*FFY 2021-2026*


# FLORIDA'S FAMILY FIRST PREVENTION PLAN

Updated October 2022, January, February, and March 2023

**Table of Contents**

## 1. INTRODUCTION

The mission of the Florida Department of Children and Families (Department) is to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.

The Family First Prevention Services Act (FFPSA) was signed into law on February 9, 2018 as part of Public Law (P.L.) 115-123 and has several provisions to enhance support for families to help children remain at home, reduce the unnecessary use of congregate care, and build the capacity of communities to support children and families. (Child Welfare Capacity Building Collaborative, n.d.) This act challenged states to redesign their child welfare systems, putting the focus on preventing children from entering foster care and, when removal is necessary, ensuring children are cared for in the best, family-like settings.

FFPSA provides an opportunity for Florida to deepen its commitment to prevention by further activating available resources to holistically serve children and families utilizing an integrative model, specifically by enhancing the service array in local communities to address mental health and substance misuse needs, promoting economic self-sufficiency, proactively reducing the need for crisis intervention services, and building parent and caregiver skills to promote strong, resilient families. FFPSA implementation provides an opportunity for Florida to enhance its community-based model by deepening its commitment to prevention and enhancing partnerships with stakeholders to ensure that evidence-based services are readily available within local communities to improve long-term safety, permanency, and well-being outcomes for children and families.

Florida began shifting to a Community-Based Care model in 2005 to support the long-standing vision that services are best delivered when developed and driven by local communities. Florida has seen improved outcomes for children and families since this transition that includes a reduction of children placed in out-of-home care from a historic pre-Title IV-E waiver high of 28,444 children on October 31, 2003, to 22,334 children on December 31, 2020. Florida's child welfare system is comprised of an allegation intake and child protective investigation process conducted by Department staff and seven (7) sheriff offices and supported by privatized contracted child placing agencies that offer a case management system provided by Community-Based Care lead agencies (CBCs).

The Department is enhancing and expanding Florida's child welfare approach by integrating services to holistically address the needs of children and their families, and prevent further crisis. The Department will operationalize and hardwire prevention into the culture and practice of the Department, modernize and create efficiencies in our systems to improve workforce stability and capacity, improve accountability and quality across all systems, and improve financial health by leveraging all revenue sources to improve the service array in Florida's communities. In June 2022, the Department launched Family Navigation to wrap around high-risk families and ensure families receive the right services at the right time.

Florida's Collaboration Model requires the Department, CBCs, community stakeholders, families, youth, and local communities to establish a human-centered continuum of services that aims to ***Promote*** community and family strengths through primary prevention and the expansion of evidence-based services. This collaborative model will ***Safeguard*** children and families by controlling active danger threats, enhancing caregiver protective capacities, and ***Restore*** family well-being conditions through trauma-informed, evidence-based interventions. In addition, the model

will support focused post-intervention and aftercare support to build ***Resilience*** for families who have been in crisis and to prevent re-entry. The framework for this model, (see Figure 1) specifically, the descriptors for prevention service provision goals, were developed in collaboration with community based prevention focus groups by the Department of Health and the University of South Florida. The framework will be used to integrate and expand the state's historic child welfare prevention lens, developed under the IV-E waiver, by helping communities build an array of evidence-based programs and a network of providers to provide coordinated, wrap-around care to meet the holistic needs of children and families. Florida families will have "no wrong door" to access community-based, coordinated, quality, and evidence-based services at the right time to meet their unique and specific needs and to support long term well-being.


- PROMOTING Community and Family Strength: Concrete community prevention supports to promote self-sufficiency through primary / secondary prevention services.
- SAFEGUARDING Children and Families: Agency and/or community early intervention supports to enhance defined protective factors for families assessed with complex family conditions through secondary / tertiary prevention services.
- RESTORING Family Well-Being: Agency and community-based crisis intervention to control active danger threats and achieve long-term behavioral change for families in crisis through tertiary prevention services.
- RESILIENCE: Agency and/or community supports to build family resilience with focused post-intervention and aftercare supports for families who have been in crisis through a wide array of prevention services.

*Figure 1. Collaborative & Coordinated Care Approach*

**Family First Prevention Services Act and the Roadmap to Child and Family Well-Being**

The Title IV-E prevention program authorized by FFPSA supports Florida's shift to focus on services that prevent foster care placement by addressing behavioral health issues and enhancing parenting skills. This builds upon the prioritization of the Department's prevention vision. While Florida believes that the best place for children is with their families, the Department recognizes that complex family dynamics, undiagnosed/untreated mental health or substance misuse issues, economic stressors, and decreased protective factors contribute to a child being removed from their home to ensure safety. The FFPSA federal reimbursement available for services that prevent the placement of children and youth in foster care, along with Medicaid and Department funding for Substance Abuse and Mental Health and local wraparound services to address economic self-sufficiency, will allow for continued investment in prevention efforts.

This plan provides a framework for how Florida intends to use FFPSA to implement and provide family-centered, trauma-informed, evidence-based services to families with the goal of preventing children and families from entering crisis services like foster care, strengthening families, and improving safety, permanency, and well-being outcomes.

The four phases outlined below include multiple pathways that are intended to revise child welfare practice, policy, and technology to create programs that move the Department toward FFPSA implementation:

- **Phase 1 Path Forward**: Secure and provide prevention resources to families, diverting them from crisis while redesigning Florida's Title IV-E claiming to support Florida's child welfare system.
- **Phase 2 Quality Placement Setting Alignment**: Increase the utilization of family-like settings concurrently building capacity and quality of congregate care to result in increased safety, permanency, and well-being.
- **Phase 3 Evidence-based Prevention Services Implementation:** Achieve better outcomes for Florida's families currently engaged with the child welfare system of care, diverting them from crisis and increasing prevention contacts by increasing Florida's utilization of evidenced-based programs (EBPs).
- **Phase 4 Community Prevention Services:** Achieve better outcomes for Florida's families not engaged with the child welfare system of care, diverting them from the child welfare system by activating not-for-profit, private sector, and faith-based partnerships within the community, and continued expansion of Florida's utilization of EBPs. **Phase 4 is an area for future development in Florida that will bridge community prevention work to foster care prevention and IV-E funding (FFPSA prevention).**

Florida implemented this phased approach to better align the state's current child welfare practices with those of FFPSA. In 2018, the Department began implementing phases in collaboration with CBCs and stakeholders and is currently focused on Phase 3. Florida intends to implement Phases 1-3 with the submission of this plan using existing processes and procedures in place across the state.

These FFPSA implementation phases will build upon a collaboration between the Department, CBCs, and local communities to establish a human-centered system of care that is informed and shaped by the families it serves.

**Child Welfare & Collaboration with Other Department Program Offices and Key Stakeholders**

The Department is composed of four program offices that provide a variety of services to individuals, families, and children. These program offices are the Office of Child and Family Well Being(OCFW), Office of Substance Abuse and Mental Health (SAMH), Office of Economic Self-Sufficiency(ESS), and the Office of Quality and Innovation (OQI). Each of these program areas meets the critical needs of the populations it serves and often attends to families with multiple complex needs. With mutually served customers and the understanding that addressing their comprehensive needs results in improved and sustained outcomes, the Department recognizes the importance of systems integration as a core competency. In order to improve the communication and engagement between program offices and to enhance partnerships with state and local stakeholders, the Department developed a care navigation model.

Hope Florida – A Pathway to Prosperity is a new initiative being implemented by the Department, utilizing 'Hope Navigation to guide Floridians on an individualized path to prosperity by focusing on community collaboration between the private sector, faith-based community, nonprofits and government entities to break down traditional community silos, maximize resources, and uncover opportunities. Hope Navigation is essential in helping individuals identify their unique and immediate barriers to prosperity, develop long-term goals, map out a strategic plan and work to ensure all sectors of the community have a 'seat at the table' and are a part of the solution. Hope Florida – A Pathway to Prosperity was initially piloted in August 2020 in six counties as a voluntary program available to Department customers receiving public benefits. Services are available statewide to: children aging out of foster care, pregnant mothers contending with substance misuse disorders, and other families in need of assistance.

As the Department explores its prevention approach, we aim to capture individuals entering the system through any of the Department program offices. Care navigation allows for coordinated intervention and aims to reduce further dependency and re-entry into the system.

The Department is committed to utilizing a holistic and integrated prevention model to address the full needs of an individual or family, regardless of how they enter the system. This focus requires a cultural shift system-wide to fully comprehend the scope of preventive intervention resources available, and collaboration with partner agencies to provide warm handoffs to services. A care navigation model will result in a more thorough assessment of an individual or family's needs, identification of services, and streamlined linkage to those resources.

A Family Navigator initiative has been created to enhance the safety and well-being of Florida children after a report of potential child abuse or neglect. The Department has worked with child protection and behavioral health leaders across the state to form a new strategy, which will improve supports for child protective investigators (CPI) to enhance outcomes for Florida's families based on the following criteria:

| | |
|---|---|
| 0-5 / Tier 1 RSF expanded 0-5<br><br>RED | • Victim or child in the home ages 0-5 AND<br>• Allegation of maltreatment of Family Violence Threatens Child and/or Intimate Partner Violence Threatens Child AND<br>• Allegation maltreatment related to substance misuse (substance misuse, substance misuse-alcohol, substance misuse-prescription drugs, substance misuse-illicit drugs, and/or substance exposed newborn) AND<br>• Allegation of maltreatment of Physical Abuse (asphyxiation, bone fracture, burns, internal injuries, physical injury) or Sexual Abuse (sexual abuse, sexual abuse-sexual battery, sexual abuse-sexual exploitation by parent, sexual abuse-sexual molestation) |
| 0-5 / Tier 2 RSF expanded 0-5<br><br>YELLOW | • Victim or child in the home ages 0-5<br>• Allegation of maltreatment of Family Violence Threatens Child and/or Intimate Partner Violence Threatens Child AND<br>• Allegation of maltreatment related to substance misuse (substance misuse, substance misuse-alcohol, substance misuse-prescription drugs, substance misuse-illicit drugs, and/or substance exposed newborn)<br>• At least 1 prior report on the child victim, another child in the home, or adult/caregiver in the home |

A key component of ensuring child safety, and family well-being, is activating community resources, supports, and mental health treatment services timely and appropriately. As trained clinicians, Family Navigators will work alongside the CPI and family to quickly help assess, locate, and provide pivotal services to ensure the family unit is stabilized, safe, and on a pathway to building a resilient family unit. Florida's child and family well-being system will continue to invest in fully embodying a trauma-responsive system of care where the Department, Community-Based Care organizations, and Managing Entities come together to provide more meaningful services that promote positive outcomes to enhance the overall, long-term well-being of the family.

The Department is working with Florida's leadership, through the work of the Florida Children and Youth Cabinet, to align a statewide prevention framework for all state agencies to establish a consistent message about the importance of

primary, secondary, and tertiary prevention services. Through, the Department Secretary's participation on the Florida Children and Youth Cabinet, and the Cabinet's interagency agreement, local, and state review teams have been established to strategically focus on complex cases. The interagency agreement can be found on the Department's website[1]. Local Review Teams are established within each judicial circuit and convene monthly to resolve case-specific issues that cannot be addressed by an individual's treatment team. In addition to scheduled monthly staffings, additional meetings may be called in the event of a crisis or emergency involving a child. Elevation to the State Review Team is requested if issues cannot be resolved at the Local Team level.

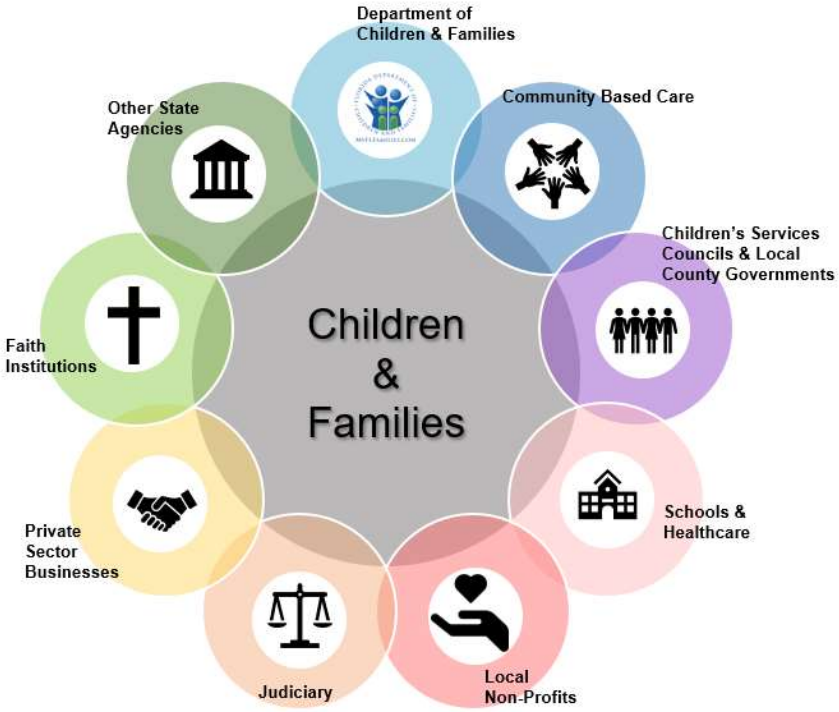


*Figure 2. Continuum of Child Welfare Stakeholders*

The Department serves as the lead to convene review teams at each level. The participants within Local Teams include state agency partners, contractors, and providers based on the types of issues and needs identified. The State Review Team includes monthly participation from Cabinet agencies, representatives, and stakeholders to review data collected from all Review Teams involving community and systems-involved youth and identify training topics to strengthen interagency collaboration and coordination. The Department recognizes the need to involve all stakeholders who may be able to support children and families and the importance of engaging these stakeholders to achieve the best outcomes. (See Figure 2).

## 2. CHILD AND FAMILY ELIGIBILITY FOR THE TITLE IV-E PREVENTION PROGRAM

A Florida FFPSA candidate for the Title IV-E Prevention Program is defined as a child or youth, formally assessed through community engagement or abuse hotline reporting to be at-risk of entering foster care, who can remain safely in their home or in a kinship placement with evidence-based prevention services delivered by/through community-based service networks (CBCs, Children Services Councils, or other county prevention agencies) or the Department of Children and Families.

[1] https://myflfamilies.com/service-programs/child-welfare/kids/publications/interagency-agreements.shtml)

A child/youth may be at imminent risk of entering foster care based on **alleged maltreatment** and/or **circumstances** and **characteristics** of the family unit, individual parents, and/or children that may **affect the parents' ability to safely care for and nurture their child in their own home**.

Circumstances or characteristics of the child, parent, or kin caregiver that could put children at imminent risk of entering foster care may include, but are not limited to:

- Experiencing or have experienced substance use or addiction.
- Experiencing or have experienced mental illness.
- Need for in-home parenting support and/or enhanced parental knowledge of child and youth development.
- Demonstrated limited capacity to function in parenting roles (i.e., interpersonal relationships that are characterized by a lack of coping, escalations to violence and/or power and control dynamics, intergenerational patterns of abuse and/or neglect).
- Parental support needed to address serious needs of a child related to the child's behavior or medical condition.
- Need support for a developmental delay.
- Need support for a physical or intellectual disability.
- Support of adoption or guardianship arrangements that are at risk of disruption.
- Support of parental resiliency and/or concrete resources (i.e., family stressors, poverty).

The Department has designated staff to render the final decision of prevention candidacy eligibility. The process is similar to the “traditional” IV-E candidacy determination process. Prevention candidacy eligibility (see section 2) will be captured in the Comprehensive Child Welfare Information System (CCWIS)/Florida Safe Families Network (FSFN). The child’s eligibility date is the date the child was determined to be a candidate for foster care or as a pregnant or parenting foster youth. The candidacy date for the family support population will be documented in CCWIS/FSFN under the family support module. Candidacy for in-home safety management populations will be documented in the CCWIS/FSFN under the living arrangement module, and the out of home care while pregnant and parenting will be documented in the out of home placement module. Adoption populations will be documented in the adoptions module in CCWIS/FSFN. The Department will use a modified quality assurance system tool to support the prevention candidacy determinations/redeterminations. The tool provides the ability to aggregate data for both qualitative and quantitative measure by the Department for rendering the final decision and provides the ability to monitor determinations. (See Figure 3.)

| Data Element | Family Support In-Home (Prevention/Voluntary) | In-Home Dependency and Reunified (Post-Placement) | Out of Home while Pregnant & Parenting | Adoption |
|---|---|---|---|---|
| Candidacy Begin Date | Family Support Begin Date | Living Arrangement Begin Date | Out of Home Placement + Pregnancy = 'Yes' Date | *Post-Adoption Service Coordination* |
| Candidacy End Date | Family Support End Date | Living Arrangement End Date | Out of Home Placement + Pregnancy = 'No' Date | *Post-Adoption Service Coordination* |
| Need Assessment for Risk, Safety, EBP | Needs Assessment | Family Functioning Assessment-Ongoing | Progress Update | Needs Assessment |
| Ongoing Periodic Risk & Safety | Needs Assessment | Progress Update | Progress Update | Needs Assessment |
| Prevention Strategy/Plan | Family Support Plan Worksheet | Case Plan Worksheet + Safety Plan | Case Plan Worksheet | Family Support Plan Worksheet |
| EBP w/in Plan | Service Sub-Category on Family Support Plan Worksheet | Service Sub-Category on Case Plan Worksheet | Service Sub-Category on Case Plan Worksheet | Service Sub-Category on Prevention Plan Worksheet |
| EBP service extended beyond 12 – months | Needs Assessment | Progress Update | Progress Update | Need Assessment |
| Entry into Foster Care w/in 12-month service delivery | Family Support Status Ending Comments + Out of Home Placement | Progress Update + Out of Home Placement | N/A | Post-Adoption Service Coordination + Out of Home Placement |
| Service Type Set-up | CBC creates with direction from DCF | CBC creates with direction from DCF | CBC creates with direction from DCF | OCW Adoption Program Specialist |
| Service Delivered | Service page | Service page | Service page | Service page (linked to Post-Adoption Services page) |
| Expenditure | Payment generated from Service page mapped to OCA | Payment generated from Service page mapped to OCA | Payment generated from Service page mapped to OCA | Payment generated from Service page mapped to OCA |

*Figure 3. Prevention Candidacy Eligibility*
*Source: CFOP 170-1 Chapter 17*

## 3. SERVICE DESCRIPTION AND OVERSIGHT

Florida has 67 counties and 412 incorporated municipalities (283 cities, 109 towns, and 20 villages). It has the third highest population in the nation with more than 21 million residents, including 1.15 million residents who are under the age of five. Florida has worked with community and child welfare stakeholders to identify the existing "service array" of currently available, evidence-based services with the goal of leveraging and expanding service arrays to meet the needs of children and families. The Department partnered with Casey Family Programs in October 2017 to establish the Child Service Array Workgroup, comprised of CBCs and stakeholders. It worked to inform the assessment and expansion of treatment and well-being services to enhance the availability of evidence-based and promising interventions.

The methodology to identify child needs included an expert panel of recognized national and state experts in child welfare and behavioral health. A latent class analysis was conducted by Casey Family Programs and utilized the Child and Adolescent Needs and Strengths (CANS) assessment to better meet the child's needs. The Department also extrapolated data from the FSFN to create "child profiles" based on child needs identified in the Family Functioning Assessment – Ongoing (FFA-O). The results of this workgroup identified 29 promising, supported, or well-supported interventions and set the foundation for the second phase, which looked at capacity and provided a gap analysis. Casey Family Programs contracted with the University of South Florida to conduct a survey of Community-Based Care Lead Agencies. The survey collected information on the availability and funding for the 29 interventions identified in the first phase. Funding information included Medicaid and Department behavioral health funding contracted through Managing Entities.

The Department contracts with the Managing Entities for behavioral health services through regional systems of care. These entities do not provide direct services; rather, they allow the Department's funding to be tailored to the specific behavioral health needs in the various regions of the State. Executed Managing Entity contract documents are available on the Florida Accountability Contract Tracking System (FACTS), maintained by the Florida Department of Financial Services.

Prior to selecting the evidence-based program providers for FFPSA, the subcommittee held meetings to identify existing programs in operation around the state and evaluate the programs for implementation that offered the most appropriate services based on the needs of the children and families in Florida. The service array work was expanded by surveying Community-Based Care Lead Agencies and Managing Entities on their capacity and the importance of local capacity building for evidence-based programs rated as well-supported, supported, or promising by the Clearinghouse (see Figure 4). The survey results were used by the Family First Transition Act Workgroup to inform the selection of an array of prevention programs that meet the evidence levels required by the FFPSA. The consultation efforts helped the Department establish the actions needed to expand the current service array for evidence-based mental health and substance use disorder prevention and treatment services, and in-home skilled based programs to move Florida toward the creation and implementation of a prevention plan.

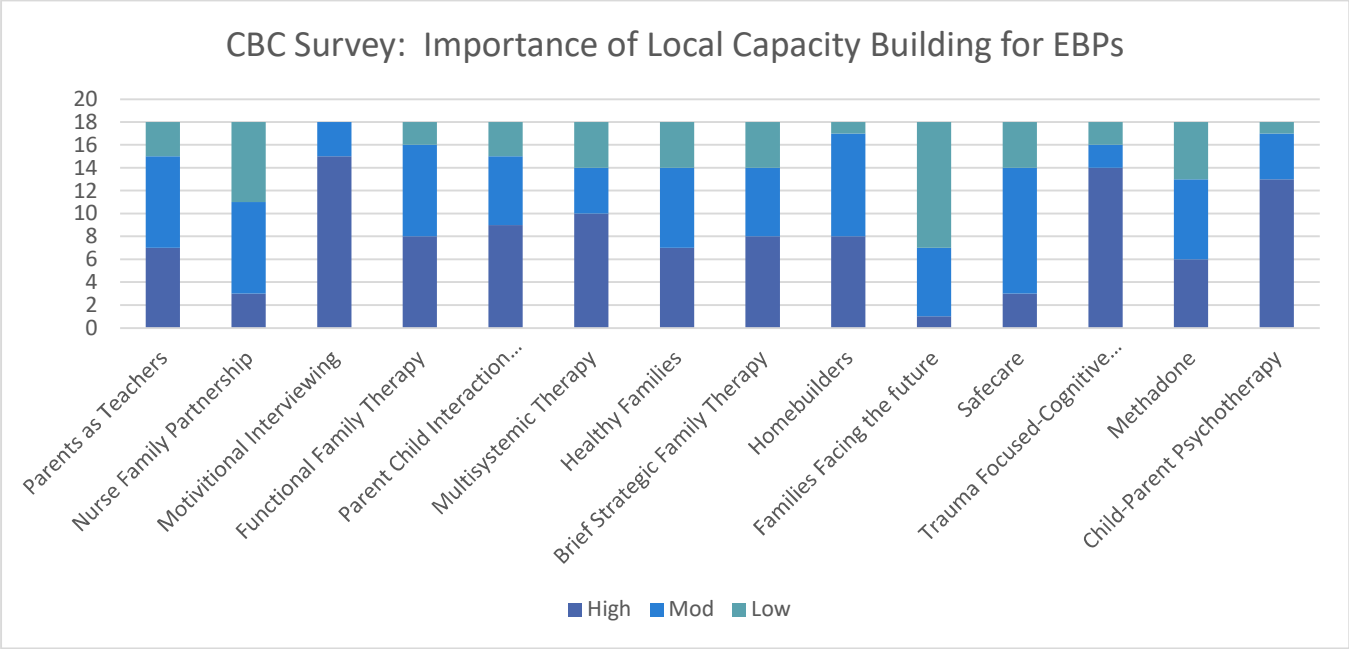


*Figure 4.CBC Survey: Importance of EBPs*

System Continuous Quality Improvement (CQI), monitoring, and evaluation activities will work in tandem to assess fidelity to the program model, to evaluate program effectiveness, to refine and improve practices, and to assess outcomes for children and families. Well-supported Evidence Based Practice Services (EBPs) have defined fidelity measures that will be integrated into contractual requirements for service providers. Use of tools, checklists, and coaching identified by program developers will be required by service providers. Quarterly program reporting will also be included in the contract requirements for providers delivering this EBP. In addition to outcome reporting, providers will report basic demographic information on program participants, numbers of referrals to the program by referral source, number and percentage of participants engaged in the EBP, the number and percentage of participants initiating treatment, the number and percentage not initiating treatment, and reasons why. The reporting will be shared with the contracted vendor conducting the evaluation of EBP service delivery to fidelity.

Approved, well-supported, evidence-based, mental health and substance use disorder prevention and treatment and in-home parent skill–based programs will be provided to a child and the child's parent or kin caregiver for up to 12 months for each prevention period beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child-specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan. The effective date for claiming for the EBPs services selected in Florida's prevention plan is October 1, 2021.

Florida will utilize the one-time flexible Family First Transition Act funding to provide training for CBC employees in specific EBPs to support capacity building of prevention services. Additionally, Sunshine Health, Florida's Specified Medicaid Child Welfare Specialty Plan, and CBCs will offer start-up and training opportunities in line with Florida's selected EBPs. Florida is formally proposing nine (9) evidence-based practices in this five-year plan. (See Table 1.)

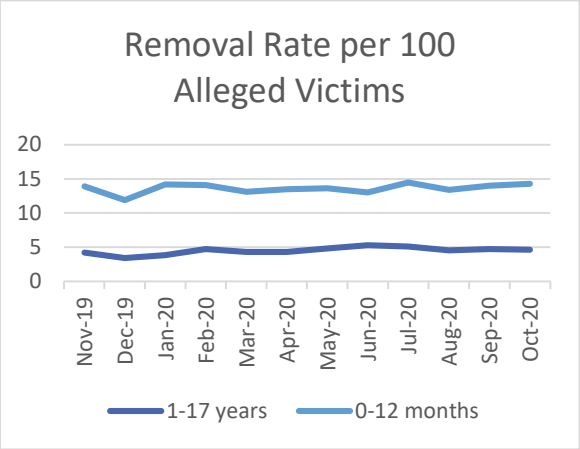


*Figure 5. Continuum of Child Welfare Stakeholders*

In Florida, children from birth to 1 are at the highest risk for removal. **Healthy Families America (HFA)**, **Nurse Family Partnership (NFP)**, and **Parents as Teachers (PAT)** work with new and expectant parents. These home visiting programs offer an opportunity to enhance the parent-child relationship as early as possible and prepare expectant parents with the skills needed to provide a healthy and safe environment for their children. It is important to note that each of these model programs are designed to allow for the initiation of services prior to the birth of the child. A child cannot meet the definition of a candidate for foster care prior to being born for purposes of IV-E reimbursement. However, pregnant youth in foster care can potentially meet eligibility criteria prenatally for purposes of IV-E reimbursement. Thus, with the exception of pregnant youth in foster care, enrollment in these programs may begin prenatally, but IV-E reimbursement for these home visiting programs would only be from birth (See Table 1).

**Homebuilders – Intensive Family Preservation and Reunification Services** aims at reducing out-of-home placement. This service is provided in-home or in the community and collaborates with the family to develop goals and service plans, utilizing research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy. Families also have access to their therapist 24 hours a day, 7 days a week. This intensive service intervention is achieved by maintaining low caseloads (2-3 cases at a time) and can address basic needs, such as food, clothing, and shelter. Families receive time-limited, concentrated services to resolve immediate crises and learn the skills necessary to remain together and prevent further entry into the child welfare system. Florida has selected HOMEBUILDERS standards 4.1 revised 9/4/14 ( http://www.institutefamily.org/pdf/HOMEBUILDERS-Standards-4-1.pdf ) for implementation and will use HOMEBUILDERS Fidelity Measures – Abridged 3.0 revised 5/30/14 (http://www.institutefamily.org/pdf/HOMEBUILDERS-Fidelity-Measures-Abridged-3.0.pdf). The Homebuilders' model has established extensive program standards and fidelity measures that will be integrated into contractual requirements for service providers. The Homebuilders' quality enhancement system, known as QUEST, is designed to assure quality through the development and continual improvement of the knowledge and skills necessary to obtain model fidelity and service outcomes. Data collection strategies for this EBP are anticipated to be through administrative data/reporting.

**Parent-Child Interaction Therapy (PCIT)** provides a family-centered treatment approach for children with disruptive behaviors, ages 2-7 years old. This approach targets the behaviors of both the parent and child using play therapy and immediate feedback and coaching to the parent. PCIT has also shown positive outcomes specific to child welfare populations where the parent/caregiver is the perpetrator of physical abuse.

Florida has selected **Brief Strategic Family Therapy**, **Functional Family Therapy**, and **Multisystemic Therapy** to address the population of older youth that may enter the child welfare system due to behavioral problems. Expansion of these EBPs in Florida will provide more capacity to intervene before behaviors become ungovernable and result in out-of-home placement. Each of these models uses a family-centered approach to develop prosocial behaviors and positive family functioning.

**Motivational Interviewing (MI)** is currently the only well-supported EBP on the Clearinghouse that addresses parent/caregiver substance use as the target population. Florida is offering training on Motivational Interviewing to Family Intensive Treatment (FIT) teams and Child Welfare case management.

The FIT team model was designed to provide intensive team-based, family-focused, comprehensive treatment services to families in the child welfare system experiencing parental substance misuse. A core component of the FIT model is the integration of substance misuse, mental health, and child welfare services for families served.

FIT Team Providers accept families referred by the child protective investigator, child welfare case manager or Community-Based Care Lead Agency. Providers and stakeholders working with child welfare families, such as engagement programs and the dependency court system, can also refer eligible parent(s)/guardian(s). By utilizing the principles of MI, treatment providers can more effectively engage parents, retain them in substance use treatment, and improve outcomes.

The longevity of a family's involvement with child welfare is greater under the assignment of a case manager; therefore, Florida's strategy is to use MI as a tool to enhance a case manager's ability to engage families in treatment services and serve as a reinforcement for overall good case practice. Case managers will be expected to utilize MI once the family is transferred from the investigations team. Casework for prevention services aligns with the practice model, which focuses on the skills of engaging, assessing, teaming, planning, and intervening.

Currently, Florida does not plan to claim IV-E reimbursement for the delivery of MI as an individual EBP or as a bundled service. When claiming MI for administrative costs, the Department must determine the child to be eligible with a child-specific prevention plan. Prevention candidacy eligibility will be captured in the Comprehensive Child Welfare Information System (CCWIS)/Florida Safe Families Network (FSFN). The child's eligibility date is the date the child was determined to be a candidate for foster care or as a pregnant or parenting foster youth. Candidacy for in-home safety management populations will be documented in the CCWIS/FSFN under the living arrangement module, and the out of home care while pregnant and parenting will be documented in the out of home placement module.

The Department will use a modified quality assurance system tool to support the prevention candidacy determinations/redeterminations. The tool provides the ability to aggregate data for both qualitative and quantitative measures by the Department for rendering the final decision and provides the ability to monitor determinations. The Department has designated staff to render the final decision of prevention candidacy eligibility.

MI will be carried out with fidelity as an integral component of the practice model and case management for families served under this plan. MI will be carried out by case managers both as:

(1) Stand Alone Evidence-Based Service: To advance case goals identified in the child specific prevention plan in partnership with families, regardless of whether the family participates in any additional EBP services throughout the life of the family's prevention case.

(2) Adjunctive Evidence-Based Service: When participation in an additional EBP is appropriate, to improve appropriate selection of the additional EBP for both children and caregivers, ensure that each family has the dedicated support and motivation to sustain engagement in often intensive service interventions—thereby bolstering outcomes of additional EBPs. The empirical evidence available in the psychological literature has

strengthened commitment to designing and implementing MI not only as a stand-alone service integrated within case management, but also as a service adjunctive to a broader range of preventive EBPs.

*Table 1. Florida Selected Evidence-Based Programs*

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| **Homebuilders – Intensive Family Preservation and Reunification Services. HB is being implemented without adaptation.**<br><br>**HB Standards 4.1 revised 9/4/14 will be implemented.**<br><br>**Book/Manual/Available documentation:**<br>**Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together: The HOMEBUILDERS model*. Taylor Francis.** | In-home Parent Skill-Based | Families with children from birth to 18 years at imminent risk of placement into or needing intensive services to avoid placement into foster care, group or residential treatment, psychiatric hospitals, or juvenile rehabilitation facilities. | This program is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning and by enlisting them as partners in assessment, goal setting and treatment planning. | Florida will seek leverage with favorable outcomes referenced by the Prevention Services Clearinghouse for families receiving Homebuilders services:<br>• Adult Well-Being:<br>○ Improved Family Functioning: Families who complete the service show progress on goal attainment ratings for at least one goal at service closure (excluding ineligible referrals).<br>○ Reduce family conflict<br>○ Child Well-Being<br>○ Improved behavioral and emotional functioning<br>○ Reduced delinquent behavior<br>○ Reduced substance Abuse<br><br>Outcome Measures:<br>% successfully avoid out –of-home placement 6 months following closure of intensive services (excluding ineligible referrals) | • Staff qualifications<br>• Staff successful completion of required training<br>• Staff: supervisor ratio<br>• 24-hour availability<br>• Services provided in their natural environment<br>• Caseload limit 1 staff to 18 to 22 families/year<br>• Supervisor availability<br><br>Fidelity Monitoring Tool:<br>Homebuilders Fidelity Measures-Abridged |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| **Motivational Interviewing (MI). MI is being implemented without adaptation.**<br><br>**Book/manual/ documentation: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.** | Substance Abuse | Parents/caregivers with substance use disorder who have children from birth to 18 years who are at imminent risk of placement into foster care. | MI is a person-centered, directive method designed to enhance a person's internal motivation for behavior change, to reinforce this motivation and develop a plan to achieve change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate individuals for other treatment modalities. MI can be used to promote behavior change with a range of | Florida will seek leverage with favorable outcomes referenced by the Prevention Services Clearinghouse for the use of Motivational Interviewing skills to :<br>○ Engage with youth and families.<br>○ Reducing risk through building skills and assisting the youth to remain or tranisiton back into their community.<br>○ Coordination of multi disciplinary meetings.<br>○ Development of prevention plans.<br>○ Enhance internal motivation to change<br>○ Enhanced substance use treatment initiation | • Staff successful completion of required model training: initial and booster<br>• Counselor competence/model adherence: collaboration, evocation, and autonomy<br>• Counselor skill demonstration: empathy<br><br>Monitoring Tool:<br><br>Evaluation completed by the University of South Florida (USF) on delivery and targeted outcomes, through participation in meetings; performing data and documentation gathering; researching; conducting data analysis; development of surveys; and conducting technical reviews. |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | target populations and for a variety of problem areas. | | Use of the Length of Case Review Tool by the Quality Office during ongoing random moment sampling. |
| **Healthy Families America. Healthy Families America is being implemented without adaptation.**<br><br>**Book/Manual/ documentation: The *Best Practice Standards* are implemented in conjunction with the *State/Multi-Site System Central Administration Standards.***<br>***Healthy Families America. (2018) Best practice standards. Prevent Child Abuse America.***<br>***Healthy Families America. (2018). State/multi-site system central administration standards. Prevent Child Abuse America. And the Child Welfare HFA Protocol.*** | In-home Parent Skill-based | Families of children (Enrollment during prenatal or within 3 months of birth) who have increasd risk for maltreatment or other adverse childhood experiences | Healthy Families is a multi-year, intensive, home visiting program for new parents. The program best serves families who are high-risk, including those families who may have histories of trauma, intimate partner violence, mental health issues and/or substance use issues. Services focus on promoting healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for Healthy Families America, Florida expects to see the following outcomes for children and families receiving this service:<br><br>• Increased nurturing parent-child relationships<br>• Enhanced family functioning<br>• Increased protective factors<br>• Reduced risk for child abuse and neglect<br><br>Outcome Measures:<br>• Reduction in reports of child maltreatment. | • Staff and supervisory caseload<br>• Service duration<br>• Service Dosage<br><br>Monitoring Tool: HFA Best Practice Standards |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | and use of services, and reducing social isolation. | • Improvement in child behavioral and emotional functioning.<br>• Improvement in child cognitive functions and abilities.<br>• Reduction of delinquent behavior.<br>• Increased educational achievement and attainment;<br>• Increased positive parenting practices.<br>• Improvement of parent/caregiver mental or emotional health.<br>• Improvement of family functioning. | |
| **Functional Family Therapy (FFT). FFT is being implemented without adaptation.**<br><br>**Book/Manual/ Documentation: Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavioral problems.* American Psychological Association.**<br>**Sexton, T. L. (2010). *Functional Family Therapy in clinical*** | Mental Health | Youth 11 to 18 years of age who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Youth with family at discord is also a | FFT is a family intervention program for at-risk youth and their families. The programming is delivered by master's level therapists, meeting weekly with families face-to-face for 60 to 90 minutes and by phone for up to | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, Florida expects to see the following outcomes for children and families receiving this service:<br><br>• Reduce family conflict<br>• Reduce youth referral problems (i.e., delinquency, oppositional | Fidelity of implementation will be monitored with program specific tools. FFT has intensive procedures for monitoring quality of implementation on a continuous basis and Fidelity and outcome measures are reported |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| ***practice: An evidence-based treatment model for at risk adolescents*. Routledge.**<br><br>**** The Providers delivering FFT fidelity must determine which manual will be used. The provider will advise which manual is being used and can not alter between the two during service delivery with the family. Verification will be captured through fidelity monitoring and Quality Assurance reviews.** | | target factor for this program. | 30 minutes. On average, most families complete the FFT program in 8 to 14 sessions delivered over three to six months. Up to 30 sessions can be delivered for severe cases. | behaviors, violence, substance use)<br>• Improve prosocial behaviors (i.e., school attendance)<br>• Improve family functioning and skills<br><br>Outcome Measures:<br>• % of youth, siblings, and caregivers who remain in the community.<br>• % of cases without an intensification of referral problems.<br>• % of youth attending school.<br>• % of youth without law violations.<br>• % of families without safety incidents. | to model developer on an ongoing basis in all FFT sites.<br>• Staff qualifications<br>• Staff successful completion of required model training<br>• Weekly supervision Checklist<br>• Global Therapist Rating<br><br>Monitoring Tools:<br><br>Global Therapist Checklist/Weekly Supervsiorion Checklist-FFT,LLC.<br><br>Therapist Adherence Measure (TAM). Supervisor Adherence Measure (SAM)- FFT Partners. |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| **Brief Strategic Family Therapy (BSFT). BSFT will be implemented without adaptation.**<br><br>**Book/Manual/Documentation:**<br><br>**Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse.** | Mental Health, Substance Abuse, In-home Parent Skill-based | Families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying or truancy. | BSFT is a brief intervention used to treat adolescent drug use, conduct problems, oppositional behavior, delinquency, aggressive and violent behavior, and risky sexual behavior. BSFT is a family systems approach which recognizes that patterns of interaction in the family influence the behavior of each family member. The BSFT counselor identifies the patterns of family interaction that are associated with the adolescent's behavior problems and plans interventions that specifically target and provide practical ways to change those patterns of | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for BSFT, Florida expects to see the following outcomes for children and families receiving this service:<br><br>Child Well Being<br>○ Reduced delinquent behavior<br>Adult Well-Being<br>○ Improved family functioning<br><br>**Outcome Measure:**<br>% decrease in delinquent behavior<br>% Improved family functioning children remain in the home | • Model identified fidelity requirements for licensure<br>• Staff qualifications<br>• Staff successful completion of required model training<br><br>Monitoring Tools:<br><br>The Therapist Adherence Scale |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | interactions that are directly linked to the adolescent's problem behavior. BSFT directly provides services to parents/caregivers and addresses lack of parental leadership, unhealthy parental collaboration, lack of guidance and nurturance to adolescents in their care. | | |
| **Multisystemic Therapy (MST). MST is being implemented without adaptation.**<br><br>**Book/Manual/ Documentation: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and* ** | Mental Health, Substance Abuse | Youth between the ages of 12 and 17 who are at-risk for or engaging in delinquent activity or substance misuse, experience mental health issues and are at-risk for out-of-home | MST is an intensive treatment for troubled youth. The program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, substance use and out-of-home placements. MST addresses the | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for MST , Florida expects to see the following outcomes for children and families receiving this service<br>• Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) | • MST Institute data reporting requirements for fidelity assurance<br>• Staff qualifications<br>• Staff successful completion of required model training<br>• Caseload: max 6 families per therapist |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| ***adolescents* (2nd ed.). Guilford Press** | | placement and their families. | core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, school, and community. The intervention strategies are personalized to address the identified drivers. | • Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents<br>• Empower youth to cope with family, peer, school, and neighborhood problems<br><br>Outcome Measures:<br>○ % of youth living at home<br>○ % of youth with no new arrests<br>○ % of youth in school/working | Monitoring Tools:<br>The Therapist Adherence Measure Revised (TAM-R).<br>The Supervisor Adherence Measure (SAM). |
| **Nurse-Family Partnership (NFP). NFP is being implemented without adaptation.**<br>**Book/Manual/ Documentation: Nurse Family Partnership. (2020) Visit-to-vist guidelines** | In-home Parent Skill-based | First time, low-income mothers from birth through their child's first two years, or pregnant or parenting youth in foster care. | The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low -income mothers beginning during pregnancy and continuing through the child's second | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for NFP, Florida expects to see the following outcomes for children and families receiving this service:<br>• Child development | Data reporting requirements specified by the Nurse-Family Partnership National Service Office (NFP NSO). NFP NSO reports assess agencies, guide program implementation, and assess model fidelity. |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | birthday. The program promotes women's health, pregnancy outcomes, early childhood development, and parenting capacity. It also enhances relationships and economic well-being of mothers and their children. Nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. | • Child well-being<br>• Positive parenting practices<br><br>Outcome Measures:<br>○ Reduced child welfare administrative reports.<br>○ Improved cognitive functions and abilities.<br>○ Improved physical development and health.<br>○ Improved economic and housing stability. | • Staff qualifications<br>• Staff successful completion of required model training<br>• Staff: supervisor ratio no more that 1:6<br>• Caseload limit 25 clients per nurse<br><br>Monitoring Tool:<br><br>Adherence to 19 Fidelity Standards |
| **Parent-Child Interaction Therapy (PCIT). PCIT is being implemented without adaptation.**<br><br>**Book/Manual/ Documentation: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction*** | Mental Health | Parents/ caregivers with children who are between 2 years and 7 years old who experience frequent, intense | PCIT is a dyadic behavioral intervention for children ages 2-7 years and their parent or caregivers. PCIT | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, | Providers of PCIT are required to implement fidelity monitoring and outcome measurement using PCIT tools which are available through |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| ***Therapy protocol: 2011.*** **PCIT International, Inc.** | | emotional, and behavioral problems. | 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 reinforcement of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with | Florida expects to see the following outcomes for children and families receiving this service:<br>• Increased parent-child closeness<br>• Decreased anger and frustration<br>• Increased self-esteem<br>• Increased parental ability to comfort the child<br>• Improved parenting skills in behavior management and communication<br><br>Outcome Measures:<br>○ Improved child behavioral and emotional functioning<br>○ Improved positive parenting practices<br>○ Improved parent/caregiver mental or emotional health | PCIT International. PCIT is guided by weekly data from the Eyberg Child Behavior Inventory (ECBI) and the Dyadic Parent-Child Interaction Coding System (DPICS).<br><br>Monitoring Tool:<br>PCIT Fidelity Checklist |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | immediate feedback on their use of the new parenting skills, which enables them to apply the skill and master them rapidly. | | |
| **Parents as Teachers (PAT). PAT is being implemented without adaptation.**<br><br>**Book/Manual/ Documentation: Parents as Teachers National Center, Inc. (2016). *Foundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.*** | In-home Parent Skill-based | Parents with young children (birth-5 years) in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance use in the family and chronic health condition, or pregnant or parenting youth in foster care. | PAT is an early childhood parent education, family support, family well-being, and school readiness home visiting model. It teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. The PAT model includes four core components: personal home visits, supportive group connection events, child health and | Consistent with the outcomes identified as having a positive effect through the review of research conducted by the Title IV-E Prevention Services Clearinghouse for PAT, Florida expects to see the following outcomes for children and families receiving this service:<br>• Improved child behavioral and emotional functioning<br>• Increased positive parenting practices<br>• Improved parent/caregiver mental or emotional health<br>• Increased child safety<br><br>Outcome Measures: | The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an affiliate performance report. Providers of PAT are required to implement fidelity monitoring and outcome measurement using PAT planning and reporting tools.<br>Essential requirement:<br>• Staffing/ staff oversight<br>• visit frequency<br>• delivering home visits using the required forms |

| Program or Service | Service Category | Target Population | Program Information | Outcomes | Fidelity Monitoring |
|---|---|---|---|---|---|
| | | | developmental screenings, and community resource networks. | • Reduction in reports of child maltreatment.<br>• Improvement in child social functioning.<br>• Improvement in child cognitive functions and abilities. | • participating in model fidelity reviews.<br><br>Monitoring Tool: Parents as Teachers "Essential Requirements" |

Cross-EBP research questions related to outcomes:

a. Well-Being

i. Do children/families that receive prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (this will be tailored to the EBP-specific program goals)?

ii. Do children/families that complete prevention services experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (this will be tailored to the EBP-specific program goals)?

b. Safety

i. Does receipt of prevention services reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?

ii. Does prevention service completion reduce maltreatment? Are children referred or re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?

c. Permanency

i. Does receipt of prevention services reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?

ii. Does completion of prevention services reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?

EBP model developers use designated monitoring tools and web-based systems to collect from providers, information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Florida plans to modify contracts as needed to ensure all necessary monitoring tools data and quality improvement data is being collected from each provider, including the data reported to model developers. Florida intends to utilize these data and EBP data systems, internal child welfare systems, and other data collection processes to inform its CQI effort.

## 4. EVALUATION STRATEGY AND WAIVER REQUEST

All evidence-based programs selected for this initial five-year prevention plan have been rated as well-supported by the Title IV-E Prevention Services Clearinghouse. Florida will be seeking a waiver for evaluation of these programs. (See Attachment II, State Request for Waiver of Evaluation Requirement for a Well Supported Practice.) Florida has selected to waive the evaluation for all nine EBP based on evidence (See Section 12: References) that supports each EBP is effective for the populations Florida will serve.

The Department has entered into a contract effective May 2022 with the University of South Florida (USF) for services to evaluate the implementation to fidelity of each of the EBPs contained in this plan. As required by the contract, USF has assembled a diverse team of researchers with extensive expertise in designing evaluation research studies, implementation science, and evaluation of evidence-based and promising practices, as well as a long history of relationships with organizations throughout Florida's child welfare system. The team will build on their collective depth of experience in systems change efforts to provide comprehensive, mixed methods evaluation of fidelity to EBP's (process, fidelity, and outcomes), create a CQI system for collection of data for analysis, and a responsive technical assistance (TA) plan for meeting challenges identified.

This partnership will actively collaborate with the Department, Regional and Community Based Care leadership, Subject Matter Experts, Universities, and providers responsible for the training and implementation of the selected Evidence Based Practices (EBPs), and other key stakeholders to promote optimal development, implementation, and sustainability efforts to support Florida's Families First Prevention Plan.

The first deliverable in the contract with USF is a comprehensive project evaluation plan. This plan will include details and a timeline for the evaluation, inclusive of specific methodology for the process, outcome, and fidelity components, and how data will be used for technical assistance to support the goal of fidelity for the EBPs in the Florida Families First Prevention Plan.

The process evaluation will assess the practice components of each of the EBPs at the state and individual local level (across counties and across proposed pathways) based on the tools recommended by each model developer. Thus, the process evaluation will tailor data collection strategies for monitoring for each EBP. The objective is to provide ongoing feedback to the Department regarding progress and challenges to provide recommendations for improving implementation. The information learned from this continuous monitoring will be used to improve practice. The first Process Evaluation Report for each EBP is due in April 2023 and the first action plan for each EBP is due in May 2023. The action plan for each EBP will identify strengths and weaknesses of the EBP and the USF team will work with the service providers to develop action plans to address any weaknesses with the implementation, if found.

The USF evaluation will also assess the achievement of the target outcome measures of each EBP. Table 1 contains proximal outcomes for each EBP, and Figure 8 contains distal outcomes that are anticipated to be achieved with the implementation of these EBPs. The final list of proximal and distal outcomes will be contained in the comprehensive project evaluation plan. It is anticipated that data collection strategies for monitoring outcomes will primarily be through standardized instruments and administrative data. The USF outcome evaluation will include tracking the quantitative and qualitative outcome measures of each EBP monitored at the state and individual local level.

The first outcome and fidelity evaluation brief is due June 1, 2023. This report will contain preliminary data for each individualized EBP monitored at the state and individual local level on the evaluation of fidelity and outcomes, recommendations for delivery to fidelity, and target outcomes for each EBP that was identified as not meeting fidelity standards. Process evaluation, fidelity, and outcome monitoring will continue under this contract through June 30, 2024.

Florida will also leverage the existing Results-Oriented Accountability Program (ROA) and the Office of Quality and Innovation to operationalize a consistent statewide evaluation strategy and fidelity monitoring of Florida's FFPSA prevention service delivery through Title IV-E.

In 2020, Florida passed the Department Accountability Act creating the OQI. The OQI, in partnership with OCFW, uses the ROA framework described below for measuring the success of efforts to improve child welfare safety, permanency, and well-being outcomes, while promoting a culture of transparency and accountability. The OQI increases the Department's insight into the quality of the work at the front line, enhances the analytical capacity of the Department, and facilitates performance improvement projects to support the operations teams and improve outcomes for children and families. These processes also facilitate all Florida child welfare community stakeholders to identify and manage their contributions to the achievement of outcomes for children and their families. Once vendor selection is complete, an evaluation plan will be developed utilizing the ROA framework. (See Figure 6.)

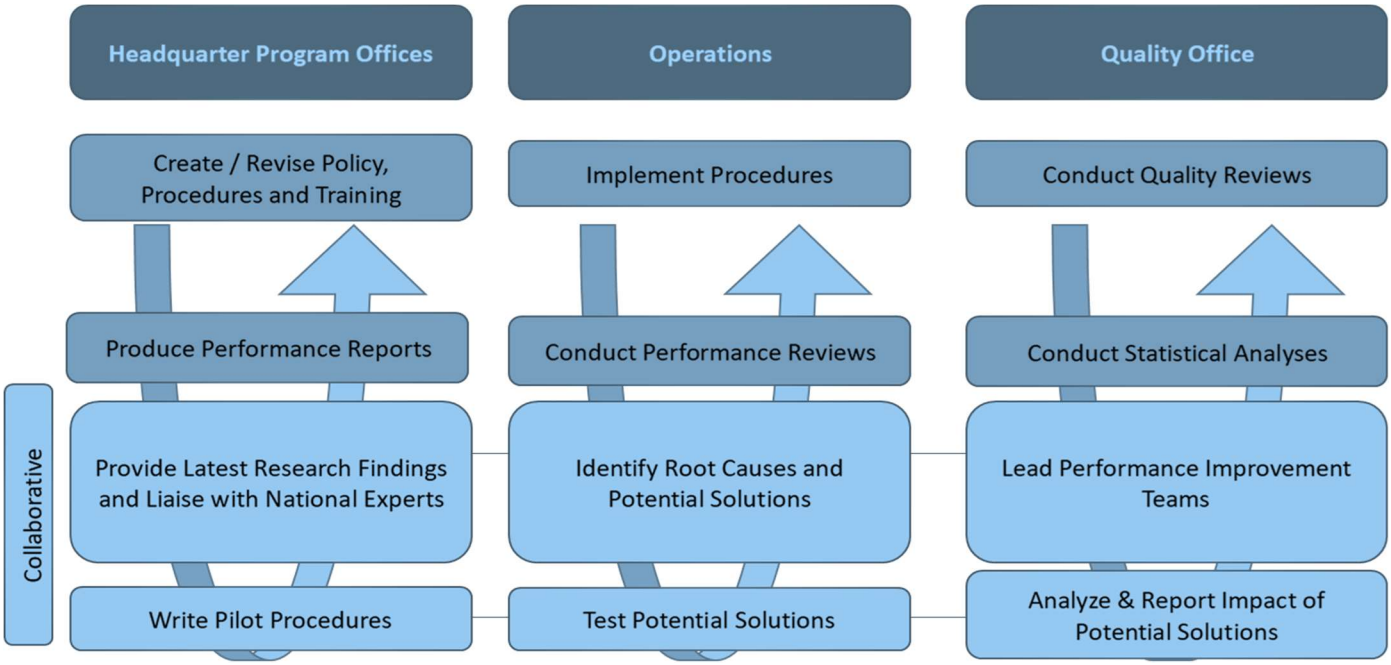


*Figure 6. Department's Quality Improvement Framework*

The unique partnerships within Florida's child welfare community create opportunities for long-term improvement by bringing together many perspectives and experiences with a singular focus on improving the lives and safety of families in Florida. These key stakeholders and partners include the Department, CBCs, communities, providers, contractors, faith-based institutions, private sector businesses, other state agencies, Tribes, and the Judiciary.

ROA prompts the child welfare community to take a long-term view, and to confirm with research and evidence that interventions used are effective in realizing positive outcomes for families. While it will take time to fully realize the benefits of ROA, successful implementation will fundamentally change the way the system works. Significant impacts are expected in the following areas:

- **Policy** – The agency will use ROA/OQI results to shape policy in the Child & Family Community.
- **Practice** – Research and evidence created and corroborated by ROA will identify effective interventions currently utilized and create opportunities to validate promising interventions, ultimately leading to practice changes.
- **People** – A fundamental culture shift will occur as the system becomes a learning, reflexive entity and encourages the use of research, evidence, and data for decision-making.
- **Organization** – Organizational borders will expand to include new partners to accomplish meaningful research and evidence-informed outcomes for children.
- **Technology** – Innovation resulting from ROA will lead to new solutions to support child welfare improvements.
- **Shared Accountability** – Assigning accountability to those organizations and entities having a role in achieving outcomes for children extends the vision of child welfare accountability to all stakeholders, such as the Department of Health, the Department of Juvenile Justice, the Department of Education, the Agency for Persons with Disabilities, the Agency for Health Care Administration, the Juvenile Court System, and other community partners.

The ROA design is based on a cycle of accountability framework focused on results and continuous quality improvement. The cycle of accountability relies on operationalizing five key activities, or phases, to further advance the child welfare system's efforts to evaluate performance on outcomes, identify new or promising interventions and strategies, review the validity of programs, and conduct continuous quality improvement to ensure the Child Welfare Community is learning and moving toward the accomplishment of goals which positively impact children and their families.

The five phases included in the cycle of accountability are:

1. **Outcomes Monitoring** - activities to define, validate, implement, and monitor outcome measures throughout the Child Welfare Community. In this phase, outcome goals are defined, valid and reliable performance measures are constructed, and data is collected to evaluate and corroborate performance. These activities establish construct validity, or the match between measures and the complex ideas or theories they are supposed to represent.
2. **Data Analysis** - approaches and procedures to critically study performance results to determine if variances discovered are in fact issues which should be explored further. This phase is concerned with determining the statistical validity of the observed gap (i.e., is the variance spurious or is it an actual issue to be explored further based on statistical tests), as well as understanding the nature of the problem through empirical data analysis.
3. **Research Review** - a series of activities to gather and validate evidence to support the development and implementation of interventions to address areas for improvement. This phase assesses external validity, or the credibility of promising interventions in a variety of settings, with different populations.

4. **Evaluation** - activities to assess promising interventions for children and families to determine if deployment to a larger population is warranted. This phase helps to establish internal validity of the intervention through development of empirical evidence that the intervention is causally linked to the desired outcomes.
5. **Quality Improvement** - a series of actions to implement interventions across new domains, or to challenge, change, and test new assumptions about the underlying goals supporting the child welfare practice model. Quality improvement increases or validates construct validity by creating a culture in which performance is tracked, actions are taken, and new strategies are developed. This phase reinforces organizational learning and reflexivity through double-loop learning, including regularly analyzing existing practices and exploring innovative solutions.


*Figure 7. Evidence-based Service Monitoring and Evaluation*

Florida intends to operationalize evidence-based service selection, installation, and fidelity monitoring using this framework. The fidelity monitoring and impact analysis of evidence-based service delivery will be specifically operationalized in three of the five phases outlined: research Review (Phase 3), Evaluation (Phase 4), and Continuous Quality Improvement (Phase 5). Florida has used the procurement mechanisms and leveraged university partnerships to initially operationalize fidelity monitoring of selected state implemented evidenced-based services as the Office of Quality and Innovation matures and builds capacity.

EBP model developers use their own web-based systems to collect from providers, information related to the type of services clients receive, frequency, content and duration of sessions; EBP skills utilized in sessions; and outcomes data. Florida plans to modify contracts as needed to ensure all necessary quality improvement data is being collected from each provider, including the data reported to model developers. Florida intends to utilize these data systems and others to inform its CQI effort.

Florida plans to integrate FFPSA goals and outcomes by delivering evidence-based prevention service delivery and monitoring the results through the cycle of accountability. The existing ROA process will be augmented to include a

multi-tiered FFPSA evaluation process (see Figure 7) that feeds evaluation, fidelity monitoring and continuous quality improvement activities. These activities will trigger enhancements and reporting updates to the state prevention plan in conjunction with regional/community developed prevention plans.

- Reduce the number of children placed in Out of Home Care
- Increase the number of children receiving in-home services
- Increase prevention services delivered to in-home cases
- Increase the number and quality of pre-crisis contacts
- Decrease the number of reports to the Florida Abuse Hotline
- Increase the number of formalized care coordination models
- Reduce the rate of recurrence of maltreatment
- Reduce the rate of re-entry into the child welfare system

# FFPSA Evaluation and Claiming


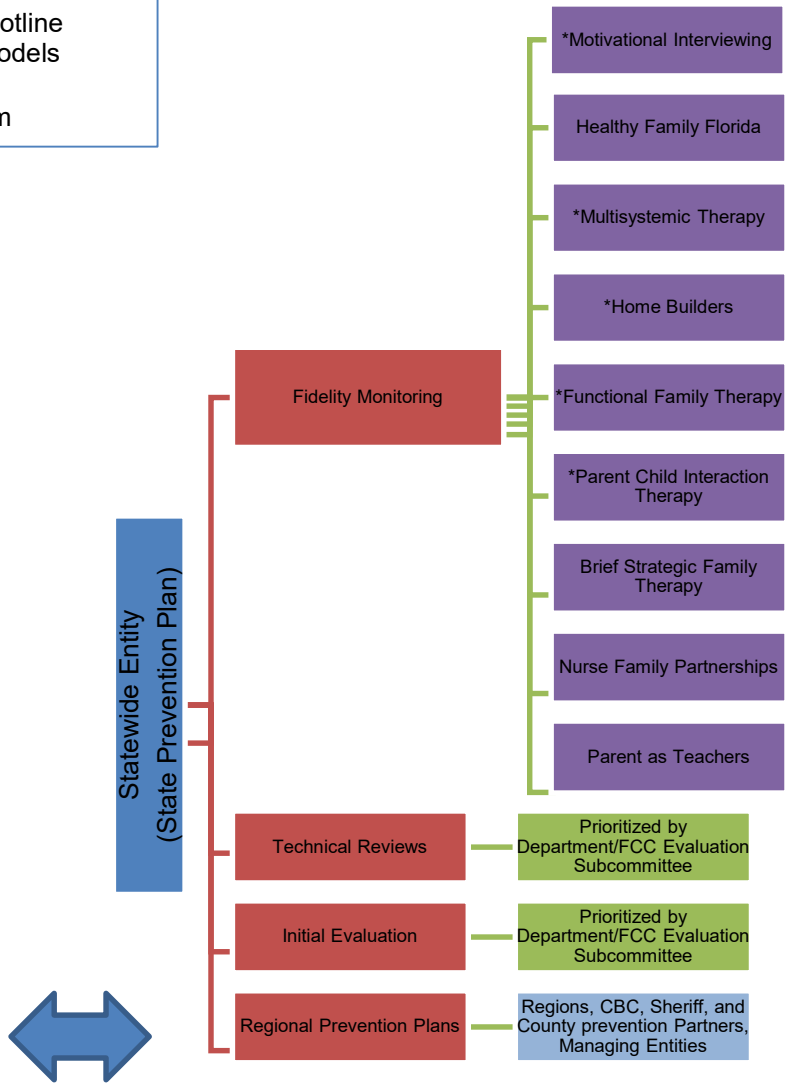


*Figure 8. FFPSA Evaluation Process*

## 5. MONITORING CHILD SAFETY

The Department implemented the Florida Practice Model with a Structured Decision Making component in 2014 under Florida's Title IV-E waiver. Florida's practice model applies to Florida Abuse Hotline (Hotline) staff, child protection investigators (CPI), case managers, and licensing, adoption, and independent living specialists. The practice incorporates safety concepts for formal and prevention child welfare intervention and treatment, provides uniform definitions and standard ratings for the evaluation of caregiver protective capacities, child strengths and needs, the quality and frequency of family visitation, and progress in achieving case plan outcomes.

Florida's Practice Model provides a set of common core safety concepts for determining when children are safe, unsafe, or at risk of subsequent harm, and how to engage caregivers in achieving change. When Florida's Abuse Hotline accepts a report for alleged maltreatment of abuse, neglect, or abandonment, the intake is assigned to the county office correlated with the family residence. A CPI must respond to the location where the child is most likely located, meet with the family, and engage relevant participants outside the home, depending on the outcome of the present danger assessment. An impending danger safety assessment is then conducted using the family functioning assessment, and risk assessment is completed at the end of the investigation to assess the likelihood of future harm and prioritize the family for prevention services.

Florida's Practice Model includes the expectation that when children are determined to be **safe, but at high or very high risk for future maltreatment**, affirmative outreach and efforts will be provided to engage families in family support services designed to prevent future maltreatment. While service interventions are voluntary for children determined to be safe, at high or very high risk of future maltreatment, the child welfare professional should diligently strive to use motivational interviewing skills to facilitate the parent/legal guardian's understanding of the need for taking action in the present to protect their children from future harm. When children are determined to be **unsafe**, meaning there is an active danger threat, safety management and case planning are required. To accomplish effective application of the safety concepts, seven professional practices are employed: Engagement, Partnership, Collection of Information, Assessing and Understanding Information, Planning for Child Safety, Planning for Family Change, and Monitoring and Adaptation of Case Plans.

Florida plans to leverage its current practice model which embeds structured decision making to enhance and expand Florida's prevention response for the populations in Figure 9. Beginning October 1, 2021, Florida plans to utilize the CCWIS/FSFN system to capture Florida's **overarching prevention strategy** for each family using multiple tools geared to the specific needs of those families to ensure the overarching prevention strategy/plan is successfully implemented. This strategy includes Department candidacy determinations based on family assessed needs that will be utilized to develop a co-constructed prevention plan document that encapsulates the identified EBP. When it is determined through an assessment that the child's risk for entering foster care remains high at 12-months, despite the provision of EBP services, the case must be scheduled for a multidisciplinary team (MDT) staffing pursuant to s. 39.4022, F.S., to develop a plan to achieve child safety. During the staffing, the potential need to generate an abuse or neglect report, unresolved service needs and benefits to the family, implementation of additional services, attempts to re-engage the family, and ongoing risk and safety will be discussed and the outcome documented in CCWIS. At a minimum, those individuals included in

the staffing must be the family, the referring community-based network, service providers working with the family, the individual responsible for case coordination, case manager/oversight, and a Department representative.

The Department will continue to provide ongoing monitoring and oversight for each case through quality reviews and will use its CCWIS system practice tools/application to monitor ongoing prevention strategy progress, and to capture decision making and periodic ongoing risk and safety monitoring to four primary candidacy populations outlined in the figure below. The CCWIS system practice tools/applications require manual data entry and identification if a child is at risk or unsafe. The CCWIS system has automated capabilities to only determine if the case meets the eligibility requirements for Title IV-E reimbursement for the use of the EBP.

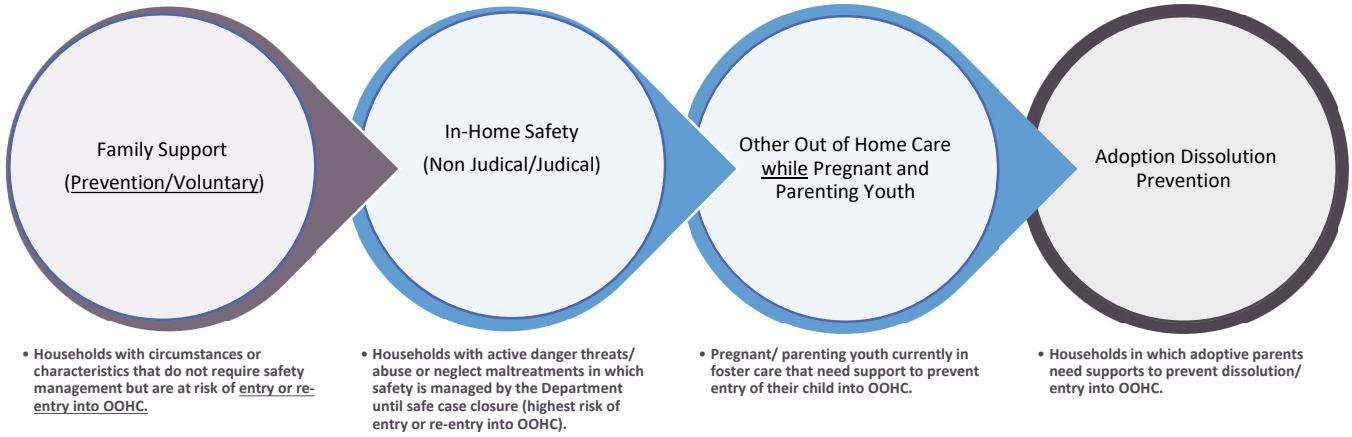


*Figure 9. Prevention Candidacy Populations.*

**Family Support (Prevention/Voluntary)**

When a child has been assessed as safe as a result of an investigation or no abuse or neglect has been alleged, but the parent or caregiver is requesting assistance, the family will be offered care navigation services or provided family support services. Families offered care navigation services will be transferred to the Department's care navigation support team. Families offered voluntary family support services will be transferred to one of Florida's privatized contracted child placing agencies known as the CBCs or the CBC's subcontracted provider to provide oversight and support for the family. The CBC may also partner with a local community prevention agency/provider/community stakeholders; such as Children Services Councils, under a Memorandum of Understanding (MOU) with the CBC or Department to provide pre-crisis, early, upfront community-driven service referrals to families who are not under dependency supervision or an active investigation for alleged abuse, abandonment, or neglect, with oversight from the CBC.

Upon acceptance of case transfer or through service referrals, the contracted or subcontracted provider, or community stakeholder under a MOU, will complete a needs assessment summary in the CCWIS/FSFN family support services module, designed to determine if the child is an eligible candidate for foster care based on the risk and safety of the child through the identification of circumstances or characteristics of the child and caregiver. At the time of assessment, the child must be in the care of their caregiver. The provider will be required to conduct periodic ongoing risk and safety assessments and update the needs assessment at minimum every 90 days or at a critical juncture. The needs assessment must include a rationale when services extend beyond 12 months and is completed through the family support module in CCWIS/FSFN.

The outcome of the needs assessment must be used to co-construct and amend a prevention plan with the family, and connect the family to the identified services. The prevention plan is completed through the family support plan worksheet in the CCWIS/FSFN family support services module.

Updates to the needs assessment, prevention plan, and prevention plan monitoring will be the basis for future redeterminations of service needs and closure.

**In-Home Safety Management (Non-Judicial/ Judicial)**

Children served through in-home safety management cases that have been assessed by the CPI to be unsafe due to an active danger threat in the home require oversight and formal safety and case management by a certified child welfare professional. Community Based Care Lead Agencies provide oversight and support for the family.

A child actively receiving services under in-home safety management could be eligible for prevention services if they are determined through the family functioning assessment or progress update to be a candidate at risk of entering foster care. At the time of assessment, the child must be in the care of their caregiver under post-reunification, under a judicial case that did not result in the removal and reunification of a child when a determination deemed the child to be unsafe with an active safety plan, or under a non-judicial case when the child is determined to be unsafe with an active safety plan.

These case managers utilize the Family Functioning Assessment Ongoing (FFA-O) to assess the initial case plan and safety plan services needed to prevent the child from entering out-of-home care (foster care). The initial FFA-O must be completed within 30 calendar days following case transfer. The case plan in FSFN that is co-constructed with the family will link the FFA-O assessed needs to EBP service provisions and the prevention strategy to ensure the child's safety. At minimum of every 90 days, or at critical junctures, the case management organization shall utilize the Progress Update (PU) Assessment in FSFN to assess ongoing family needs, risk, safety and safety plan modifications, assess case plan progress, and assess for safe case closure. The PU must include a rationale when services extend beyond 12 months. The case manager shall make face-to-face contact with the child every 30 days in the child's residence.

**Out-of-home Care While Pregnant and Parenting Youth**

When a youth in out-of-home-care (foster care) is pregnant or parenting, the youth is designated as pregnant or parenting in the FSFN system. The CBC and subcontracted providers provide oversight and support to youth in out-of-

home care while pregnant or parenting and must facilitate a multidisciplinary team staffing for review and assessment with the Department for FFPSA candidacy. A minor parent actively receiving services in foster care could be an eligible candidate for prevention services if they are determined through the family functioning assessment or progress update to be at risk of having their child removed from their care and custody and legally placed in foster care. The minor parent must be identified in the CCWIS/FSFN as pregnant or parenting.

The CBC will assess the needs of the youth and the youth's child utilizing the FFA-O/PU in FSFN to ensure the safety of the youth and their child and to link the youth to needed services to be outlined in the youth's case plan. The case plan will capture the prevention strategy that ensures the child's safety while in the care of the youth. Ongoing safety/risk monitoring will be captured in the PU every 90 days or at critical junctures, and during visits. The PU will include a rationale when services extend beyond 12 months.

**Adoption Dissolution Prevention**

The Department offers post adoption services supports through the CBC, or the CBC's subcontracted provider. The CBC may also partner with a local community prevention agency/provider/community stakeholders, such as Children Services Councils, under a Memorandum of Understanding (MOU) with the CBC or Department.

A child receiving post adoption services must be an eligible candidate for foster care determined through a needs assessment. At the time of assessment, the child must by in the care of their caregiver.

The provider will complete a needs assessment summary in the CCWIS/FSFN post adoption support services module, designed to determine the risk and safety of the child through the identification of circumstances or characteristics of the child and caregiver. The provider will also be required to conduct periodic ongoing risk and safety assessments, and update the needs assessment at minimum every 90 days or at a critical juncture until termination of services. The assessment is completed through the family support module in CCWIS/FSFN.

The outcome of the needs assessment must be used to co-construct and amend a prevention plan with the family, identify the prevention strategy, and connect the family to the identified services. The prevention plan is completed through the family support plan worksheet in the CCWIS/FSFN adoption support services module. Updates to the needs assessment, prevention plan, and prevention plan monitoring will be the basis for future redeterminations of service needs and closure.

## 6. CONSULTATION AND COORDINATION

Upon the passage of the FFPSA, the Department's leadership team held multiple information sharing forums to educate stakeholders on the new federal requirements and raise awareness regarding the new opportunity for states to use federal funding to provide enhanced support to children and families. The Department has and continues to consult on FFPSA impacts and changes with other organizational programs, state agencies responsible for administering mental health and substance use disorder prevention and treatment services, and other public and private agencies with

experience in administering child and family services including economic instability programs. The Department established the FFPSA Executive Steering Committee to help inform the overall planning and implementation of provisions of the FFPSA. The steering committee consists of members of executive leadership within the Department, Community Based Care Lead Agencies, State Court Administrator Partners, Youth formerly in Foster Care, Foster/Adoptive Parents, Sheriff's offices, and the Child and Family Well-Being Council which includes the Child Welfare Practice Task Force .

The steering committee created several sub-committees to address the implementation of the different aspects of the FFPSA. Sub-committee members include representation from the Department, CBCs, community partners/providers, and other child welfare stakeholders. In-person and virtual meetings were held with community partners/providers in order to gain their feedback.


*Figure 10. FFPSA Committees*

Casey Family Programs has been a resource by hosting the bi-weekly FFPSA planning collaborative conference calls involving states that were also early adopters of Family First. These calls have been helpful in navigating the new and shifting program landscape. It has been beneficial for Florida to hear about and reach out to other states to understand how they overcame implementation challenges and their successes experienced thus far.

The Department hosts monthly conference calls with the State Office of Court Administrators to share updates on the work and action occurring for implementation of FFPSA. Several of the group members serve/participate in the committee work.

The Department has also partnered closely with behavioral health providers on the planning and implementation of FFPSA. Decisions around service array, specifically as it relates to prevention in the community, has included the evaluation of existing evidence-based programs funded by Medicaid through the Agency for Health Care Administration (AHCA) and behavioral health services contracted through Managing Entities in order to leverage community behavioral health providers. The Department worked with AHCA to maintain coverage for parents with out-of-home placement so they can receive the behavioral health services needed to return their children home. Additionally, Sunshine Health, the state's primary Medicaid health plan for children, worked with the Department on training and service delivery as it relates to child needs. Placement alignment conversations continue to occur with Florida's AHCA. The Department and partners have been integrated into monthly conversations occurring at all levels on FFPSA updates, feedback, and action items. Ongoing collaboration with AHCA, the Department SAMH, and Sunshine Health is integral in bringing all parts of the system of care together, with a long-term goal of integrating FFPSA prevention planning into the Florida's statewide prevention plan.

The Department works with many state agencies through various data sharing agreements and MOUs. The Department also serves on advisory councils and steering committees to promote partnership and a collaborative approach to the needs of the State. Through these various partnerships, critical stakeholders work together in a coordinated and integrated effort to serve individuals and families that cross multiple systems and achieve common goals. This allows Florida to ensure families are served along a continuum of care across systems.

Florida's agencies collaborate to coordinate services and support for children served by more than one agency through an Interagency Agreement between the Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Children and Families, Department of Juvenile Justice, Department of Education, Department of Health, Guardian ad Litem Program, and Florida's Office of Early Learning. The Interagency Agreement addresses the statutory responsibilities of the Children and Youth Cabinet per Section 402.56, Florida Statutes. At the local, regional, and state levels, personnel from each agency are appointed on behalf of their agency and meet on a monthly basis. Representatives from contractors and providers of member agencies are also included.

Recently, the Office of Child and Family Well-Being redesigned the Child Welfare Practice Taskforce and launched the Child and Family Well-Being Council. The desired outcome of this Council is to not only have a regular cadence with traditional system-engaged stakeholders such as child welfare providers, lead agencies, and managing entities, but to also engage lived experience and non-traditional partners. It is the Department's desire to engage various stakeholders, monitor programs and services, and to make recommendations with a larger focus on prevention and integration of state and community resources. OCFW also intends to make sure policies and practices are informed by those with lived experience. . It is through the power of genuine collaboration with partners and weaving in lived experience that the Department is able to make tiny changes that create remarkable results for Florida families.

Florida has incorporated the expansion of community prevention for additional insight on the best practices for the use of funding from the Family First Transition Act to support the implementation of FFPSA, system redesign that will allow for community providers to enter data and share information for reporting purposes, and the identification of appropriate EBP throughout Florida.

The Department, Community Based Lead Agencies, or a Community Based Lead Agencies' subcontracted provider's assigned child welfare professional will be responsible for coordinating services or programs on behalf of the child and family. This includes ongoing assessment and coordination of services that are not evidence based and offered through the IV-B plan. A local community prevention agency/provider/community stakeholders, such as Children Services Councils and Hillsborough County Government, under a MOU with the CBC or Department will be responsible for coordination of services or programs that are under the IV-B plan. The MOU will clearly define the requirement to refer children and families or their caregivers to all appropriate services as determined by the needs assessment.

***Local Match Working Agreements***

The Florida Legislature passed the Revenue Maximization Act (F.S. 409.071) in the mid-1990s which authorized the use of certified local funding for federal matching programs possible to support local services. State agencies were charged with the expectation to provide proactive support to implement the legislative priority. The intent was that the initiative would be cost-neutral to state funds. While the reference of "certified local funding" implies the funding of a local agency, the fund sources available to claim additional federal reimbursement are entitlement grants which require certified public expenditures to be used as match. The primary federal funds available for reimbursement are the entitlement grants of Title IV-E, Medicaid, and the Supplemental Nutrition Assistance Program. Each of these grants requires public dollars to be used to claim the reimbursement.

The federal guidance at 2 CFR 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Grants, provides in 200.1 the definition for "local agency" that means any unit of government within a state, including county, borough, municipality, city, town, township, parish, local public authority, special district, school district, intrastate district, the council of governments, and any other agency or instrumentality of intra-State or local government. All these agencies have certified public expenditures. The Federal authority to claim certified public expenditures is provided in 2 CFR 200 and 45 CFR 75.03 Cost Sharing or Matching (b) 1-7, and (c) provisions are available to outline the allowable costs and reporting requirements. Sections 409.071 and 409. 26731, Florida Statutes, provide authority for the state agencies to certify local funds as match for Title IV-E reimbursement. The match for this fund source must be certified public funding to claim any reimbursement. Local funding, as stated in the legislation, is much broader than generally considered local agency funding. Subsequent to phase 3 of Florida's FFPSA implementation, the Department will seek to leverage the current local match process with 6 established local match agreements to help build a roadmap for the rolling out of Phase 4 Community Prevention Services Implementation. The Department has convened a FFPSA Implementation Sub-Committee to make recommendations to the Department to help guide the planning and implementation efforts necessary to promote, foster, and maximize the implementation of evidence-based prevention services within local communities. The subcommittee will be tasked with presenting recommendations on the desired approach for the delivery of prevention services in the community, major milestones to implement this approach, implementation factors to consider, and policy and procedures.

The Department continues to build partnerships with other state agencies and community providers to bridge the gaps, remove barriers, and provide support and resources to all families.

## 7. CHILD WELFARE WORKFORCE SUPPORT

The Department is committed to establishing a culture of "we" through integration and intentional collaboration. We will do this by demonstrating value across the Department and the network workforce, supporting and enhancing a competent, skilled, and professional workforce, and providing state agency supports to staff working in local offices of the Department and the CBCs.

The Department's workforce is made up of many child welfare professionals that hold degrees including Bachelor or Master of Social Work or related degrees in the human services field from an accredited college, and complete certification through the Florida Certification Board. Child Welfare Professionals also attend trainings provided through pre-service (average of 2.5 months) for new hires, and in-service for ongoing staff education. Child welfare professionals are required to complete pre-service training to become provisionally certified as they work towards achieving a full certification as a child welfare professional. Pre-service training prepares child welfare professionals with the ability to complete risk assessments and family functioning assessments to determine safety for children through interviewing, observation, and information gathering. Child welfare professionals use additional tools such as the case plan, safety plan, present/impending danger plans, and needs assessment summary in the family support services module to identify risk, implement services, and support children and their families to prevent entry into care or achieve permanency. A fully certified child welfare professional meets the qualifications to assess for risk, determine the safety of the child and develop prevention plans with the appropriate EBP to reduce the probability of entry into foster care. The CBCs are required to uphold the same qualifications and educational training for their staff. Additionally, CBC subcontracted providers and community providers under MOU must hold the same or equivalent education and training necessary to complete the duties in which they are being contracted to provide.

The Department and the Florida Cerfitication Board have expanded eligibility of persons seeking employment and certification in Florida's child welfare system). This expansion is called the Workforce/Caseload Relief Reinstatement program and is for individuals who were previously certified, are currently employed in the field of child welfare, and have been temporialy deployed to perform job tasks typically performed by certified investigators, case managers, counselors and their supervisors in an effort to provide workforce/caseload relief.[2]

The Department offers additional trainings and workshops to all child welfare professionals, their supervisors, program administrators, community partners, and caregivers to strengthen areas to include, but not limited to, trauma-responsive practice, engagement, and identification of adequate service array.

Child Protection Investigation (CPI) Supervisors and Program Administrators (PAs) are charged with critical performance expectations that include, but are not limited to, providing training and development opportunities and promoting a supportive work environment.

[2] CW Workforce/Caseload Relief Certification Reinstatement (https://flcertificationboard.org/fcb-child-welfare-workforce-caseload-relief-programs/

Quality Management staff members with the CBC conduct similar reviews for open in-home services cases. Further qualitative reviews include the Florida CQI and Performance Improvement Plan monitored cases using the Child and Family Services Review (CFSR) portal to gauge performance around the federal outcomes and systemic factors. In addition to the qualitative measures, the Department includes quantitative data on its scorecards to continuously monitor performance around safety and risk assessment and services across all investigations and case management cases.

All supportive activities provided to Florida's workforce will assist in the fulfillment and ongoing enhancements to the Title IV-E Prevention Program. The Department has recently revised the structure of the OQI to provide support and training to the workforce in a consistent manner across the state. Within the Department, the OCFW and OQI will work in collaboration to develop a tool for the purposes of conducting randomized reviews of prevention plans and service delivery fidelity. Additionally, OCFW and OQI will develop and implement technical assistance protocols to provide ongoing guidance and necessary refresher training based on the outcomes of the randomized prevention plan reviews.

OCFW's policy and practice team provides support, education, and training to child welfare professionals, community providers, and non-governmental organizations invested in child welfare. Additionally , OCFW working in conjunction with OQI developed a career ladder for frontline Child Welfare Professionals to include multiple levels of CPI classifications, corresponding milestones for classes, and professional development opportunities for advancement with compensation ranges.

The Strong Foundations cooperative agreement, under the funding opportunity Strengthening Child Welfare Systems to Achieve Expected Child and Family Outcomes and in collaboration with OCFW, Guardian Ad Litem Program, Office of Court Improvement, and the Florida Certification Board, have been working on revising the core competencies, training, and the certification process for child welfare professionals in Florida. Investing in child welfare supervisors will increase their understanding of core supervisory competencies and enhance their ability to provide supervision and ongoing support to their staff. This will allow the Department and the CBCs to invest in their workforce through coaching and mentoring staff, developing critical thinking skills, and creating opportunities for staff growth. The Department believes that these key elements will increase and stabilize the retention rate of child welfare staff.

OCFW collaborates with other stakeholders through various advisory bodies, solution-focused meetings, and other forms of communication. The following list provides a summary of the various major organizational partners with whom the Department actively engages. This list is not all inclusive in terms of collaborative partners or the description of activities with each partner.

- Office of Adoption and Child Protection was created, within the Executive Office of the Governor, which raises public awareness and implements meaningful practice around prevention activities.
- The Department's SAMH continues to be a significant partner with the child welfare system in developing policies for the integration of child welfare and behavioral health services, implementing innovative programs and approaches, and contracting with Managing Entities which includes contract standards and provisions for services involving families served by child welfare.

- The Department's ESS provides a valuable collaboration with the child welfare system to provide holistic service delivery through the utilization of Hope Navigation for early engagement with families, using a rolodex of community partners to connect customers based on their unique needs.
- Florida Institute for Child Welfare provides ongoing research and evaluation of the child welfare workforce and provides ongoing partnership around technical assistance and training.
- Florida Center for Prevention and Early Intervention Policy leads the state's development and implementation of infant mental health services, including training for infant mental health specialists who provide evidence-based infant mental health services, such as Child-Parent Psychotherapy.
- The Quality Parenting Initiative (QPI), a strategy of the Youth Law Center, is an approach to strengthening foster care, refocusing on excellent parenting for all children in the child welfare system. It was launched in 2008 in Florida, and as of 2018, over 75 jurisdictions in 10 states (California, Florida, Illinois, Louisiana, Minnesota, Nevada, Ohio, Pennsylvania, Texas and Wisconsin) have adopted the QPI approach.
- The Annie E. Casey Foundation (AECF®) is devoted to developing a brighter future for millions of children at risk of poor educational, economic, social and health outcomes.
- One Voice Impact, Youth SHINE, and other organizations represent former foster youth and provide lived experience and youth voice that inform the development of programs that serve current and former foster youth.
- Angel Armies, CarePortal, and other representatives of Florida's faith-based organizations that are committed to supporting vulnerable children and their families, and work to connect families in need with services from local churches and their congregations.

In preparation for the Title IV-E prevention services, Florida plans to implement MI for all child welfare case management through training provided by contracted providers specializing in MI. The implementation of MI is designed for the child welfare case managers as an additional support through enhanced engagement skills. The implementation of MI will be utilized as an administrative function by case managers to identify services to support the reduction of risk and increase the safety of children. In addition to the newly gained skills in MI, the case managers will use their existing skills and competency in trauma-informed care that were gained during pre-service training described in Section 8 Child Welfare Workforce Training and ongoing training each year. Case managers will not administer the EBP, but refer each family to the identified prevention service to promote, safeguard, and restore children and their families while building resilience to prevent entry into foster care. Each EBP will be delivered through contracted providers.

Florida has contracted with a vendor to monitor the fidelity process for each of the nine EBPs to prevent the entry of children into foster care and monitor the program and service domains of (a) Child Safety, (b) Child Permanency, (c) Child Well-Being, and/or (d) Adult Well-Being. The vendor will conduct statewide evaluations on the delivery and outcomes of the EBPs identified through examination of outcome impacts, data analysis, conducting research, and technical review.

## 8. CHILD WELFARE WORKFORCE TRAINING

The Department requires all child welfare professionals (CWPs) to attend orientation and pre-service training. Every CWP is required to complete the core curriculum in addition to the specialty track they are assigned to depending on

their position in child protection services, case management, or licensing. The core curriculum and specialty track contain material on Structured Decision Making (SDM), which includes safety and risk assessments, identifying protective capacity, and child strengths and needs. Lab days with hands-on FSFN training are offered throughout the pre-services course. CWPs are also given the opportunity to complete field days which allow them to observe and shadow seasoned CWPs in the field.

The Department is investing in building the engagement skills of child welfare case managers by providing training on the evidence-based practice, Motivational Interviewing. This model encourages family engagement and family involvement in decision-making and empowers the family in the change process. With this training, child welfare case managers will be better prepared to encourage parents and youth to develop the motivation to change and engage parents and youth to complete recommended services and goals included in the child-specific prevention plan.

In addition to enhanced case management skills through Motivational Interviewing, Florida offers trauma-informed service delivery through pre-service and in-service trainings, as well as partners with organizations in the community, who offer training on trauma to include vicarious trauma. The following is an outline of the trauma training offered in Florida's core curriculum pre-services training.

| **Trauma and its Impact on the Child** | |
|---|---|
| ▪ What is Trauma?<br>▪ Types of Childhood Trauma<br>▪ What is Child Traumatic Stress (CTS)?<br>▪ Child Development Stages Matrix<br>▪ Impact of Trauma on the Child's Brain<br>▪ The Impact of Trauma on Very Young Children<br>▪ Compact Trauma and How it Impacts Children | ▪ Impact of Traumatic Stress on Visible Behavior<br>▪ Trauma-Related Behavior in Children of Various Ages<br>▪ Adverse Childhood Experiences (ACE) Study<br>▪ Long Term Impact of Trauma<br>▪ Culture and Trauma<br>▪ Historical Trauma |
| **Approaching Children and Families in a Trauma-Informed Manner** | |
| ▪ Henry's Story<br>▪ Worksheet: Rewriting Henry's Experience with Us<br>▪ Using a Trauma-Informed Approach in Child Welfare Practice | ▪ My Rules of Thumb – How I will behave in a Trauma-Informed Manner<br>▪ Parents Must Truly Address the Roots of Their Trauma<br>▪ How People Exposed to Trauma React to Authority |
| **Referring and Advocating for the Child and Family in a Trauma-Informed Manner** | |
| ▪ Screening, Assessments and Evaluation<br>▪ Other Referrals and Advocacy<br>▪ Pharmacology and the Child or Adult<br>▪ What Medication Does NOT Help<br>▪ Evidence-Based Trauma-Informed Treatment Practices | ▪ Ways to Better Ensure a Trauma-Informed Approach When Culture and Historical Trauma are Considerations<br>▪ Cultural Scenarios<br>▪ Cultural Scenarios Worksheet |

In addition to the core curriculum and specialty track, Florida offers enhanced specialized training to certified CPIs conducting investigations for medical neglect and institutional cases, as well as human trafficking for CPIs, case managers, and their supervisors.

With the implementation of the Title IV-E FFPSA Prevention Program, Florida will incorporate in the core curriculum, the use of prevention plans, definition of IV-E prevention candidacy, FSFN entry, the ability to identify the need for prevention services, and how to access and deliver these services. The FFA is the process by which child welfare professionals apply critical thinking skills to guide decision-making regarding child safety and risk based upon having an extensive and comprehensive knowledge of the individual and family conditions in the home. The FFA is the Department's formal assessment that provides the basis for the case plan and guides the child welfare professional on selecting the most appropriate trauma-informed and evidence-based services. This process is summarized in information domains and is essential to the child welfare professional being able to accurately identify impending danger threats, assess the sufficiency of caregiver protective capacities, complete a safety analysis, implement a safety plan (as appropriate), and determine the risk for future maltreatment to the child(ren).

Evaluating family progress is a collaborative review and conclusion about enhanced caregiver protective capacities and child needs. The evaluation includes information from stakeholders involved in the child's life. The evaluation of family progress should be continuous and result in timely modifications to case plans as progress, or lack thereof, is made. Sufficient evaluation of family progress is critical to achieving goals for children in accordance with established timeframes. The evaluation of family progress is documented in Progress Updates which provide the agency's formal justification and record for the current safety plan and all case plan actions and future prevention plans. The child welfare professional will complete contact to assess and evaluate the family's progress on their prevention plan and update the assessment every 90 days or at critical junctures.

The Department's family engagement standards for exploration, incorporated in Operating Procedures (CFOP) 170-9 Chapter 4, are intended to promote the case manager's interactions with parents/legal guardians in order to raise self-awareness, recognize and diffuse any parent resistance, and build constructive working relationships. The exploration standards facilitate deeper information gathering about adult functioning, parenting, caregiver protective capacities, and the relationship of all to the identified danger threats. The exploration stage lays the final groundwork for developing a family change strategy, including the child's need for a safe and permanent home.

As EBPs are rated in the Clearinghouse and added to Florida's Title IV-E Prevention Plan, service providers will conduct trainings as they become available in the community. The Department expects all EBP providers are working with families to ensure staff meets the qualification and training requirements.

The OCFW policy and practice team will provide statewide training in the format of a train the trainer session to case management, CBCs, CPIs, and community partners with an MOU to partner on the Title IV-E Prevention Program. Each organization will ensure their teams are trained and well versed in the new program and receive ongoing training as necessary. OCFW will also provide ongoing technical assistance. Training topics will include the newly developed operating procedure CFOP 170-1 Chapter 16 on prevention services, the Title IV-E Prevention Program, target population, IV-E claiming, FSFN enhancements, development and monitoring of prevention plans, data collection, evaluation and monitoring, service delivery and local service array, and provider outreach and family engagement.

## 9. PREVENTION CASELOADS

Florida regulates caseload requirements for child welfare professionals during their pre-service training and during their provisional child welfare certification. Child welfare professionals do not carry a caseload when in training. It is not until they have completed pre-service training and upon receiving a provisional certification, that each CWP is given a training caseload of a reduced number of investigations (for CPIs), a reduced number of cases (for case managers), or a reduced number of foster family home studies (for licensing counselors) for 30 calendar days.

The training caseload for Child Protective Investigators is limited to no more than four open, active investigations at any time, not to exceed a total of eight investigations during the 30 calendar days following the date the individual passed the waiver or post-test. After the 30 days, a CPI caseload ratio maximum is 1:15.

The training caseload for case managers is limited to no more than five (5) open, active cases, not to exceed 10 children at any time during the 30 calendar days following the date the individual passed the waiver or post-test. After the protected training caseload timeframe (30 calendar days), while each CBC can set guidelines for dependency case management caseloads in their contract with case management organizations, a standard has not been developed for the post-training phase caseload statewide. The case management organizations are required, per s. 409.988, F.S., to post the average caseload of case managers on their website by the 15$^{th}$ day of each month.

The training caseload for licensing counselors is limited to no more than three (3) open, active home studies at any time; not to exceed a total of five (5) licensed foster homes during the 30 calendar days following the date the individual passed the waiver or post-test.

Upon implementation of the Title IV-E Prevention Program, staff caseload will be recommended on average a caseload size 25 active cases; however, clinical team approaches and prevention response structure will be considered to allow flexibility to caseload limits. The Department will require alignment with Florida's caseload recommendations once established for CBCs and any subcontracted providers. Each provider will be required to share data on prevention caseloads on the 15$^{th}$ day of each month for the preceding month. The Department also expects all EBP providers working with families to uphold the staffing and caseload requirements specified by each EBPs model to ensure fidelity to the model.

Child welfare professionals will continue to provide oversight of all in-home safety management and out-of-home while pregnant and parenting cases. Oversight for family support prevention/voluntary and adoption dissolution prevention cases are provided by child welfare professionals, subcontracted providers, or community stakeholders under a MOU.

The CBCs or the CBC's subcontracted providers are responsible for individuals assigned to manage prevention plans, conduct assessments, and identify appropriate EBP. Individuals supporting prevention families will be expected to adhere to the Department’s case load recommendations, policies, contract deliverables, and MOU for decision-making, case determinations, data sharing, and eligibility for candidacy. The Department, CBC, and CBC's subcontracted providers must continue to implement coordinating efforts across various communities to ensure children and their

families receive appropriate services. An MDT may be used when there are presenting barriers to a collaborative approach. The MDT may include a representative from the Department to assist in the decision making as outlined in the CFOP.

## 10. ASSURANCE DESIGN

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

## 11. ATTACHMENTS

## 12. REFERENCES

**Brief Strategic Family Therapy:**

Brief Strategic Family Therapy (BSFT) has received a rating of Well-Supported by the Prevention Services Clearinghouse. The program is currently offered in the state as a program to support children and families to increase capacity to intervene before child behaviors become unmanageable and result in out of home placement. BSFT has been studied to treat families with children or adolescents (6 to 17 years) (Horigian et al., 2015; Santisteban et al., 2003), which is aligned with the proposed target population in the state including children and adolescents ages 6-17 who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying or truancy. Research regarding BSFT has shown positive outcomes across multiple domains, including both child and adult well-being. For example, a study by Horigian et al., demonstrated participation in BSFT improved child outcomes by reducing child behaviors (Horigian et al., 2015). A second study by Santisteban et al., demonstrated changes in adult well-being outcomes including improvements in family functioning (Santisteban et al., 2003). These outcomes are both aligned with outcomes in the state for BFST including reduced delinquent behavior for enrolled youth and improved family functioning.


Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., . . . Szapocznik, J. (2011). Brief Strategic Family Therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. Journal of Consulting and Clinical Psychology, 79(6), 713-727.

Horigian, V. E., Weems, C. F., Robbins, M. S., Feaster, D. J., Ucha, J., Miller, M., & Werstlein, R. (2013). Reductions in anxiety and depression symptoms in youth receiving substance use treatment. The American Journal On Addictions, 22(4), 329-337. doi:10.1111/j.1521-0391.2013.12031.x

Horigian, V. E., Feaster, D. J., Robbins, M. S., Brincks, A. M., Ucha, J., Rohrbaugh, M. J., . . . Szapocznik, J. (2015). A cross-sectional assessment of the long term effects of Brief Strategic Family Therapy for adolescent substance use. The American Journal On Addictions, 24(7), 637-645. doi:10.1111/ajad.12278

Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. Addictive Behaviors, 42, 44-50. doi:10.1016/j.addbeh.2014.10.024

Robbins, M. S., Szapocznik, J., Horigian, V. E., Feaster, D. J., Puccinelli, M., Jacobs, P., . . . Brigham, G. (2009). Brief Strategic Family Therapy for adolescent drug abusers: A multi-site effectiveness study. Contemporary Clinical Trials, 30(3), 269-278. doi:10.1016/j.cct.2009.01.004

Feaster, D. J., Robbins, M. S., Horigian, V., & Szapocznik, J. (2004). Statistical issues in multisite effectiveness trials: The case of Brief Strategic Family Therapy for adolescent drug abuse treatment. Clinical Trials, 1(5), 428-439.

Horigian, V. E., Robbins, M. S., Dominguez, R., Ucha, J., & Rosa, C. L. (2010). Principles for defining adverse events in behavioral intervention research: Lessons from a family-focused adolescent drug abuse trial. Clinical Trials, 7(1), 58-68. doi:10.1177/1740774509356575

Robbins, M. S., Feaster, D. J., Horigian, V. E., Puccinelli, M. J., Henderson, C., & Szapocznik, J. (2011). Therapist adherence in Brief Strategic Family Therapy for adolescent drug abusers. Journal of Consulting and Clinical Psychology, 79(1), 43-53.

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Kurtines, W. M., Schwartz, S. J., LaPerriere, A., & Szapocznik, J. (2003). Efficacy of Brief Strategic Family Therapy in modifying hispanic adolescent behavior problems and substance use. Journal Of Family Psychology, 17(1), 121-133.

**Functional Family Therapy:**

Functional Family Therapy (FFT) has received a rating of Well-Supported by the Prevention Services Clearinghouse. The program is currently offered in the state targeting a population of older youth ages 11-18 who may enter the child welfare system due to behavioral problems to prevent entry into out of home care. FFT has been studied with children and families, demonstrating positive effects across both child and adult well-being outcomes. For example, a study by Celinska et al., demonstrated improved outcomes for youth related to behavioral and emotional functioning, including alcohol and drug use, reduction in delinquent behaviors, and out-of-home placements. In addition, in multiple studies, the implementation of FFT has demonstrated improved family functioning outcomes by improving communication skills (Slesnick & Prestopnik, 2009; Darnell & Schuler, 2015; Celinska et al., 2023). These outcomes are aligned with the proposed outcomes in the state for FFT including reduction in family conflict, improvement in family functioning, reduction in referrals for delinquent, oppositional, or violent behaviors.

Slesnick, N., & Prestopnik, J. L. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. Alcohol Treatment Quarterly, 22(2), 3-19. doi:10.1300/J020v22n02_02

Slesnick, N., & Prestopnik, J. L. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. Journal of Marital and Family Therapy, 35(3), 255-277. doi:10.1111/j.1752-0606.2009.00121.x

Humayun, S., Herlitz, L., Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. Journal of Child Psychology and Psychiatry, 58(9), 1023-1032. doi:10.1111/jcpp.12743

Celinska, K., Furrer, S., & Cheng, C.-C. (2013). An outcome-based evaluation of Functional Family Therapy for youth with behavioral problems. OJJDP Journal of Juvenile Justice, 2(2), 23-36.

Barnoski, R. (2004). Outcome Evaluation of Washington State's Research-Based Programs for Juvenile Offenders. Olympia, WA: Washington State Institute for Public Policy.

Barnoski, R. (2002). Washington State's Implementation of Functional Family Therapy for Juvenile Offenders: Preliminary Findings. Olympia, WA: Washington State Institute for Public Policy.

Sexton, T., & Turner, C. W. (2010). The effectiveness of Functional Family Therapy for youth with behavioral problems in a community practice setting. Journal of Family Psychology, 24(3), 339-348. doi:10.1037/a0019406

Darnell, A. J., & Schuler, M. S. (2015). Quasi-experimental study of functional family therapy effectiveness for juvenile justice aftercare in a racially and ethnically diverse community sample. Children and Youth Services Review, 50, 75-82. doi:10.1016/j.childyouth.2015.01.013

**Heathly Families America:**

Healthy Families America (HFA) has received a rating of Well-Supported by the Prevention Services Clearinghouse. The state has selected HFA as a program or service to provide services to expectant pregnant and parenting teens, and families with young children. The state also intends to utilize the child welfare protocols as part of the HFA model, enabling the enrollment of children up to 24-months of age. An analysis of the state's removal data shows elevated child welfare involvement and removals among young children. Healthy Families America has been evaluated among children and families and has shown to increase child safety by reducing risk factors for child abuse and neglect (Duggan et al., 2004; Mitchell-Herzfeld et al., 2005). In addition, existing research has shown improvement in enhanced family functioning, and enhancement in nurturing parent-child relationships (Caldera et al., 2007; Duggan et al., 2005). Related to the implementation of the child welfare protocol, existing research has demonstrated effectiveness with child welfare involved families related to reduction of foster care entry (Lee et al., 2018). These outcomes in the literature are aligned

with outcomes proposed in the state through implementation including reduction in risk for child abuse and neglect, enhanced family functioning, and increased nurturing parent-child relationships.

Green, B. L., Tarte, J. M., Harrison, P. M., Nygren, M., & Sanders, M. B. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. Children and Youth Services Review, 44, 288-298. doi:http://dx.doi.org/10.1016/j.childyouth.2014.06.006

Green, B. L., Sanders, M. B., & Tarte, J. (2017). Using administrative data to evaluate the effectiveness of the Healthy Families Oregon home visiting program: 2-year impacts on child maltreatment & service utilization. Children and Youth Services Review, 75, 77-86. doi:http://dx.doi.org/10.1016/j.childyouth.2017.02.019

Green, B., Sanders, M. B., & Tarte, J. M. (2018). Effects of home visiting program implementation on preventive health care access and utilization: Results from a randomized trial of Healthy Families Oregon. Prevention Science. (Online Advance) https://doi.org/10.1007/s11121-018-0964-8

Earle, R.B. (1995).Helping to prevent child abuse and future criminal consequences: Hawai'i Healthy Start. Washington, DC: National Institute of Justice. (ERIC Document Reproduction Service No. ED 394651).

Duggan, A. K., McFarlane, E. C., Windham, A. M., Rohde, C. A., Salkever, D. S., Fuddy, L., . . . Sia, C. C. J. (1999). Evaluation of Hawaii's Healthy Start program. Future of Children, 9(1), 66-90.

Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors. Child Abuse & Neglect, 28(6), 623-643. doi:http://dx.doi.org/10.1016/j.chiabu.2003.08.008

Duggan, A., McFarlane, E., Fuddy, L., Burrell, L., Higman, S. M., Windham, A., & Sia, C. (2004). Randomized trial of a statewide home visiting program to prevent child abuse: Impact in preventing child abuse and neglect. Child Abuse & Neglect, 28(6), 597-622. doi:10.1016/j.chiabu.2003.08.007

El-Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii's Healthy Start home visiting program: Determinants and impact of rapid repeat birth. Pediatrics, 114(3), e317-326.

King, T. M., Rosenberg, L. A., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2005). Prevalence and early identification of language delays among at-risk three year olds. Journal of Developmental and Behavioral Pediatrics, 26(4), 293-303. doi:10.1097/00004703-200508000-00006

Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. Archives of Pediatrics & Adolescent Medicine, 164(1), 16-23. doi:10.1001/archpediatrics.2009.237

McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning.Prevention Science, 14(1), 25-39.

reene, R., Heck, J., Lee, E., Griffith, J., Mitchell-Herzfeld, S., & Senkulics, D. (2001).Evaluation findings of the Healthy Families New York home visiting program.Rensselaer, NY: State of New York, Office of Children and Family Services.

Mitchell-Herzfeld, S., Izzo, C., Greene, R., Lee, E., & Lowenfels, A. (2005). Evaluation of Healthy Families New York (HFNY): First year program impacts. Albany, NY: University at Albany, Center for Human Services Research.

DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., & Rodriguez, M. (2006). Healthy Families New York (HFNY) randomized trial: Impacts on parenting after the first two years.Working Paper Series: Evaluating Healthy Families, OCFS Working Paper #1.

DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. Child Abuse & Neglect, 32(3), 295-315. doi:http://dx.doi.org/10.1016/j.chiabu.2007.07.007

DuMont, K. A., Mitchell-Herzfeld, S. D., Kirkland, K., Rodriguez, M., Walden, N., Greene, R., et al. (2008).Effects of Healthy Families New York on maternal behaviors: Observational assessments of positive and negative parenting. Rensselaer, New York: New York State Office of Children and Family Services.

Lee, E., Mitchell-Herzfeld, S. D., Lowenfels, A. A., Greene, R., Dorabawila, V., & DuMont, K. A. (2009). Reducing low birth weight through home visitation: A randomized controlled trial. American Journal of Preventive Medicine, 36(2), 154-160. doi:http://dx.doi.org/10.1016/j.amepre.2008.09.029

DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., ... & Greene, R. (2010).A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment?Rensselaer, NY: New York State Office of Children & Family Services and Albany, NY: University of Albany, State University of New York.

Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. Child Abuse & Neglect, 34(10), 711-723. doi:http://dx.doi.org/10.1016/j.chiabu.2010.03.004

Kirkland, K., & Mitchell-Herzfeld, S. (2012). Evaluating the effectiveness of home visiting services in promoting children's adjustment in school. Washington, DC: The Pew Charitable Trusts.

Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. Child Abuse & Neglect, 86, 55-66. doi:http://dx.doi.org/10.1016/j.chiabu.2018.09.004

Duggan, A., Caldera, D. Rodriguez, K., Burrell, L., Shea, S., & Rohde, C. (2005). Evaluation of the Healthy Families Alaska program: Final report. Juneau, AK: Alaska State Department of Health and Social Services.

Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). Impact of a statewide home visiting program on parenting and on child health and development. Child Abuse & Neglect, 31(8), 829-852. doi:http://dx.doi.org/10.1016/j.chiabu.2007.02.008

Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Impact of a statewide home visiting program to prevent child abuse. Child Abuse & Neglect, 31(8), 801-827. doi:http://dx.doi.org/10.1016/j.chiabu.2006.06.011

Duggan, A. K., Berlin, L. J., Cassidy, J., Burrell, L., & Tandon, S. D. (2009). Examining maternal depression and attachment insecurity as moderators of the impacts of home visiting for at-risk mothers and infants. Journal of Consulting and Clinical Psychology, 77(4), 788-799. doi:http://dx.doi.org/10.1037/a0015709

Cluxton-Keller, F., Burrell, L., Crowne, S. S., McFarlane, E., Tandon, S. D., Leaf, P. J., & Duggan, A. K. (2014). Maternal relationship insecurity and depressive symptoms as moderators of home visiting impacts on child outcomes. Journal of Child and Family Studies, 23(8), 1430-1443. doi:http://dx.doi.org/10.1007/s10826-013-9799-x

Easterbrooks, M. A., Bartlett, J. D., Raskin, M., Goldberg, J., Contreras, M. M., Kotake, C., . . . Jacobs, F. H. (2013). Limiting home visiting effects: Maternal depression as a moderator of child maltreatment. Pediatrics, S126-133. doi:10.1542/peds.2013-1021K

Jacobs, F., Easterbrooks, A., Mistry, J., Bumgarner, E., Fauth, R., Goldberg, J., ... & Scott, J. (2015). The Massachusetts Healthy Families Evaluation-2 (MHFE-2): A randomized controlled trial of a statewide home visiting program for young parents. Medford, MA: Tufts University.

Jacobs, F., Easterbrooks, M. A., Goldberg, J., Mistry, J., Bumgarner, E., Raskin, M., . . . Fauth, R. (2016). Improving adolescent parenting: Results from a randomized controlled trial of a home visiting program for young families. American Journal of Public Health, 106(2), 342-349. doi:http://dx.doi.org/10.2105/AJPH.2015.302919

Tufts Interdisciplinary Evaluation Research (TIER) (2017). The Massachusetts Healthy Families Evaluation-2 Early Childhood (MHFE-2EC): Follow-up study of a randomized, controlled trial of a statewide home visiting program for young parents. Final report to Massachusetts Department of Public Health, Children's Trust of Massachusetts. Medford, MA: Tufts University.

Raskin, M., Easterbrooks, M. A., Fauth, R. C., Jacobs, F., Fosse, N. E., Goldberg, J. L., & Mistry, J. (2017). Patterns of goal attainment among young mothers in a home visiting program.Applied Developmental Science. (Online Advance). DOI: 10.1080/10888691.2017.1357475

Stargel, L. E., Fauth, R. C., & Easterbrooks, M. A. (2018). Home visiting program impacts on reducing homelessness among young mothers.Journal of Social Distress and the Homeless, 27(1), 8992.

Easterbrooks, M. A., Jacobs, F. H., Bartlett, J. D., Goldberg, J., Contreras, M. M., Kotake, C., ... & Chaudhuri, J. H. (2012). Initial findings from a randomized, controlled trial of Healthy Families Massachusetts: Early program impacts on young mothers parenting. Washington, DC: Pew Charitable Trusts.

Easterbrooks, M. A., Kotake, C., Raskin, M., & Bumgarner, E. (2016). Patterns of depression among adolescent mothers: Resilience related to father support and home visiting program.American Journal of Orthopsychiatry, 86(1), 61-68.

Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized control trial. American Journal of Public Health. (Online Advance). doi:10.2105/AJPH.2019.304957

LeCroy, C. W., & Krysik, J. (2011). Randomized trial of the Healthy Families Arizona home visiting program. Children and Youth Services Review, 33(10), 1761-1766. doi:10.1016/j.childyouth.2011.04.036

**Homebuilders-Intensive Family Preservation and Reunification Services:**

Homebuilders (HB) has received a rating of Well-Supported by the Prevention Services Clearinghouse. The program provides intensive services for families who have children ages 0-18 at risk for out-of-home placement. Consistent with this target population, the state has selected this program to service families with children ages 0-18 who are at imminent risk of placement into out-of-home care. Homebuilders has been studied with children and families, and research has demonstrated positive findings across multiple outcomes related to child permanency and family well-being. For example, one study showed improvement in child permanency by preventing out of home placement because of involvement and participation in the program at both six and 12 months after the end of treatment (Walton et al., 1993). Additional research has demonstrated improvement in family outcomes related to improvement in economic and housing stability and food security (Westat, 2002). These outcomes align with outcomes proposed in the state including reduction in family conflict, and reduction in placement out of the home.

Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. Child Welfare, 72(5), 473-487.

Walton, E. (1996). Family functioning as a measure of success in intensive family preservation services. Journal of Family Social Work, 1(3), 67-82.

Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. Social Work Research, 22(4), 205-214. doi:10.1093/swr/22.4.205

Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up. Children and Youth Services Review, 18(4-5), 335-361. doi:https://doi.org/10.1016/0190-7409(96)00009-6

Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). Evaluation of Family Preservation and Reunification Programs: Final Report. Washington, DC: U.S. Department of Health and Human Services.

Westat, Chapin Hall Center for Children, & James Bell Associates. Evaluation of family preservation and reunification programs: Interim report

**Motivational Interviewing:**

Motivational Interviewing (MI) will be implemented in the state as a standalone intervention and adjunctive strategy to promote client engagement and motivation. The evidence for MI is strong across multiple areas to improve outcomes for

adolescents and adults. MI has been rated as Well-Supported by the Prevention Services Clearinghouse with outcomes across multiple domains. For example, research has demonstrated effectiveness with child welfare involved children and families. For instance, one study by Forrester et al., demonstrated effectiveness in family engagement during the assessment and child protection process (Forrester et al., 2008). In addition, evidence has demonstrated improvement in case outcomes, including parent skill development, retention in services, and child welfare recidivism (Higgns, 2015; Burke et al., 2003; Lundahl et al., 2010). These outcomes are both aligned with outcomes in the state for Motivational Interviewing including increased engagement and reduction of risk through skill building.

D'Amico, E. J., Parast, L., Shadel, W. G., Meredith, L. S., Seelam, R., & Stein, B. D. (2018). Brief motivational interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care. Journal of Consulting and Clinical Psychology, 86(9), 775-786. doi:http://dx.doi.org/10.1037/ccp0000332

Roy-Byrne, P., Bumgardner, K., Krupski, A., Dunn, C., Ries, R., Donovan, D., . . . Zarkin, G. A. (2014). Brief intervention for problem drug use in safety-net primary care settings: A randomized clinical trial. JAMA, 312(5), 492-501. doi:http://dx.doi.org/10.1001/jama.2014.7860

Stein, M. D., Hagerty, C. E., Herman, D. S., Phipps, M. G., & Anderson, B. J. (2011). A brief marijuana intervention for non-treatment-seeking young adult women. Journal of Substance Abuse Treatment, 40(2), 189-198. doi:http://dx.doi.org/10.1016/j.jsat.2010.11.001

Field, C., Walters, S., Marti, C. N., Jun, J., Foreman, M., & Brown, C. (2014). A multisite randomized controlled trial of brief intervention to reduce drinking in the trauma care setting: How brief is brief? Annals Of Surgery, 259(5), 873-880. doi:10.1097/SLA.0000000000000339

Saitz, R., Palfai, T. P., Cheng, D. M., Horton, N. J., Freedner, N., Dukes, K., . . . Samet, J. H. (2007). Brief intervention for medical inpatients with unhealthy alcohol use: A randomized, controlled trial. Annals Of Internal Medicine, 146(3), 167-176. doi:10.7326/0003-4819-146-3-200702060-00005

Gaume, J., Gmel, G., Faouzi, M., Bertholet, N., & Daeppen, J. B. (2011). Is brief motivational intervention effective in reducing alcohol use among young men voluntarily receiving it? A randomized controlled trial. Alcoholism, 35(10), 1822-1830. doi: 10.1111/j.1530-0277.2011.01526.x

Hansen, A. B. G., Becker, U., Nielsen, A. S., Grønbæk, M., & Tolstrup, J. S. (2012). Brief alcohol intervention by newly trained workers versus leaflets: Comparison of effect in older heavy drinkers identified in a population health examination survey: A randomized controlled trial. Alcohol and Alcoholism, 47(1), 25-32. doi: 10.1093/alcalc/agr140

Cunningham, R. M., Chermack, S. T., Ehrlich, P. F., Carter, P. M., Booth, B. M., Blow, F. C., . . . Walton, M. A. (2015). Alcohol interventions among underage drinkers in the ED: A randomized controlled trial. Pediatrics, 136(4), e783-e793. doi:10.1542/peds.2015-1260

Fuster, D., Cheng, D. M., Wang, N., Bernstein, J. A., Palfai, T. P., Alford, D. P., . . . Saitz, R. (2016). Brief intervention for daily marijuana users identified by screening in primary care: A subgroup analysis of the aspire randomized clinical trial. Substance Abuse, 37(2), 336-342. doi:http://dx.doi.org/10.1080/08897077.2015.1075932

Saitz, R., Palfai, T. P. A., Cheng, D. M., Alford, D. P., Bernstein, J. A., Lloyd-Travaglini, C. A., . . . Samet, J. H. (2014). Screening and brief intervention for drug use in primary care: The ASPIRE randomized clinical trial. JAMA, 312(5), 502-513. doi:http://dx.doi.org/10.1001/jama.2014.7862

Arnaud, N., Diestelkamp, S., Wartberg, L., Sack, P.-M., Daubmann, A., & Thomasius, R. (2017). Short- to midterm effectiveness of a brief motivational intervention to reduce alcohol use and related problems for alcohol intoxicated children and adolescents in pediatric emergency departments: A randomized controlled trial. Academic Emergency Medicine, 24(2), 186-200. doi:10.1111/acem.13126

Diestelkamp, S., Arnaud, N., Sack, P.-M., Wartberg, L., Daubmann, A., & Thomasius, R. (2014). Brief motivational intervention for adolescents treated in emergency departments for acute alcohol intoxication - a randomized-controlled trial. BMC Emergency Medicine, 14, 13. doi:10.1186/1471-227X-14-13

Bernstein, J., Heeren, T., Edward, E., Dorfman, D., Bliss, C., Winter, M., & Bernstein, E. (2010). A brief motivational interview in a pediatric emergency department, plus 10-day telephone follow-up, increases attempts to quit drinking among youth and young adults who screen positive for problematic drinking. Academic Emergency Medicine, 17(8), 890-902. doi:10.1111/j.1553-2712.2010.00818.x

Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., . . . Ries, R. R. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Annals Of Surgery, 230(4), 473-480.

Carey, K. B., Carey, M. P., Maisto, S. A., & Henson, J. M. (2006). Brief motivational interventions for heavy college drinkers: A randomized control trial. Journal of Consulting and Clinical Psychology, 74(5), 943-954. doi: 10.1037/0022-006X.74.5.943

Merrill, J. E., Reid, A. E., Carey, M. P., & Carey, K. B. (2014). Gender and depression moderate response to brief motivational intervention for alcohol misuse among college students. Journal of Consulting and Clinical Psychology, 82(6), 984-992. doi:http://dx.doi.org/10.1037/a0037039

Stein, M. D., Herman, D. S., & Anderson, B. J. (2009). A motivational intervention trial to reduce cocaine use. Journal of Substance Abuse Treatment, 36(1), 118-125. doi:http://dx.doi.org/10.1016/j.jsat.2008.05.003

Field, C., & Caetano, R. (2010). The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with hispanics. Alcoholism, 34(2), 262-271. doi:http://dx.doi.org/10.1111/j.1530-0277.2009.01089.x

Field, C. A., & Caetano, R. (2010). The effectiveness of brief intervention among injured patients with alcohol dependence: Who benefits from brief interventions? Drug and Alcohol Dependence, 111(1-2), 13-20. doi:http://dx.doi.org/10.1016/j.drugalcdep.2009.11.025

Field, C. A., Caetano, R., Harris, T. R., Frankowski, R., & Roudsari, B. (2010). Ethnic differences in drinking outcomes following a brief alcohol intervention in the trauma care setting. Addiction, 105(1), 62-73. doi:http://dx.doi.org/10.1111/j.1360-0443.2009.02737.x

Roudsari, B., Caetano, R., Frankowski, R., & Field, C. (2009). Do minority or white patients respond to brief alcohol interventions in trauma centers? A randomized trial. Annals of Emergency Medicine, 54(2), 285-293. doi:

Freyer-Adam, J., Coder, B., Baumeister, S. E., Bischof, G., Riedel, J., Paatsch, K., . . . Hapke, U. (2008). Brief alcohol intervention for general hospital inpatients: A randomized controlled trial. Drug and Alcohol Dependence, 93(3), 233-243. doi:http://dx.doi.org/10.1016/j.drugalcdep.2007.09.016

Fernandez, A. C., Waller, R., Walton, M. A., Bonar, E. E., Ignacio, R. V., Chermack, S. T., . . . Blow, F. C. (2019). Alcohol use severity and age moderate the effects of brief interventions in an emergency department randomized controlled trial. Drug & Alcohol Dependence, 194, 386-394. doi:10.1016/j.drugalcdep.2018.10.021

Marlatt, G. A., Baer, J. S., Kivlahan, D. R., Dimeff, L. A., Larimer, M. E., Quigley, L. A., . . . Williams, E. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. Journal of Consulting and Clinical Psychology, 66(4), 604-615. doi:10.1037/0022-006X.66.4.604

Baer, J. S., Kivlahan, D. R., Blume, A. W., McKnight, P., & Marlatt, G. A. (2001). Brief intervention for heavy-drinking college students: 4-year follow-up and natural history. American Journal of Public Health, 91(8), 1310-1316. doi:10.2105/ajph.91.8.1310

Diaz Gomez, C., Ngantcha, M., Le Garjean, N., Brouard, N., Lasbleiz, M., Perennes, M., . . . Bellou, A. (2019). Effect of a brief motivational intervention in reducing alcohol consumption in the emergency department: A randomized controlled trial. European Journal Of Emergency Medicine, 26(1), 59-64. doi:10.1097/MEJ.0000000000000488

Palm, A., Olofsson, N., Danielsson, I., Skalkidou, A., Wennberg, P., & Högberg, U. (2016). Motivational interviewing does not affect risk drinking among young women: A randomised, controlled intervention study in Swedish youth health centres. Scandinavian Journal of Public Health, 44(6), 611-618. doi:http://dx.doi.org/10.1177/1403494816654047

Rendall-Mkosi, K., Morojele, N., London, L., Moodley, S., Singh, C., & Girdler-Brown, B. (2013). A randomized controlled trial of motivational interviewing to prevent risk for an alcohol-exposed pregnancy in the Western Cape, South Africa. Addiction, 108(4), 725-732. doi:http://dx.doi.org/10.1111/add.12081

**Multisystemic Therapy:**

MultiSystemic Therapy (MST) is a treatment program for youth ages 12-17 who are at risk of criminal activity, experiencing mental health issues, and are at-risk of out of home placement. This target population aligns with the target population in the state of youth ages 12-17 who are determined to be at-risk. MST is currently rated Well-Supported by the Prevention Services Clearinghouse. MST has been extensively evaluated with positive outcomes across child permanency, child and adult well-being, and child permanency. For example, MST has demonstrated a reduction in out of home placement for problematic youth behavior (Vidal et al., 2017). In addition, multiple studies have demonstrated improved youth behavioral and emotional functioning such as mental health systems, conduct disorder, and other kinds of internalizing and externalizing behaviors (Asscher et al., 2013; Henggeler et al., 1997; Ogden & Halliday-Boykins, 2004). Related to adult well-being, MST has a proven track record for improving adult well-being outcomes such as positive discipline, increased parental involvement, reductions in inconsistent discipline, and overall improvements in family functioning, family satisfaction, and family cohesion (Asscher et al., 2013; Borduin et al., 1995). These outcomes align with the targeted outcomes in the state such as reducing youth behavior, empowering parents with the skills and resources to raise children, and empowering children and their families.

Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65(5), 821-833.

Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994). Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. Journal of Emotional and Behavioral Disorders, 2(4), 198-206. doi:http://dx.doi.org/10.1177/106342669400200402

Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., & Prins, P. J. M. (2013). A randomized controlled trial of the effectiveness of Multisystemic Therapy in the Netherlands: Post-treatment changes and moderator effects. Journal of Experimental Criminology, 9(2), 169-187.

Asscher, J. J., Dekovic, M., Manders, W., van der Laan, P. H., Prins, P. J. M., van Arum, S., & Dutch MST Cost-Effectiveness Study Group. (2014). Sustainability of the effects of Multisystemic Therapy for juvenile delinquents in the Netherlands: Effects on delinquency and recidivism. Journal of Experimental Criminology, 10(2), 227-243.

Dekovic, M., Asscher, J. J., Manders, W. A., Prins, P. J. M., & van der Laan, P. (2012). Within-intervention change: Mediators of intervention effects during Multisystemic Therapy. Journal of Consulting and Clinical Psychology, 80(4), 574-587.

Manders, W. A., Dekovic, M., Asscher, J. J., van der Laan, P. H., & Prins, P. J. M. (2013). Psychopathy as predictor and moderator of Multisystemic Therapy outcomes among adolescents treated for antisocial behavior. Journal of Abnormal Child Psychology, 41(7), 1121-1132.

Asscher, J. J., Dekovic, M., Van den Akker, A. L., Prins, P. J. M., & Van der Laan, P. H. (2018). Do extremely violent juveniles respond differently to treatment? International Journal of Offender Therapy and Comparative Criminology, 62(4), 958-977. doi:10.1177/0306624X16670951

Jansen, D. E. M. C., Vermeulen, K. M., Schuurman-Luinge, A. H., Knorth, E. J., Buskens, E., & Reijneveld, S. A. (2013). Cost-effectiveness of Multisystemic Therapy for adolescents with antisocial behaviour: Study protocol of a randomized controlled trial. BMC Public Health, 13, 369-369. doi:10.1186/1471-2458-13-369

Vermeulen, K. M., Jansen, D. E. M. C., Knorth, E. J., Buskens, E., & Reijneveld, S. A. (2017). Cost?effectiveness of Multisystemic Therapy versus usual treatment for young people with antisocial problems. Criminal Behaviour and Mental Health, 27(1), 89-102. doi:http://dx.doi.org/10.1002/cbm.1988

Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. Journal of Consulting and Clinical Psychology, 81(6), 1027-1039. doi:10.1037/a0033928

Weiss, B., Han, S. S., Tran, N. T., Gallop, R., & Ngo, V. K. (2015). Test of facilitation vs. proximal process moderator models for the effects of Multisystemic Therapy on adolescents with severe conduct problem. Journal of Abnormal Child Psychology, 43(5), 971-983. doi:619722141; 2001-95012-326.

Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., . . . Goodyer, I. M. (2018). Multisystemic Therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): A pragmatic, randomised controlled, superiority trial. The Lancet. Psychiatry, 5(2), 119-133. doi:10.1016/S2215-0366(18)30001-4

Fonagy, P., Butler, S., Goodyer, I., Cottrell, D., Scott, S., Pilling, S., . . . Haley, R. (2013). Evaluation of Multisystemic Therapy pilot services in the Systemic Therapy for At Risk Teens (START) trial: Study protocol for a randomised controlled trial. Trials, 14(1), 1-9. doi:10.1186/1745-6215-14-265

Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63(4), 569-578.

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., & Fucci, B. R. (1991). Effects of Multisystemic Therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. Family Dynamics of Addiction Quarterly, 1, 40-51.

Sawyer, A. M., & Borduin, C. M. (2011). Effects of Multisystemic Therapy through midlife: A 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders. Journal of Consulting and Clinical Psychology, 79(5), 643-652.

Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of Multisystemic Therapy with serious and violent juvenile offenders. Journal of Consulting and Clinical Psychology, 73(3), 445-453.

Wagner, D. V., Borduin, C. M., Sawyer, A. M., & Dopp, A. R. (2014). Long-term prevention of criminality in siblings of serious and violent juvenile offenders: A 25-year follow-up to a randomized clinical trial of Multisystemic Therapy. Journal of Consulting and Clinical Psychology, 82(3), 492-499.

Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of Multisystemic Therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. Journal of Consulting and Clinical Psychology, 85(4), 323-334. doi:10.1037/ccp0000199

Klietz, S. J., Borduin, C. M., & Schaeffer, C. M. (2010). Cost-benefit analysis of Multisystemic Therapy with serious and violent juvenile offenders. Journal Of Family Psychology, 24(5), 657-666. doi:10.1037/a0020838

Dopp, A. R., Borduin, C. M., Wagner, D. V., & Sawyer, A. M. (2014). The economic impact of Multisystemic Therapy through midlife: A costbenefit analysis with serious juvenile offenders and their siblings. Journal of Consulting and Clinical Psychology, 82(4), 694-705. doi:http://dx.doi.org/10.1037/a0036415

Dopp, A. R., Borduin, C. M., Willroth, E. C., & Sorg, A. A. (2017). Long-term economic benefits of psychological interventions for criminality: Comparing and integrating estimation methods. Psychology, Public Policy, and Law, 23(3), 312-323. doi:http://dx.doi.org/10.1037/law0000134

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. International Journal of Offender Therapy and Comparative Criminology, 34(2), 105-113.

Mann, B. J., Borduin, C. M., Henggeler, S. W., & Blaske, D. M. (1990). An investigation of systemic conceptualizations of parent-child coalitions and symptom change. Journal of Consulting and Clinical Psychology, 58(3), 336-344. doi:http://dx.doi.org/10.1037/0022-006X.58.3.336

Henggeler, S. W., Halliday-Boykins, C. A., Cunningham, P. B., Randall, J., Shapiro, S. B., & Chapman, J. E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. Journal of Consulting and Clinical Psychology, 74(1), 42-54.

Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A randomized controlled trial of Multisystemic Therapy and a statutory therapeutic intervention for young offenders. Journal of the American Academy of Child & Adolescent Psychiatry, 50(12), 1220-1235.e2. doi:https://doi.org/10.1016/j.jaac.2011.09.017

Cary, M., Butler, S., Baruch, G., Hickey, N., & Byford, S. (2013). Economic evaluation of Multisystemic Therapy for young people at risk for continuing criminal activity in the UK. PLoS ONE, 8(4), e61070-e61070. doi:10.1371/journal.pone.0061070

Vidal, S., Steeger, C. M., Caron, C., Lasher, L., & Connell, C. M. (2017). Placement and delinquency outcomes among system-involved youth referred to Multisystemic Therapy: A propensity score matching analysis. Administration and Policy in Mental Health and Mental Health Services Research, 44(6), 853-866. doi:10.1111/1745-9133.12064

Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behaviour problems in youth: Sustainability of effectiveness two years after intake. Child and Adolescent Mental Health, 11(3), 142-149.

Ogden, T., & Hagen, K. A. (2009). What works for whom? Gender differences in intake characteristics and treatment outcomes following Multisystemic Therapy. Journal of Adolescence, 32(6), 1425-1435.

Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. Child and Adolescent Mental Health, 9(2), 77-83. doi:doi:10.1111/j.1475-3588.2004.00085.x

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. Journal of Consulting and Clinical Psychology, 60(6), 953-961.

Henggeler, S. W., Melton, G. B., Smith, L. A., Schoenwald, S. K., & Hanley, J. H. (1993). Family preservation using multisystemic treatment: Long-term follow-up to a clinical trial with serious juvenile offenders. Journal of Child and Family Studies, 2(4), 283-293.

**Nurse Family Partnership:**

Nurse Family Partnership (NFP) is a home visiting program that is implemented by trained providers, targeting support to young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. In Florida, children from birth to 1 are at the highest risk for removal, with a targeted population in the state of young mothers, including pregnant or parenting youth. Because of the emphasis on young first-time parents, NFP is a well-suited intervention to serve families in the state. NFP has been studied across populations with outcomes across multiple domains related to child safety, child well-being, and adult well-being. For instance, NFP has demonstrated effects of reducing interaction

with Child Protective Services (Mejdoubi et al., 2015). For example, multiple studies related to child well-being have demonstrated improved cognitive functions and abilities along with physical health and development (Kitzman et al., 1997; Robling et al., 2016; Thorland & Currie, 2017). And finally, studies of NFP have also demonstrated improvements in caregiver employment (Olds et al., 2002). These outcomes align with the targeted outcomes in the state including reduced child welfare administrative reports, improved cognitive functions and abilities, improved physical development and health, and improved economic and housing stability.

Olds, D. L. (2002). Prenatal and infancy home visiting by nurses: From randomized trials to community replication. Prevention Science, 3(3), 153-172. doi:http://dx.doi.org/10.1023/A:1019990432161

Olds, D. L., Robinson, J., Pettitt, L., Luckey, D. W., Holmberg, J., Ng, R. K., & Henderson, C. R. (2004). Effects of home visits by paraprofessionals and by nurses: Age 4 follow-up results of a randomized trial. Pediatrics, 114(6), 1560-1568.

Miller, T. R., Olds, D., Knudtson, M., Luckey, D., Bondy, J., & Stevenson, A. (2011). Return on investment: Nurse and paraprofessional home visitation, Denver. Grant 2005-MU-MU-0001

Holmberg, J., Luckey, D., & Olds, D. (2011). Teacher data for the Denver year-9 follow-up. Grant 2005-MU-MU-0001

Olds, D. L., Holmberg, J. R., Donelan-McCall, N., Luckey, D. W., Knudtson, M. D., & Robinson, J. (2014). Effects of home visits by paraprofessionals and by nurses on children: Follow-up of a randomized trial at ages 6 and 9 years. JAMA Pediatrics, 168(2), 114-121.

Miller, T., Hendrie, D., & Miller, T. R. (2015). Nurse Family Partnership: Comparing costs per family in randomized trials versus scale-up. Journal of Primary Prevention, 36(6), 419-425. doi:10.1007/s10935-015-0406-3

Sanders, J., Owen-Jones, E., & Robling, M. (2011). Evaluating the Family Nurse Partnership in England: The Building Blocks trial. The Practising Midwife, 14(7), 13-15.

Owen-Jones, E., Bekkers, M.-J., Butler, C. C., Cannings-John, R., Channon, S., Hood, K., . . . Robling, M. (2013). The effectiveness and cost-effectiveness of the Family Nurse Partnership home visiting programme for first time teenage mothers in England: A protocol for the Building Blocks randomised controlled trial. BMC Pediatrics, 13, 114. doi:10.1186/1471-2431-13-114

Robling, M., Bekkers, M.-J., Bell, K., Butler, C. C., Cannings-John, R., Channon, S., . . . Kemp, A. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): A pragmatic randomised controlled trial. The Lancet, 387(10014), 146-155.

Corbacho, B., Bell, K., Stamuli, E., Richardson, G., Ronaldson, S., Hood, K., . . . Torgerson, D. (2017). Cost-effectiveness of the Family Nurse Partnership (FNP) programme in England: Evidence from the Building Blocks trial. Journal of Evaluation in Clinical Practice, 23(6), 1367-1374. doi:10.1111/jep.12799

Lugg-Widger, F. V., Cannings-John, R., Channon, S., Fitzsimmons, D., Hood, K., Jones, K. H., . . . Robling, M. (2017). Assessing the medium-term impact of a home-visiting programme on child maltreatment in England: Protocol for a routine data linkage study. BMJ Open, 7:e015728. Doi:10.1136/bmjopen-2016-015728

Matone, M., Kellom, K., Griffis, H., Quarshie, W., Faerber, J., Gierlach, P., . . . Cronholm, P. F. (2018). A mixed methods evaluation of early childhood abuse prevention within evidence-based home visiting programs. Maternal and Child Health Journal. Doi:http://dx.doi.org/10.1007/s10995-018-2530-1

Matone, M., OReilly, A. L. R., Luan, X., Localio, A. R., & Rubin, D. M. (2012). Emergency department visits and hospitalizations for injuries among infants and children following statewide implementation of a home visitation model. Maternal and Child Health Journal, 16(9), 1754-1761.

Matone, M., O'Reilly, A. L., Luan, X., Localio, R., & Rubin, D. M. (2012). Home visitation program effectiveness and the influence of community behavioral norms: A propensity score matched analysis of prenatal smoking cessation. BMC Public Health, 12(1), 1016.

Mejdoubi, J., van den Heijkant, S., Struijf, E., van Leerdam, F., HiraSing, R., & Crijnen, A. (2011). Addressing risk factors for child abuse among high risk pregnant women: Design of a randomised controlled trial of the Nurse Family Partnership in Dutch preventive health care. BMC Public Health, 11, 823. doi:10.1186/1471-2458-11-823

Mejdoubi, J., van den Heijkant, S. C. C. M., van Leerdam, F. J. M., Heymans, M. W., Hirasing, R. A., & Crijnen, A. A. M. (2013). Effect of nurse home visits vs. usual care on reducing intimate partner violence in young high-risk pregnant women: A randomized controlled trial. PLoS One, 8(10), e78185.

Mejdoubi, J., van den Heijkant, S. C. C. M., van Leerdam, F. J. M., Crone, M., Crijnen, A., & HiraSing, R. A. (2014). Effects of nurse home visitation on cigarette smoking, pregnancy outcomes and breastfeeding: A randomized controlled trial. Midwifery, 30(6), 688-695. doi:10.1016/j.midw.2013.08.006

Mejdoubi, J., van den Heijkant, S. C. C. M., van Leerdam, F. J. M., Heymans, M. W., Crijnen, A., & Hirasing, R. A. (2015). The effect of VoorZorg, the Dutch Nurse-Family Partnership, on child maltreatment and development: A randomized controlled trial. PLoS ONE, 10(4), e0120182. doi:10.1371/journal.pone.0120182

Thorland, W., Currie, D., Wiegand, E. R., Walsh, J., & Mader, N. (2017). Status of breastfeeding and child immunization outcomes in clients of the NurseFamily Partnership. Maternal and Child Health Journal, 21(3), 439-445. doi:http://dx.doi.org/10.1007/s10995-016-2231-6

Thorland, W., & Currie, D. (2017). Status of birth outcomes in clients of the Nurse-Family Partnership. Maternal and Child Health Journal, 21(5), 995-1001. doi:10.1007/s10995-017-2267-2

Kitzman, H., Olds, D. L., Henderson, C. R., Jr., Hanks, C., Cole, R., Tatelbaum, R., . . . McConnochie, K. M. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing. A randomized controlled trial. JAMA, 278(8), 644-652.

Olds, D., Henderson, C., Jr., Kitzman, H., Eckenrode, J., Cole, R., & Tatelbaum, R. (1998). The promise of home visitation: Results of two randomized trials. Journal of Community Psychology, 26(1), 5-21. doi:http://dx.doi.org/10.1002/(SICI)1520-6629(199801)26:1<5::AID-JCOP2>3.0.CO;2-Y

Kitzman, H., Olds, D. L., Sidora, K., Henderson Jr, C. R., Hanks, C., Cole, R., . . . Glazner, J. (2000). Enduring effects of nurse home visitation on maternal life course: A 3-year follow-up of a randomized trial. JAMA, 283(15), 1983-1989.

Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., . . . Holmberg, J. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. Pediatrics, 114(6), 1550-1559.

Olds, D. L. (2007). Preventing crime with prenatal and infancy support of parents: The Nurse-Family Partnership. Victims & Offenders, 2(2), 205-225. doi:http://dx.doi.org/10.1080/15564880701263569

Kitzman, H. J., Olds, D. L., Cole, R. E., Hanks, C. A., Anson, E. A., Arcoleo, K. J., . . . Holmberg, J. R. (2010). Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. Archives of Pediatrics & Adolescent Medicine, 164(5), 412-418.

Olds, D. L., Kitzman, H., Knudtson, M. D., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality: Results of a 2-decade follow-up of a randomized clinical trial. JAMA Pediatrics, 168(9): 800-806. doi:10.1001/jamapediatrics.2014.472

Enoch, M.-A., Kitzman, H., Smith, J. A., Anson, E., Hodgkinson, C. A., Goldman, D., & Olds, D. L. (2016). A prospective cohort study of influences on externalizing behaviors across childhood: Results from a nurse home visiting randomized controlled trial. Journal of the American Academy of Child & Adolescent Psychiatry, 55(5), 376-382. doi:http://dx.doi.org/10.1016/j.jaac.2016.02.007

Holland, M. L., Groth, S. W., Smith, J. A., Meng, Y., & Kitzman, H. (2018). Low birthweight in second children after nurse home visiting. Journal Of Perinatology, 38(12), 1610-1619. doi:10.1038/s41372-018-0222-8

Sidora-Arcoleo, K., Anson, E., Lorber, M., Cole, R., Olds, D., & Kitzman, H. (2010). Differential effects of a nurse home-visiting intervention on physically aggressive behavior in children. Journal of Pediatric Nursing, 25(1), 35-45.

Bean, K. F. (2012). Differential ratings of and maternal impact on anxiety and depression among African American children in special education. Children and Youth Services Review, 34(9), 1868-1875. doi:http://dx.doi.org/10.1016/j.childyouth.2012.05.024

Bean, K. F., & Sidora-Arcoleo, K. (2012). The relationship between environment, efficacy beliefs, and academic achievement of low-income African American children in special education. Journal of Social Work in Disability & Rehabilitation, 11(4), 268-286.

Bean, K. F. (2013). Disproportionality and acting-out behaviors among African American children in special education. Child & Adolescent Social Work Journal, 30(6), 487-504. doi:http://dx.doi.org/10.1007/s10560-013-0304-6

DeSocio, J. E., Holland, M. L., Kitzman, H. J., & Cole, R. E. (2013). The influence of social-developmental context and nurse visitation intervention on self-agency change in unmarried adolescent mothers. Research In Nursing & Health, 36(2), 158-170. doi:10.1002/nur.21525

Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J. ... & Stevenson, A. J. (2010). Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years. Archives of Pediatric and Adolescent Medicine, 164(5): 419-424. doi:10.1001/archpediatrics.2010.49

**Parent Child Interaction Therapy:**

Parent Child Interaction Therapy (PCIT) is a program for children ages three to seven and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. This target population aligns with the target population in the state of young children who experience frequent, intense, emotional, and behavioral problems. The Prevention Services Clearinghouse rated PCIT as a Well-Supported EBP following review of multiple studies found favorable effects in the target outcomes of child and adult well-being. Research in this area has demonstrated improved outcomes across multiple domains related to child behavioral and emotional functioning in areas such as child compliance, internalizing and externalizing behaviors, and reduction in overall reduction in behaviors (Bagner, D. M., & Eyberg, S. M. (2007), Matos, M., Bauermeister, J. J., & Bernal, G. (2009), Thomas, R., & Zimmer-Gembeck, M. J. (2011). Related to adult well-being outcomes, PCIT has demonstrated efficacy in enhancing positive parenting behaviors such as using encouraging commands and praise, effective child- and parent-led play skills and reducing the frequency of corporal punishment (Bagner et al. (2007). Related to caregiver outcomes, research has found a reduction in parental stress, depression, and anxiety (Leung et al., 2017) after engagement in the program. These outcomes are aligned with outcomes in the state related to increased parent-child closeness, decreased anger and frustration, increased parental ability to comfort the child, and improved parenting skills in behavior management and communication.

McCabe, K., & Yeh, M. (2009). Parent-Child Interaction Therapy for Mexican Americans: A randomized clinical trial. Journal of Clinical Child and Adolescent Psychology, 38(5), 753-759. doi:10.1080/15374410903103544

McCabe, K., Yeh, M., Lau, A., Argote, C. B., McCabe, K., Yeh, M., . . . Argote, C. B. (2012). Parent-Child Interaction Therapy for Mexican Americans: results of a pilot randomized clinical trial at follow-up. Behavior Therapy, 43(3), 606-618. doi:10.1016/j.beth.2011.11.001

Leung, C., Tsang, S., Ng, G. S. H., & Choi, S. Y. (2017). Efficacy of Parent-Child Interaction Therapy with Chinese ADHD children: Randomized controlled trial. Research on Social Work Practice, 27(1), 36-47.

Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial. Research on Social Work Practice, 25(1), 117-128.

Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008). The effectiveness of Parent-Child Interaction Therapy for families of children on the autism spectrum. Journal of Autism and Developmental Disorders, 38(9), 1767-1776. doi:10.1007/s10803-008-0567-5

Bjorseth, A., & Wichstrom, L. (2016). Effectiveness of Parent-Child Interaction Therapy (PCIT) in the treatment of young children's behavior problems. A randomized controlled study. PLoS ONE, 11(9), e0159845. doi:10.1371/journal.pone.0159845

Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-Child Interaction Therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. Family Process, 48(2), 232-252.

Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for Parent-Child Interaction Therapy in the prevention of child maltreatment. Child Development, 82(1), 177-192.

Bagner, D. M., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M. (2010). Parenting intervention for externalizing behavior problems in children born premature: An initial examination. Journal of Developmental Behavioral Pediatrics, 31(3), 209-216.

Bagner, D. M., Graziano, P. A., Jaccard, J., Sheinkopf, S. J., Vohr, B. R., & Lester, B. M. (2012). An initial investigation of baseline respiratory sinus arrhythmia as a moderator of treatment outcome for young children born premature with externalizing behavior problems. Behavior Therapy, 43(3), 652-665. doi:00004703-200506000-00008.

Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance. Journal of Clinical Child Psychology, 27(1), 34-45.

Bagner, D. M., & Eyberg, S. M. (2007). Parent-Child Interaction Therapy for disruptive behavior in children with mental retardation: A randomized controlled trial. Journal of Clinical Child and Adolescent Psychology, 36(3), 418-429. doi:10.1080/15374410701448448

Bagner, D. M. (2013). Fathers role in parent training for children with developmental delay. Journal of Family Psychology, 27(4), 650-657. doi:http://dx.doi.org/10.1037/a0033465

Abrahamse, M. E., Junger, M., van Wouwe, M. A., Boer, F., & Lindauer, R. J. (2016). Treating child disruptive behavior in high-risk families: A comparative effectiveness trial from a community-based implementation. Journal of Child and Family Studies, 25, 1605-1622. doi:10.1007/s10826-015-0322-4

**Parents As Teachers:**

Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. Consistent with the target population as identified by the model, the state intends to target parents with young children ages birth to five in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance use in the family, chronic health conditions, or pregnant and parenting youth in foster care. PAT has been rated as Well-Supported by the Prevention Services Clearinghouse, with positive outcomes across multiple domains including child safety, and child well-being. Related to child safety, involvement in the PAT program has demonstrated increases in child safety by reducing child abuse and neglect (Chaiyachati et al., 2018). Related to child well-being outcomes, the program has demonstrated positive outcomes related to improving social and cognitive functioning and abilities (Neuhauser et al., 2018; Wagner & Clayton, 1999). These outcomes align with the proposed targeted outcomes in the state including improved child behavioral and emotional functioning, and increased child safety.

Neuhauser, A., Ramseier, E., Schaub, S., Burkhardt, S. C. A., & Lanfranchi, A. (2018). Mediating role of maternal sensitivity: Enhancing language development in at?risk families. Infant Mental Health Journal, 39(5), 522-536. doi:http://dx.doi.org/10.1002/imhj.21738

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

Wagner, M. M., & Clayton, S. L. (1999). The Parents as Teachers program: Results from two demonstrations. The Future of Children, 9(1), 91-115.

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