

Practitioners, supervisors and program managers receive initial and ongoing training, consultation and support to deliver quality services and ensure fidelity to the Homebuilders® model. The Homebuilders® Quality Enhancement System includes start up consultation and technical assistance, webinars, 15 -17 days of workshop training for all staff during the first two years, an additional 2-4 days of workshop training for supervisors and program managers, ongoing team and supervisor consultation with a highly trained and experienced Homebuilders® consultant, fidelity reviews and site visits.

Implementation

For families with an open DCYF child welfare case, Homebuilders® is initiated by referral to the Institute for Family Development (IFD). IFD implements the service based upon a Client Service Contract containing terms and agreements to ensure services are delivered with adherence to the Homebuilders® standards and utilizing the Homebuilders® structural and intervention components. IFD service providers complete 38 hours or more hours of face-to-face contact during the intervention. They review safety plans and crisis plans, complete the NCFAS and Family Service Plan, and facilitate transition plan meetings to prepare families for service completion.

Risk factors are evaluated, and families may be offered Homebuilders® for placement prevention to strengthen families in their natural environment, assisting to make change and increase family functioning when there is:

- A serious threat of substantial harm to the child’s health, safety, or welfare (physical abuse, neglect, unsafe child).
- Severe family conflict.
- To assist families to reunify after placement to increase ongoing success.
- To divert a child or youth from entering foster placement, or to stabilize a current foster or alternative placement for a dependent youth.

Homebuilders® is a four to six-week intensive intervention with about 10 hours per week spent with the family in the home.

Target Population

Homebuilders® serves families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services.

Fidelity Monitoring & Continuous Quality Improvement

Fidelity monitoring and quality assurance is managed by the model developer, the Institute for Family Development. DCYF contracts directly with the Institute for Family Development who provide their therapists for this intervention. The Institute for Family Development provides ongoing consultation, quality enhancement activities, and assistance.

Workforce Support and Training

The model developer, The Institute for Family Development, ensures therapists are qualified to deliver trauma-informed and evidence-based services consistent with the model. This consists of the Homebuilders® Quality Enhancement System, Homebuilders® Fidelity Measures and Program Structure Standards.

Prevention Caseloads

Homebuilders® therapists carry caseloads of two families at a time on average but can be as high as five.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for Homebuilders, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather than formal evaluation.

The Prevention Services Clearinghouse has rated Homebuilders® as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Clearinghouse identified three studies eligible for review, two of which achieved a moderate rating. Outcomes of interest for Homebuilders® were related to child safety and permanency and adult well-being.

Homebuilders® has been rated as supported by the CEBC with a high child welfare relevance for topic areas including family stabilization programs, interventions for neglect, post-permanency services, and reunification programs; for the post-reunification topic area, it has been rated as promising, also with high child welfare relevance. The CEBC found that Homebuilders® reduces rates of out-of-home placements and time spent in out-of-home placements up to one year after service completion.

In a 2023 meta-analysis of program effects, the Washington State Institute for Public Policy (WSIPP) found that Washington state families who participated in Homebuilders® had significantly reduced rates of child abuse and neglect and out-of-home placements. According to the [WSIPP Benefit-Cost Model](#), for every \$1 spent on Homebuilders, the state can expect a return of \$5.13.

Functional Family Therapy

Rated: Well-Supported

Service Type: Mental Health Programs & Services

Manual: Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavioral problems*. American Psychological Association.

Program Selection and Outcomes

DCYF has selected Functional Family Therapy (FFT) based in part on contracts DCYF already has in place for prevention, as well as community partner feedback, state and federal guidance.

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FFT program outcomes include eliminating youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use), improved prosocial behaviors (i.e., school attendance), and improved family and individual skills.

Service Description and Training

Functional Family Therapy is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11- to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context.

The FFT Clinical Training Series consists of a 3-day Initial Clinical Training and three follow-up trainings in Washington state. To be fully trained in the FFT Model, therapists are required to attend all four training courses. Once fully trained, the therapists are certified as a Washington state FFT therapist, if they have obtained and maintain the minimum statewide dissemination adherence and fidelity standards. Once certified, therapists must attend an annual booster training and maintain minimum dissemination adherence and fidelity standards. Therapists who do not maintain the minimum statewide adherence and fidelity standards and yearly training standards will be de-certified and can no longer provide FFT as a service.

Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of three to six months. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as eight sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. Each phase includes specific goals, assessment foci, specific techniques of intervention and therapist skills necessary for success.

Implementation

For families with an open DCYF child welfare case, FFT is implemented through the Combined In-Home Services (CIHS) contract group. CIHS helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered FFT for placement prevention if the family needs support in helping troubled youth and their families to overcome delinquency, substance abuse and violence, or if the family needs support across multiple systems (juvenile justice or schools).

Youth may exhibit external behaviors, internal symptoms, and/or substance abuse: conduct disorder, oppositional defiant disorder, drug use/abuse, anxiety/depression with behavior disorder symptoms expressions, violence, school problems, truancy, etc.

Target Population

FFT is intended for 11- to 18-year-old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.

Fidelity Monitoring & Continuous Quality Improvement

DCYF implements the Washington state Functional Family Therapy Project for quality assurance and quality improvement.

Prevention Caseloads

Master's level therapists have caseloads of 10-12 families.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for FFT, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather formal evaluation. See Attachment II.

The Prevention Services Clearinghouse has rated Functional Family Therapy as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Prevention Clearinghouse identified nine studies eligible for review, two of which achieved a high rating, and four others which achieved a moderate rating. Outcomes of interest for FFT were related to child and adult well-being.

FFT has been rated as well-supported by the CEBC with a medium child welfare relevance for the disruptive behavior treatment topic area for children and adolescents; for the topic areas of alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, and substance abuse treatments for adolescents, it has been rated as supported, also with medium child welfare relevance. Positive outcomes of FFT were found by the CEBC to include reduced recidivism among offending adolescents, improved family

interaction, and immediate and intermediate-term reductions in substance use among adolescents.

DCYF has implemented FFT with populations involved in its Child Welfare and Juvenile Rehabilitation divisions. A [study](#) using a sample of over 900 Washington state FFT participants found that, when the program is delivered by therapists with high adherence to the program model, recidivism rates in felonies by 35%, violent crimes by 30%, and misdemeanors by 21% compared to probation alone.

Multisystemic Therapy

Rated: Well-Supported

Service Type: Substance Abuse Programs & Services, Mental Health Programs & Services

Manual: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents (2nd ed.)*. Guilford Press.

Program Selection and Outcomes

DCYF has selected Multisystemic Therapy (MST) based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

MST outcomes include eliminating or significantly reducing 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 arise in raising children and adolescents and empower youth to cope with family, peers, school, and neighborhood problems.

Service Description and Training

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

Training for Multi-Systemic Therapy (MST) is designed to ensure that therapists deliver high-quality, evidence-based interventions. MST is provided by licensed teams and organizations, and all therapists undergo an initial five-day training program led by Ph.D. and master's level mental health specialists. To qualify as supervisors, individuals must hold a minimum of a master's degree in a mental health field.

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Once a team successfully completes the Multisystemic Therapy Program Development, Licensing, and Training processes, they receive MST Services' licensing. This licensing is contingent upon the team's adherence to MST's quality assurance standards. In addition to initial training, therapists engage in ongoing professional development, including quarterly booster sessions aimed at refreshing their MST skills and weekly consultations with MST experts.

Training requirements also include mandatory virtual pre-training followed by two days of in-person training. Supervisors receive an additional two-day orientation and training session. Each team benefits from four in-person booster days for both clinicians and supervisors throughout the year.

In some locales, MST training and implementation are closely coordinated with juvenile probation services, ensuring that supervision and consultation are effectively integrated into the program.

Implementation

Juvenile justice involved youth are assessed and referred to MST based on eligibility scoring criteria using the Washington State Juvenile Assessment Scoring Tool. Traditionally these youth have had juvenile justice involvement at the county or state level with specific risk factors that meet MST criteria.

In the community, youth 12 to 17 years of age with an available family/potential support structure who are exhibiting behavioral challenges, significantly interrupting functioning across multiple domains, and/or are at high risk of being placed out-of-home care are eligible for MST services. Families receive a referral from a behavioral health system, justice system, child welfare system, schools or other community-based agency. The referral is reviewed by a behavioral health resources referral manager and if eligible, assigned to an MST therapist.

Therapists evaluate what is working and identify ongoing challenges, focusing on the reasons for referral. Goals are established to be behaviorally specific, enabling families to track weekly progress—such as reducing substance use, violent behavior, or running away. Utilizing the FIT assessment, MST emphasizes empowering parents by enhancing their skills to manage behaviors without resorting to yelling or conflict. The intensity of services varies based on clinical needs, with therapists and families collaboratively determining the frequency and timing of interventions throughout treatment.

MST adheres to established principles while allowing for adaptations to address cultural needs and incorporate Motivational Interviewing techniques. Building hope is crucial; therapists aim to foster understanding and connection, particularly for parents who may have felt judged or shamed. Engagement strategies, such as offering small financial incentives, further promote a sense of belonging and connection to the process.

Target Population

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.

Fidelity Monitoring & Continuous Quality Improvement

Fidelity and CQI for MST is overseen by MST Services. MST Services offers comprehensive assistance with the full development of MST programs by providing program startup assistance, initial and ongoing clinical training and program quality assurance support services. DCYF works with MST Services to implement the MST Quality Assurance/Quality Improvement (QA/QI) Program.

Prevention Caseloads

MST therapists provide services for four to six families at a time.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for MST, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather than formal evaluation. See Attachment II.

The Prevention Services Clearinghouse has rated Multisystemic Therapy (MST) as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Clearinghouse identified 16 studies eligible for review, seven of which achieved a high rating, and three others which achieved a moderate rating. Outcomes of interest for MST were related to child permanency and well-being and adult well-being.

MST has also been rated as well-supported by the CEBC a medium child welfare relevance for the topic areas of alternatives to long-term residential care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment for children and adolescents, and substance abuse treatments for adolescents. Studies evaluated by the CEBC found that MST reduced re-arrest rates for sexual and other criminal offenses, improved family and peer relations, and decreased internalizing and externalizing symptoms among adolescent participants.

A [pilot program](#) implemented in Washington state found similar results among statewide youth as other national-level studies. Among 101 youth involved in the MST pilot program, 12-month rates of conviction decreased from 68% before service initiation to 35% after enrollment.

Additionally, MST enrollment was associated with higher rates of mental health service and crisis service utilization.

Parent-Child Interaction Therapy

Rated: Well-Supported

Service Type: Mental Health Programs and Services

Manual: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011*. PCIT International Inc.

Program Selection and Outcomes

DCYF has selected Parent-Child Interaction Therapy (PCIT) based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance. DCYF leverages the Washington State Institute for Public Policy to assess the effectiveness, efficiency, and cost-effectiveness of different interventions, providing policymakers and program administrators with data-driven insights. PCIT can be cost-effective, as it may reduce the need for more intensive services later, such as special education or mental health interventions. Further, the therapy is associated with positive long-term outcomes, including improved emotional regulation and better academic performance for children, which can lead to reduced costs for public services over time.

PCIT program outcomes include building close relationships between parents and their children, fostering warmth and security so children feel safe, increasing children's organizational and play skills, and improving child social skills. PCIT teaches parents how to communicate with young children, use specific discipline techniques, develop confidence and be consistent and predictable.

Service Description and Training

PCIT is a dyadic behavioral intervention for children and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. Coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly.

PCIT consists of two phases:

- Child-Directed Interaction
 - Parents learn to praise positive behaviors and interact positively with the child while starting to decrease the child's behavior.

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- Parent-Directed Interaction
 - Parents learn specific and effective parenting skills to manage their child’s behavior, use clear positively stated and direct commands, and use consistent consequences for compliant and non-compliant behavior.

PCIT is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior.

Therapists are eligible to train in a 40-hour basic training if they hold a master’s degree or above in social services with an emphasis or focus on the treatment of adult and child mental health. Exceptions may be granted by the Regional Trainer in conjunction with DCYF if the trainee is in a credited school and seeking a master’s degree. All trainees and trainers participate in a quality assurance plan to ensure model fidelity.

Implementation

For families with an open DCYF child welfare case, PCIT is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF’s resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Risk factors are evaluated, and families may be offered PCIT for placement prevention to strengthen families in their natural environment, assisting to make change and increase family functioning when there is:

Young children with emotional and behavioral disorders

- Emphasis and support on improving the parent-child relationship
- Parent needs to establish clear limit setting and consistent discipline
- Parent needs support to establish a secure attachment/relationship

The average number of sessions is 14 but varies from 10 to 20 sessions. Treatment continues until the parent master’s the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits. PCIT is implemented in the client’s home or clinic.

Target Population

Caregivers with children ages 2-7 years old.

Continuous Quality Improvement & Fidelity Monitoring

DCYF implements the Parent-Child Interaction Therapy Quality Assurance Plan for quality assurance and quality improvement and fidelity monitoring.

Prevention Caseloads

PCIT therapists may carry caseloads of 15-20 clients but generally serve 12 clients.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for PCIT, and upon approval, will assess program implementation and fidelity through a robust continuous quality process rather formal evaluation.

The Prevention Services Clearinghouse has rated PCIT as a well-supported practice, a designation granted only to EBPs with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes. After rigorous review, the Clearinghouse identified 21 studies eligible for review, five of which achieved a high rating, and six others which achieved a moderate rating. Outcomes of interest for PCIT were related to child and adult well-being.

PCIT has also been rated as well-supported by the CEBC with a medium child welfare relevance for the topic areas of disruptive behavior treatment for both children and adults, and parent training programs that address behavior problems in children and adolescents. Studies evaluated by the CEBC found that PCIT reduced rereports to the child welfare system while improving child compliance and behavior and reducing parental stress.

The Washington State Institute for Public Policy (WSIPP) conducted a meta-analysis in 2023, which calculated adjusted effect sizes that showed reduced child symptomology for attention-deficit/hyperactivity disorder, disruptive behavior disorder, and internalizing behavior problems, as well as reduced parent stress and depression. The adjusted effect sizes were used to calculate benefits from the [WSIPP benefit cost model](#), meaning effect sizes take into account the cost benefits of PCIT for Washington state.

Motivational Interviewing

Rated: Well-Supported

Service Type: Substance Abuse Programs and Services

Manual: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change (3rd ed.)*. Guilford Press.

Miller, W. & Rollnick, S. (2023). *Motivational Interviewing: Helping people change and grow (4th Edition)*.

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The developer of Motivational Interviewing has updated the manual that was reviewed and approved by Clearinghouse when it assigned the rating. DCYF will be implementing the service as approved by the Clearinghouse.

Program Selection and Outcomes

DCYF has selected Motivational Interviewing (MI) as a prominent service and case management tool in the field of child welfare beyond substance abuse. MI is a human-centered and cross-cultural service that provides a shared language between service providers and caseworkers with families. 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 those eligible for DCYF's prevention services.

DCYF anticipates increased client initiation of EBPs, increasing dosage of EBPs, and increasing completion of EBPs by clients over time. These outcomes are achieved by staff and provider completion of the model training, case documentation, and EBP model fidelity. DCYF manages performance through targeted case review and the Motivational Interviewing Competency Assessment.

Service Description and Training

MI is a method of counseling clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible. MI can be used to promote behavior change with a range of target populations and for a variety of problem areas.

DCYF child welfare workers will use MI with clients to reduce resistance when discussing behavioral change. Currently, caseworkers receive introductory and advanced training in Motivational Interviewing from a MINT certified training vendor. After completion of these trainings, staff are supported with coaching and coding utilizing the MICA to ensure the skills and qualifications of the caseworker meet the necessary fidelity standards for client-centered, competent, and proficient MI.

Contracted Service Providers: MI will also be used by contracted providers who provide services for DCYF clients or through community pathways. Contracted service providers are receiving specialized training and support through a partnership with a MINT certified training vendor. As part of this initiative, the trainers, who are also among the original developers of the MICA tool,

deliver 20 hours of comprehensive training. This program includes coding and coaching to help the providers effectively implement MI in their practice.

Implementation

For families with an open DCYF child welfare case, MI is implemented by caseworkers within case management to enhance engagement, assessment and case planning. Clients receiving Family Preservation Services or other EBPs by a contracted provider with DCYF or within the community will receive MI during the intervention as a stand-alone evidence-based prevention service and/or in conjunction with other EBPs to promote greater service uptake and improve outcomes. The dosage will be tailored the individual needs of the client.

Target Population

MI can be used to promote behavior change with a range of target populations and for a variety of problem areas. DCYF will implement MI to work with all clients to reduce resistance, resolve ambivalence, and promote long term behavior change.

Fidelity Monitoring & Continuous Quality Improvement

DCYF uses a quality assurance process to ensure model fidelity with caseworkers and contracted providers by utilizing the MICA. The MICA provides professionals with easily digestible, structured, and specific feedback through qualitative assessment of their effort to use MI with their clients. No other tool found in the research utilized a Likert scale which assessed for MI performed at a 'person-centered' skill level. Further, the MICA provides continuous feedback opportunities for a practitioner to improve with every response they make in a conversation and allows for an assessment of a practitioner's way of being with clients.

DCYF implements the Motivational Interviewing Quality Assurance Plan for quality assurance and quality improvement for child welfare staff.

Providers implementing Motivational Interviewing receive technical assistance for continuous quality improvement from a Motivational Interviewing Network of Trainers certified contracted vendor.

Workforce Support and Training

DCYF caseworkers are supported to implement MI to fidelity through continuous quality improvement. Caseworkers are offered an introductory and advanced course in MI, opportunities to record conversations and receive coding using the MICA, coaching, and individual and peer learning.

Trainers are MINT certified and provide consultation.

Prevention Caseloads

Caseworkers using MI are to be held to the same caseload standard outlined in Section 7. For providers utilizing MI as a standalone intervention, their caseload requirements are built into their contract rate models with 12 cases being a full caseload. Providers utilizing MI in conjunction with another EBP will follow the prevention caseload requirements of that EBP.

Cultural Adaptations of Evidence-Based Services

Cultural adaptations are changes made to a service reviewed by the Title IV-E Clearinghouse to support the context of the communities served, while ensuring that the core elements of the original service, upon which the evidence was built, remain intact.

Motivational Interviewing is implemented with Native families utilizing manuals and through collaboration with Tribes to derive a set of traditional concepts, values, and ideas regarding tribal community healing, cultural preservation, and strengthening of cultural identity:

Walker, D., Pearson, C. R., & Kaysen, D. (2020). *Healing seasons: MIST therapy manual*. In full collaboration with the Yakama Nation.

Venner, K. L., Feldstein, S. W., & Tafoya, M. (2006). *Native American motivational interviewing: Weaving Native American and Western practices: A manual for counselors in Native American communities*.

These small changes increase the cultural relevancy of the intervention without changing practice components. The service description, training, implementation, target population, CQI and fidelity monitoring is not impacted in this cultural adaptation.

Waiver Request & Compelling Evidence of Effectiveness

DCYF is seeking an evaluation waiver for MI, and upon approval, will assess program implementation and fidelity through a robust continuous quality process.

The Prevention Services Clearinghouse has rated Motivational Interviewing as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

After rigorous review, the Clearinghouse identified 75 studies eligible for review, 13 of which achieved a high rating, and an additional eight achieved a moderate rating. Outcomes of interest for MI were related to child and adult well-being.

MI has also been rated as well-supported by the CEBC with a medium child welfare relevance for the topic areas of motivation and engagement programs and substance abuse treatments for adults. The CEBC highlighted MI's versatility as a program that can be implemented by itself, or in tangent with other programs to engage clients, increase motivation, and achieve change.

Additionally, a [review](#) of 16 studies evaluating the use of MI in child welfare showed that combining MI with other programs can reduce recidivism among substance abusing caregivers, strengthen family preservation, and remain engaged in programs. Four of these studies evaluated MI as a tool for child welfare workers in case management strategies, mirroring DCYF’s MI implementation strategy.

Promoting First Relationships

Rated: Supported

Service Type: In-home Parent Skill-based Programs and Services

Manual: Kelly, J. F., Zuckerman, T. G., Sandoval, D., & Buehlman, K. (2016). *Promoting First Relationships: A program for service providers to help parents and other caregivers nurture young children’s social and emotional development (3rd ed.)*. Parent-Child Relationship Programs at the Barnard Center, University of Washington.

Program Selection and Outcomes

DCYF has selected Promoting First Relationships (PFR) based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

PFR outcomes include improved child social-emotional development, improved trust and security between children and caregivers, improved emotion regulation and self-reflection for children and caregivers, and improved caregiver ability to address child challenging behaviors.

Service Description and Training

PFR is a home visiting prevention program designed for caregivers of children ages 0–5 years. PFR aims to promote secure and healthy relationships between caregivers and children through strength-based parenting strategies. PFR uses reflective processes to help caregivers understand their own feelings and needs and those of their children. PFR promotes children’s social-emotional development, builds trust and security between children and caregivers, encourages children and caregivers’ emotion regulation and self-reflection, and helps caregivers address challenging behaviors.

Providers deliver weekly sessions to caregivers and their children. Providers use five strategies during sessions to enhance caregivers’ confidence and support children’s social-emotional development: (1) joining, in which the provider makes observational statements and asks open-ended non-judgmental questions to form emotional connections with caregivers; (2) reflective observation, in which the provider observes the relationships between caregivers and children and teaches caregivers how to observe children and respond to their needs, sometimes using videotaping to help caregivers reflect; (3) verbal feedback, in which the provider offers positive comments about observed interactions to enhance caregivers’ confidence and competence; (4) supporting reflective capacity, in which the provider discusses the importance of feelings and

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needs, helps caregivers understand how children's behavior is linked to social and emotional needs, and teaches caregivers to read children's nonverbal cues and to empathize with and provide comfort to children in distress; and (5) sharing information, in which providers offer caregivers resources about children's social and emotional development.

PFR providers can be infant mental health specialists, child welfare providers, social workers, home visitors, early interventionists, family service workers, childcare providers, early childhood education teachers, and public health nurses.

The PFR Level 1 Training educates providers about how to use the program within their practice. The 14-hour training is delivered either in person over two days or virtually over four half days. Participants learn about attachment theory, promoting secure caregiver-child relationships, development of self, understanding challenging behaviors, building caregiver reflective capacity, and use of consultation strategies.

Level 2 Certified Provider Training is a 15-week virtual mentoring professional development program for providers who have already completed the PFR Level 1 Training. For the first five weeks, providers watch intervention session videos to hone infant mental health observation and reflection skills. Providers discuss the videos with a master trainer and their peers. For the next 10 weeks, providers deliver the intervention with a caregiver/child dyad and receive individual mentoring. To become certified, providers must record and submit a full PFR session video that demonstrates fidelity to the model.

Level 3 Agency Training is for certified providers who exhibit high fidelity to the model and is offered by invitation only. Level 3 Training includes 15 weeks of additional mentoring from a master trainer. During the first 3 weeks, providers complete readings and view videos of parent-child interactions to hone observational skills. Providers meet weekly with the master trainer to discuss the content of the readings and videos. Providers then implement the intervention with a caregiver/child dyad for 10 weeks to grow their expertise and reflective skills. To become a certified PFR Agency Trainer, providers must record and submit a second full PFR session video that demonstrates fidelity to the model. Providers receive two additional training sessions to prepare them to train others within their agency. Certified PFR agency trainers participate in monthly group reflective consultation with a master trainer as they train and mentor others within their organization.

Implementation

For families with an open DCYF child welfare case, Promoting First Relationships is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience

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goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered PFR for placement prevention if there are concerns about the quality of parent-child relationship, the child is being reunified after being out of the parent's care for a period of time, the parent needs information about infant and toddler social and emotional development, parent needs help developing and expressing empathy towards their child, parent needs support to establish a secure attachment relationship. PFR is designed to be completed in approximately 10 to 14 weekly sessions, around 60 minutes each.

Target Population

PFR is designed for caregivers of children ages 0–5 years. Providers can implement PFR with multiple populations, including parents, grandparents, childcare teachers, families experiencing homelessness, caregivers with a mental health diagnosis, adolescent mothers, first-time parents, foster parents, families with children in the child welfare system, or families of children with special needs.

Fidelity Monitoring & Continuous Quality Improvement

DCYF uses a quality assurance process to ensure model fidelity. Promoting First relationships contracted providers are required to participate in the following:

Steps to become a Certified PFR Provider:

1. Attend the PFR Level 1 Workshop; conducted over 4 half days via zoom or 2 full days in person.
2. Successfully complete PFR Level 2 training including phase one and phase two (or equivalent provided by a Certified PFR Agency Train-the-Trainer):
 - a. Phase One: View 11-set Video Training series while being mentored online by a PFR Master Trainer weekly for five weeks, or until all videos have been viewed and discussed.
 - b. Phase Two: Implement a 10-week PFR outline with a training family while being mentored weekly online by a PFR Master Trainer to discuss all core PFR concepts, view caregiver-child interaction videos, review videos of yourself doing PFR to prepare for weekly visits.
3. Meet PFR fidelity requirements on a self-recording of a whole PFR session, measured using the Fidelity Feedback form (see attached measure). Fidelity video must be submitted to PFR program within two months of finishing training to be eligible for

scoring. If Provider does not meet fidelity requirements, further mentoring as listed below can be taken, upon approval of DCYF.

Ongoing Fidelity Requirements:

1. Attend monthly PFR reflective consultation group. Regular attendance is mandatory (Cannot miss more than two meetings per year, unless provider seeks a waiver from the PFR program due to special circumstance). Reflective Consultation (RC) group activities can include:
 - a. Watching and discussing caregiver-child interaction videos
 - b. Viewing/reflecting on videos of a provider working with a dyad while giving video feedback to parent, or doing another curriculum piece
 - c. Discussing core PFR principles and applying to dyads on caseload and
 - d. Discussing one's own feelings about the work and/or dyad
2. The RC groups will be online, video-based meetings and therefore need to be conducted in a location that supports video conference participation.
3. Newly certified providers need to submit a fidelity video six months after their initial certification to renew PFR certification. Once this six-month fidelity video meets certification requirements, then yearly fidelity checks are required to remain a certified PFR provider. The fidelity video must be a self-recording of a whole PFR session, which will be reviewed and measured using the Fidelity Feedback form.

Remediation and/or Further Mentoring for Providers not meeting Fidelity Compliance of Regular Attendance at Reflective Consultation meetings; and/or Not Meeting Fidelity requirements after completing first training family:

1. Meet online or in-person with PFR Master Trainer, DCYF PFR Lead, or PFR Agency Train-the Trainer, as appropriate, to discuss fidelity challenges and to receive further mentoring to meet fidelity. The remediation/further mentoring period may take one to two sessions for minor shifts to occur or may take up to 10 sessions to address bigger discrepancies in fidelity. DCYF will approve the number of visits.
2. Remediation/further mentoring sessions will include viewing caregiver-child interaction videos to enhance observational skills; provider recording self and watching and discussing areas of strength and growth areas that require a shift in consultation strategy, understanding of PFR concepts, or way of being in order to achieve fidelity; being assigned additional reading and discussing these core concepts during sessions; and/or discussing personal feelings/motivations that are getting in the way of implementing PFR as intended.
3. Upon completion of the specified number of remediation visits, Provider will submit a Whole Session Fidelity video that includes Video feedback. This submittal will be coded for fidelity, and if the provider meets the fidelity requirements, the Provider will be

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certified to continue to deliver PFR services to families on their caseload. If Provider does not meet fidelity following remediation/further mentoring, Provider is not considered certified to implement PFR. At this point, Agency can decide whether to pay for additional remediation at its’ own expense, to help Provider achieve fidelity

Prevention Caseloads

Model developers do not have a caseload ratio requirement; however, 12-15 clients are recommended.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|--|---|--|
| 1. Were PFR services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in PFR? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |
| 3. Were families who received PFR less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |
| 4. Were families who received PFR less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF's internal statewide child welfare case management system, FamLink (Washington's SACWIS system), and complementary data reporting system, InfoFamLink, will be used to obtain child, family, and case-level data. The SACWIS system will provide the following information:

Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
- Current and prior case openings
- Current and prior service provision
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child, family, and household information

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

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Service Data:

- Service referrals
- Service initiation
- Dosage
- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for PFR. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator 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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement

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and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

SafeCare

Rated: Supported

Service Type: In-Home Parent Skill-Based Programs and Services

Manual: Lutzker, J. R. (2016). SafeCare provider manual (version 4.1.1).

Program Selection and Outcomes

DCYF has selected SafeCare based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

SafeCare is an in-home behavioral parenting program that promotes the following outcomes: positive parent-child interactions, informed caregiver response to childhood illness and injury, and a safe home environment.

Service Description and Training

SafeCare is designed for parents and caregivers of children, birth-through 5 years old who are either at-risk for or have a history of child neglect and/or physical abuse and the program aims to reduce child maltreatment.

The SafeCare curriculum is delivered by trained and certified providers. The curriculum includes three modules: (1) the home safety module targets risk factors for environmental neglect and unintentional injury by helping parents/caregivers identify and eliminate common household hazards and teaching them about age-appropriate supervision; (2) the health module targets risk factors for medical neglect by teaching parents/caregivers how to identify and address illness, injury, and health generally; (3) the parent-child/parent-infant interaction module targets risk factors associated with neglect and physical abuse by teaching parents/caregivers how to positively interact with their infant/child, and how to structure activities to engage their children and promote positive behavior.

Each module is designed to be delivered in six sessions (18 total), but some families may need fewer or more sessions to reach skill mastery. Each session typically lasts 50 to 90 minutes and is delivered in the family's home or at another location of the parent's choice.

To become a SafeCare Provider, the required training is conducted over 32 hours during 4 consecutive days of workshop training, followed by observations of at least nine sessions by a certified SafeCare Coach or Trainer. To become a SafeCare Coach, one needs to be a certified SafeCare Provider and attend an additional 16 hours of workshop training over 2 days, plus observations of at least six coaching sessions by a certified SafeCare Trainer. To become a SafeCare Trainer, one needs to be a certified SafeCare Coach and attend an additional 16 hours

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of workshop training over two days, plus a four-to-five-day observation of a Provider Workshop.

Implementation

For families with an open DCYF child welfare case, SafeCare is implemented through the Combined In-Home Services (CIHS) contract group. CIHS helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered SafeCare for placement prevention if there are concerns for basic parenting skills, understanding and management of child's illness and/or injuries, and when home safety are primary areas of concern. SafeCare is designed to be completed in approximately 18 sessions, though some parents may need fewer or more sessions to master new skills. During this time, providers deliver three curriculum modules, with each module lasting for six sessions. Providers typically meet with clients weekly for about 50 to 90 minutes.

Target Population

SafeCare is designed for parents/caregivers of children 0-5 who are either at-risk for or have a history of child neglect and/or abuse.

Fidelity Monitoring & Continuous Quality Improvement

There are three fidelity assessment forms that are used for each SafeCare module to assess the provider's delivery of the program to a family. Each assesses approximately 30 behaviors that should be performed during the SafeCare session (e.g., opens session, observes parent behavior during practice, provides positive and corrective feedback). Each item is rated as "implemented," "not implemented," or "not applicable" to that session. Coaching sessions are also rated for fidelity using coach fidelity assessment form. DCYF uses a quality assurance process to ensure model fidelity. SafeCare contracted providers are required to participate in the following:

SafeCare Certified Coach

1. Complete the two-day SafeCare coach training
2. Complete the certification process by:
 - a. Listening to six HV sessions, two from each module

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- b. Score the HV's fidelity in the SafeCare Portal and complete a coaching session for each HV session you listen to
- c. Submit the HV recording and the coaching session recording to a trainer and pass with 85% fidelity

Ongoing coach fidelity requirements

For New Providers, not yet certified:

1. Monitor three sessions from each of the modules: Health, Home Safety and PCI/PII for nine total, if possible, observing two of those fidelity monitoring sessions live, in person.
 - a. Observe and use a fidelity checklist (input into the SafeCare Portal) to ensure each Provider's adherence to the SafeCare model
2. Review and discuss observations and fidelity checklist of each session with each Provider.
3. Until certified, conduct weekly fidelity monitoring/coaching meetings.

For Certified Providers

1. Beyond fidelity monitoring for the first 9 sessions, conduct fidelity monitoring one time per month, ensuring that over one year all modules of SafeCare are observed. This can be done by in-home observation and/or audio-recording review.
2. After becoming certified, conduct monthly meetings to ensure fidelity and review recordings listened to. Input model fidelity reviews into the SafeCare Portal.

All Providers: Ensure ongoing SafeCare model fidelity by:

1. Providing instruction when necessary to Providers
2. If a HV falls below 85% in any recording, the coach will meet with that HV and listen to the two following sessions, and any sessions thereafter until the HV reaches 85%.
3. After Providers are certified for two years the coach can listen to recordings quarterly. However, it is still recommended that the coach meet with the Provider monthly.
 - a. Participate in bi-monthly quality assurance phone calls with a SafeCare trainer/DCYF staff.
 - b. Submit a minimum of 2 coach recordings per year and achieve 85% reliability. Coaches will be notified 30 days in advance of when they need to submit a coach session and the accompanying HV session via the SafeCare Portal.

SafeCare Provider Fidelity

Steps to becoming and SafeCare Certified Provider (provider)

1. Complete the four-day Provider Training
2. Complete the certification process by:
 - a. Submit 9 sessions to your coach, 2 from each module

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- b. Complete a coaching session for each of these recordings
- c. Pass each session with 85% fidelity

Ongoing Provider Certification Requirements:

1. For Certified Providers: Submit one recorded session per month to your coach and receive an 85% fidelity score.
 - a. Attend monthly meetings to ensure fidelity and review recordings listened to.
 - b. After two years of being certified, the HV can submit recordings to their coach quarterly, but monthly check-ins between coach and HV are still strongly recommended.
2. All Providers: Ensure ongoing SafeCare model fidelity by:
 - a. If a HV falls below 85% in any recording, the coach will meet with that HV and listen to the two following sessions, and any sessions thereafter until the HV reaches 85%

Prevention Caseloads

Caseload standards are built into the contract rate models for SafeCare with 12 cases being a full caseload for a SafeCare coach.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|---|--|--|
| 1. Were SafeCare services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in SafeCare? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |

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| Research Question | Data | Analysis |
|---|---|--|
| 3. Were families who received SafeCare less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |
| 4. Were families who received SafeCare less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF’s internal statewide child welfare case management system, FamLink (Washington’s SACWIS system), and complementary data reporting system, InfoFamLink, will be used to

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obtain child, family, and case-level data. The SACWIS system will provide the following information:

Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
- Current and prior case openings
- Current and prior service provision
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

Service Data:

- Service referrals
- Service initiation
- Dosage
- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for SafeCare. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental

methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator 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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

Family Spirit

Rating: Promising

Service Type: In-Home Parent Skill-Based Programs and Services

Manual: The Family Spirit® Implementation Guide is implemented in conjunction with the Lesson Plans:

Family Spirit Program: Implementation guide. (2019). Johns Hopkins Center for American Indian Health.

Family Spirit Program: Lesson plans. (2019). Johns Hopkins Center for American Indian Health.

Program Selection and Outcomes:

DCYF worked with University of Washington researchers who produced a systematic review on tribal child welfare prevention programs in Washington state. This review assessed Positive Indian Parenting, Family Spirit, Healing of the Canoe (Canoe Journey), and Family Circle (Talking Circle or Healing Circle) against criteria informed by the Title IV-E Prevention Services Clearinghouse. This review concluded that only one of the four program models evaluated in the report, Family Spirit, had enough evidence available to be rated under the Title IV-E Prevention Clearinghouse.

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Outcomes for Family Spirit include increased maternal knowledge and self-efficacy, increased protective factors, decreased parenting stress and maternal depression, decreased substance use and fewer behavioral problems in children through age 3, reduction in child maltreatment, and improved parent-child interaction.

Service Description and Training

Family Spirit is a grounded home visiting program designed for young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy. The goal of Family Spirit is to address intergenerational behavioral health problems and promote positive behavioral and emotional outcomes among mothers and children. The program uses a responsive, strengths-based approach for helping mothers develop positive parenting practices, strengthen their coping skills, and learn how to avoid coercive parenting behaviors and substance abuse.

Community health paraprofessional home visitors deliver program lessons to participating mothers through six modules: (1) Prenatal care, (2) infant care, (3) your growing child, (4) toddler care, (5) my family and me, and (6) healthy living. The program encourages other family members to participate in the lessons alongside mothers. Home visitors also provide case management and help families access services, as needed. Family Spirit is designed to serve mothers for as long as possible, from 28 weeks gestation until 3 years postpartum. Home visitors teach 63 lessons during 52 home visits. Each visit is 45-90 minutes long. Visit frequency tapers over time. Specifically, mothers receive weekly visits from 28 weeks gestation to 3 months postpartum, biweekly visits between three and six months postpartum, monthly visits between seven and 22 months postpartum, and bimonthly visits between 23 and 36 months postpartum.

Training consists of mandatory in-person training for home visitors before they can become certified to administer the program. The training includes the topic areas Introduction to the Family Spirit Program, Family Spirit Curriculum, Tools for Home Visitors, Troubleshooting, and Program Evaluation and Fidelity which is tailored to the DCYF and Tribe goals. Trainees must pass knowledge assessments (80% or higher) on 63 lessons and achieve at least 3 out of 4 on a quality assurance measure for administering lessons. Successful completion earns certification to administer the Family Spirit program.

Implementation

Families are referred primarily through DCYF or community-based agencies. A trained facilitator initiates contact with the family to introduce the program, establish a trusting relationship and outline the program's goals and methodologies. The facilitator conducts an in-person meeting with the family to gain a comprehensive understanding of their current circumstances and administer the Family Advocacy Support Tool (FAST) to evaluate the family's strengths, needs,

values, and belief systems. This assessment helps pinpoint specific areas requiring support, particularly concerning child safety and family stability.

Upon completion of the assessment, the Family Spirit services are initiated, with the facilitator ensuring that support is effectively delivered, and family engagement is maintained. Ongoing communication is established through weekly check-ins and monthly wrap meetings, enabling continuous monitoring of progress and adjustments to the service plan as needed. The facilitator coordinates closely with community resources, tribal partners, and the Elders Panel to provide comprehensive wraparound support. This approach addresses the family's needs holistically, facilitating crisis intervention when necessary. As families demonstrate progress, the focus shifts to preparing for program closure. Transition planning involves developing a maintenance plan and identifying community resources that families can access independently post-program. The program concludes with a blanket ceremony, symbolizing the family's connection to their culture and the empowerment they have gained. This ceremony serves as a formal recognition of their journey and accomplishments.

A final review meeting is held to evaluate the family's progress and address any remaining concerns before program closure. Families complete an end-of-service survey to provide feedback on their experiences and the program's effectiveness. Scheduled follow-ups are conducted at intervals of 30 days, 60 days, 90 days, six months, and one-year post-service. These follow-ups assess the family's ongoing progress and provide additional support as needed. The program maintains an open-door policy, encouraging families to reach out for further assistance at any time, thereby ensuring ongoing support and connection.

Target Population

Family Spirit is designed to serve young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy. Other family members can participate in the program lessons alongside mothers. DCYF service delivery for this EBP will focus claiming on individuals who meet FFPSA candidacy eligibility. A child cannot meet the definition of a candidate for foster care prior to being born for purposes of IV-E reimbursement.

Fidelity Monitoring & Continuous Quality Improvement

Family Spirit is currently being implemented with the following fidelity and CQI structure as part of the contract with the provider:

CQI Structure: The provider shall implement the following CQI Structure during the entire contract term:

1. Focus CQI activities on one of the following topics:
 - a. Family Engagement and Retention
 - b. Staff engagement and retention (Team Support and Well-Being)

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- c. Caregiver Mental Health
 - d. Other topic areas approved by DCYF
2. Establish an internal CQI staff team to oversee, support, and implement CQI activities to assess program processes and outcomes; the CQI Team members are expected to participate in regular CQI team meetings, CQI webinars, and CQI project activities.

CQI Activities: The provider shall participate in the following CQI Activities throughout the contract term:

1. Participate in monthly CQI calls/webinars to share information and learn from peers. The aim is to sustain collaboration and peer support related to improving practice and program implementation
2. Conduct and track data ongoing rapid cycle PDSA tests and ramps, at least monthly, to test, adapt, and implement changes and reflect on that data
3. Report on CQI Activities and Reflections to DCYF through existing deliverables - Monthly Enrollment Reports and Quarterly Progress Reports; DCYF will share these with Start Early WA and DOH for review and feedback to the provider
 - a. As part of ongoing quarterly progress reports, the provider will share details about their ongoing PDSA testing, data collected, reflections, and any adaptations.
 - b. Providers experiencing Minimum Active Enrollment Caseload below 85% of the Maximum Service Capacity, as defined in Section 6 (c) of this statement of work, will report monthly via the Monthly Enrollment Report on CQI activities, including PDSA tests, data and reflections, to address understanding and improving their Active Enrollment Caseload.
4. Create a plan for sustaining gains made through CQI activities.

Technical Assistance (TA) is available to the provider to assist in maintaining model fidelity, implementing best practices, and assuring improving quality of home visiting service delivery. DCYF contracts with Start Early WA to provide technical assistance for the HVSA. The provider shall work with DCYF’s designated technical assistance provider for support in achieving contract milestones including, but not limited to, the following areas:

1. Program model fidelity as described by the Family Spirit model developer
2. Staff qualifications, and selection and onboarding of home visitors and supervisors
3. Reflective supervision process
4. Staff retention and vacancy planning
5. Participant outreach, recruitment, enrollment and retention
6. Model specific service delivery and case planning
7. Leadership development and organizational support for home visiting model
8. CQI planning, implementation and analysis.

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Prevention Caseloads

Providers can carry up to 12 families on their caseload.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|--|---|--|
| 1. Were Family Spirit services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in Family Spirit? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |
| 3. Were families who received Family Spirit less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |
| 4. Were families who received Family Spirit less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers

and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF's internal statewide child welfare case management system, FamLink (Washington's SACWIS system), and complementary data reporting system, InfoFamLink, will be used to obtain child, family, and case-level data. The SACWIS system will provide the following information:

Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
- Current and prior case openings
- Current and prior service provision
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

Service Data:

- Service referrals
- Service initiation
- Dosage

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- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators. In addition, certain program data are available from DCYF partners and OIAA will have data accessible via appropriate data sharing agreements and/or contracts.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for Family Spirit. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator 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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

Incredible Years

Rated: Promising

Service Type: Mental Health Programs and Services

Manual: Webster-Stratton, C. (2011). *Incredible Years parents, teachers and children's training series: Program content, methods, research, and dissemination, 1980 – 2011*. Incredible Years, Inc.

Incredible Years, Inc. (2019). *Toddler basic curriculum set*.

Incredible Years, Inc. (2019). *School age basic curriculum set*.

Program Selection and Outcomes

DCYF has selected Incredible Years-Toddler Basic Program & School Age Basic Program based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

IY Toddler Basic Program outcomes include improved parent-child interactions, building positive relationships and attachment, improved parental functioning, less harsh and more nurturing parenting, increased parental social support and problem solving.

IY School Aged Basic outcomes include improved teacher-student relationships, proactive classroom management skills, and strengthened teacher-parent partnerships.

Service Description and Training

The Incredible Years – Toddler Basic Program (“IY-Toddlers”) is a group-based program designed for parents with toddlers (1 to 3 years). The program typically targets higher risk parents who need support forming secure attachments with their toddlers or addressing their toddlers’ behavior problems. It also helps parents create secure and safe environments for children, establish routines, use appropriate discipline, and reduce behavior problems.

IY-Toddlers focuses on eight developmentally appropriate topics during the sessions: (1) child-directed play, (2) promoting toddler’s language, (3) social and emotion coaching, (4) praise and encouragement, (5) incentives, (6) separations and reunions, (7) limit setting, and (8) handling misbehavior.

The Incredible Years - School Age Basic program (“IY-School Age”) can be offered as a group-based prevention or treatment program designed for parents of children (6 to 12 years). The program typically targets higher risk populations and parents of children diagnosed with problems such as oppositional defiant disorder and attention deficit hyperactivity disorder (ADHD). IY-School Age aims to strengthen parent-child interactions and attachment and reduce harsh discipline. It also aims to foster parents’ abilities to promote children’s social, emotional, and academic development and reduce behavior problems. IY-School Age focuses on 3

developmentally appropriate topics during the sessions: (1) promoting positive behavior, (2) reducing inappropriate behaviors, and (3) supporting children's education.

During each group session, parents watch eight to 10 situational video vignettes. They engage in discussions facilitated by the group leaders and problem solve about best parenting practices. Parents are encouraged to complete activities at home to apply the skills they learned with the group.

Incredible Years offers a three-day, in-person training for IY-Toddlers or IY-School Age group leaders. The training is highly recommended for all group leaders and is required for group leaders who plan to become certified. It is recommended that at least one of the two leaders working with a group has a master's degree or comparable education/background. Group leaders who have attended training can become certified by demonstrating positive participant evaluations, positive trainer/mentor evaluations of videotape review, positive peer review, and satisfactory completion of session protocols. Group leaders come from a variety of backgrounds, including social work, psychology, nursing, medicine or education. Additionally, they should have taken at least one course in child development or social learning theory.

Steps to become an Incredible Years Certified Group Leader or Home Coach:

1. Attend an accredited Incredible Years Workshop approved by the model developer and DCYF.
2. Successfully complete Incredible Years Group Leader or Home Coach Certification:
 - a. Complete two full parenting groups (18 sessions for preschool, 13-14 for toddlers, and eight to 10 sessions for baby)
 - b. Video tape one session during the first parenting group or home coach session and send to Incredible Years.
 - c. Video tape another session when ready and send to Incredible Years. Group leaders will need to send at least one video from every 18-week Incredible Years series (or 14 for toddlers and 10 for baby) until they are notified that their video has passed towards their certification. Most group leaders pass a certification review within 2-3 videos.
 - d. Attend at least one Incredible Years accredited consultation per year, if made available through DCYF
 - e. Upon passing a video review, apply for certification with Incredible Years

Implementation

For families with an open DCYF child welfare case, Incredible Years is implemented through the Combined In-Home Services (CIHS) contract group. CIHS helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP

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model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered IY for placement prevention if there are concerns about parenting and discipline skills, social and emotional development, and negative parent child relationship. IY Toddlers is provided over 12-17 weeks in either a peer group setting or in-home. IY School Age is provided over 12-20 weekly group sessions, each group lasts about 2 hours. The model uses videos, written curriculum, role plays, homework, and self-evaluation. Providers complete one weekly contact by provider outside class for group classes.

Target Population

IY-Toddlers is designed for parents with toddlers (1 to 3 years). The program typically targets higher risk parents who need support forming secure attachments with their toddlers or addressing their toddlers' behavior problems.

IY-School Age is designed for parents of children 6 to 12 years. The program typically targets higher risk populations and parents of children with behavior problems.

Fidelity Monitoring & Continuous Quality Improvement

DCYF implements the Incredible Years Quality Assurance Plan

Ongoing Fidelity Requirements:

1. Attend at least one accredited Incredible Years consultation per year, when made available by DCYF
 - a. Record yourself leading an Incredible Years parent group or home coach session and bring that recording to the consultation and you will have the opportunity to:
 - i. View/reflect on videos of group leaders/ home coaches working with child welfare involved families and giving feedback about that work to groups of 10-12 group leaders/ home coaches
 - ii. Discuss Incredible Years principles and applying to families on caseload; and
 - iii. Discuss one's own successes and challenges with working with Incredible Years and child welfare involved families.
2. Group Leaders and Home coaches should meet regularly within their agency to support group leaders/home coaches towards and after they have completed group leader/home coach certification.

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- a. Peer and self-review are part of the process towards group leader/ home coach certification, and it is important for certified group leaders/ home coaches to maintain fidelity in their work.
- b. Group leaders/ home coaches are recommended to meet as a group within their agency (or could be intra-agency) at least once a month.
- c. One group leader/ home coach prepares a video for this meeting, prints out the peer and self-evaluation form from the Incredible Years website and completes the peer and self-evaluation for the video everyone is viewing.
- d. At least 2 to 2.5 hours should be set aside for this meeting.

Prevention Caseloads

IY is offered in a class format. Model developers recommend IY-Toddler and IY-School Age group sizes are 12 to 14.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|--|---|--|
| 1. Were IY services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in IY? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |
| 3. Were families who received IY less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |

| Research Question | Data | Analysis |
|---|---|--|
| 4. Were families who received IY less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF’s internal statewide child welfare case management system, FamLink (Washington’s SACWIS system), and complementary data reporting system, Info FamLink, will be used to obtain child, family, and case-level data. The SACWIS system will provide the following information:

Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
- Current and prior case openings
- Current and prior service provision

- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

Service Data:

- Service referrals
- Service initiation
- Dosage
- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for IY. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator will establish a robust readiness assessment and data collection procedure, there could be limitations with the collection and use of administrative

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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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

Child Parent Psychotherapy

Rated: Promising

Service Type: Mental Health Programs and Services

Manual: Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy: A manual for Child-Parent Psychotherapy with young children exposed to violence and other trauma (2nd ed.)*. Zero to Three.

Program Selection and Outcomes

DCYF has selected Child Parent Psychotherapy (CPP) because of its current utilization in behavioral health clinics, as well as community partner feedback and federal guidance.

CPP is a treatment for trauma-exposed children age birth to 5. Typically, the child is seen with their primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health.

Outcomes for CPP include decrease of child's PTSD symptoms, child comorbid diagnoses (including depression), child general behavior problems, including aggression and attentional difficulties. Additional outcomes include improved child capacity to regulate emotions, child cognitive functioning and children's perceptions of caregivers and themselves and attachment with their caregiver. Outcomes for the caregiver in the intervention include improvement in caregivers' PTSD symptoms, caregivers' empathy towards children and caregivers' ability to interact in positive ways with children.

Service Description and Training

Treatment 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

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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. Together, these approaches for Child-Parent Psychotherapy serve to support families to reach the following primary goals:

1. Restore and protect the child’s mental health.
2. Support family strengths and relationships, helping families heal after stressful experiences.

All CPP providers must have experience as mental health professionals and participate in the required training. CPP offers three types of training models: (1) CPP Learning Collaborative (LC), (2) CPP Agency Mentorship Program (CAMP), and (3) Endorsed CPP internship. In CPP LC, teams of trainees attend an initial 3-day didactic training, participate in two competency building workshops (six and 12 months after the initial training), provide CPP, and receive feedback through supervision and consult calls over an 18-month period. After an agency has completed the CPP LC, they may apply for CAMP, in which they identify a team of CPP trainers within their agency to train new CPP providers (with oversight from CPP mentors). Several organizations offer endorsed CPP internship programs, which are structured as 1- to 2-year training programs for students in a mental health field who have completed their graduate coursework.

Implementation

For families with an open DCYF child welfare case or accessing services in the community, children and caregivers receive a referral from a behavioral health system, justice system, child welfare system, schools, or other community-based agencies or can self-refer. The referral is reviewed by the clinical community-based agency that provides CPP and if eligible, the caregiver and child are assigned to a CPP clinician.

Family risk factors are evaluated and may be offered CPP for placement prevention if the caregiver needs psychoeducation about infant and toddler social and emotional development, caregiver needs support to establish a secure attachment relationship and to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning.

CPP therapy sessions are typically delivered weekly for 20 to 32 weeks. Therapy duration is based on clinical need. Sessions are typically 60 to 90 minutes and occur in the clinic or in the client’s home.

Target Population

CPP is designed for children ages birth through 5 and their parents/caregivers.

Fidelity Monitoring & Continuous Quality Improvement

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Two tools used to monitor and maintain fidelity are the Fidelity Compass and Fidelity Packets, both of which help guide and assess how closely therapists adhere to the core principles and techniques of the CPP model.

The Fidelity Compass acts as a structured framework to evaluate a therapist’s adherence to CPP’s key elements. It includes a set of specific criteria that reflect the critical components of the therapy, such as the emotional process, trauma framework, and procedural. Supervisors use this tool to observe and assess therapy sessions, either through direct observation or by reviewing session recordings. The Fidelity Compass helps identify areas where a therapist might need additional guidance, ensuring the treatment is being delivered as intended and that the therapist remains aligned with CPP’s core principles.

Fidelity Packets provide therapists with a collection of resources, guidelines, and self-assessment tools to support them in delivering CPP faithfully. These packets contain detailed descriptions of the model’s techniques, checklists to track adherence, and feedback tools for ongoing reflection and improvement. They also include supervision guidelines to help therapists receive constructive feedback from their supervisors. The packets serve as a practical reference, helping therapists stay aligned with the CPP model throughout their work and continuously improve their practice.

Together, the Fidelity Compass and Fidelity Packets help ensure that therapists provide consistent, high-quality care. While the Fidelity Compass provides a way to monitor and assess fidelity, the Fidelity Packets offer resources and tools for continuous quality improvement.

Prevention Caseloads: Therapists serve eight to 12 families at a time.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|--|--|--|
| 1. Were CPP services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in CPP? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |

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| Research Question | Data | Analysis |
|--|---|--|
| 3. Were families who received CPP less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |
| 4. Were families who received CPP less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF’s internal statewide child welfare case management system, FamLink (Washington’s SACWIS system), and complementary data reporting system, InfoFamLink, will be used to obtain child, family, and case-level data. The SACWIS system will provide the following information:

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Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
- Current and prior case openings
- Current and prior service provision
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

Service Data:

- Service referrals
- Service initiation
- Dosage
- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators. In addition, certain program data are available from DCYF partners and OIAA will have data accessible via appropriate data sharing agreements and/or contracts.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for CPP. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator 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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

Triple P

Rated: Promising

Service Type: Mental Health & In-Home Parent Skill-Based Programs and Services

Manual: Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2013). *Practitioner's manual for Standard Triple P (2nd ed.)*. Triple P International Pty Ltd.

Program Selection and Outcomes

DCYF has selected Triple P based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

Outcomes for Triple P include improved understanding of child development, improved caregiver ability to manage misbehavior, and improved caregiver ability to implement planned activities and routines to encourage independent child play.

Service Description and Training

Triple P – Positive Parenting Program – Standard (Level 4) (“Triple P-Standard”) is a parenting intervention for families with concerns about their child’s moderate to severe behavioral problem. DCYF has chosen Triple P based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

Triple P draws on social learning, cognitive behavioral and developmental theory, in addition to research into risk factors associated with the development of social and behavioral problems in children. This service promotes a more positive parent-child relationship while supporting families with individual support. Families receive 10 weekly one-on-one sessions with a practitioner lasting about 1 hour.

Sessions are parent-driven, with some child involvement. There are multiple parent assessments, guided participation and role plays. The model uses DVD clips, homework, behavior monitoring tools, and a parent handbook. The five Core Principles are:

- Ensuring a safe, interesting environment
- Creating a positive learning environment
- Using assertive discipline
- Having realistic expectations
- Taking care of oneself as a parent.

All Triple P-Standard practitioners must complete a 3-day training program. This training covers topics including applying positive parenting strategies, identifying risk and protective factors in families, assessing child and family functioning, and making referrals. Practitioners must also participate in a 1-day pre-accreditation workshop where they practice specific competencies associated with delivery of the model and receive individualized feedback. Then, six to eight weeks later, practitioners complete a half-day accreditation workshop in which they pass a written exam and demonstrate proficiency in key competency areas. Successful practitioners come from all sectors. Minimum training requirements include a desire to learn and experience working with children and families.

Implementation

For families with an open DCYF child welfare case, Triple P is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home six- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered Triple P for placement prevention if child behavioral issues are the primary area of concern and a primary safety issue for the family is directly related to the behavioral issues of the child. Triple P also supports if caregivers need

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help with their conflicting parenting decisions or to develop age-appropriate and effective discipline strategies.

Triple P – Standard, parents receive 10 weekly one-on-one sessions with a practitioner. Each session lasts about 1 hour.

Target Population

Triple P-Standard serves families with children (up to 12 years) who exhibit behavior problems or emotional difficulties.

Fidelity Monitoring & Continuous Quality Improvement

DCYF uses a quality assurance process to ensure model fidelity. Triple P contracted providers are required to participate in the following:

| Activity | Quality Assurance Requirements | Who is Responsible |
|--|---|---|
| Initial training/case consultation | Complete certified training course Implementation of Triple P in the workplace, including development of peer support networks Gain access to Triple P Provider Network | Triple P Provider ¹ |
| Documentation of knowledge/skill acquisition | Completion of accreditation session, including required competency demonstrations and passing required quizzes Completion of DCYF staffing process. | Triple P Provider Triple P Consultant ² DCYF EBP Regional Lead |
| Intra-agency consultation procedures | Participation in X1/mo. peer group supervision, must attend 75% of meetings (minimum 9/year). | All Triple P Providers |
| Ongoing Consultation, Training & Coaching | | |
| Accredited and Staffed Practitioner | Attend at least 75% of monthly consultation calls. If attendance drops below 75% then must submit a remediation plan within two weeks. If 'make-up' sessions are needed, practitioners can join other consultation group. | Triple P Provider Triple P Consultant |
| Experienced Triple P Practitioner consultation | Attend at least 3 monthly consultation calls yearly | Triple P Provider Triple P Consultant |

If provider assessment does not meet the standards around competence or compliance, the Trainer/Consultant will initiate a performance improvement process.

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Prevention Caseloads

Caseload standards are built into the contract rate models for Triple P with 12 cases being a full caseload for a Triple P practitioner.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions using data and analysis as below:

| Research Question | Data | Analysis |
|---|---|--|
| 1. Were Triple P services referred to and initiated in a timely manner? | Service referral, initiation | Descriptive: referrals within 90 days of intake, service initiation within 30 days of receipt of referral |
| 2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in Triple P? | Service referral, initiation, dosage, completion Family characteristics, risk factors | Multivariate: family characteristics and risk factors associated with varying levels of service engagement |
| 3. Were families who received Triple P less likely to have a screened-in CPS intake compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare screened-in intakes | Propensity score matching: outcome of screened-in referrals within six months, controlling for covariates of family characteristics and risk factors |
| 4. Were families who received Triple P less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program? Does this outcome vary by level of service engagement? | Service referral, initiation, dosage, completion Family characteristics, risk factors Child welfare entries into out-of-home care | Propensity score matching: outcome of entry into out-of-home care within six months, controlling for covariates of family characteristics and risk factors |

Outcomes of Interest

Outcomes relevant to child welfare and the prevention of out-of-home placement, as is the intent of this plan, will be prioritized for this program evaluation. Under the DCYF Performance-Based Contracting initiative, DCYF program staff have worked directly with service providers

and OIAA researchers to identify relevant outcomes, which include and will be measured by the following:

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.
- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a six-month follow-up period from date of service initiation, and at six- and 12-months following service conclusion.

Data Collection Methods

This evaluation will include data on the child, family, case, and service levels. This integrated data collection approach will provide a comprehensive and nuanced understanding of the services being provided to EBP participants.

DCYF's internal statewide child welfare case management system, FamLink (Washington's SACWIS system), and complementary data reporting system, InfoFamLink, will be used to obtain child, family, and case-level data. The SACWIS system will provide the following information:

Family Characteristics:

- Child, family, and household information

Family Risk Factors:

- Prior CPS intakes
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- Current and prior service provision
- Safety assessments
- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records

Child Welfare Data:

- CPS screened-in intakes
- Entries into out-of-home care

Service Data:

- Service referrals
- Service initiation
- Dosage

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- Service completion

Service-level data will come directly from providers via data reports which include service completion records and assessment results. All data sources listed above are fully available to OIAA program evaluators.

Sampling and Analysis

The target and study populations for this evaluation will be all individuals served by DCYF who were determined eligible for Triple P. The OIAA evaluator will compile descriptive statistics to compare family risk and case characteristics by service referral, initiation, dosage, and completion status. The OIAA evaluator will assure statistical approaches to this evaluation are rigorous while still ethical using quasi-experimental methodologies. The comparison group will include eligible families who did not receive the EBP, and equivalency between groups will be addressed via Propensity Score Matching to adjust for differences between those groups.

Limitations

While randomized controlled trials are often considered the “gold standard” of evaluations of program effectiveness, the feasibility of such among the population served by DCYF can be expensive, unethical, or impractical. Therefore, the evaluator will use quasi-experimental methods as appropriate to replicate a scientific experiment without use of selection randomization.

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

Additionally, while the evaluator 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 program evaluations because they could confine the scope of the analysis or prevent the discovery of meaningful correlation.

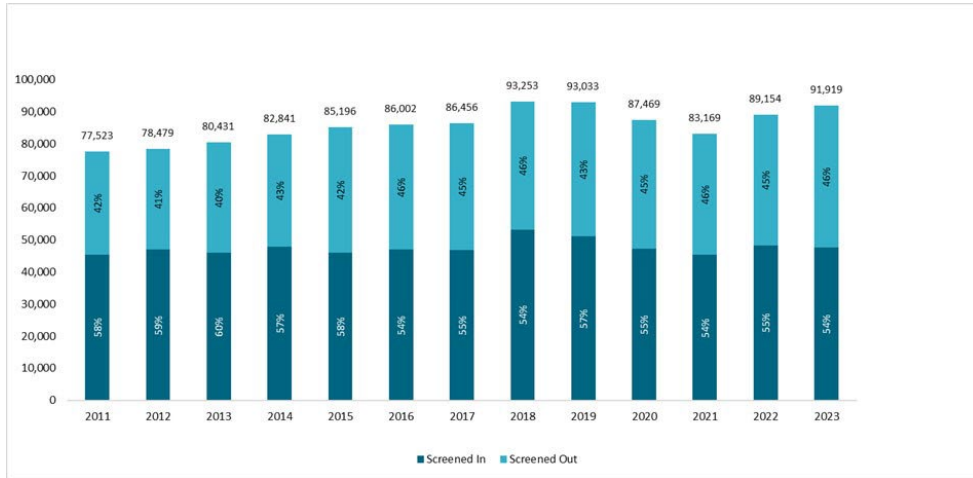
Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners. Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

Appendix B: Child Welfare Data

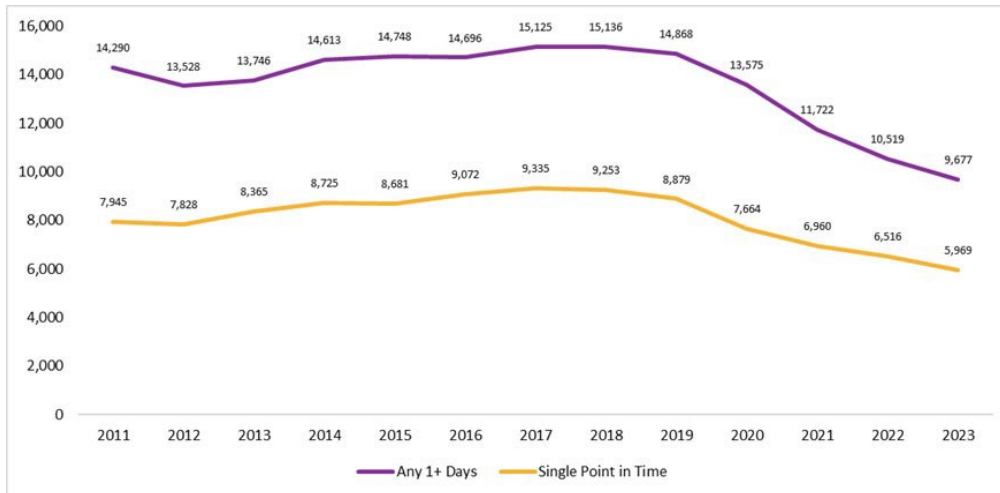
DCYF is committed to a data-informed approach when evaluating agency performance, the measurement of which is tasked to the Office of Innovation, Accountability, and Alignment (OIAA). The following data visualizations represent indicators of numerous agency strategic priorities most relevant to child welfare and the prevention of out-of-home placement.

Chart 1: Intakes by Screening Decision and State Fiscal Year, CY 2010-2023



In the State Fiscal Year 2023, 54% of children referred for intake had cases that were screened in for further investigation. Since 2010, Washington State’s population has grown by 18%, and the number of annual intakes has accordingly increased. The percentage of children whose intake cases were screened-in, however, has remained fairly consistent since 2015.

Chart 2: Children and Youth under 18 in Out-of-Home Care, SFY 2011-2023



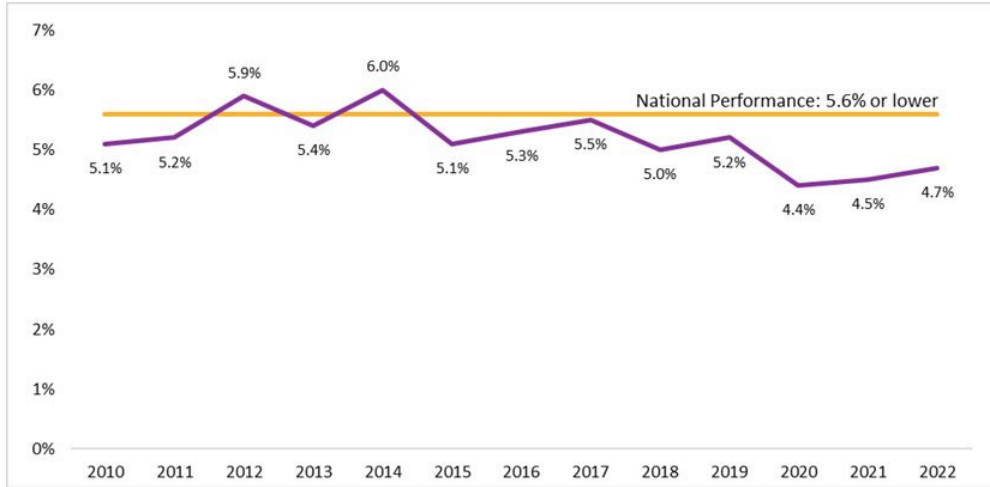
Note: Single Point in Time includes only children and youth who were in out-of-home care on the last day of the SFY.

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Approved for distribution by Secretary Tana Senn

The number of children in out-of-home care has been declining since 2017. On the last day of the state fiscal year 2023, there were 5,969 children and youth in out-of-home care. At that time, 55.9 percent of all children and youth under 18 in out-of-home care were placed with kin or relatives.

Chart 3: Children Who Re-Enter Care within 12 Months of Exit, SFY 2010-2022



In the State fiscal year 2022, 4.7 percent of children who exited out-of-home care to permanency through reunification or guardianship re-entered care in the following 12 months. The national performance, which is the standard to which DCYF is held, is 5.6 percent or less.

Appendix C: Attachments

Attachment I: Prevention Program Reporting Assurances

Attachment II: Request for Waivers (Functional Family Therapy, Motivational Interviewing, Multi-Systemic Therapy, Homebuilders, Nurse Family Partnership, Parent-Child Interaction Therapy, Parents as Teachers)

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

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