NEW YORK STATE | Office of Children and Family Services

New York State
Family First Prevention Services Act
Prevention Plan

Governor Kathy Hochul

OCFS Commissioner Sheila J. Poole

July 29, 2022

Federal approval by Administration for Children and Families – August 2, 2022

ACKNOWLEDGEMENT

The New York State child welfare system is in a period of transformation, moving from the status quo of child protection as a primary prevention strategy and moving toward services and resources that strengthen families and enable children to remain safely at home. With a collective voice and a shared vision, New York State submits this Family First Prevention Plan, a plan that combines intention with action and outlines a strategy to narrowing the front door to child welfare and creating a child and family well-being system of the 21st Century.

The New York State Office of Children and Family Services (OCFS) is deeply grateful to the roughly 400 stakeholders – local departments of social services, voluntary foster care agencies, community-based organizations, youth and parent advisory boards, national experts, and child welfare advocates – who took the time to read and provide thoughtful comments and recommendations that will move New York State in the direction of a culturally sensitive, trauma-informed system that incorporates the voice of those with lived experience in policy and practice decisions and moves toward increasing collaboration to combine resources to collectively help all our children and families.

Our groundbreaking preventive work will leave a positive impact upon the lives of parents, children, and caregivers throughout New York State. This would not be possible without the help of each and every one of our partners. We sincerely thank you for being a part of this transformative moment.

Table of Contents

Reimagining Child Welfare Services:
New York State's Child Welfare Modernization Vision
and Title IV-E Prevention Services Plan

Introduction

New York State's child welfare system is at an inflection point. The New York State Office of Children and Family Services (OCFS) has been charged with charting a course — bold and innovative — designed to transform and modernize New York State's child welfare system by building upon our strong history of preventive services and forging new pathways to achieve family and child well-being. The contributions we make to family strengthening and prevention as a child welfare system must further evolve from a system that focuses on child protective services and removal as a primary intervention strategy to one that focuses on prevention strategies to keep children safely at home. New York State's Title IV-E Prevention Services Plan, submitted herein pursuant to the Family First Prevention Services Act (FFPSA or Family First), sets forth our vision for transformation, describes our aspirational goals, and details the steps we will take over the course of the next five years to fundamentally change the way child welfare at the state and county levels work with other governmental agencies, not-for-profit providers, community based organizations, and philanthropic partners to engage with families and strengthen communities so parents and children can thrive together as a family. This plan articulates our path to becoming a family and child well-being system of the 21st century.

New York State's bold vision for modernizing child welfare is centered on strengthening and investing in parents, families and communities, and intentionally tackling inequities and disparities in the social determinants of health – poverty; lack of affordable, quality child care; education barriers; housing instability; food insecurity; lack of affordable, quality physical and mental health care; intimate partner violence; maternal depression; family mental illness; substance use disorder; and discrimination – which are identifiable root causes that bring families to the attention of child welfare. We know the child welfare system cannot address these social and psychosocial needs alone, yet the families we serve need us to be familiar with and provide robust resources to address these issues. If we do not change our approach, we are destined to achieve the same outcomes. New York State is ready to chart a new course. With access to new Title IV-E federal prevention funding, a continued state commitment to open-ended prevention funding (62/38) and realigned state funding, deepened government partnerships, and a public health perspective, we can transition from a child-centric system to a family and child well-being system. We know, and the data tell us, that a child's connection to their family is paramount to healthy family bonds and provides the foundation upon which safety, permanency, and well-being can truly be achieved. To that end, we have begun to reimagine our system to be one in which we:

(1) embrace listening to parents, youth, and kin caregivers as they tell us what they want and need,

(2) marshal our own resources and the resources across the public platform and in communities to address those needs from a public health perspective,

(3) embrace diversity, equity, inclusion, and accessibility (DEIA) recognizing the disparate impact our policies have had on people with varied racial, ethnic, gender, socio-economic status by providing opportunities for individuals to gain access to a wide range of resources and services across all sectors,

(4) deploy evidence-based practices designed to strengthen and support families, and

(5) invest in community-based programs which reflect the communities they serve.

Implementation of Family First is a key step toward achieving New York State's goal of a family and child well-being system. However, Family First is the floor – it is not our ceiling. New York State knows Family First does not go far enough. We cannot wait for a call to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) and begin to "fix" a family during crisis or wait for a youth's behaviors to bring them to the attention of the juvenile justice system before supporting the youth and family. Using a public health lens, we must meet families where they are and have the capacity to rapidly engage with culturally relevant supports and resources that are within reach of families. While Family First is focused upon secondary and tertiary prevention[1], New York State is building a more robust system, centered upon culturally responsive and accessible primary prevention services coupled with the concrete and economic supports available to families upstream, well before contact with or entry into the child welfare system is ever contemplated.

Children do well when their parents, caregivers, families, and communities are healthy and stable. OCFS believes that a child's connection to their parents, family and community is paramount and provides the context in which safety, permanency, and greater well-being should occur. A child welfare system of the 21st century recognizes parent, youth, family, and community well-being as foundational to any effort to reduce the incidence of child maltreatment, abuse, and neglect. Moreover, meaningful prevention efforts must center upon addressing the social and economic needs of families and their networks of natural supports well before involvement with social services is necessary.

For too long, the child welfare system has focused its efforts and resources into fixing perceived individual deficits that contribute to child abuse and maltreatment, but research shows child abuse and maltreatment have multiple, complex causes including poverty-related neglect. In 2019, 57% of New York State's child protective services reports were substantiated based on maltreatment rather than abuse[2]. Our goal is to significantly reduce, if not eliminate, the need to call the SCR by meeting families' needs long before the crises emerge. New York State is committed to implementing Family First, fully leveraging this opportunity to use Title IV-E dollars in a manner designed to keep children safely in their homes, to keep their families intact, and to reduce the need for foster care. Family First is one core lever at the center of a broader array of strategies designed to transform child welfare in New York State.

Plan Overview

This document serves several purposes. It is both blueprint and vision: a description of New York State's plan, in partnership with our diverse stakeholders for growing and enhancing preventive services under Family First and an invitation to ourselves and our state and federal partners to think bigger, to push beyond the opportunities currently afforded under Family First, and to create a more comprehensive, interdisciplinary, upstream approach to child protective services and foster care. *Section 1* outlines New York State's goals setting forth the three core bodies of work being undertaken to support this vision. *Sections 2-8* dive deeply into Family First implementation and lay out the primary components of New York State's Title IV-E Prevention Plan.

Section 1: New York State's Vision for Child Welfare Modernization

Guiding Principles

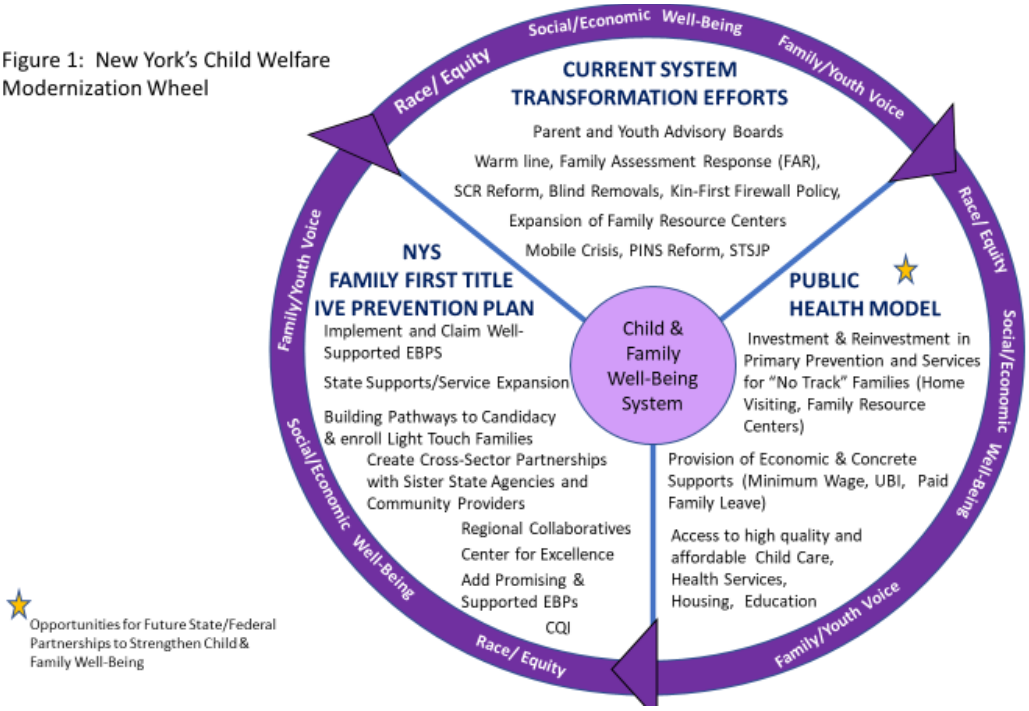
Surrounding and guiding New York State's transformation are three guiding principles intended to keep families and communities at the forefront of the work, shaping how questions are asked, how solutions are pursued, and the criteria by which outcomes are evaluated:

- Race Equity and Gender Identity – advancing a child welfare system where all children and families, regardless of race and Sexual Orientation, Gender Identity and Expression (SOGIE) have the same opportunity to reach their potential

- Social and Economic Well-Being – promoting and supporting a trauma-informed system where basic human needs are met

- Parent and Youth Partnership – authentically and effectively sustaining the involvement of parents, youth and when applicable, kin in our shared outcomes

Figure 1: New York's Child Welfare Modernization Wheel



I. CURRENT SYSTEM TRANSFORMATION EFFORTS

a. Theory of Change

Poverty-related factors such as food insecurity, housing instability, and lack of quality, affordable child-care and health care should not be reasons why a family comes to the attention of child protective services (CPS). Therefore, New York State will leverage a vast array of prevention services, including economic and concrete supports, to provide families with the resources and services they need so children can remain safely at home and families are supported. New York State will work with intention to reduce disproportionality and disparity in the child welfare system. New York State will remain data informed, partner with those with lived experiences, sister state agencies, not-for-profit providers, and philanthropic community as we advance policies and

practices that strengthen communities and strive to provide economic stability and concrete supports for families.

While New York State is fully committed to implementing Family First, there must be an acknowledgement that many, if not all, of the approved evidence-based programs (EBPs), are not designed to serve the culturally, racially, and ethnically diverse children and families of New York State. Indeed, guidance from the Administration for Children and Families (ACF), Information Memorandum 21-04, allows states to make eligible adaptations of approved programs reviewed in the Title IV-E Prevention Services Clearinghouse (Clearinghouse). While New York State appreciates and welcomes the ability to make adaptations, we question whether the use of EBPs, which are not backed by scientific evidence to demonstrate effectiveness for diverse populations, is the best strategy to serve our children and families.

b. New York State Logic Model

New York State is committed to utilizing the opportunity presented by Family First to increase the number of children and families that receive an EBP, thereby reducing the number of children at risk of removal from their homes and/or entering foster care. While our theory of change is our "North Star" for a child and family well-being system, the logic model presented below provides a road map as to how our vision and goal to improve outcomes to support family and child well-being will be achieved.

Figure 2: New York State Logic Model – Preventive Services

Target Populations

The state and its partners intend to increase the number of children and families receiving Family First and other needed preventive services by expanding the availability of services to the following target populations:

Family First: Wave 1

- Pregnant and parenting youth in foster care.
- "Candidates for foster care" defined as:
  - Children with an open preventive services case (aka Child Welfare Track families)
  - Children eligible and receiving Healthy Families New York home visiting services

Family First: Wave 2

All of the above, and expansion of "candidates for foster care" to include:

- Children who meet the criteria for opening a preventive services case that are identified and served by community-based providers or sister state agencies outside the formal child welfare system (aka Community Prevention/Light Touch families)

Public Health Model

- "No Track" families with economic, concrete, or other preventive service needs served through primary prevention programs without opening a services case, with outcomes monitored at the program level

Interventions: Family First

Interventions include (but are not limited to):

Wave 1:

- Brief Strategic Family Therapy (BFST)
- Family Check-Up (FCU)
- Familias Unidas
- Functional Family Therapy (FFT)
- Healthy Families America (HFA)
- HOMEBUILDERS
- Motivational Interviewing (MI)
- Multisystemic Therapy (MST)
- Nurse-Family Partnership (NFP)
- Parent-Child Interaction Therapy (PCIT)
- Parents as Teachers (PAT)

Wave Two:

- Additional interventions TBD

Proximal Outcomes

Parents and children will experience improved family functioning as they achieve the desired outcomes indicated by the provided service. These outcomes include, (but are not limited to):

- Improved child social, emotional, and behavioral functioning
- Increased child safety
- Improved child cognitive functioning
- Improved child physical development and health
- Increased adult emotional and mental well-being
- Improved positive parenting practices
- Reduced parent substance use
- Improved protective factors

Distal Outcomes

The number of children and families served with Family First EBPs and primary prevention programs will increase, leading to a reduced number of children removed from their homes, fewer child protective services (CPS) contacts, and reduced foster care entries. Outcomes to be monitored include the following:

- Number of pregnant and parenting youth in foster care provided a Family First EBP each year
- Number of children served on Child Welfare, Healthy Families New York (HFNY), and Community Prevention track each year
- Number and percentage of children named as an alleged or substantiated victim in a CPS report (both Traditional and FAR) after receiving preventive services/Family First EBP
- Number and percentage of children entering foster care after receiving Family First EBP or preventive service

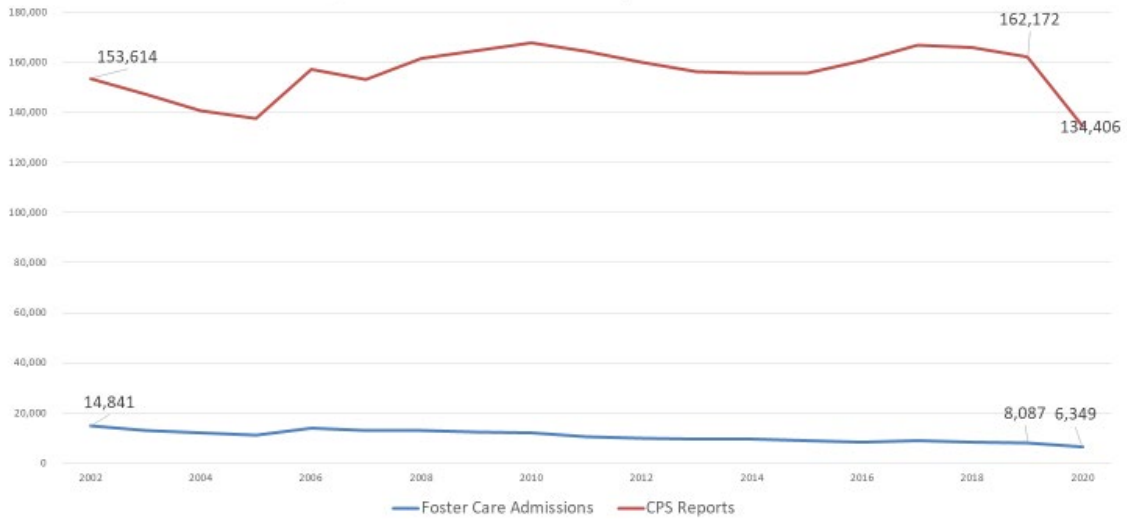
c. Building Upon New York State's Momentum

As New York State continues its transformation into a system oriented upon strengthening families, we are building on ample recent progress. At the center of New York State's long-standing approach to prevention is a primary prevention strategy and service array, including but not limited to, family resource centers (FRCs), parenting education programs, home visiting programs, and domestic violence services. OCFS depends on its valued partners to plan and deliver preventive services in each local department of social services (LDSS) and in the community through direct state administered contracts (e.g., HFNY, FRCs etc.), and as we adapt our strategy, these partnerships will be more important than ever. Throughout state fiscal years (SFY) 2019 - 2021, the state and local share (not including federal funds) in such primary prevention programs exceeded $195 million.

The wide availability of secondary preventive services to families with known child welfare contact is equally important in preventing further child abuse and maltreatment and reducing the need for foster care. In 2020, 134,406[3] reports were accepted by the New York State Statewide Central Register of Child Abuse and Maltreatment (SCR), and 6,349[4] children were admitted into foster care. For these children and their families, New York State's innovative child welfare financing approach supports LDSSs in purchasing an array of preventive services aimed at keeping children safe at home or shortening their time in out-of-home care. In 1979, New York State was the first state in the nation to provide open-ended state reimbursement for child preventive services. In addition, in June 2002, New York State passed a landmark legislation package known as Child Welfare Financing Reform (CWF). The package uncapped state funding for preventive, child protective, adoption, after care, and independent living services and capped state reimbursement to LDSSs for foster care services. The premise underlying CWF is that it is important to provide a reliable, uncapped source of funding for child welfare that enables LDSSs to invest in services that promote family stability and permanency for children in safe, home-based settings. While foster care is a component of all child welfare systems, New York State believes that the provision of services to alleviate imminent risk, the need for foster care, or reduce the time in foster care is critical to family preservation efforts. Under CWF, New York State splits the cost of funding with LDSSs for preventive services for families with open child welfare services cases. New York States pays 62% incurred costs and the LDSS pays 38%. Throughout the state fiscal years 2019-2021, New York State and LDSSs invested over $3.4 billion (not including federal funds) in secondary preventive services. This enabled LDSSs to provide over 80,000[5] children and their families with preventive services in 2020.

Outcome data speak to the effectiveness of CWF and New York State's approach to reducing imminent risk and preventing a child's entry into foster care. While the number of New York State's children reported to the SCR each year showed a modest increase (6%)[6] between 2002 and 2019, the number of children admitted into foster care dropped substantially. In 2002, nearly 15,000 children entered New York State's foster care system compared to just over 8,000 in 2019, a decline of 46%[7]. With the onset of the pandemic, CPS reports declined nearly 1% between 2019 and 2020, and foster care admissions declined by 21%[8]. Annual outcome metrics have repeatedly shown that less than 6% of children authorized to receive preventive services enter foster care within 12 months[9]. As a result, New York State currently has one of the lowest foster care admission rates nationwide (1.5 children for every 1,000 in 2020)[10]. This is a tremendous achievement and well-positions New York State to further reduce imminent risk and entry into foster care through Family First implementation and supports the approach New York State aims to implement as described in this plan.

Figure 3: NYS Child Welfare System: 2002-2020



Family First builds upon all of New York State's success in supporting prevention – primary, secondary, and tertiary – to support families and reduce entry and re-entry into foster care. Family First will allow New York State to expand the number of families served through preventive services, improving the quality and effectiveness of offered program models and strengthen our partnerships with communities and across systems to identify and reach families earlier. Through Family First, more families will be identified and served through formal partnerships with community-based programs and other public agencies, reducing the need for families to interface with the child welfare system. This approach is necessary in New York State as we know that most children entering foster care have not received preventive services. Of the 6,349 children admitted into foster care in 2020, 60% (3,824) did not receive prevention services in the 12 months prior to their admission[11]. OCFS's current investments and strategies have had a significant effect in reducing imminent risk of foster care, but they have not been sufficient or deployed where and when many families need them the most. We will expand our capacity and partnerships to strengthen families and meet their needs to further reduce imminent risk of entry into foster care.

The New York State Kinship Navigator Program

In those instances where foster care is needed, OCFS believes in the importance of kinship and relative support as a key strategy to reduce the need for non-relative foster care. A robust and meaningful kin-first culture leads to the very best outcomes for children and families. Research shows that when out-of-home placement is deemed a needed intervention, placing a child with a relative lead to stronger family bonds between the parent and child, fewer placement disruptions, shorter lengths of stay, and reduces the impact of trauma[12]. Indeed in 2018, New York State expanded its definition of who qualified as a relative to access kinship support to include a person who has a positive relationship with the child, including, but not limited to a stepparent, godparent, neighbor, or family friend.

OCFS has a rich history of supporting the New York State Kinship Navigator. The New York State Kinship Navigator is an information, referral, education, and advocacy program for kinship caregivers in New York State. The navigator seeks to assist kinship caregivers in providing stability and permanency to a child they are caring for by providing information on financial assistance, legal information, and referrals to other services and supports to address issues that caregivers face when raising child.

The Kinship Navigator's county resources assist kinship caregivers by providing access to resources available in their specific county to meet the needs of the children they are caring for. The Kinship Navigator maintains a website with relevant resource information for caregivers as well as the ability to elevate concerns and request additional resources for the relative children in their care. Each county displays kinship, legal, aging, youth, and any other services that are available in that county, along with program descriptions and contact information.

To date only one kinship navigator program has been approved by the Clearinghouse. OCFS will implement in New York State this model in Wave 2 of the prevention plan as a strategy to support children in relative care. Additionally, OCFS will continue to partner with the New York State Kinship Navigator on a New York State specific model that is aimed at improving services to support kinship caregivers who are caring for children outside of the child welfare system. It is New York State's goal that this model will meet the Clearinghouse requirements. This will be done through a separate Kinship Navigator Plan.

d. **A Renewed Focus on, and Understanding of, Well-being**

A decade ago, as a child welfare system, New York State embraced well-being as an organizing framework. At that time, the prevailing narrative in child welfare was that the responsibility for the well-being of children resided in other systems – such as education and health – with limited responsibility for child well-being assumed by the child welfare system. The Health and Human Services/Administration for Children, Youth and Families (HHS/ACYF) well-being framework created the impetus for New York State to provide new services and supports to improve the social and emotional well-being of children.

Today, New York State is crafting a new vision for how we will support families and children over the next five years and beyond. This will include promoting not just child well-being but also parent, family, and community well-being by focusing, with intention, on the needs of the entire family and its network of natural supports before child protective services or foster care placement are considered. New York State will further support parents and other caregivers and invest in communities knowing that children will thrive when their homes are strong and supported.

As with safety and permanency, well-being is not just the responsibility of child welfare and LDSSs; rather, the entire community plays a role. OCFS will be asking much of ourselves, our LDSSs, our provider network, and our public partners, asking them to help us craft a vision together and do the hard work of operationalizing it. Our business model and the family service eco-system can change to meet the demands of the 21st century, to be more responsive to what parents, families, youth, and communities have been asking from us for years: a trauma-informed, inclusive, accessible, culturally responsive system that supports, strengthens, and empowers families and their natural supports so that children can thrive.

e. **Critical Role of Federal Partners and Investments**

The state's perspective and understanding of what is required to support families has evolved over the past several years beginning with the passage of Family First and its emphasis on prevention and furthered by recent unprecedented events including national calls for race equity, gender inclusivity, our personal and collective experiences during the pandemic, and the powerful voices of constituents and community members. Many of these same experiences have been cited by the Children's Bureau as the rationale for emphasizing prevention and bringing to bear public-private, as well as community-family driven partnerships and resources to strengthen families and prevent child abuse and neglect. We embrace federal leadership and support as states begin this critical journey of transforming child welfare from a foster care-oriented system to one defined by prevention and family strengthening and empowerment.

Thus, as we join with our federal partners in this important endeavor, we invite them to ensure that New York has the flexibility necessary to robustly leverage Title IV-E funds through Family First to serve families in need "upstream" before child welfare is alerted through a child protective service report to the SCR or a youth enters the juvenile justice system. In addition, we invite our federal partners to infuse Community-Based Child Abuse Prevention (CBCAP) and Title IV-B with the additional resources and flexibility that are needed to eliminate racial inequity and disparity through expanded upstream family-supporting, community-strengthening services. To the extent that these investments result in a reduction in foster care entries, we hope to retain and reinvest those savings in further upstream services, completing a feedback loop that fuels progressively deeper investments in families while keeping children safely out of foster care.

New York State is well-positioned to continue our existing investment and make new investments in prevention to augment federal resources to address the often poverty related root causes of imminent risk and foster care entry. We intend to allocate state funds as a down payment on investing in families to meet their needs before a crisis occurs. We expect this initial investment, paired with a flexible federal investment, will result in:

- reducing avoidable foster care entries across the state
- eliminating racial disproportionality in foster care. and
- increasing the well-being of parents, children, families, and communities.

f. **New York State's Transformation Policy and Practice Strategies**

At the top of New York State's modernization wheel is OCFS's current suite of transformative strategies. These recent and emerging policies and practices predate and complement our developing Family First implementation efforts, and support the shared goals of amplifying family voice, reducing unnecessary foster care admissions and shortening the length of stay in foster care. In visioning a New York State child and family well-being system, we have collected the perspective of different stakeholder groups. We are listening to our partners and their calls for us to collectively address root causes of family needs, imminent risk of foster care entry, and to take a public health approach to child abuse and maltreatment prevention. This approach recognizes that the health and well-being of individuals and communities depends on multiple systems at the community and societal level which leverage existing resources before child abuse and maltreatment happens.[13] These resources can include concrete supports for families, such as clothing, housing, quality affordable child care and food, as well as economic support.

We have learned a great deal in the last decade about these root causes and possible solutions and find ourselves with renewed energy to move from child protection as the primary intervention strategy to prevention programs and concrete economic supports that move us ever closer to a family and child well-being system.

Today, we seek to strengthen families in a variety of ways far before placement into foster care is contemplated. We aim for the next generation to experience a continuum of care without the fear that has plagued child welfare involvement in the past. The following will be the key strategic cornerstones of our approach to ignite and operationalize the system transformation we envision:

- Realigning policy to support and drive the transformation
- Strengthening partnerships to form a public health approach
- Promoting race equity
- Prioritizing economic and concrete supports for families
- Expanding and aligning evidence-based preventive services

Examples of these policy and practice strategies designed to put children and families first include:

- Prevention Investment and Reimbursement: With its reimbursement to counties for preventive services (i.e., 62% state share/38% local share reimbursement not including federal funds), New York has long been a national leader in family support and prevention, offering robust funding for preventive, child protective, adoption, aftercare, and independent living services statewide.

- Block-Granting Foster Care Financing: New York has a long-standing policy of capping funds for foster care, limiting the state's investment in out-of-home interventions, while making flexible funds available for prevention.

- Community Optional Preventive Services (COPS): COPS funding is provided by a state and local partnership to fund community services that support youth and families with emerging needs before a serious problem develops. Rather than serving youth at immediate risk for placement, a key goal is to reduce the need for foster care and keep children with their families and communities. COPS-funded programs rely on communities to know what their families need, placing key decision-making in the hands of each individual community. LDSSs offer a wide range of services and COPS serves as a model for delivering community-based resources to children and families.

- Workforce Recruitment and Retention Workgroup: A strong, stable, and professional workforce is paramount to a family and child well-being system. Since 2019, OCFS, in collaboration with the New York State Civil Service and local civil service partners, LDSSs commissioners and directors, University at Albany School of Social Welfare, and the New York Public Welfare Association (NYPWA) have convened to improve worker recruitment, selection, and retention. Three key areas of focus include qualifications and competencies, testing, and a statewide media campaign.

- Parent Advisory Board (PAB): OCFS's PAB gives a voice to parents, foster (kin and non-relative) and adoptive parents and kinship caregivers in our policy making process.

Members provide feedback on their experiences in child welfare contribute to policy alignment and implementation of state and federal initiatives to improve safety, permanency and well-being for children and families. Members are compensated for their time.

• Parent Advocates: OCFS is developing a program that will amplify the voice of parents and caregivers with experience child welfare experience by incorporating them within New York State's child welfare structure. This effort is divided into two key components:

1. Policy Family Advisors (Advisors): The Advisors will be located within OCFS working side by side with the existing state workforce as we provide oversight, monitoring and set the policy and regulatory framework with New York State's state supervised county administer child welfare system.
2. Family Peer Advocates (Advocates): Advocates will model the structure of the Policy Family Advisors but will be embedded within LDSSs. The Advocates, who have lived experiences with the child welfare system, will assist caseworkers to understand the needs of families, and parents to understand the child welfare system. We believe the implementation of a statewide parent advocate structure will improve child and family well-being by keeping families together, reducing the need for removals, or when a removal is deemed necessary, hasten a child's return from an out-of-home placement.

• Youth Advisory Board (YAB): The OCFS YAB is comprised of young adults between the ages of 18-24 who have lived experience in foster care. Members are recruited from LDSSs and voluntary authorized agencies (VAs), apply for the position, and are chosen by OCFS staff and approved by the commissioner. Youth are compensated for their time and contribute actively to OCFS policy and programmatic decisions.

• Warm Line Support for Families: OCFS is in the process of establishing a new phone line to proactively support families and provide information on services to reduce the number of families entering the CPS system through a report to the SCR.

• Family Assessment Response (FAR): FAR is New York State's differential response program. Families referred to the SCR for certain types of CPS allegations may be reassigned to the FAR track. FAR does not require an investigation or findings related to the allegation. OCFS is encouraging the use of FAR statewide, thereby allowing LDSSs to utilize this less intrusive and more supportive pathway to strengthen families.

• CarePortal: CarePortal is a technology platform that connects children and families to resources in their communities. A child welfare caseworker or other agency worker enters the need of a family – whether it be a crib or a new washing machine – into the CarePortal. The CarePortal then alerts local churches and community members to that need, allowing them to respond in real-time. CarePortal strengthens families and may prevent children entering foster care. There are currently several counties in New York State who are using the CarePortal and partnering with non-profits, churches, local businesses, and other entities in their counties to provide resources to families and children in need. OCFS is working with CarePortal to implement this resource statewide.

• SCR Reform: The SCR reform includes a two-pronged policy change to reduce system overreach in the lives of families. First, beginning in 2022, indicated reports for child abuse

and maltreatment older than eight years will no longer be considered "relevant and reasonably related to employment." This may reduce secondary employment restrictions (e.g., not being able to work with children), which can have the effect of perpetuating the cycle of families' inability to adequately resource their needs. Second, we are raising the level of evidence required to substantiate an investigation.

• Blind Removal Policy: OCFS is deeply committed to advancing and affirming practices of equity and inclusion and to uphold the values of our agency on behalf of the children and families of New York State. The goal of the Blind Removal Process is to eliminate bias in decision-making during the CPS removal process, decrease the overall number of children being removed from their homes, and build a more equitable system of care. The Blind Removal process is a strategy to reduce racial disparity and disproportionality in child welfare by removing all family demographic information from decision-makers to prevent implicit bias from impacting a removal decision. OCFS developed an Administrative Directive (20-OCFS-ADM-19) to introduce a way implicit bias can be mitigated. The directive covers; assessment, training, data review and process change activities that must be present to ensure fidelity to a blind removal process. Ongoing training in the mind science of bias and extensive support activities have been developed and continue throughout the state.

• Kin-First Firewall Policy: The statewide Kin-First Firewall policy requires a "second look" when a child is removed from their home, seeing that all steps have been taken to make their first foster care placement a kinship placement that is safe, appropriate, and in the child's best interests. The policy requires a review to verify that all viable relatives and significant adults in a child's life have been explored to achieve a kinship placement before a non-kinship placement is made.

• Expansion of Family Resource Centers (FRCs): New York State's FRCs provide services to strengthen families and increase protective factors that can reduce risk of child abuse and maltreatment. FRCs utilize an approach that is family-centered, strengths-based, and responsive to community needs. They also serve as a hub of local inter-agency and community collaboration to support families across the child welfare continuum. OCFS plans to open FRCs in more counties statewide and partner with sister state agencies such as the New York State Education Department (SED), Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS) to build upon the FRCs and create Family Opportunity Centers (FOCs) so that more families of young children can participate in FRC services in an inviting community location. Recent research showed that FRCs in New York State make a real difference in families' lives. Families who attended FRCs showed statistically significant improvements in protective factors, and the most vulnerable families showed the greatest improvements. Testimonials from participants revealed that the services FRCs provided had real, tangible impacts for children and their families.[14] Families need spaces close to home that support their growth, with opportunities to develop strong relationships with other parents.

• Mobile Crisis Response: Efforts are underway to expand Mobile Crisis Response in collaboration with the OMH to respond not only to children in foster care but also to families and children receiving preventive services. With new mobile crisis vans, designated to serve areas of the state with fewer mental health supports, families involved in child welfare will have ready access to skilled professionals to help stabilize emergency

situations. These supports have the potential to keep children safely in their homes, thereby reducing foster care placements, reinforce natural supports in the community, and stabilize placements at risk of disruption.

• Status Reform: In 2020, New York State ended the use of detention for status offenders and narrowed the options for out of home placement for youth who are deemed a Person in Need of Supervision (PINS). The reform included expansion of Supervision and Treatment Services for Juveniles Program (STSJP), which can provide services to youth who are at risk of PINS as well as delinquency and court involvement. STSJP provides resources to support family mediation, respite and supports to families so that youth can be diverted from court and successfully stay in the community

• Anti-trafficking Investments: OCFS's efforts to address human trafficking over the last decade include raising awareness, providing training and technical assistance, developing, and implementing the Safe Harbour: NY program, and guiding the implementation of the federal Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183). Safe Harbour: NY is a program that implements a system-level approach within existing child welfare and allied youth-serving systems to create a more effective and efficient response to youth who have experienced commercial sexual exploitation or trafficking, or who are vulnerable to it. As of 2020, all LDSSs within New York State receive funding to support anti-trafficking efforts.

In addition, New York State has boosted its investment in economic supports to families with children, and the impacts of these programs are already being felt across the state. OCFS's transformation will build toward a broader landscape of economic and concrete supports that these policies have created:

- Raising the minimum wage to increase investments in families: As part of the 2016-17 State Budget, a statewide $15 minimum wage plan was enacted, to be phased in over five years. Raissian & Bullinger (2017)[15] found that increases to the minimum wage were associated with a decline in overall child maltreatment reports, particularly neglect reports. Even a $1 increase in the minimum wage was associated with reduced neglect reports by almost 10% and was especially impactful for children under age 12.[16]

- Paid family leave enhancements: New York State has implemented the most comprehensive family leave policy of any state. Employees have access to up to 12 weeks of protected, paid time off to bond with a new child, care for a family member with a serious health condition, to assist loved ones when a family member is deployed abroad on active military service. Moreover, as of 2021, working families benefitted from increased wage replacement up to 67% of their average weekly wage, reflecting New York State's commitment to strengthening family connections and building up their financial security.

- Child Care: New York is actively investing in efforts strengthening the child care system and increasing access to child care for low-income families. On an annual basis, New York allocates over $800 million to support low-income families through the child care subsidy program. Recent changes to the subsidy program to reduce the financial burden associated with child care and better serve the most vulnerable families have included raising the statewide definition of very low income to 200% of the Federal Poverty Level, and eliminating co-payment requirements for certain categories of families (children in

foster care, child care provided to families in receipt of protective or preventive services or when a child lives with a person other than their legal guardian). In SFY 2021-22 New York administered the Essential Worker Scholarship grant opportunity, funded through the federal Coronavirus Response and Relief Supplemental Appropriations Act, to provide supplemental funding to cover the child care costs of essential workers for up to 12 weeks. This program provided scholarships to over 42,000 children over a 12-week period. During this same time period, New York also awarded $900 million to almost 15,000 eligible child care providers through the Child Care Stabilization Grant, which was made available through the federal American Rescue Plan Act, provided financial relief to child care providers to help cover unexpected business costs associated with the COVID-19 pandemic, and helped stabilize their operations so they may continue to provide care. The Child Care Stabilization Grant represents an unprecedented opportunity and investment to effectively stabilize the child care sector. Future plans for supporting the child care sector include long-term business improvement trainings with Early Care and Learning Council and other partners for ongoing efforts until 2023.

- Recognizing that there are areas of the state with a lack of supply of child care, further limiting families' choices, NYS is investing $100M to address so-called "Child Care Deserts." These funds will directly address shortages in child care slots, as well as bring online quality early childhood programs in parts of the state hardest hit by COVID-19. Child care providers and their staff are primarily women and people of color, making this funding opportunity a chance to partner with these leaders and entrepreneurs and make impactful investments that can make real change for families and communities.

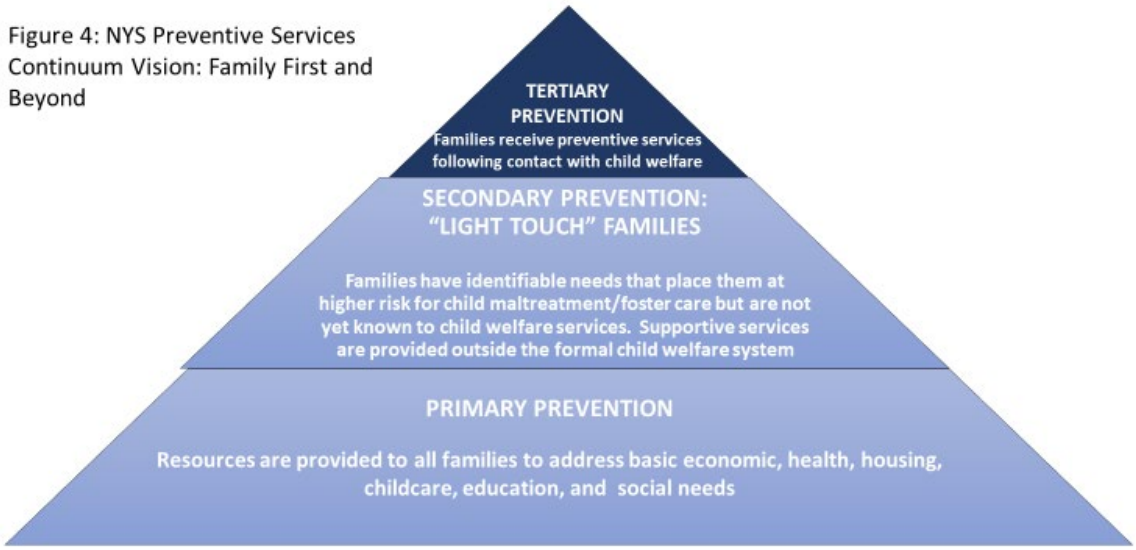
II. PARTNERSHIPS AND A PUBLIC HEALTH APPROACH

New York State is committed to establishing an integrated interagency public health approach to serving and strengthening families. The second spoke of New York State's child welfare modernization wheel takes a public health approach designed to tackle complex social needs and promote parent, child, and family well-being by focusing on prevention, cross-system collaboration, and community supports. Simply stated: when systems collaborate, parents and families benefit, and children thrive.

OCFS's intention to push toward a public health approach, consistent with Family First, will be a major driver of this expansion. As shown in Figure 4 below, most families receiving preventive services are tertiary prevention cases; these families receive preventive services after a CPS investigation, family court contact, or foster care discharge to protect against future maltreatment and/or foster care entry. Under the New York State Title IV-E Prevention Plan, New York State will leverage federal dollars to expand the use of evidence-based programs to families before they become known to CPS. This push toward secondary prevention services, will leverage relationships with sister state agencies and community-based providers to assess the needs of the families they serve and to make connections to preventive services when appropriate. Experience tells us that many families served by our sister state agencies and community providers have needs that place them at serious risk for child maltreatment and/or foster care and intervening early with these families may reduce the need for tertiary services provided by child welfare. By creating a community-based pathway to preventive services, New York State hopes to reach and serve more families in community-based settings. Families served through this model receive services and supports funded by federal, state, and/or local dollars but do not need

to have a preventive case opened with an LDSS to be enrolled, creating opportunities for families to benefit from services without fear of over surveillance and unnecessary net widening. At the base of New York State's preventive services continuum is our public health model that includes initiatives that provide for families to have access to the basic resources they need to enhance parent, child, and family well-being. New York State hopes to grow this base through the expansion of a public health model and targeted reinvestment in primary preventive programs.

Figure 4: NYS Preventive Services Continuum Vision: Family First and Beyond



OCFS will deepen connections with our sister state agencies to promote upstream delivery of services and support to families who could benefit from services coming through any "door." We know from experience that families at imminent risk of foster care entry seek assistance from other systems before they come to the attention of child welfare; therefore, to achieve a family and child well-being system, OCFS will engage in cross-system planning and collaboration, reducing the need for crisis-driven interventions later. New York State plans to bring services further upstream through community pathways, leading an effort to improve coordination with other sister state agencies, leveraging our collective resources and enhance service delivery.

Our sister state agencies, not-for-profit providers, community-based organizations, advocates, and philanthropic partners bring expertise and a track record of innovation in their fields to strengthen families; we hope to both learn from their promising practices and use Title IV-E prevention funds to support the evidence-based programming they already provide to prevent the serious risk of placement of children into foster care. For example, OASAS has demonstrated success with peer supports in substance abuse recovery. OCFS is implementing a similar peer-support approach with parent advocates. We are exploring which Family First evidence-based model may meet our needs in the future and how we could utilize the lessons learned from OASAS's peer support programming across the state. We also envision a formal Family First partnership with the New York State Office of Temporary and Disability Assistance (OTDA) as a

pathway for families to receive evidence-based services when families are showing signs of economic strain and imminent risk. The OMH is committed to developing meaningful systems-of-care networks to meet the mental health needs of individuals, especially children in their local communities. SED continues to work closely with OCFS to improve the educational outcomes of children and youth in foster care in addition to working with child welfare to develop a robust service provision, which would meet family needs without having to contact child welfare to find services for families. Through these partnerships, family well-being will be at the center of our service continuum.

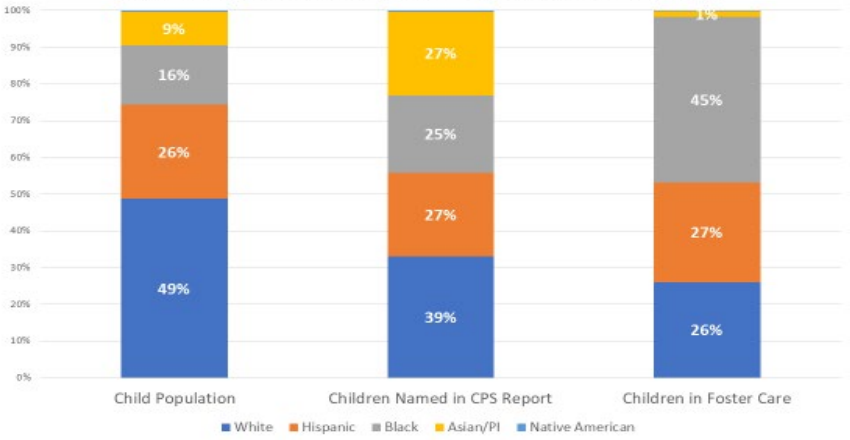
OCFS can also partner with sister state agencies, such as the New York State Department of Health (DOH), to serve children and families, including Family First candidates, by building and increasing cross-system capacity to implement Clearinghouse-approved evidence-based practices (e.g., Nurse Family Partnership, HFA). We additionally plan to deliver Motivational Interviewing (MI) through the continuum of child welfare as a case management tool, and along with our sister state agency liaisons to address mental health, substance abuse and parenting needs to promote that families experience consistency in how they are engaged and motivated to accomplish their prevention plan goals.

Leveraging research and evaluation capacity will be essential for planning and monitoring Family First, so to that end we will explore university and foundation partnerships.

a. **A Public Health Approach to Eliminating Racial Disparities in Child Welfare**

It is critical to approach racial disparities and inequities in the child welfare system through a broad public health approach lens. Our nation and our state's historic structures have under-resourced and divested in communities and families of color. Child welfare policy has furthered that divestment through disproportionate CPS investigations and reliance on foster care, deploying these as primary interventions, rather than investing, empowering, and strengthening families. Over 50% of African American children experience a CPS engagement by their 18th birthday in the United States,[17] and they are placed into foster care disproportionally. Nationally, Black children make up 14% of the general population but are 23% of children in foster care.[18] In New York State, while black children represent 16% of the general population, they represent 25% of CPS investigations and 45% of children in foster care.[19] We separate far too many children of color from their families, homes, communities, and culture. OCFS has made notable progress shifting resources from foster care to prevention, but more **must** be done. Family First, with our broader vision, provides critical new tools for us to eliminate disparities and disproportionality. We plan to further promote equity through our partnerships and intentional investment in communities and families of color.

Figure 5: Disproportionality in NYS Child Welfare Services: 2020



When planning our investments, fear of a fiscal disallowance from the federal government, often related to a lack of clear guidance, inconsistencies across regions, and shifting priorities, holds us back from investing more deeply. This too often drives us and other states to invest narrowly and meekly, thereby limiting transformation and maintaining the status quo. As a result, we do not have the reach necessary to strengthen families sufficiently to prevent child abuse and neglect, reduce entry into foster care, and promote well-being, especially with families of color. We thus believe it would be a recapitulation of past deprivation to deploy Family First narrowly to protect our child welfare system rather than investing in families. We would yet again be creating policy conditions that foster disparity and racial inequity. We are rising to this moment to address the structural racism embedded in our own state system and call upon our federal partners to engage with and help us to achieve safety, permanency, and well-being more swiftly for all children and families in New York State.

Concerns regarding potential over surveillance of families and increased entry into foster care as a result of prevention service expansion will be monitored closely as we move forward. As preventive services have expanded in New York State in the past decade, our foster care entry rate has decreased and is one of the lowest in the country—we believe this is the direct result of our investments in prevention and family-centered ways in which we deliver these services. Family First services will be offered in a similar manner and, we believe, with even more positive results. We also look to the Clearinghouse to review and include interventions that have proven effective with minority populations and meet the needs of children and families of color. Our plan seeks to identify one or more locally/community-developed practices and build the evidence for review by the Clearinghouse.

We believe that Congress and our federal partners will support our efforts to expand prevention services to reduce disparity and disproportionality, including Family First prevention services. We echo their intent to put families first and prevent foster care entry and would like to act accordingly by deploying federal funding streams, augmented with our own investments, to deliver services in the communities and with families that need them most. This investment will not be without accountability. Throughout this work, we will use continuous quality improvement and other

strategies to closely track whether and how our supports to families have the intended effect to maximize family well-being and limit disproportionality, while generating lessons learned for other jurisdictions and the field. We will also collaborate across public, private, federal, state, and local levels to reduce disparities and achieve meaningful and lasting change.

Meeting the Needs of American Indian Children and Families

Being culturally responsive requires us to work intentionally with our Native American partners. New York is committed to meeting the unique needs of American Indian children and families by seeing that services are provided in a manner consistent with the Indian Child Welfare Act (ICWA) of 1978 (25 U.S.C. Sec. 1901 et seq.) and implementing state statutes.

American Indian children are provided prevention services by local prevention programs. Currently in New York, only one tribe of nine, St. Regis Mohawk, has a state/tribal Title IV-E agreement with the state pursuant to Social Services Law section 39 and to Chapter 436 of the Laws of 1997, to operate foster care, adoption, and CPS services.

LDSSs must inquire whether a child who is referred to the SCR or being placed into foster care is or may be an American Indian child. For all American Indian children, the LDSS must notify the child's tribe with an invitation to partner in the initial and ongoing assessments of the family and the development and implementation of the family's prevention plan.

Furthermore, the LDSS will see that preventive services to American Indian children and families are provided in a manner consistent with active efforts as described in state and federal law. These requirements reaffirm the state's commitment to meeting the unique needs of American Indian children and families by seeing that services are provided in a manner consistent with the ICWA of 1978 (25 U.S.C. Sec. 1901 et seq.) and implementing state statutes.

The OCFS Office of Native American Services hosts meets six times a year, two tribal consultation meetings and four regional meetings. These meetings allow OCFS to collaborate with and address the needs of the Tribal Nations in a respectful and culturally aware manner. The tribal consultation meetings allow a platform for the nine Tribal Nations to meet and discuss with various state stakeholders the policies and practices that may inadvertently affect their child welfare programs and allows OCFS to address their community and family needs holistically. Regional meetings allow OCFS and Tribal Nations to focus on child welfare issues and programming.

b. **Prioritize Economic and Concrete Supports for Families**

Emerging research demonstrates that poverty, loss of income, and material hardship are the greatest predictors of child welfare involvement.[20] Economic hardships like utility shutoffs, food insecurity, difficulty paying for housing, and material economic stress are associated with increased risk of child welfare involvement among high-risk families.[21] Many families experiencing these hardships become involved in child welfare because of concerns that the children's primary needs are being neglected; however, a caregiver's ability to overcome significant hardship is seldom enhanced by being investigated and supervised. In New York State, 57% of CPS findings statewide relate to "neglect only."[22] Intervening upstream to address families' economic and concrete needs is likely to reduce intrusive involvement by CPS and reduce unnecessary reports of maltreatment that place additional strain on struggling families.

Recent research shows that even modest economic and concrete supports are associated with reduced child maltreatment and involvement with child welfare.[23] In a recent study related to the provision of additional funding through differential child support operations, Cancian et al.[24] found that mothers were 10% less likely to have a screened in maltreatment report when provided as little as $100 per year in additional monthly child support payments. Rostad et al.[25] found that for families with open child welfare cases and receiving home-based services, those offered financial support (averaging $314 per family) were less likely to experience a child maltreatment report during the first year of services. The study also found that provision of concrete supports worth approximately $3,300 could avert one maltreatment report and receiving any concrete supports (vs. no support) reduced subsequent maltreatment reports by nearly 17%. In sum, the evidence is compelling: economic and concrete supports represent a core lever for strengthening families. Further, an increase in income can have far reaching positive impacts on child development and family well-being as a whole.[26]

New York State seeks to invest in provision of concrete supports (including child care, housing, and economic) while forming the partnerships necessary to improve access to these benefits and reach families in need early — and OCFS hopes that our federal partners will engage with us in how to operationalize and propel our efforts. OCFS also seeks to implement programs and services that address the economic and concrete needs of families as a prevention strategy given the growing evidence that in doing so there are associated reductions in mental health needs, child maltreatment, and involvement with child welfare. OCFS encourages our federal partners to engage with us and other interested states on the policy, programmatic, and evidence-building pathways necessary to achieve the adult well-being outcomes described in the Title IV-E Prevention Services Clearinghouse.[27] Additionally, we encourage evidence-based program model developers to include and test economic and concrete supports as core components of interventions as several do so already (e.g., Homebuilders, Intercept, Incredible Years).

OCFS will also explore testing a Universal Basic Income Pilot as part of its broader efforts to further address the conditions that bring families to the attention of child welfare. Since the creation of Temporary Assistance to Needy Families (TANF) in 1996, financial assistance to poor families has declined immensely – for every 100 families in poverty, the number receiving TANF basic assistance has dropped from 68 when the program was first created in 1996 to just 23 in 2019,[28] and New York State's basic assistance has dropped from 79 families to 42 families.[29] The first statutory goal of TANF is to provide assistance to needy families so that children may remain in their homes. This is a shared goal with child welfare that presents an opportunity to join together in innovative solutions as the provision of cash assistance is showing promise in other states to improve mental health outcomes, employment outcomes, and financial stability outcomes. OCFS is interested in testing whether Universal Basic Income specifically can improve parental stability (e.g., reduce maltreatment) and reduce involvement with child welfare. New York State seeks to work with families who have open Family Assessment Response (FAR) differential response track case with identified risks to child safety and well-being that are poverty-related including food and housing instability and job insecurity. We have identified potential federal and private funding sources to provide the economic support for families, the casework families request, and the evaluation to bolster our hypothesis that even modest increases in income can keep children out of the child welfare system. Further, we have begun discussions with our partners at OTDA and the Center for Guaranteed Income Research (CGIR) at the University of Pennsylvania to create an Economic Support pilot.

c. **Supporting Expansion of Preventive Services Statewide**

At the center of New York State's envisioned transformation sits Family First, the legislation around which the state's broader transformation is built. Family First brings federal funding to evidence-based substance abuse, mental health, and parenting services, allowing for their expansion statewide to serve New York State's most vulnerable children and families. We invite our LDSSs to join with us to realize our broader vision, with Family First at its core.

To realize our plans for Family First, OCFS proposes a new type of partnership with local jurisdictions—whereby LDSSs will be active partners in identifying local needs and infrastructure while OCFS proactively creates opportunities for LDSSs to adopt new EBPs and to expand collaborations with sister state agencies. OCFS will partner with LDSSs to understand and address the challenges and barriers to implementing Family First EBPs in every LDSS in the state, affording LDSSs the technical and logistical supports they need to make Family First a success.

Individual LDSSs, especially those that are small or rural, too often face a critical lack of infrastructure, capacity, and resources to stand up EBPs. The scale of investment required to start up and maintain EBPs is simply unattainable in some local jurisdictions, placing Family First seemingly out of reach.

To address this challenge, New York State will draw on lessons learned from its centralized administration of HFNY in the past decade by establishing a Center for Excellence (CfE) to provide statewide implementation support and promote the success of Family First EBPs. The center will provide technical assistance and support with training, fidelity monitoring, and continuous quality improvement (CQI) for Family First EBPs. As with HFNY, this will be instrumental for standardizing implementation, ensuring fidelity to the model, and achieving strong outcomes. The CfE will include a collaboration between OCFS and a statewide partner with expertise in implementation, CQI, and evaluation. The CfE will contribute to the capacity and expertise required to realize the potential of Family First in New York State.

OCFS proposes forming an adjunctive regional collaborative approach to support implementation of a sub-set of Family First EBPs with expansion possible over time. OCFS plans to initiate contracts for two to three well-supported EBPs with opportunities available regionally while local capacity is being built for independent procurement and implementation. This regional approach would serve as hubs for supports, technical assistance, or resources from OCFS and the CfE while offering a forum for regional partners to collaborate on planning, contracting, implementing, and CQI for Family First EBPs. Regional collaboratives could engage with local community members and families to obtain input and direction, facilitate sharing of services by smaller LDSSs, and be charged with leveraging technology to expand availability and enhance service delivery regionally. OCFS will partner with LDSSs to study existing and past regional collaborations to inform the format, functioning, and potential expansion of a regional Family First approach.

New York State's infrastructure for Family First will facilitate cross-region collaboration and dissemination of resources and best practices throughout the state while enhancing EBP implementation, fidelity, and continuous quality improvement. We are committed to promoting feasibility and successful implementation, so that Family First can thrive in New York State.

d. Building Toward Success

While we approach our vision with urgency, we must also be intentional and disciplined in our efforts. With this in mind, we imagine a systematic, phased approach to build out our transformation. Our five-year transformation plan will roll out in overlapping waves, not discrete phases, gradually moving family engagement and supports further upstream while deepening cross-system partnerships over time. The planned waves are described below and will evolve as we learn more through implementation and continuous quality improvement.

The Title IV-E Prevention Plan articulated in the remaining sections of this plan reflect the initial approach in our waved implementation, a relatively narrow scope for which we request approval, which will be expanded over time.

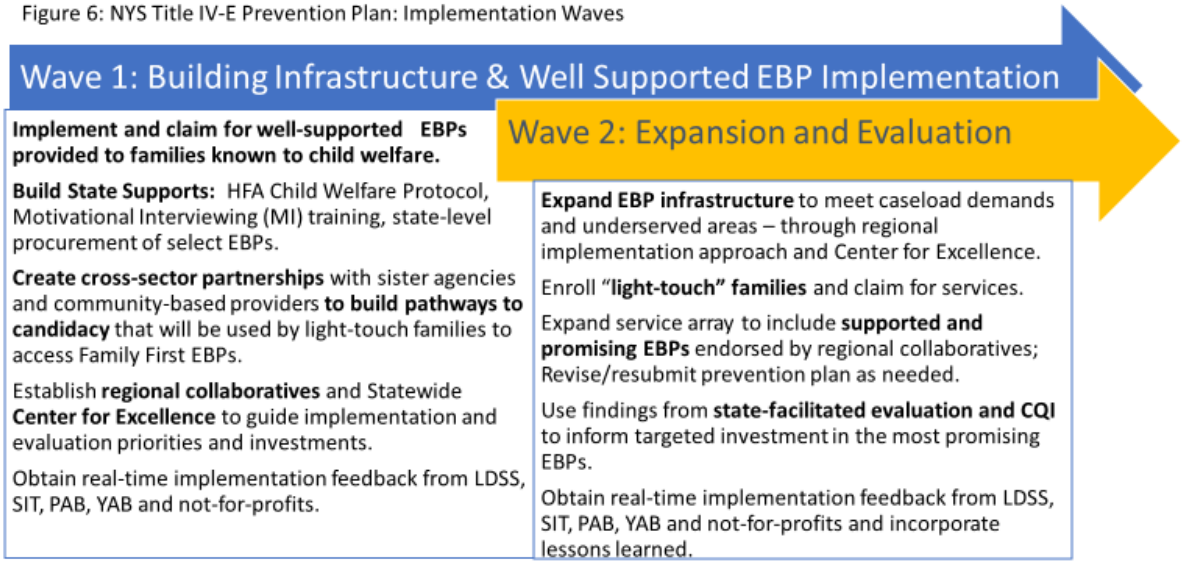
Throughout these implementation waves, New York State's pathways to Family First services will expand. While initially families with child welfare open preventive cases will be served, in the second wave families identified by sister state agencies will also be eligible so long as there is an open preventive case.

New York State envisions Family First as a strategy to expand our public health approach that supports family and child well-being, as we know that factors related to imminent risk of foster care entry can emerge quickly and are best addressed in the community-based programs where families turn to for support.

III. New York State Title IV-E Prevention Plan

The third spoke of New York State's Child Welfare Modernization Wheel is the state's Title IV-E Prevention Plan for which New York State is currently seeking federal approval. The details of this plan are outlined in Sections 2-8 of this document and encompass activities spread across two overlapping implementation waves. To help paint the broader New York State modernization vision, highlights of the plan are introduced in Figure 6, below.

Figure 6: NYS Title IV-E Prevention Plan: Implementation Waves



Family First brings federal funding to evidence-based substance abuse, mental health, and parenting services. New York State intends to utilize this new funding opportunity in coordination with the state's plan for the use of Title IV-B funds to expand the menu of EBPs used across the state within these three domains and to grow the number of children and families able to benefit from their availability prior to child welfare involvement, gradually pushing services further upstream.

Implement and Claim for Well-Supported EBPs provided to families known to child welfare - The first wave of Family First implementation will focus on maximizing immediate service and claiming opportunities. As described in Section 3 later in this plan, several LDSSs already contract for, or are in the process of contracting for, Family First EBPs provided to children and families with open preventive cases. Approval of the New York State plan will allow LDSSs to claim federal dollars for these services and to leverage savings to expand EBP infrastructure to include new service opportunities and/or investments in additional EBPs.

Build State Supports - New York State is a state-supervised, county administered child welfare system. As such, selection, implementation, and evaluation of preventive services programs has historically resided with LDSSs. Recognizing that implementation of EBPs can be costly and challenging, particularly in more rural areas with fewer provider resources, OCFS will make state level investments in EBP implementation. OCFS will apply for approval to use the Healthy Families America Child Welfare Protocol, plan and complete a statewide roll-out of MI for all child welfare workers, and initiate time-limited state procurement for a subset of EBPs to attract EBP providers to under resourced areas, making these EBP services more accessible for all LDSSs.

Build Pathways to Candidacy and Enroll "Light Touch" Families - New York State currently serves over 40,000 families a year through the provision of preventive services. Most of these families are offered preventive services following contact with CPS or family court, or at foster care discharge to prevent re-entry. Under Family First, OCFS intends to build and broaden pathways to preventive services for families before they become known to child welfare. We know from experience that families at imminent risk of foster care entry often seek assistance from other systems (e.g., housing, public assistance, education) and community health providers before coming to child welfare's attention. Through cross-system planning and collaboration, OCFS will work with our sister state agencies and community-based providers to connect these families to Family First EBPs at point of initial contact.

Create Cross-Sector Partnerships - Creation of cross-sector partnerships is key to building and strengthening pathways to candidacy and offers additional benefits of improved service delivery. OCFS's sister state agencies and community-based organizations bring expertise and a track record of innovation in their fields to strengthen families; OCFS hopes to both learn from their implementation experiences and use Title IV-E prevention funds to support the evidence-based programming they already provide. For example, OASAS has demonstrated success with peer supports in substance abuse recovery and is sharing lessons learned as OCFS develops its own program of family peer advocates. Our sister state agencies have provider networks with experience with several Family First EBPs (e.g., Motivational Interviewing, Nurse Family Partnerships,) which may help to align and expand service networks. OCFS, OASAS and DOH have been collaborating on the implementation of plans of safe care (POSC) for infants born affected by substance abuse and their caregivers. Additionally, OCFS, OASAS, DOH, OTDA, OMH and the Office for People with Developmental Disabilities (OPWDD) meet monthly to

discuss the work each of our agencies is doing, and to address challenges that may overlap each of our agencies.

Cross-sector partnerships also support OCFS's commitment to adopting a public health approach. Public health models tackle complex social needs and promote community, parent, child, and family well-being by focusing on prevention, cross-system collaboration, and community supports. When systems collaborate, parents and families benefit, and children thrive. For example, OCFS engaged our state education partners (SED) after an increase in educational neglect calls during the COVID-19 pandemic. In October and November of 2020, two joint webinars were held, followed by the issuance of joint guidance in February 2021. This outreach provided clear guidance to the field on what will and will not be accepted as educational neglect, expectations of school districts to call in a report of educational neglect as a last resort and utilizing points of contacts (POCs) within both systems to identify family needs and provide supports and services they need before abuse or maltreatment occurs.

Regional Collaboratives - Development of New York State's vision for prevention and family-strengthening and its Title IV-E prevention plan has been, and will continue to be, a collaborative effort. To realize OCFS's plans for Family First, OCFS proposes a new type of partnership with local jurisdictions, whereby families, LDSSs, and provider agencies will be active partners in identifying local needs and infrastructure while OCFS proactively creates opportunities for LDSSs to adopt new EBPs and to expand collaborations with sister state agencies. Through the formation of regional collaboratives, including families, providers, LDSSs, state agency partners, and a state- supported CfE, New York State will address the challenges and barriers to implementing Family First EBPs in every LDSS in the state, affording LDSSs the technical and logistical supports they need to make Family First a success.

Center for Excellence (CfE) and State Facilitated Evaluation and CQI - OCFS will support the establishment of a CfE to provide technical assistance and support with training, fidelity monitoring, and meeting continuous quality improvement (CQI) and evaluation requirements for Family First EBPs. The CfE will assist LDSSs in identifying programs well-suited to local needs, study the impacts of selected EBPs and assist the state in better aligning its preventive supports. Central to this work will be the application of a race/equity lens, to determine that selected programs are effective with minority populations and meet the needs of children and families of color, without exacerbating disparities (e.g., over surveillance of families, increased CPS, and foster care contact). The CfE will also assist OCFS in developing and implementing a statewide plan to support the evaluation of programs that New York State would like to see added to its preventive services continuum. Under Family First, states must have a federally approved evaluation plan in place for promising/supported EBPs to enable IV-E claiming. The CfE will work with local and state partners to identify and prioritize EBPs for consideration for state-facilitated evaluation efforts and will provide technical assistance to LDSSs wishing to build the evidence base surrounding programs unrated by the Clearinghouse.

New York State is committed to reimaging child welfare services. The full preventive and family support continuum we envision—a family and child well-being system—relies on collective efforts to deepen local, state, and federal partnerships and collaboration, increase resource integration and joint accountability, and a sharing of power and decision-making with parents and youth with lived experience. As described in the remaining sections of this document, this work begins with the implementation of our five-year Title IV-E Family First Prevention Services Plan.

Section 2: Eligibility and Candidacy Identification (pre-print section 9)

The remaining body of this document (Sections 2-8), dives into the details of the third spoke of the modernization wheel and constitutes the Title IV-E Prevention Plan for which New York State is seeking approval, in addition to our request for greater flexibility to provide upstream services and supports to families and communities.

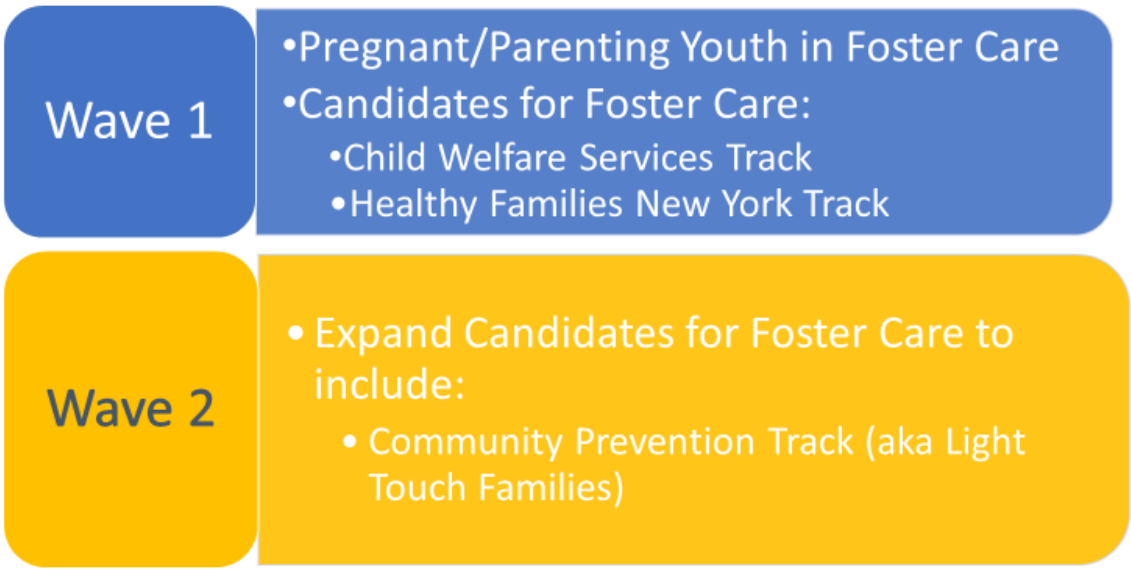
Pursuant to Family First, states can claim Title IV-E prevention services funds for any approved services provided to:

- children in foster care who are pregnant or parenting,
- candidates for foster care, and
- the caregivers of children in either of the above groups.

To be considered a "candidate for foster care", a child must be under 18, at imminent risk of foster care placement or re-entry, and be able to be safely retained in the home of their parents or caregivers with provision of mental health, substance abuse disorder, or in-home parenting skills evidence-based services.

Overview of New York State Target Population

Figure 7 – Waves



As shown in Figure 7, New York State intends to target three groups of children and their caregivers for inclusion in its Title IV-E Prevention Plan. In addition to children in foster care who are pregnant or parenting, candidates for foster care will be identified through two tracks in Wave 1: 1) Child Welfare Services, and 2) Healthy Families New York (HFNY). In Wave 2, the definition of "candidate for foster care" will be expanded to include children identified through our to-be-developed Community Prevention track.

Child Welfare Services Track: This track includes all children in an open preventive services case who are living in a community-based setting. In New York State, LDSSs open preventive services cases when a child is considered at serious, or imminent risk of foster care entry, or re-entry, due to one or more of the following case circumstances:

- Risk to health and safety of the child-this standard typically applies when a child has been referred to CPS and allegations of child maltreatment have been substantiated.
- Parental refusal- Parents or caretakers have refused to maintain the child in home or are considering surrendering the child.
- Parent unavailability- Parents or caretakers are unavailable due to hospitalization, arrest, detainment, death, or unknown whereabouts.
- Parental service need- Parents or caretakers have a condition that impairs ability to care for the child.
- Child service need- Child has physical, mental, behavioral, or other special needs for supervision or services that cannot be adequately met by parents or caretakers without services.
- Pregnancy- Mother is pregnant or has given birth and is unable to adequately provide care for unborn or infant child.

For children recently discharged from foster care, imminent risk of re-entry is considered to exist if any of the following case circumstances are present:

- Family court contact,
- Unplanned discharge, or
- Recurrence of the reason for placement.

Any child meeting the above criteria would be considered eligible for Family First preventive services under New York State's proposed child welfare "candidate for foster care" track. This includes children who come to the attention of child welfare services who are living with kin outside of the formal foster care system (e.g., 1017 direct placements made by Family Court), children with active family court cases related to delinquency or person-in-need of supervision cases, children served on the state's differential response track following an SCR report, and children whose caregivers voluntarily seek assistance from a LDSS. This track is well-established, with New York State providing preventive services to around 40,000 children each year. In the initial stages of Family First, LDSSs will focus on connecting and enrolling these known families to the Family First EBPs approved for use in the state's prevention plan.

Healthy Families New York: New York State children who meet the criteria for enrollment in the state's Healthy Families America (HFA) program, referred to as Healthy Families New York (HFNY), will be categorically approved as "candidates for foster care", regardless of whether the child enters under the program's "Signature" or "Child Welfare" Protocol (see Section 3 for more information on these two protocols). All families referred to HFNY will be screened for program eligibility using a five-item tool administered by HFNY staff. If a family answers yes to one or

more items or unknown to three or more items, and the targeted candidate child is between birth and 3 months of age (Signature Protocol) or between birth and less than 24 months of age (Child Welfare Protocol) the targeted candidate child will be considered eligible for HFNY services. OCFS staff will have access to HFNY screening tool results and will confirm FFPSA eligibility for any HFNY- identified candidate for whom a preventive services case has not been opened by the LDSS, before Title IV-E preventive funds may be claimed. If the family enters prenatally, the targeted child/family will be considered eligible for Title IV-E at the time of the candidate child's birth. Screening criteria include:

1. late (after 12 weeks of pregnancy), no or poor compliance with prenatal care;
2. primary caregiver is unmarried (single, separated, divorced, widowed);
3. primary caregiver is under age 21;
4. inadequate income (TANF or Medicaid, employed without insurance, or family financial concerns); and
5. child welfare referral

Community Prevention Track: In Wave 2, New York State intends to expand its criteria for "candidates for foster care" to include children identified directly by sister state agencies and/or contracted community-based provider agencies that do not have an active preventive services case with their local LDSS but meet the criteria for preventive services set forth in the Preventive Services Manual. This pathway to candidacy remains under development, and New York State will submit an amendment to its Title IV-E Prevention Plan when plans are finalized. Current planning discussions are exploring using a web-based module, like the Family Assessment Service Plan (FASP) used with families on the Child Welfare track, to assess eligibility and document the child-specific prevention plan. The primary difference between children served on the Community-Prevention track and those served on the Child Welfare services track would be the case manager. Community-Prevention track families would not have an open preventive services case with the LDSSs; rather these "light touch" families would be served in community settings and have a community-based provider responsible for case management and ongoing safety and risk assessment. OCFS state staff would have access to Community- Prevention track families case records to determine eligibility, monitor case practice, and collect needed federal reporting elements, but families' records would not be accessible to LDSSs.

Eligibility Documentation

Child Welfare Services Track: New York State's CCWIS system, CONNECTIONS, will serve as the system of record for all children with an open preventive services case receiving a Family First EBP. Within CONNECTIONS, a Family Assessment and Service Plan, or FASP, is created for every child with an open services case. Included within the FASP is a programmatic eligibility section. When selecting preventive services as a program choice the caseworker must select which criteria makes the child eligible for preventive services at the time the FASP is being completed. The criteria to be selected includes any one or more of the following case circumstances:

- Health and safety of the child
- Parental refusal or surrender
- Parent unavailability

- Parent service needs
- Child service needs
- Pregnancy or parenting
- Family court contact
- Unplanned discharge
- Recurrence of reason for placement

HFNY: If a child is referred to HFNY services by an LDSS and a preventive services case is also opened by the LDSS, the child will be treated as a child welfare services track candidate and eligibility and monitoring for Family First will be documented through the FASP. HFNY service delivery will be documented in the HFNY Management Information System (MIS). For children served solely by HFNY, with no open preventive services case, the HFNY MIS will serve as the system of record. Results of the five-item screen will be captured in MIS and will be made available to OCFS HFNY state staff responsible for determining eligibility and monitoring.

All children up to age 24 months and their caregivers who are receiving Healthy Family NY services are categorically eligible per New York State's definition of "candidate for foster care".

For families also receiving preventive services, eligibility is automatically done by the local department of social services. For families receiving Healthy Family NY, without a concurrent preventive services case, OCFS will review the eligibility screen completed by HFNY staff and confirm FFPSA eligibility.

The New York State Office and Children and Family Services (OCFS) funds, manages, coordinates and provides oversight of Healthy Families New York programs. OCFS contracts with all funded programs to provide Healthy Families services. OCFS Program Contract Manager's monitor program performance on best practice standards, performance targets, and performance indicators, conduct at minimum annual site visits to assess program and contractual compliance with requirements, and provide quality assurance and technical assistance to programs.

Healthy Families New York programs receive feedback from OCFS following a site visit that identifies areas of strength and areas needing improvement. In some instances, a Program Improvement Plan is required and follow up on improvement is tracked through quarterly reporting. Healthy Families New York program also receive technical assistance in a variety of ways (calls, virtually, in person) to help support program implementation and performance. In addition to the above, with the implementation of the HFA Child Welfare Protocols, OCFS will also monitor the implementation of the Child Welfare Protocols by site to promote fidelity to the model and review appropriateness of assessments and the child's prevention plan leading to eligibility. Healthy Families New York programs will also be required to code family data in such a way that it can be analyzed and reported separately.

Community Prevention Track/Wave 2: Plans for Wave 2 candidacy are still in progress, and OCFS will submit a plan amendment prior to implementing this track. As noted above, OCFS is exploring creating a separate data collection module within our CCWIS system to support the eligibility and service plan documentation for Community-Prevention families. Module components would likely mirror the structure and content of the eligibility and service plan screens developed for use in open preventive services cases but would have firewalls to limit who can access and view case records. Access would be restricted to those with a need to know/direct case involvement, such as community providers and state oversight staff.

Section 3: Title IV-E Prevention Services (pre-print section 1; Attachment III)

Planning and Development

Development of New York State's Title IV-E Preventive Services Plan has been a multiyear, collaborative effort. OCFS staff spearheaded planning activities, with significant collaboration and input gathered from partners statewide, including LDSSs, preventive service and not-for-profit providers, youth and parent advisory boards, sister state agencies, advocates, and national experts such as Chapin Hall, Casey Family Programs, and Redlich Horwitz Foundation. Key activities that helped to shape the content and timeline of this plan are described below.

LDSS and Voluntary Agency Provider Surveys

Under New York State's state-supervised, county-administered child welfare system, LDSSs are responsible for selecting and purchasing the preventive services that best fit the needs, composition, and culture of their community. To better understand how Family First might fit into and impact this existing structure, in 2019, OCFS conducted an environmental scan of existing evidenced-based preventive services available across the state. The purpose of the survey was to gather information on specific program models, including current LDSS usage, available providers, and existing system infrastructure. Two complementary surveys were created, one for LDSSs and one for preventive providers. The surveys captured prior and existing capacity for every program approved and/or under review in the Clearinghouse at the time the survey was released. Respondents were also invited to write in any utilized or desired preventive programs not specifically listed on the survey. Survey questions included, but were not limited to, whether the listed EBP had been offered in the past, was currently being offered, and/or was a program of interest for future offerings. If a program currently existed, respondents were asked to provide information on their satisfaction with the program and available infrastructure and capacity.

Findings from the survey and follow-up discussions with respondents indicated that while there were pockets of EBP availability across the state, several LDSSs had little to no EBP availability. Where infrastructure did exist, it tended to be present for those programs rated as well-supported (e.g., Healthy Families New York, Multi-Systemic Therapy (MST), Family Functional Therapy (FFT), Nurse Family Partnerships) and in more populous areas. Many LDSSs were interested in adding programs to their continuum but noted barriers to service acquisition. Both LDSSs and providers indicated that finding and keeping qualified staff, particularly those with the ability to address clinical needs, was difficult, especially in rural LDSSs. Similarly, a mismatch between implementation costs and target numbers was also noted. Programs such as MST and FFT were seen as potentially beneficial but too expensive to support in areas with lower caseloads.

Initial Needs Assessment

To better understand the needs of families utilizing preventive services, OCFS extracted information on child and caregiver strengths, needs and risks from the FASP for a statewide sample of mandated preventive services cases authorized in 2019. A child and/or caregiver were classified as having a parenting, mental health, and/or substance abuse service needs based on responses to specific FASP items. For example, if a caregiver was identified as having unrealistic and developmentally inappropriate expectations for a child, a parenting need was flagged.

Similarly, a child rated as having moderate or serious mental health problems was classified as having a mental health need.

Next, need profiles were created at the state, regional and county level. Profiles included estimated counts of preventive candidates by age group and associated need type (e.g., parenting, mental health, substance use), and were paired with information on EBP availability obtained from the LDSS survey. Profiles were then shared with each LDSS and their preventive planning teams during the regional planning forums described below to assist them in assessing service alignment and potential gaps.

At the state level, OCFS's review of these initial profiles suggested that parenting and child/adolescent mental health needs had large potential client pools, and that multiple areas had minimal or insufficient EBP coverage in these areas, presenting ample opportunity for expansion.

Regional Planning Forums

In August of 2020, OCFS worked with Chapin Hall to convene a series of informational meetings and regional planning forums with LDSSs and their preventive planning partners. Prior to each forum, OCFS provided each LDSS with their own county-level needs profile and the needs profiles for their designated region, and all regional members. LDSSs were encouraged to review their data with local service providers and planning partners prior to the meetings and were asked to come prepared to speak about the needs and strengths they perceived in their current service array, as well as barriers and challenges to implementation.

Each regional forum had the same format: a morning session where OCFS data experts presented data to help LDSSs understand the estimated number of Family First candidates in their region and their service needs, followed by 2-3 smaller facilitated discussions with LDSS partners. The purpose of the facilitated discussions was to obtain LDSS input on key aspects of Family First implementation planning, especially selection of Family First EBPs. The discussions were guided by a structured set of questions, exploring service gaps and needs, barriers and challenges in service delivery, existing preventive services, support and capacity needs, and regional/organizational collaboration opportunities. To encourage open and honest input, OCFS elected to have Chapin Hall, an external entity, facilitate the discussions.

Following the regional forums, Chapin Hall completed a comprehensive analysis of the discussions and shared with OCFS key findings and recommendations to guide selection of EBP services and implementation.

Feedback from Advisory Groups

OCFS convenes monthly Family First meetings with partners on its Statewide Implementation Team (SIT), eliciting rich discussions and key decisions related to many aspects of Family First. The SIT is comprised of leadership from LDSSs, voluntary agencies (VAs), the Office of Court Administration, the Council of Family and Child Caring Agencies (COFCCA), and advocates. OCFS looks to its valued partners on the SIT as a sounding board when considering and developing policies and practices aimed at improving child welfare services and safely reducing the use of foster care. Many of the SIT members, in turn, obtain input and share information with their local implementation teams and constituent groups, and work to assist OCFS in the implementation of policies and system change. Voices of parents, youth and communities are amplified in OCFS policy decisions through this vital mechanism.

Feedback through the SIT has been formative throughout the development of New York State's prevention plan. SIT members provided critical input on the state's target population, EBPs selection, implementation considerations, and the broader vision for transformation. OCFS has also engaged its Parent Advisory Board and Youth Advisory Board to share information about Family First and its system transformation and to seek their input and direction.

Stakeholder Review of Draft Implementation Plan

A complete working draft of New York State Title IV-E Prevention Plan was distributed broadly statewide prior to OCFS finalizing its submission. Included on the distribution list were: LDSSs, VAs, parent and youth advisory board members, Office of Court Administration staff, advocacy agencies, and administrative leaders in sister state agencies. Stakeholders were given a month to review and asked to provide feedback on the draft using a questionnaire, which included both structured questions and open-ended comments section. Responses and recommendations were received, reviewed by OCFS, and used to revise and improve the final Title IV-E Prevention Plan.

Lessons Learned

Several themes emerged from the planning and analytic efforts described above, which were instrumental in shaping the selection of EBPs and implementing the work plan put forth in this Title IV-E Prevention Plan. These themes included:

a. Service characteristics: LDSSs and partners preferred EBPs that (1) could address the needs of more than one individual in the family system; (2) address complex and inter-related challenges; (3) serve families in-home; (4) incorporate strategies to promote engagement and reach families with barriers to EBP participation; and (5) offered intensive services to address youth behavioral challenges.

b. Need areas: Parenting, child behavior, and adolescent mental health services were repeatedly identified as high need/high interest areas addressable under Family First.

c. EBPs in use: Stakeholders advocated for the inclusion of EBPs already in use in larger LDSSs, to leverage existing capacity and allow jurisdictions with EBP experience to share best practices and lessons learned with LDSSs starting EBPs for the first time.

d. Maximize impact: Even with Family First and state resources, resource constraints were seen as a barrier, leading stakeholders to advocate for a systemic assessment of the achievability of implementing new EBPs, considering constraints and versatility of each model, as well as supports that would be required to build capacity statewide.

e. Targeted supports: State supports should address greatest challenges for LDSSs in implementing EBPs and focus on building LDSSs' capacity. Statewide contracting was voiced as a strategy to ease the burden of implementation on under-resourced LDSSs.

f. Continued need for 62/38 reimbursement: While Family First creates new opportunities for federal funding for preventive services, many stakeholders noted that families need more than parenting, substance abuse, or mental health services to prevent foster care, (e.g., programs

addressing domestic violence, trauma) and urged New York State to continue its robust commitment to sharing costs for preventive services falling outside the scope of Family First.

g. State-supported research and evaluation: Adding to the list of programs intended to serve populations known to be disproportionality impacted by foster care (e.g., families of color, LGBTQIA+ youth) was also raised as a priority, with calls for state-supported research and evaluation activities to contribute to the research base on what works best with these populations.

Estimation of Wave 1 Target Population and Needs

Pregnant and Parenting Foster Youth: Information on the number of foster care youth that are pregnant and/or parenting and therefore eligible to participate in Family First preventive services is not readily extractable from the existing state system. While CONNECTIONS captures information related to pregnancy in an extractable data field, information on male and female foster care youth's parenting status is not currently uniformly collected; it may appear in progress notes, a family relationship matrix, and/or placement matching criteria. Explorations across these fields indicate that approximately 140 of youth in foster care were expecting or parenting on any given day in the past two years. Changes to CONNECTIONS to standardize data collection and improve identification of parenting youth are underway.

Child Welfare Track: To determine the potential volume of children eligible for consideration for Family First services through the child welfare services track during Wave 1, OCFS updated its initial 2019 needs assessment in early 2021. Sample criteria were expanded to include all children with a preventive case opening across a multi-year period to better capture OCFS's finalized candidacy definition and identify trends. As shown below, findings suggest around 42,000 children enter preventive services each year. Need for parent skills training is high, with caseworker's indicating parenting challenges in over 80% of opened cases. The second most needed service was mental health, with 45% of all children identified as experiencing moderate or serious mental health problems, along with 16% of their caregivers. Among older adolescents the need for mental health services was even more pronounced, with 70% of children between the ages of 12 to 18 scoring as having mental health challenges. These findings complemented concerns raised during regional prevention planning meetings, where multiple LDSSs voiced a need for mental health services specifically designed for adolescents and their caregivers. Five percent of children with opened preventive services cases had a caregiver with an identified substance abuse issue, another area where local services are often unavailable.

Table 1: Estimation of Child Welfare Track Candidates and Needs

Average Number of Children with Preventive Cases Opened Annually: 2018-2020	Need	Estimated # of Candidates with Need	
		#	%
42,123	Parenting	35,352	84%
	Parent Mental Health	6,536	16%

	Parent Substance Use	3,685	9%
	Child Mental Health	18,988	45%
	Child Substance Use	2,040	5%

Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

HFNY: New York State HFNY programs currently serve approximately 5,700 target children and their families each year. Programs are funded by OCFS through contracts with local providers. Programs accept referrals from a wide array of community partners, with the most referrals coming from hospitals, health clinics, and Women, Infants, and Children program (WIC). Under Family First, OCFS hopes to expand the number of HFNY sites to include the 21 counties not yet served by a HFNY program, and to add additional opportunities to existing sites where demand exists. While only a small number of HFNY referrals currently come from child welfare services, OCFS anticipates that these numbers will grow with the implementation of the Child Welfare Protocols at all HFNY sites (see EBP Selection and Rationale below for more details). Feedback from LDSSs partners indicates that many families who could benefit from HFNY services are currently not referred, as the target child is older than 3 months (the upper age limit for HFA Signature Protocol) when LDSSs becomes involved.

Evidence-Based Practice Selection and Rationale

Based on the lessons learned from our planning efforts, New York State has selected 11 EBPs to be included in the first wave of Family First implementation. This list represents the preventive service models for which New York State intends to claim IV-E funds for but is not intended to represent the full continuum of preventive service models that LDSSs may choose to incorporate in their local preventive plans. In addition to the programs listed below, LDSSs may continue to utilize 62/38 reimbursement for any preventive services program identified as meeting local needs. As discussed under implementation supports, OCFS will work with LDSSs to explore how to best build the evidence base surrounding programs not included in Wave 1. This will help position the state to meet the evaluation requirements needed to amend the state's Prevention Plan in Wave 2 to include supported/promising EBPs and assist unreviewed programs in gaining the research base needed to be considered for review by the Clearinghouse.

All 11 programs for which New York State is currently seeking approval in Wave 1 are rated as well-supported in the Clearinghouse and have an existing infrastructure or interest in at least one LDSS in the state. They target identified needs, including parenting and adolescent mental health and behavioral needs. Additionally, many of the programs reflect service characteristics identified as desirable by LDSSs and providers, including working with complex and inter-related needs, serving families in-home, incorporating engagement strategies, and targeting youth with complex behavioral needs. The selected programs are:

- Brief Strategic Family Therapy (BSFT)
- Family Check-Up (FCU)
- Familias Unidas
- Functional Family Therapy (FFT)

- Healthy Families America (HFA)
- Homebuilders (HB)
- Motivational Interviewing (MI)
- Multisystemic Therapy (MST)
- Nurse Family Partnership (NFP)
- Parent-Child Interaction Therapy (PCIT)
- Parents as Teachers (PAT)

Information on EBP manuals, target population, and intended outcomes for each of these selected models are summarized in Appendix A, with additional justification provided in Section 6. In the interest of clarity and transparency, additional information on how four of our selected models will be operationalized is provided below. The Title IV-E *Prevention Services Clearinghouse Handbook of Standards and Procedures*, Version 1 (2019) states that EBP programs that adhere to the approved manual and involve modest changes to program processes may be viewed as the same as the original model (Section 4.1.6, pages 14-15, and Exhibit 4.1). New York State is seeking approval to claim for services delivered in a manner consistent with this described standard. Specific program models falling under this umbrella include:

- New York City's Functional Family Therapy- Therapeutic Case Management (FFT-TCM) and Functional Family Therapy-Child Welfare (FFT-CW) programs. While children between 10-18 years of age are provided with FFT-TCM and FFT-CW services on the high-risk track by New York City's Administration for Children's Services, only those children ages 11-18 will have their services claimed for under Family First and only after these evidence-based programs have been reviewed and rated by the Family First Prevention Clearinghouse as being well-supported, supported or promising. Both programs adhere to the most recent approved manual for FFT and apply the core change mechanisms, fidelity monitoring, and clinical approach as standard FFT. Please see Attachments A and B for letters attesting to these facts from the model purveyors.

- New York City's Multi-Systemic Therapy- Substance Abuse (MST-SA) and Multi-Systemic Therapy -Prevention (MST PRV). MST-SA and MST-PRV rely on the same manual as MST and do not change the relevant content from training or implementation. Both programs fall under the category of "making small changes to increase the cultural relevancy of the intervention (without changing program components)", as noted in the Title IV-E *Prevention Services Clearinghouse Handbook of Standards and Procedures* (Section 4.1.6, pages 14-15, and Exhibit 4.1). The model purveyor, *MST Services*, has provided a letter of support further explicating these points and affirming that the above information is accurate. See Attachment C. Claims for reimbursement of the costs of this evidence-based service will only be made after the Family First Prevention Clearinghouse has reviewed and rated it as being well-supported, supported, or promising.

- Healthy Families New York (HFNY)-Child Welfare Protocol. Healthy Families America (HFA) is recognized by the Clearinghouse as a well-supported, home-visiting program. Included under HFA are two sets of protocols: 1) the "Signature HFA Model," which accepts referrals from any source and enrolls families identified prenatally or within the first three months of the targeted child's birth, and 2) the "Child Welfare Protocol," which is limited to

families referred by child welfare services and accepts families with a target child who is less than 24 months old. New York State currently has state-funded HFNY programs in 41 counties, including New York City's five boroughs, that operate under the Signature HFA Model. As part of its Prevention Plan, New York State is seeking approval to claim for both the Signature HFA Model and the HFA Child Welfare Protocol. New York State intends to add the Child Welfare Protocol across existing sites already implementing the Signature Protocol, and bring on new HFNY programs, offering both protocols, in un-served areas. HFNY is a core component of New York State's child abuse prevention efforts, and currently serves approximately 5,700 families statewide per year under the Signature HFA Model. Yet, gaps still exist. During planning conversations, many LDSSs reported that they could not take advantage of the existing HFNY slots for the families on their caseloads, as the targeted child was often older than 3 months when the family became known to child welfare services. Adding the Child Welfare Protocol to existing HFNY sites will help New York State address the demonstrated statewide need for parenting services for caregivers with young children.

- Motivational Interviewing (MI). MI is currently approved in the Clearinghouse as a well-supported EBP for adults with substance use issues. However, research suggests that it is also effective at improving outcomes in other need areas, including when it is utilized in conjunction with other treatments and services. MI is a flexible engagement strategy or practice that can be used in a variety of settings and contexts, with various target populations, and to produce a wide range of behavioral changes.

  Consistent with other jurisdictions, New York State requests approval from the Children's Bureau to utilize MI as a foundational EBP across our preventive services spectrum with any child/family meeting candidacy requirements. Under this broad approach, MI would be a tool to bring about desired change for families dealing with mental health, parenting, and substance abuse issues when used as: 1) a stand-alone evidence-based preventive service and 2) in conjunction with other EBPs, to promote greater service uptake and improved outcomes, 3) a case management and engagement service provided by caseworkers to families receiving preventive services, including families not otherwise enrolled in a FFPSA approved EBP. Under New York State's plan, an LDSS may choose to contract with a trained provider for MI services, alone or in conjunction with another EBP, or directly incorporate MI as part of preventive casework practice, with the goal of using MI to increase a family engagement and participation in preventive services. OCFS intends to seek FFPSA reimbursement for MI services provided directly by LDSS caseworkers and caseworkers in sister public agencies like OTDA, via a memorandum of understanding or contract, where joint planning and service delivery is being provided to candidates and their families. While caseworkers may be engaging families through the use of MI at the point of intake, claiming for MI will not occur until the child's prevention plan is developed and approved and MI is included in the plan as an evidence-based service that the child/family will benefit from.

Implementation Plan

New York State proposes a phased in approach for Family First participation. In Wave 1, New York State will focus on leveraging existing infrastructure to expand the use of well-supported,

EPBs in active preventive cases, while simultaneously building the infrastructure needed for expansion through the establishment of regional collaboratives and a CfE. In Wave 2, OCFS will utilize the collaboratives and CfE to expand both pathways to candidacy and the menu of Family First programs available across the state.

State Level Implementation Supports

1. Building a Trauma-Informed Infrastructure. ACYF-CB-PI-18-09 states that approved EBPs must be provided in a trauma-informed context. Under section 471(e)(4)(B) of the Act, trauma-informed is described as when services or programs are provided "under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing". While many of the EBPs selected for inclusion in New York State's prevention plan incorporate trauma-informed practices within the treatment model, this does not guarantee that those clinical services are being provided within an agency that has adopted a trauma-informed structure across their program operations. Under Family First, OCFS will require all FF EBP providers to be trauma-informed at the system level and will provide LDSSs with guidance on how to incorporate trauma-informed criteria into their local procurement contracts. OCFS's Bureau of Training and Development will work with the proposed CfE to set the criteria, which will likely require providers to document their adherence to a trauma-informed model (e.g., Sanctuary, CARES, etc.) or complete a series of trauma trainings recognized and/or sponsored by OCFS.

2. *Expansion of HFNY.* New York State will work with HFA to obtain state-level approval to offer HFA's Child Welfare Protocol at all state-funded sites. OCFS funds, and participates in, an extensive central administrative infrastructure for HFNY that provides on-going and model-specific training, quality assurance, technical assistance, oversight, information management system, evaluation, and continuous quality improvement resources. To comply with child welfare protocol requirements, OCFS will expand funded trainings to include child welfare basics, motivational interviewing in the context of the HFNY model, (engaging families involved with the child welfare system), and reflective supervision; modify policies and best practice standards; expand curriculum options; adjust caseloads; and make changes to the management information system and CQI practices. Each site will eventually be expected to serve a combination of HFA Signature Protocol families and families referred by child welfare services under the Child Welfare Protocol as local readiness and funding allows with no cost to LDSSs.

3. *State funded EBPs.* In response to rural counties' concerns regarding the challenges of establishing a sufficient funding base and target population size to support EBP implementation, OCFS has set aside funds from the federal Family First Transition Fund to establish time-limited, regional, state-administered contracts. Providers would be expected to offer services to a multi-county area, with guaranteed payment for a time-limited period, in hopes of generating sufficient volume to motivate agency providers to make infrastructure investments. All costs for the selected EBP(s) would initially be covered by the state, with opportunities allocated based on county need and volume. CfE and regional collaboratives will play a central role in selecting which of the EBP(s) from

the state's list of approved programs to implement and will work with LDSSs and providers to develop a plan for transitioning service procurement to individual LDSSs or regional collaboratives at the end of the state funded period.

4. *Motivational Interview (MI) Training.* OCFS's Bureau of Training and Development is currently developing an in-house MI curriculum that could be offered to all caseworkers, case managers, and preventive service providers across the state. This would include staff in LDSSs, provider agencies, and sister state agencies that interface with candidate children and their families, such as OTDA. By establishing a centralized, state funded, infrastructure for MI training, OCFS hopes to make the adoption of MI feasible for all LDSSs and their contracted preventive providers.

5. *Regional Collaboratives.* OCFS staff will interface with CfE, LDSSs, provider agency staff and families with lived experience to develop regional collaboratives focused on Family First implementation. These entities will serve as a forum for building local collaborations focused on planning, contracting and implementation of Family First EBPs that are informed by and responsive to family and community voice. Regional collaboratives will help to shape future EBP selection and prioritization of CQI and evaluation resources, facilitate sharing of services by smaller LDSSs and be charged with evaluating strategies for enhancing regional service delivery. Specific strategies to be explored include telehealth options for EBP delivery and other ways to leverage technology to better meet community needs and/or expand service delivery capacity.

6. *Center for Excellence (CfE).* OCFS will contract with an external entity to provide LDSSs and regional collaboratives with technical assistance, training support, fidelity monitoring, and continuous quality improvement activities. The CfE will serve as a one-stop resource for information on EBP models, costs, and training requirements, procurement, and model contract templates, and CQI resources. As detailed in Section 6, the CfE will also play a significant role in CQI and evaluation activities, facilitating the collection and interpretation of fidelity, satisfaction, and intermediate outcome measures, documenting the effectiveness of any utilized telehealth approaches, and helping to build the evidence base for programs not rated as well-supported by the Clearinghouse.

7. *OCFS Data Support*. OCFS will provide data and technical support to assist LDSSs, regional collaboratives and CfE in assessing preventive needs and outcomes. OCFS will release annual data on LDSSs candidacy populations, needs and strengths as captured by the FASP/preventive service plan process. As detailed further in Section 6, information on the number of candidates experiencing child protective and foster care involvement post-service delivery will also be provided.

Monitoring Activities

LDSSs and county youth bureaus are required by state statute to develop and submit to OCFS local, multi-year plans for the provision of child welfare services and the allocation of resources. Plans include a section devoted to preventive services that will be expanded to capture Family First implementation activities. LDSSs will be required to list each of the Family First EBPs they intend to use, the target populations to be served, and information about their approach to CQI and fidelity monitoring to improve service delivery. Plans are updated annually and submitted to OCFS for review and approval.

For each EBP included in their county plan, LDSSs will be required to complete, sign, and return to OCFS a Family First Preventive Services Attestation Form. In the form, LDSS will be required to do the following:

- List the name(s) of the contracted provider and number of opportunities procured
- Affirm that the selected EBP will be provided to model fidelity, using the manual approved by the Clearinghouse, and delivered in a trauma-informed environment
- Attest that the LDSS, or contracted provider, will make available to the CfE/OCFS upon request examples of the fidelity and short-term outcome data.

OCFS's plans for monitoring, CQI and evaluation are described in Section 6.

Section 4: Child-Specific Prevention Plan (pre-print section 4)

The process and system used to develop child specific prevention plans will vary according to a child's candidacy track. Pregnant and parenting youth in foster care and candidates identified via the child welfare services track will have active cases with LDSSs; the child-specific preventive service plan for these children and youth will be housed within CONNECTIONS, the state's CCWIS system. Candidates entering on the HFNY track will have their cases managed by HFNY using approved HFA protocols and case planning tools.

Pregnant and Parenting Youth in Foster Care and Child Welfare Services Track

The FASP, developed by the caseworker (also known as the case planner), with the parents/caregivers, and children, where appropriate, clearly identifies the desired outcome, what needs to change in the family and the services that are designed to achieve that change. It provides the family, caseworkers, supervisors, and other service providers with a clear blueprint of who is going to do what to achieve the child and family's goals.

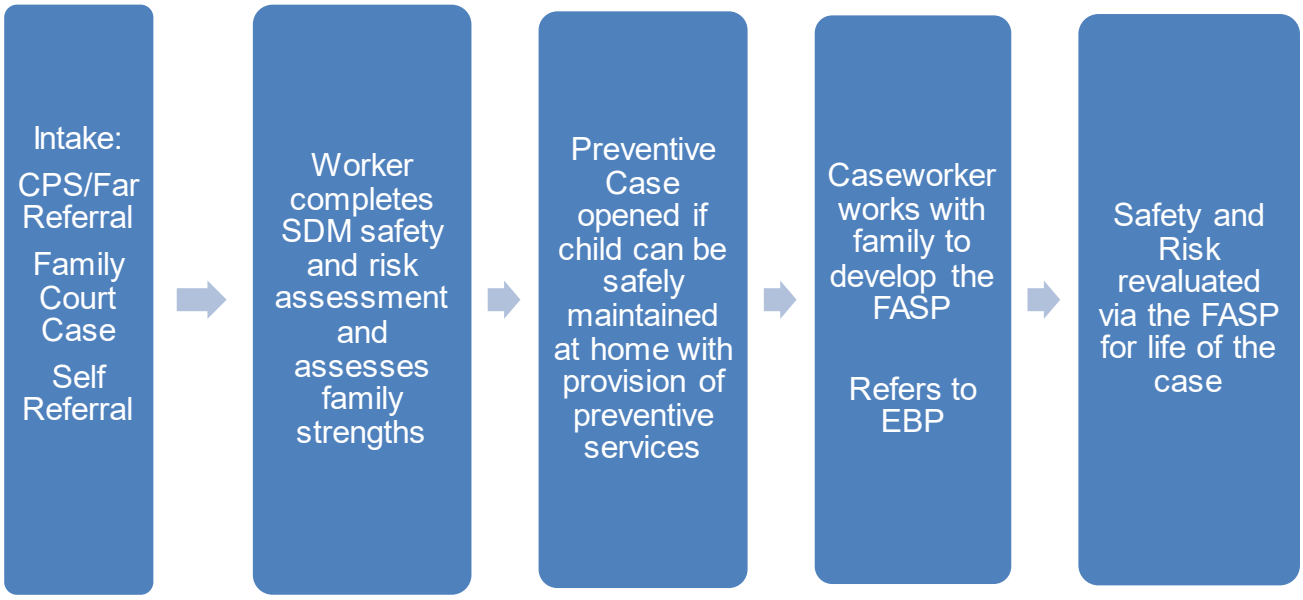
Within the FASP is the Service Plan section, which details the child's specific prevention plan. It includes the needs and goals of the child and family and the strategies that will be put in place to prevent the child's removal from the home, and the list of services that address the criteria noted in the Programmatic Eligibility section of the FASP.

The FASP is completed and revised regularly throughout the case to provide an accurate reflection of the case circumstances and the child-specific service needs. The Initial FASP is completed in CONNECTIONS within 30 days of the case initiation date, the Comprehensive FASP is within 90 days, and the Reassessment within six months, and every six months thereafter.

Developing Child-Specific Prevention Plans and Connecting Families to Services

Each child's individual service needs are addressed in the Service Plan section of the FASP for every preventive case. Child-specific prevention plans will be developed by LDSS caseworkers in collaboration with the family as part of the established service planning process. The diagram below illustrates the process.

Figure 8: Business Process for Development of Child-Specific Prevention Plans



Based on information collected and the completion of the Strengths, Needs, and Risks Assessment Tool within the FASP, the following information is used in deciding what preventive services are needed:

- The presenting problem and referral source
- The family's relevant service history, including actions taken in the past to meet the family's needs, such as a summary of casework contacts, service referrals, services provided, court involvement
- The current functioning of the family, such as family members' interaction, their ability to cope with stress, family strengths, and the caregiver's capacity to care for children
- Support currently available to the family
- The family's need for services and its ability to benefit from the provision of services
- A permanency planning goal for each child for whom services are authorized
- Program choice consistent with the assessment of the family's needs
- Placement information, including appropriateness of placement determination and parenting plan, if a youth is pregnant or parenting and is receiving foster care

The above information is analyzed and discussed with the family by the caseworker with an eye towards selecting services that will help remediate the circumstances that are placing the child at risk of removal or to assist the pregnant or parenting youth in foster care to prepare for or to care for their child. This process will be the same in determining the appropriate evidence-based services under Family First for children and caregivers experiencing substance abuse, mental health, and parenting issues. When selecting services, the availability of the service in both location and hours of operation are taken into consideration, especially for working caregivers.

The 12-month eligibility period for Family First services will initiate when the initial FASP is completed. Caseworkers are required to help coordinate the appropriate services, including facilitating a warm handoff to the provider and assisting the family in setting up appointments if needed.

The caseworker provides ongoing monitoring and coordination of the child specific prevention plan, contained within the FASP, by staying in frequent and regular contact with both the service providers and the family to support service provision and assess progress made and/or help identify any adjustments needed to the services. Ongoing assessment of the need for the service is done through casework contacts with the family and the provider of the service.

Needed services and eligibility determination will be reviewed as part of the Family Assessment and Service Plan Reviews process done at the 90-day and six-month time frame, and every six months thereafter while the case is open for preventive services. During Family Assessment and Service Plan Reviews, the family and service providers discuss progress to date, and what changes to the services may be needed to keep the child safely in the home. The provision of the Family First evidence-based services will be coordinated with any additional services provided to the family as to not overwhelm the child/caregiver. These forums will be leveraged as key touchpoints for monitoring progress and ongoing appropriateness of FF services.

At the 12-month point, each child's eligibility will be re-assessed to determine if the child's risk level of entering foster care remains high. If the risk remains high, a new child's prevention plan will be developed noting which Family First evidence-based services will be provided.

The Role of the Case Manager

The case manager, who is separate and distinct from the case planner/caseworker, plays a key role in the approval of the FASP. The LDSS assigns a case manager for each case. In New York City, although eligibility for preventive services is determined by the Administration for Children's Services (ACS), the case manager role is assigned by the private agency providing preventive services.

There is one case manager for each family receiving preventive services, even when the household is receiving multiple child welfare services, such as foster care, preventive services, child protective services, and/or adoption services.

In general, case management includes the following activities, as defined by state regulations:

- Determining or approving a determination of eligibility for services
- Approving and supervising a Service Plan and coordination of services that are both related to Family First and other services provided through the IV-B plan
- Authorizing the scope, type, and duration of services
- Monitoring casework contacts
- Maintaining information, including a case record for each family receiving services
- Preparing and filing reports

The case manager provides oversight of the case and reviews the FASP, which upon approval of the case manager becomes effective. When preventive services are mandated by a court order,

the case manager must follow the appropriate orders of the court in planning and authorizing services to be provided.

In general, the case manager assigns responsibilities for case planning and makes sure that all participants in the case are actively involved in the assessment and Service Plan functions. This is especially important when services overlap or when a case is being transferred from one service area to another. The case manager will also monitor the integration of Family First evidence-based services within the prevention unit to promote a full continuum of services is available to all families needing assistance.

Healthy Families New York Track

HFNY home visitors, who are reflective of the communities they serve, work with their supervisors to use the responses from the Family Resilience and Opportunities for Growth (FROG) scale and other HFNY screening tools to create an individualized preventive service plan (i.e., HFNY Family Service Plan) that documents the family's (1) protective factors and strengths, (2) risk factors and areas for support, (3) planned interventions (e.g., reflective strategies, screenings, referrals, activities, observations, family goals, curriculum use), and (4) follow-up on planned interventions. OCFS will work with all HFNY programs to promote that they are culturally competent, and that the services and materials provided to the families is in the language used by the family.

During the initial assessment and in ongoing contacts with families (e.g., home visits, groups, etc.), home visitors assess needs, risks, and safety factors, and provide information and referrals to health care and other community resources as appropriate. When referrals are made, home visitors follow-up with the family or the referral source (with signed consent), as necessary, to support the connection and promote follow-through. As other challenges/risks are identified in the family, the individualized service plan in updated.

HFNY is designed to provide on-going services to families up to the targeted child's fifth birthday. Families who meet the enrollment criteria for HFNY will be considered to remain candidates for foster care up until the target child is no longer program eligible. For candidates who remain active in HFNY services longer than 12-months, an updated service plan at the 12, 24, 36, 48-month mark will serve as the new FFPSA prevention plan.

Section 5: Monitoring Child Safety (pre-print section 3)

During Wave 1, New York State will leverage the existing safety and risk monitoring tools already built into child welfare services and HFNY daily operations to monitor and oversee the safety of children receiving Family First preventive services.

Pregnant and Parenting Youth in Foster Care and Child Welfare Services Track

The safety of children in preventive services and foster care cases, as in all child welfare work, is of paramount importance. For Family First, caseworkers and supervisors will use the same process and tools that are currently in place for all preventive services and foster care cases to assess and monitor the safety and risk of children receiving a Family First EBP through either the Child Welfare Services or Pregnant and Parenting Youth in Foster Care Tracks. By using the same tools that workers are already trained on, the safety and risk of children receiving Family First Services will be consistent with current practice and the implementation of Family First services will not be delayed.

It is the responsibility of all child welfare caseworkers and supervisors to continually assess the immediate safety and the risk of abuse or maltreatment of all children in the case throughout the time the family's case is open for preventive services and while in foster care. All caseworkers, those at the LDSS and those with whom the LDSS contracts with, are responsible for developing the FASP and must use the Safety Assessment and the Risk Assessment Profile (RAP) tools that are embedded in the FASP. These tools include assessments related to substance use, mental health, and parenting in meeting the child's needs.

While helping a child, youth, and family to implement the child specific prevention plan, the caseworker must simultaneously focus on the immediate safety of all children in the home and the future risk of abuse and maltreatment. This occurs during every contact with the family and pregnant and parenting youth in foster care, even when other topics are being discussed. Information gathered from the child, youth, family, and from other sources serves to apprise the caseworker of the family's functioning and current circumstances that impact the parent's ability to care for their children inclusive of ongoing safety and risk assessment.

Minimum Frequency of Casework Contacts

While conducting casework contacts, the caseworker is required to assess the safety and risk to each child in the home, or to the pregnant or parenting youth in foster care, using the safety and risk factors outline below. The caseworker records in the progress notes any concerns observed or discussed. More formal safety and risk assessments are completed each time the FASP is completed (Initial within 30 days, Comprehensive within 90 days, and Reassessment at six months, and every six months thereafter) as detailed further below. Based on the safety and risk factors identified by the caseworker, more preventive services may be needed, and the FASP is updated accordingly. Caseworkers will continuously be assessing the child and caregiver to determine if they would benefit from any of the evidence-based services noted in the state's prevention plan and if so, make the necessary referrals.

There must be at least 12 casework contacts with a child and/or family receiving preventive services within each six-month period of services. The first six-month period of services begins at the case initiation date (CID) or at the initiation of preventive services. Subsequent six-month service periods are calculated from the Service Plan due date.

At least six of the 12 casework contacts must be made by the case planner or by a caseworker, as assigned by the case planner.

- Four of these casework contacts must be individual, face-to-face meetings with the child and/or the family.
- Two of these contacts must take place in the family's home.

No more than two of the remaining six contacts in any six-month period may be made by supportive service providers.

For youth in foster care who are pregnant or parenting, casework contacts are required at least twice within the first 30 days of placement, with at least one of the contacts in the foster home, and then monthly thereafter. At least two of the monthly contacts every 90 days must be at the child's placement location.

Assessing Safety

Caseworkers identify any presenting safety factors and determine what actions or immediate interventions are needed to protect the child, family, or community to establish safety. The Safety Assessment is completed as part of each FASP, which is completed initially when the case is being opened, at 90 days, at six months and every six months thereafter.

Both the safety decision and the safety planning process are informed by the individual, family, and community strengths that surround the family, and the entire process utilizes the application of critical thinking skills to reduce worker bias and errors in decision-making.

Documenting the Safety Assessment within the FASP

The Safety Assessment is included in the FASP in the CONNECTIONS system. It helps guide and support the caseworker's professional judgment. It is also the place where the safety assessment process, including the safety decision and safety plan, if needed, are documented by the caseworker, and reviewed/approved by the supervisor. Non-protective safety issues are summarized in a narrative form in CONNECTIONS.

Safety Factors

The Safety Factors listed below are included in the safety assessment within the FASP and are used by caseworkers when conducting safety assessments. Safety factors are behaviors, conditions, or circumstances that have the potential to place a child in immediate or impending danger of serious harm. These include specific parent/caretaker behaviors, conditions in the home, family dynamics, history, and other circumstances. The caseworker uses all available information to assess whether any of the safety factors are currently present in the child's living situation. Sources of information include, but are not limited to, direct observation of the family and the home environment, interviews with family members [including the child(ren)], and information gathered from credible collateral sources of information.

New York State has defined 18 safety factors. The caseworker also has the option for "No safety factors present at this time."

1. Based on your present assessment and review of prior history of abuse or maltreatment, the parent(s)/caretaker(s) is unable or unwilling to protect the child(ren).

2. Parent(s)/Caretaker(s) currently uses alcohol to the extent that it negatively impacts his/her ability to supervise, protect, and/or care for the child(ren).
3. Parent(s)/Caretaker(s) currently uses illicit drugs or misuses prescription medication to the extent that it negatively impacts his/her ability to supervise, protect, and/or care for the child(ren).
4. Child(ren) has experienced or is likely to experience physical or psychological harm because of domestic violence in the household.
5. Parent(s)'/Caretaker(s)' apparent or diagnosed medical or mental health status or developmental disability negatively impacts his/her ability to supervise, protect, and/or care for the child(ren).
6. Parent(s)'s/Caretaker(s)'s has a recent history of violence and/or is currently violent and out of control.
7. Parent(s)/Caretaker(s) is unable and/or unwilling to meet the child(ren)'s needs for food, clothing, shelter, medical or mental health care and/or control child's behavior.
8. Parent(s)/Caretaker(s) is unable and/or unwilling to provide adequate supervision of the child(ren).
9. Child(ren) has experienced serious and/or repeated physical harm or injury and/or the parent(s)/caretaker(s) has made a plausible threat of serious harm or injury to the child(ren).
10. Parent(s)/Caretaker(s) views, describes, or acts toward the child(ren) in predominantly negative terms and/or has extremely unrealistic expectations of the child(ren).
11. Child(ren)'s current whereabouts cannot be ascertained and/or there is reason to believe the family is about to flee or refuses access to the child(ren).
12. Child(ren) has been or is suspected of being sexually abused or exploited and the parent(s)/caretaker(s) is unable or unwilling to provide adequate protection of the child(ren).
13. The physical condition of the home is hazardous to the safety of the child(ren).
14. Child(ren) expresses or exhibits fear of being in the home due to current behaviors of parent(s)/caretaker(s) or other persons living in or frequenting the household.
15. Child(ren) has a positive toxicology for drugs and/or alcohol.
16. Child(ren) has significant vulnerability, is developmentally delayed or medically fragile (e.g., on apnea monitor,) and the parent(s)/caretaker(s) is unable and/or unwilling to provide adequate care and/or protection of the child(ren).
17. Weapon noted in CPS report or found in the home and parent(s)/caretaker(s) is unable and/or unwilling to protect the child(ren) from potential harm.
18. Criminal activity in the home negatively impacts parent(s)'s/caretaker(s)'s ability to supervise, protect and/or care for the child(ren).

Applying the Safety Criteria

The caseworker applies safety criteria to each identified safety factor to determine whether the child is in immediate or impending danger of serious harm by considering:

- The seriousness of behaviors/circumstances reflected by the safety factor

- The number of safety factors identified
- The degree of the child's vulnerability and need for protection
- The age of the child

The Safety Decision

After identifying the safety factors that are present and applying the safety criteria to determine if the child is in immediate or impending danger of serious harm, the next step is to make a safety decision. A safety decision is a statement of the current safety status of the child(ren) and the actions that are needed to protect the child(ren) from immediate or impending danger of serious harm. The caseworker, in consultation with the supervisor, selects one of five available safety decisions:

Safety Decision 1: No safety factors were identified at this time. Based on currently available information, there is no child(ren) likely to be in immediate or impending danger of serious harm. No safety plan/controlling interventions are necessary at this time.

Safety Decision 2: Safety factors do exist, but do not rise to the level of immediate or impending danger of serious harm. No safety plan/controlling interventions are necessary at this time. However, identified safety factors have been/will be addressed with the parent(s)/caretaker(s) and reassessed.

Safety Decision 3: One or more safety factors are present that place the child in immediate or impending danger of serious harm. A safety plan is necessary and has been implemented/maintained through the actions of the parent(s)/caretaker(s) and/or either CPS or child welfare staff. The child(ren) will remain in the care of the parent(s)/caretaker(s).

Safety Decision 4: One or more safety factors are present that place the child(ren) in immediate or impending danger of serious harm. Removal to, or continued placement in, foster care or an alternative placement setting is necessary as a controlling intervention to protect the child(ren).

Note: If safety decision #4 is chosen, it is necessary to document which children were placed or remain in foster care or an alternative placement. Also, if applicable, caseworkers must identify the protecting factors that allow each child(ren), if any, to remain in the home.

Safety Decision 5: One or more safety factors are present that place or may place the child(ren) in immediate or impending danger of serious harm, but Parent(s)/Caretaker(s) has refused access to the child(ren) or fled, or the child(ren)'s whereabouts are unknown.

The Safety Plan

If a child is determined to be in immediate or impending danger of serious harm, the caseworker must develop a safety plan. This safety plan must control for the danger and protect the child from what is placing him or her in immediate or impending danger of serious harm for as long as the danger exists. This is known as managing safety.

There are several elements of the safety plan. The plan accomplishes the following:

- Provides a clearly defined set of actions, including controlling interventions when necessary, that have been or will be taken without delay to protect the child(ren) from immediate or impending danger of serious harm.

- Addresses all the behaviors, conditions, or circumstances that create the immediate or impending danger of serious harm to the child(ren).
- Specifies the tasks and responsibilities of all persons (parent/caretaker, household/family members, caseworker, or other service providers) who have a role in protecting the child(ren).
- Gives time frames associated for each action or task in the plan that must be implemented.
- Identifies how the necessary actions and tasks in the plan will be managed and by whom.

The plan must be modified, or a new plan will be developed in response to changes in the family's circumstances, as necessary, to continually protect the child(ren) throughout the life of the case. The plan must stay in place until the protective capacity of the parent/caretaker is sufficient to eliminate immediate or impending danger of serious harm to the child(ren) in the absence of any controlling interventions.

Controlling Interventions

A wide array of controlling interventions or activities can be included in safety plans to protect a child from a situation, behaviors or conditions that are associated with immediate or impending danger of serious harm. Without controlling interventions, the dangerous situations, behaviors, or conditions would still be present, would emerge, or would likely immediately return. For safety/controlling interventions to be part of a viable safety plan, they must be available immediately. Additionally, people who are integral to the plan must be capable of and committed to carrying out the interventions and the plan.

Assessing Risk of Abuse/Maltreatment

While a safety assessment is focused on the immediate or impending safety of the children, risk is future-oriented. OCFS regulations define risk assessment as "a process of information gathering and analysis that examines the interrelatedness of risk elements affecting family functioning and documents them in the form, manner and time prescribed by OCFS."

Risk Assessment Profile

The Risk Assessment Profile (RAP) is a research-based assessment protocol designed to assist workers in making informed decisions regarding the level of risk of future abuse or maltreatment. While the initial RAP is often done by CPS investigative workers, the elements in the RAP are used by preventive services workers to guide and document ongoing assessments of family functioning. In addition, when a CPS investigative worker transfers responsibility for a case to a preventive services worker, the RAP will provide information about why the case was opened and what behaviors and conditions pose risk for future abuse and maltreatment. The RAP is completed as part of each FASP, which is completed initially when the case is being opened, at 90 days, at six months and every six months thereafter. This same process will be used for assessing risk to children and caregivers receiving Family First services.

The primary goal of risk assessment is to promote and support a structured, rational, decision-making approach to child protective services case practice, without replacing professional judgment.

Risk assessment is based on a social work or rehabilitative approach to working with families. It deliberately bolsters the focus of child protective services beyond an evidentiary, allegation-driven system.

The RAP also guides and supports professional judgment regarding:

- the decision to keep a case open for services following case determination.
- the appropriate selection of treatment services to reduce risk of future abuse and maltreatment, and
- the decision to close a case based on risk reduction.

During the risk assessment process, the caseworker, in consultation with the supervisor does the following:

1. Gathers information on the presence or absence of a set of circumstances and behaviors in the parent's/caretaker's household(s). These circumstances or behaviors are known as "risk elements." Uses the CONNECTIONS system to calculate a risk score and rating. Note: FAR cases use FLAG to identify, with the family, any areas of risk revealed by the information the family shares.
2. Uses that risk rating and other circumstances to determine the family's need for services aimed at reducing the likelihood of future abuse or maltreatment of the child(ren).
3. Develops a Service Plan that targets the respective behaviors or circumstances in the parent's/caretaker's household(s) that have been identified as contributing to the risk of future abuse or maltreatment (risk elements).

Risk Elements

Risk elements are a set of circumstances and behaviors in the parent's/caretaker's household(s). Risk elements have been shown to influence the likelihood of future abuse and maltreatment. Response criteria are weighted based on a statistical analysis of their influence on risk and added together to derive an overall score. The overall score is then assigned a risk rating level ranging from low to very high, depending on state research findings and specifically designated policy considerations. When an elevated risk element is identified by the worker, the risk level is automatically raised to very high.

Risk scores and ratings

For an accurate risk score and rating to be obtained, the caseworker completing the RAP must not make assumptions or use opinion rather than the facts of the case. If the caseworker doesn't have enough information to complete the RAP, they must gather that information from various sources. These include individuals such as family members and collaterals, as well as written documents such as police reports, school records, and medical files.

If at least one of the eight (8) elevated risk elements is selected, the risk rating will automatically be very high. The risk scoring system is as follows:

Total Risk Score	Risk Rating
2 or lower	Low
3 to 6	Moderate
7 to 9	High
10 or above	Very High

The scoring from the RAP is an indicator that the child is at risk for future abuse or maltreatment. The higher the risk rating the higher probability that the child remains at risk for future abuse or maltreatment. To prevent future abuse and maltreatment, families in which the risk level/rating is high or very high should be provided services aimed at helping them make changes in their lives to reduce the future risk of harm to their children. Services, however, can be provided to families with any case risk rating, depending upon the case circumstances and the family's receptivity. Eligibility for Family First preventive services will be based on the decision to open a preventive case, regardless of RAP score.

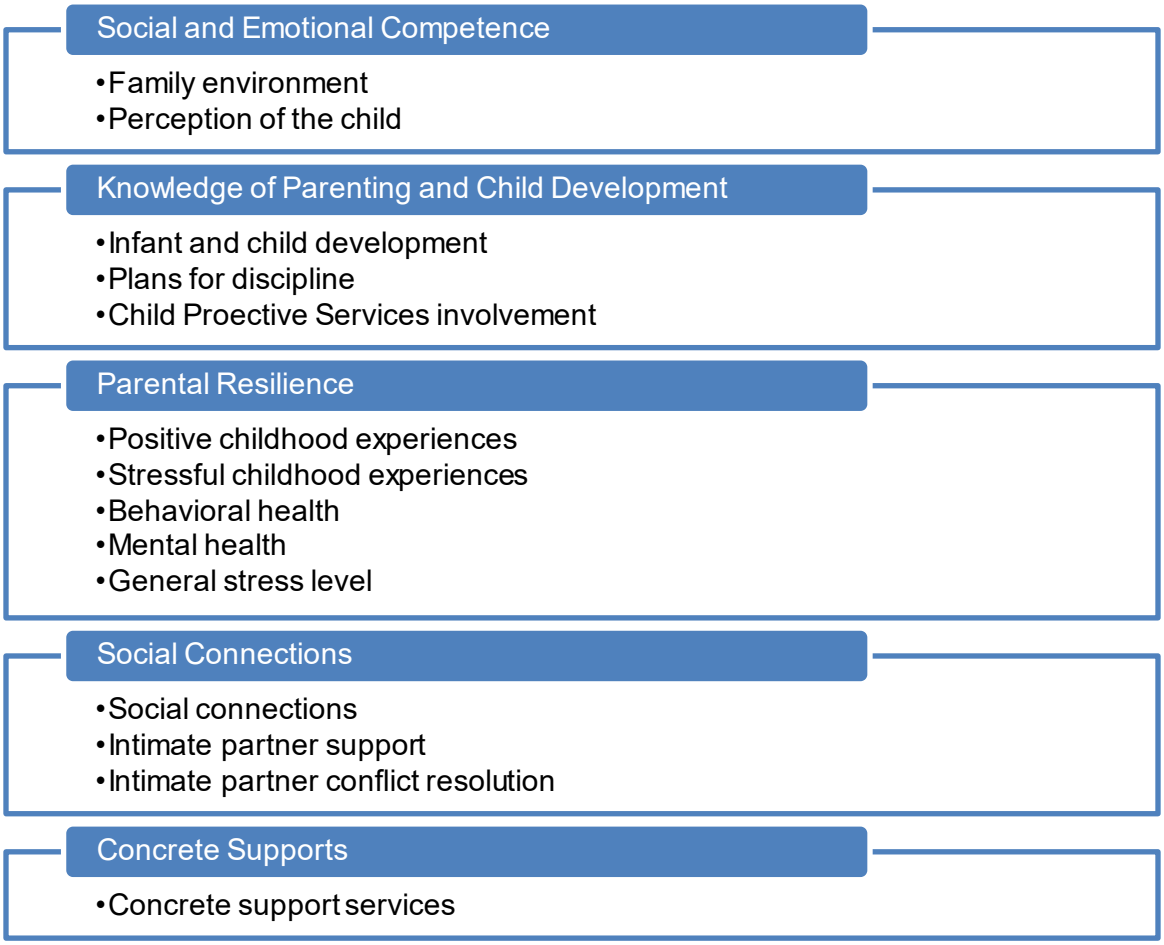
Healthy Families New York Track

Initial Assessment of Safety and Risk

HFNY will use the Family Resilience and Opportunities for Growth (FROG) (Figure 9) scale to assess for child safety and risk for all families served under the Signature or Child Welfare protocol. For families that have an open preventive case the families will also be assessed using the Safety and Risk protocol in the FASP.

The FROG explores the strengths and challenges that impact parents' ability to nurture and care for their children. The FROG allows home visitors to identify families' concerns, needs, risks, stressors, and strengths within 14 domains as they relate to the Protective Factors. Home visitors also administer a depression screen during the assessment process (Patient Health Questionnaire-2). If a participant scores a three or higher on the Patient Health Questionnaire-2, the Patient Health Questionnaire-9 will be administered. Home visitors also administer an intimate partner violence screening tool, Hurt, Insult, Threaten, and Scream (HITS) and a 3-item screen to identify at-risk alcohol use Alcohol Use Disorders Identification Test-Concise (AUDIT-C) during the assessment process. These tools may also be administered as needed during the course of service provision.

Figure 9. FROG Scale Domains



Supervision

In their weekly supervision sessions, the supervisor and home visitor review the activities that have been implemented, discuss the readiness of the family to address issues, reflect on the success of completed activities, and discuss next steps. Any challenging issues or concerns identified after the completion of the initial assessment process are added to the individualized preventive service plan.

Ongoing Assessment of Safety and Risk

Parent-Child Bonding/Attachment/Interaction: During each home visit, the home visitor observes parent-child interaction using CHEERS (Cues, Holding, Expression, Empathy, Rhythmicity/Reciprocity, and Smiles) and identifies areas of strengths, needs, and concerns. The home visitor uses Reflective Strategies (e.g., Strategic Accentuate the Positive, Explore and Wonder, Normalizing, etc.) during teachable moments to reinforce the parent's positive interaction, to promote nurturing relationship skills, and to address any concerns identified through CHEERS observations. Twice a year, home visitors also complete the CHEERS Check-In (CCI). This validated tool is designed to assess the quality of the relationship between the parent and child and their reciprocal interactions.

Developmental Delays: HFNY Home visitors assess children for developmental delays on a regular basis. The Ages and Stages Questionnaire is administered at least twice a year for

children under the age of 3 and annually for children between the ages of 3 and 5. The ASQ - SE is administered at least annually beginning at 6 months of age. When developmental concerns are indicated, home visitors make appropriate referrals for services.

Challenging Issues: Home visitors regularly assess for and make referrals (as needed) for any new challenging issues families may be facing. This may include:

- Alcohol abuse
- Substance abuse
- Physical disability/Health problems
- Depression
- Other mental illness/disability
- Developmental and intellectual disability
- Domestic violence
- Marital or relationship issues
- Financial difficulties or insufficient income
- Homelessness or inadequate housing
- Criminal activity
- Other legal problems
- Social isolations/inadequate social support
- Stress or emotional difficulties
- Inadequate food, clothing, or household goods
- Smoking

Maternal Depression: The PHQ-9 is also administered again within 30 days of the first prenatal home visit (for prenatally enrolled families), within three months of enrollment (for families enrolled postnatally), and at least once within three months of any subsequent births. Home visitors provide activities to support parents with elevated depression screening scores and refer (with consent when needed) to community-based providers for further evaluation and treatment.

Education to families on safety topics listed below: Home visitors provide education to families about important infant/child safety topics regularly and on an as needed basis. Home visitors may provide referrals to community-based services as appropriate.

- Car Seat Safety
- SIDS/Back to Sleep/Safe Sleep
- Shaken Baby
- Blunt Force Trauma
- Post-Partum Depression (Signs and Symptoms)
- Fire
- Water Temperature
- Poison
- Water Safety
- Who to leave the child with (safe caregivers)

Data collection elements (based on participant self-report or from screening tools conducted by home visitors) related to child safety and protective factors include:

- Initiation and continuation of breastfeeding (every six months)
- Child general health (every visit)
- Child developmental milestones (every visit and via regular standardized screening tools)
- Well-visits and immunizations (every visit)
- Child protective and child welfare system involvement (every visit and during each six-month follow-up)

- Visits to emergency department, urgent care, and hospitalizations (every visit)
- Lead assessment and screening results (during each six-month follow up)

Reporting Child Abuse and Maltreatment

HFNY home visitors, while not legally mandated reporters in New York State receive annual child abuse and neglect training. HFNY policy requires all suspected cases of child abuse and maltreatment be reported to the SCR, including situations where it is believed that a report has already been made by another individual or organization.

Section 6: Evaluation Strategy and Waiver Request (pre-print section 2, Attachment II)

As noted in Section 3, to permit LDSSs to immediately benefit from Family First EBPs while OCFS builds the infrastructure needed to inform and support the rigorous evaluation efforts required for supported and promising programs, New York State is currently requesting approval for only well-supported EBPs. CQI efforts will begin on day one of implementation at the OCFS and LDSS level and will expand over time as the CfE and regional collaboratives take root. Evaluation activities will begin in Wave 2 and expand over time as state and local resources allow.

Evaluation Waiver Justifications

Family First requires that each state continually assess the degree to which the EBPs provided to children and their families are being implemented as intended and achieving the desired outcomes. To accomplish this, each EBP service submitted in a state's Prevention Plan must include a well-designed and rigorous evaluation strategy. The Children's Bureau, however, may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI requirements. New York State is requesting a waiver of the evaluation requirements for all eleven of our selected well-supported programs:

- Brief Strategic Family Therapy (BSFT)
- Family Check-Up (FCU)
- Familias Unidas
- Functional Family Therapy (FFT)
- Healthy Families America (HFA)
- Homebuilders - Intensive Mandated Prevention Services and Reunification Services (Homebuilders)
- Motivational Interviewing (MI)
- Multisystemic Therapy (MST)
- Nurse-Family Partnership (NFP)
- Parents as Teachers (PAT)
- Parent-Child Interaction Therapy (PCIT)

All of these EBPs have empirical evidence that they improve outcomes in the domains of child safety, child permanency, child well-being, and/or adult well-being. Moreover, New York State is confident that these EBPs will continue to improve outcomes for the children and families we serve, as described in the section below.

Compelling Evidence for EBP Effectiveness and Waiver Justification

The comprehensive needs assessment conducted by OCFS showed an average of 42,123 children at risk for foster care placement between 2018 and 2020, with needs in all three Family First prevention service categories.[30] The most common need was for parenting services, followed by mental health and then substance abuse. This echoes feedback received from LDSSs and agency partners, who indicated a high need for increased in-home and mental health services. The interventions included in Wave 1 of implementation will effectively meet these needs.

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. New York State's analysis of the children receiving preventive services shows that approximately 65% meet the age criteria for BSFT.[31] Initial candidacy estimations described in Section 3 indicate that approximately 3% of preventive cases have concurrent juvenile justice involvement (i.e., adjudicated as Juvenile Delinquent) or showed serious behavioral problems or criminal activity at home and or within the community. BSFT is an appealing intervention for New York State because of broad eligible age range of child and youth populations, cross-system treatment focus, and the flexibly of where it can be delivered, specifically in homes. One of the service characteristics identified in the regional meetings highlighted transportation as one of the common challenges to parents accessing available services and the in-home delivery format would address this barrier. BSFT is offered in New York City and additional LDSSs are interested in building the infrastructure to offer BSFT over the next five years.

Evidence base justification

The Clearinghouse rated BSFT as a "well-supported" EBP following review of five eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- At least one study of BSFT has shown improved child well-being outcomes. Participation improved behavioral and emotional functioning by reducing externalizing behaviors. Results of this study also showed reductions in delinquent behaviors such as the number of lifetime and past year arrests and incarcerations.[32]

Adult well-being outcomes

- BSFT has demonstrated effects in improving adult well-being outcomes. In one study, parents who participated in BSFT reported less alcohol use.[33] In another study, significant overall improvements in family functioning were achieved.[34]

Program delivery and fidelity monitoring

BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes. Intervention delivery is based on the required manual: 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. BSFT counselors are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral interventions and family systems theory. Fidelity monitoring includes counselor completion of the *BSFT Therapist Adherence Form* with monitoring by a clinical supervisor documented using the *Clinical Supervision Checklist* (CEBC, Robbins et al., 2011).

Familias Unidas

Familias Unidas is a multi-level, family-centered program developed to reduce risk for drug use, risky sexual behavior, and other problematic behaviors in Hispanic youth. The intervention is delivered primarily through multi-parent groups consisting of between 12-15 parents. The activities and group discussions in the multi-parent groups aim to improve effective parenting practices, help parents protect their children from harmful behaviors, and facilitate parental

involvement in the youth's lives. Familias Unidas also helps parents meet with school personnel and plan activities involving their child's peers, which allows parents to connect to their adolescent's school and peer networks. New York State's analysis of children and families receiving preventive services shows that approximately 33% of children fit the target age range of Familias Unidas, with a subset of this population identifying as Hispanic.[35]

Evidence base justification
The Clearinghouse rated Familias Unidas as a "well-supported" EBP following review of four eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- Studies have shown that Familias Unidas has improved child well-being in behavioral and emotional functioning and substance use.[3637]

Adult well-being outcomes

- Many studies have shown that families who participate in Familias Unidas have demonstrated improvement in both positive parenting practices and family functioning.[38394041]

Program delivery and fidelity monitoring
Familias Unidas can be delivered in a variety of settings, including in the home, in schools, or in community-based organizations. The program is generally delivered over a 12-week period, with the family engaging in one session per week, for approximately 1-2 hours per session. The sessions consist of eight multiparent group sessions along with four individual family session where the adolescent is included. Facilitators must have a minimum of a bachelor's degree and the appropriate program-specific training to deliver the intervention. Facilitators adhere to standards in the following manual: Estrada, Y., Pantin, H. M., Prado, G., Tapia, M. I., & Velazquez, M. R. (2020), *UM-Familias Unidas Program: For the families of Hispanic adolescents: Intervention* manual. University of Miami. Fidelity training is provided as a part of program implementation and is evaluated using observational fidelity measures that assess the use of the key components of the intervention.

Family Check-Up (FCU)
FCU is a strengths-based, family-centered model for children ages 2 through 17 and their parents and caregivers. FCU reduces negative and coercive parenting by promoting positive family management techniques and addressing child adjustment problems. New York State's recent assessment of preventive families' needs indicates that over 80% of children in FCU's targeted age-group had a need for parenting skills/supports.[42] FCU's broad age range, focus on both parenting and mental health needs within a family-based framework, and flexibility of service delivery location (homes, schools, community mental-health settings, etc.) makes FCU an appealing prevention program for New York State. Numerous LDSSs have expressed interest in building the infrastructure to offer FCU over the next five years.

Evidence base justification
FCU is currently rated as "well-supported" on the Clearinghouse following a review of five eligible studies that indicated favorable effects in the target outcome of adult well-being.

Adult well-being outcomes

- FCU has established efficacy in improving positive parenting practices.[43] [44] [45] [46]

Program delivery and fidelity monitoring
FCU can be conducted in a variety of settings, including homes, schools, community based mental health and health providers, and Native American tribal communities. FCU consists of three main components: an initial interview that establishes rapport and explores family strengths and challenges, a comprehensive family assessment that includes input from children, parents, teachers and observations of family interactions, and a feedback session that involves a comprehensive review of the assessments and discussions of possible follow-up support and service options. Recommended service duration is between one to four months, depending on the needs of the family. Master's level clinicians deliver the intervention according to the following manual: Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019), *Family check-up in early childhood: An intervention manual* (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon. Fidelity is evaluated using validated assessments, and to become certified programs are required to meet model specific fidelity requirements.

Functional Family Therapy (FFT)
FFT is a trauma-informed evidence-based therapeutic intervention for at-risk families and juvenile justice involved youth. FFT aims to address risk and protective factors that impact the adaptive development of 11- to 18-year-old youth who have been referred for behavioral or emotional problems. New York State's analysis of the children receiving preventive services show that approximately one-third meet the age criteria for FFT with a subset having concurrent juvenile justice involvement.[47] This makes FFT an appealing intervention for New York State because of the emphasis on older children and youth, cross-system treatment focus, and the flexibly of where it can be delivered (e.g., homes, schools). FFT is currently offered in seven LDSSs in New York State and additional LDSSs are interested in building the infrastructure to offer FFT over the next five years.

Evidence base justification
FFT is currently rated as "well-supported" on the Clearinghouse following review of nine eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes
- FFT has a proven track record in improving youth behavior and emotional functioning and reducing youth alcohol and drug use.[48] [49] Participation in FFT has been shown to significantly reduce delinquent behaviors and the likelihood of out-of-home placements resulting from them. [48] [49] [50]

Adult well-being outcomes
- FFT also has established efficacy in improving overall family functioning by reducing verbal aggression between family members.[49]

Program delivery and fidelity monitoring
FFT is conducted in clinic and home settings. It can also be delivered in schools, child welfare facilities, probation and parole offices, aftercare systems, and mental health facilities. FFT is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a

broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of three to six months. Master's level therapists deliver the intervention based on the following manual: Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013), *Functional Family Therapy for Adolescent Behavior Problems*. American Psychological Association. They work as a part of an FFT-supervised unit and receive ongoing support from their local unit and FFT training organization. FFT has a rigorous fidelity monitoring infrastructure. Contracted therapists providing FFT must show proof of training and fidelity to the model, which includes three phases: clinical training, supervisor training, and maintenance phase. FFT has a web-based Client Services System (CSS), which is used to monitor program fidelity based on the Fidelity and Dissemination Adherence Scores. Quarterly ratings are then used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model (CEBC).

Healthy Families America (HFA)

HFA is a voluntary home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. Under Family First, New York State will expand its current HFA program (HFNY) to include child welfare protocols, enabling the enrollment of LDSS referred families with a child less than 24-months old. New York State's analysis of children and families receiving preventive services shows that approximately 80% of children under 2 years of age have a caregiver who would benefit from parenting services.[51] Five-year fatality trends also show that children under 1 year of age account for over half of all maltreatment-related child fatalities in New York State.[52] New York State believes that one strategy to reduce severe physical abuse resulting in child fatalities is by expanding in-home parenting services to new and expectant parents. Presently, there is an established HFA provider infrastructure in 41 counties in New York State.

Evidence base justification

HFA is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Clearinghouse following review of 22 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Although no evaluation of HFA to date has focused exclusively on families enrolled under the child welfare protocol, Easterbrooks and colleagues reported that the mean age of the target child at enrollment in their evaluation of Healthy Families Massachusetts was 2.83 months old, with standard deviation of 3.51 (Easterbrooks, Kotake & Fauth, 2019). This means that a good number of families were enrolled when the target child was older than three months. It is important to note that eligibility criteria vary among Healthy Families America programs. For example, New York limits initial eligibility to the target child's third month of life whereas Massachusetts eligibility extends through the child's first year of life. Regardless of eligibility criteria, the HFA model was originally designed for families with children ages zero to five, and staff are trained to serve families with children covering this age range. The minimum length of service delivery for HFA is three years, and families can be served for at least three years as long as the target child is less than 24 months old when the family enrolls, as per child welfare protocol criteria.

Historically the number of families enrolled in HFNY via referral from child welfare has been minimal. In FFY 21, only 252 HFNY referrals came from child welfare. Yet CPS data clearly indicate that young children make up close to 10% of those reported to child protective services. In CY 2021, approximately 24,000 children two and under were named in a report of suspected child abuse or maltreatment, with nearly 16,700 children falling in the three-to-24-

month age range at intake. Adding the child welfare protocol to existing HFNY services will make more children and families eligible for HFNY referral.

By offering the child welfare protocol, NYS seeks to expand the delivery of effective home visiting services to more families identified by LDSS who are currently ineligible. In a randomized control study of Healthy Families New York, it was found that for mothers with prior CPS reports, participation in HFNY reduced the rate of confirmed neglect by 33% and the rate of confirmed abuse by 77%, including an 88% reduction in the average number of acts of very serious physical abuse by the age of one. Indicating that HFNY has been significantly effective in allaying the risk of child maltreatment among families with prior CPS involvement. Furthermore, HFA has been shown to reduce the recurrence of maltreatment reports and increase the length of time between initial and subsequent reports of child maltreatment among child welfare-system involved families (Easterbrooks et al., 2019). The newly established HFA Child Welfare Protocol will not only expand the eligibility criteria to the target child's first 24 months of life but will also expand home visitors' knowledge of the child welfare system in order to improve collaboration with LDSS and better address the needs of child welfare involved families. It will also expand LDSS' knowledge of the benefits of HFNY in order to encourage referrals to the program. NYS believes this expansion will greatly enhance the state's prevention efforts.

Child safety outcomes

- HFA has been shown to increase child safety by reducing incidents of neglectful behaviors, minor physical aggression, psychological aggression, and frequency of severe and very severe physical abuse.[53] [54]

Child well-being outcomes

- HFA has proven efficacy in improving a range of child well-being outcomes. Findings show that participation in HFA has been shown to improve behavioral and emotional functioning and improvement in cognitive functions and abilities.[55] [56] [57] [58]

Adult well-being

- HFA also has a robust set of research documenting improvements in adult well-being. HFA participation has been linked to enhanced parenting practices, improved parent/caregiver mental or emotional health, reductions in parental stress and overall improvements in family functioning and reductions in domestic violence.[59] [60] [61] [62]

Program delivery and fidelity

HFA is delivered in the family's home and providers follow the following manuals: Healthy Families America (2018), *Best Practice Standards, Prevent Child Abuse America*, and *State/Multi-Site System Central Administration Standards*. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term, and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Enrollment begins prenatally and continues up to three months after birth for the signature model or up to 24 months of age for the child welfare protocol. Families are offered services until the child enters Head Start or kindergarten and receive weekly home visits at the start. Ongoing visit frequency is based on families' needs and progress towards goals set collaboratively with their home visitor. All HFA

home visiting staff must have a minimum of a high school diploma or equivalent and are required to attend core training and receive supplemental wrap-around training.

HFA has required fidelity monitoring requirements. Implementing sites utilize the HFA Best Practice Standards and demonstrate fidelity to the standards through annual HFNY central administration site visits and national model accreditation site visits every five years. There are 152 standards, and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model (CEBC). Additionally, states implementing HFA within a multi-site system are also required to demonstrate fidelity to the State/Multi-Site System Central Administration Standards during national model accreditation site visits.

Homebuilders-Intensive Family Preservation Services and Reunification Services (Homebuilders)

Homebuilders provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. There are currently two LDSSs in New York State that offer Homebuilders, and recent state analysis of preventive cases indicate that over 80% of new preventive cases, or approximately 35,000 children each year, could be considered for Homebuilders for referral.[63]

Evidence base justification

Homebuilders is one of the oldest Intensive Family Preservation Services (IFPS) programs in the United States (Institute for Family Development). The intervention is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Clearinghouse, following review of three eligible studies that indicated favorable effects in the target outcomes of child permanency and adult well-being.

Child permanency outcomes

- Participation in Homebuilders enhanced child permanency by preventing out-of-home placement directly after the intervention and at six and twelve months out. Additional research found that Homebuilders also improved reunification and family stability at the conclusion of child welfare involvement.[64] [65]

Adult well-being outcomes

- Homebuilders has demonstrated evidence in improving adult well-being outcomes such as overall economic and housing stability and food security.[66]

Program delivery and fidelity monitoring

Homebuilders is delivered in the family's home. Services are provided when and where the family needs them, including other community locations (e.g., school). Homebuilders is delivered according to the following manual: Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991), *Keeping Families Together: The HOMEBUILDERS Model*. New York, NY: Taylor Francis. Practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. Homebuilders' practitioners collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention, the practitioner develops safety plans and uses clinical strategies designed to promote safety. Homebuilders' services are concentrated during a period of four to six weeks with the goal of

preventing out-of-home placements and achieving reunifications. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least two years of related experience. The Homebuilders model includes fidelity measures designed to track specific indicators and performance measures (CEBC, Institute for Family Development).

Motivational Interviewing (MI)

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

The evidence base for MI is strong in the areas of addictive and health behaviors for adolescents and adults and appears to improve outcomes in other domains when added to other treatment approaches.[67] Because of this, New York State is seeking approval from the Children's Bureau to use MI as a reimbursable case worker strategy to promote client engagement and motivation. As previously noted in section two of this plan, parental substance use disorders have been found to be a leading contributing factor associated with children entering care in New York State. Since MI's efficacy is grounded in substance abuse treatment, using MI as a case management tool to engage families and enhance their motivation to participate in substance abuse services, is one way to reduce foster care entry. The analysis of preventive families indicates that approximately 9% of caregivers would benefit from substance abuse services.[68] In addition to using MI as a case management tool for families experiencing substance problems, New York State intends to offer training to all child welfare staff and not-for-profit preventive agencies providing Family First programs.

Evidence base justification

MI is currently rated as "well-supported" by the Clearinghouse as a Substance Abuse intervention following review of 75 eligible studies that indicated favorable effects in the target outcomes of adult well-being.

Adult well-being outcomes:

- MI has a robust evidence base as a substance misuse intervention. Several studies have demonstrated efficacy in reducing the quantity and frequency of alcohol use.[69] [70] [71] [72] [73] There is also evidence demonstrating reduced use of other illicit substances.[74]

MI has been proven effective in bringing about diverse behavior changes, including improved oral health behaviors,[75] self-management behaviors for patients with type II diabetes,[76] diet and exercise,[77] and cognitive and behavioral change among domestic violence offenders.[78] Additionally, research has demonstrated the effectiveness of MI in child welfare. Research demonstrates that MI may be effective in child welfare practice, including engagement of families in comprehensive assessments,[79] juvenile corrections,[80] and child protection work with alcohol-abusing parents.[81] This research also underscores the potential benefits of MI's use by child welfare caseworkers for promoting client engagement and improving case outcomes.[82] Moreover,

in a 2018 literature review of 16 articles studying the effectiveness of MI in child welfare, 12 of the articles suggested MI's value for improving outcomes, including parenting skills, parent/child mental health, retention in services, substance use, and child welfare recidivism.[83] Four systematic reviews and meta-analyses summarize existing literature on the effectiveness of MI.[84] [85] [86] [87]

Program delivery and fidelity

MI is a collaborative, goal-oriented style of communication with particular attention to the "language of change," which is designed to facilitate a personal change process from start to finish. MI can be used as needed to enhance motivation, reinforce that motivation, and promote behavior change. MI can be used prior to or in conjunction with other therapies or programs. MI can be conducted in community agencies, clinical office settings, care facilities, or hospitals. While there are no required qualifications for individuals to deliver MI, training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers. MI training by credentialed trainers use the practice manual, *Motivational Interviewing, Third Edition: Helping People Change* by Miller, W.R., & Rollnick, S. (2012), to standardize practice. MI has the Motivational Interviewing Treatment Integrity (MITI) instrument for example, as well as others, as a fidelity measure and uses coaching to work toward proficiency through observation, note review, or role playing (CEBC).

Multisystemic Therapy (MST)

MST is an intensive treatment for troubled youth delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use. The target population for MST is youth, ages 12 to 17, and for the families of youth who are (1) at risk for or engaging in delinquent activity or substance misuse, (2) experiencing mental health issues, and (3) at risk for out-of-home placement. New York State's analysis of the children receiving preventive services show that approximately 33% meet the age criteria for MST with a subset having concurrent juvenile justice involvement.[88] MST is a desired intervention for New York State because of emphasis on dual-system youth, co-occurring mental health and substance use problems, and the flexibly of where it can be delivered (e.g., homes, schools). MST is currently offered in 10 LDSSs in New York State, and the state will explore interest in re-building the infrastructure to offer it in more LDSSs over the next five years.

Evidence base justification

MST is currently rated "well-supported" as a Mental Health Program and as a Substance Abuse Program by the Clearinghouse following review of 16 eligible studies that indicated favorable effects in the target outcomes of child permanency and child and adult well-being.

Child permanency outcomes

- MST has been shown to significantly reduce out-of-home placement for problematic youth behavior. [89]

Child well-being outcomes

- Numerous studies of MST show significant improvements in youth behavioral and emotional functioning. MST participation reduces problematic mental health symptoms associated with conduct problems, conduct disorder, oppositional defiant disorder, impulsiveness, Attention Deficit Hyperactivity Disorder, and other kinds of internalizing and externalizing behaviors.[90] [91] [92] [93] [94] [95] [96] [97] MST also has a proven track record for reducing

substance misuse and a wide range on delinquent behaviors like property offenses, subsequent arrests and adjudications, and violent and non-violent crimes.[98] [99] [100] [101] [102]

Adult well-being outcomes

- MST has a proven track record of improving adult well-being outcomes. Several studies of MST demonstrate improvements in positive parenting practices such a positive discipline, increased parental involvement, improvements in monitoring and supervision, and reductions in inconsistent discipline.[103] [104] [105] MST has also been shown to improve parent/caregiver mental and emotional health and overall improvements in family functioning, family satisfaction, family cohesion, and family communication.[106]

Program delivery and fidelity monitoring

MST is delivered based on the following manual, Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009), *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). Guilford Press. The intervention addresses the 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, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

MST has a rigorous fidelity monitoring infrastructure and includes measures for the therapist and the supervisor. The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST supervisor's adherence to the MST model of supervision as reported by MST therapists (CEBC).

Nurse-Family Partnership (NFP)

NFP is a home-visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. According to the analysis of children and families receiving preventive services 80% of children in the target population had a caregiver that would benefit from receiving a parenting-skills based EBP.[107] Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. Because of the emphasis on young first-time parents, NFP is a well-suited intervention to serve New York State's foster youth who are pregnant and parenting. Presently, there are 14 counties being served by NFP programs in New York State.

Evidence base justification

NFP is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Clearinghouse following review of 10 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Child safety outcomes

- NFP has demonstrated effects of reducing the likelihood of Child Protective Services (CPS) involvement.[108]

Child well-being outcomes

- NFP has established efficacy in improving child well-being. Several studies have found that participation in NFP enhances cognitive functions and abilities and physical development and health.[109] [110] [111] [112]

Adult well-being outcomes

- NFP also has at least one study demonstrating that participation in NFP increases the likelihood of caregiver months employed after birth.[113]

Program delivery and fidelity

NFP is delivered by nurses through the core education (Nurse Family Partnership. (2020). *Visit-to-visit guidelines)* about the Nurse-Family Partnership Model. New nurses learn the visit-to-visit guidelines, which provide a consistent content and structure for each of the 64 planned home visits (CEBC). The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother. NFP aims for 60 visits that last 60-75 minutes each in the home or a location of the mother's choosing. For the first month after enrollment, visits occur weekly. Then, they are held bi-weekly or on an as-needed basis.

NFP has a robust fidelity monitoring process. Nurses collect client and home visit data as specified by the National Program Office, and all data is sent to the Nurse-Family Partnership National Program Office's national database. The Nurse-Family Partnership National Program Office reports out data to agencies to assess and guide program implementation, and agencies use these reports to monitor, identify and improve variances, and assure fidelity to the NFP model (CEBC).

Parents as Teachers (PAT)

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. Families can begin the program prenatally and continue through when their child enters kindergarten (i.e., prenatal to age 5). PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse, and neglect, and increase school readiness and success. New York State's analysis of the children receiving preventive services that approximately 35% meet the age criteria for PAT.[114] Moreover, analyses also show that children ages 5 and under are more likely than older children and youth to enter foster care after a finding of maltreatment. New York State believes that one strategy to reduce foster care entries is by expanding in-home parenting services to parents of young children.

Evidence base justification

PAT is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Clearinghouse following review of six eligible studies that indicated favorable effects in the target outcomes of child safety and child well-being.

Child safety outcomes

- Participation in PAT has been shown to increase child safety by reducing the occurrence of substantiated incidents of abuse and neglect.[115]

Child well-being outcomes

- PAT also has demonstrated efficacy in improving child well-being. In two separate studies, participation in PAT was found to improve social functioning and cognitive functioning and abilities.[116] [117] [118]

Program delivery and fidelity

The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs, and delivered using one of two age-based curriculums: PAT Foundational Curriculum is available to support families prenatally through age three; PAT Foundational 2 Curriculum is available to support families with children age 3 through kindergarten (Parents as Teachers National Center, Inc. (2016), *Foundational curriculum; and* Parents as Teachers National Center, Inc. (2014), *Foundational 2 curriculum: 3 years through kindergarten)*. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, child care centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report (CEBC).

Parent-Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) PCIT is a program for three- to seven-year-old children 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. New York State's analysis of the children receiving preventive services show that approximately 26% meet the age criteria for PCIT and some of these would benefit from a structured mental health intervention.[119] New York State currently has four LDSS offering PCIT across the state but intends to build the infrastructure and expand the availability of PCIT over the next five years.

Evidence base justification

The Clearinghouse rated PCIT as a "well-supported" EBP following review of 21 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- Several different studies of PCIT have shown that participation improves child behavioral and emotional functioning in areas such as child compliance, internalizing and externalizing behaviors, and overall reduction in problematic behaviors.[120] [121] [122] [123] [124] [125] [126] [127]

Adult well-being outcomes

- PCIT has demonstrated efficacy in enhancing positive parenting behaviors such as using encouraging commands and praise, and effective child- and parent-led play skills and reducing laxness and the frequency of corporal punishment.[128] [129] At least one study showed that PCIT reduced parental stress, depression, and anxiety.[130]

Program delivery and fidelity monitoring
PCIT is delivered using a dyadic approach based on the following manual: Eyberg, S., & Funderburk, B. (2011) Parent-Child Interaction Therapy protocol: 2011. PCIT International, Inc. Parents are coached by a trained therapist in behavior-management and relationship skills. Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families can achieve mastery of the program content in 12 to 20 one-hour sessions. PCIT has a rigorous fidelity monitoring infrastructure with a prescribed clinical tool called the Treatment Integrity Checklist (TIC) (PCIT International).

Continuous Quality Improvement (CQI) Strategy: Overview
OCFS is committed to developing a comprehensive, multi-level CQI plan for monitoring and improving the state's chosen Family First preventive programs. For HFNY, which began operating in New York in 1995, a rich, state level infrastructure for supporting CQI and evaluation activities is already in place and will continue to operate under Family First. For the remaining 10 EBPs included in Wave 1, and any other EBPs to be added in Wave 2, OCFS will use the lessons learned from the HFNY central administration team and a national scan of CfE models, to create a new state-supported, collaborative infrastructure for conducting ongoing CQI. For all EBPs, distal outcomes (e.g., CPS contact and foster care admissions) and federal reporting requirements will be monitored and reported by OCFS. Details on both CQI models can be found below.

Continuous Quality Improvement (CQI) Strategy: HFNY

Collaborative Infrastructure
HFNY is a multi-site system, administered by a central administration that provides guidance and leadership to the network of HFNY programs. The partners in the HFNY Central Administration (CA) Team include OCFS, Prevent Child Abuse New York (PCANY), a voluntary agency provider, and the Center for Human Services Research, a university-based research center (CHSR). The CA team supports the statewide system in six functional areas: (1) policy, (2) training and staff development, (3) quality assurance, (4) technical assistance, (5) evaluation, and (6) administration. The CA team also provides the system with information and networking support, access to educational resources, and assistance with national model accreditation.

HFNY engages in a rigorous performance management system that includes performance standards, performance monitoring, reporting, quality improvement, and evaluation activities. All HFNY program sites are required to collect and enter client-level data into a Management Information System (MIS). The information is regularly reviewed by local programs and HFNY CA to assess whether the program is being implemented with fidelity to the model, to monitor program performance related to key outcomes, and to improve the quality of services provided. Quality improvement activities are ongoing and evaluation activities are developed and implemented as necessary to support program improvement efforts. Figure 10 summarizes these efforts.

Figure 10. The HFNY Performance Management System

CQI Activities and Assessment Tools

Monitoring of HFNY processes and outcomes is accomplished through a variety of methods to obtain the most complete picture of what each program is doing.

- Monitoring of Family Outcomes and Model Fidelity and Process Indicators: Family Outcomes and Model Fidelity and Process Indicators are calculated regularly for each program using MIS data. Family Outcomes include indicators such as immunizations, parent-child interaction, breastfeeding, etc. Programs are required to assess and report on each of these targets on a quarterly basis. Model Fidelity and Process Indicators focus primarily on the structural aspects of the program or areas in need of improvement (e.g., retention, training, prenatal enrollment, etc.). These indicators are provided to each site and to the CA twice a year for review.
- Annual Site Visits: The OCFS contract managers conduct annual site visits. They review data, policy and procedure, program reports, and files, and they also hold conversations with program staff to get more detailed information about the work.
- Quality Assurance and Technical Assistance: Sites receive quality assurance (QA) visits and technical assistance (TA) visits annually and may access additional supports as needed to address a specific need. QA and TA visits may be provided by any arm of HFNY CA (CHSR, OCFS, PCANY).
- HFA Best Practice Standards Accreditation: Every five years the national HFA model developers assess New York State's adherence to best practice standards at both the individual program level and the state multi-site system level. The evidence for these standards may include reports, reviews of policies and practices, and conversations with program staff, state system staff and families. OCFS contract managers monitor elements of the Best Practice Standards during each annual QA site visit.

HFNY utilizes a data-driven approach to improve program processes and outcomes. Much of this work focuses on utilizing data from the HFNY MIS to assess program performance, to determine

whether the program is being implemented with fidelity to the model, and, ultimately, to improve the quality of services offered to families. Informal mechanisms, such as feedback from program staff or families, also provide essential information about programs' strengths and challenges.

Work in this area is primarily focused on providing quick feedback to support improvements. Programmed reports serve an important role in this process. Reports can be run by program managers, supervisors, and staff to support their day-to-day work activities, as well as by CA partners to provide background information on performance prior to quality assurance or other site visits. More formal assessments of performance occur at the state level on a quarterly (Performance Targets), bi-annual (Performance Indicators), and annual basis (OCFS QA site visits).

Individual HFNY programs conduct their own quality assurance activities monthly and engage in at least one quality improvement activity each year. These quality assurance and quality improvement activities are reflected in the HFNY MIS.

Additionally, HFNY CA conducts regular analyses (annually) of the HFNY CA Quality Assurance and Technical Assistance systems to improve the efficacy of the supports provided to the multi-site system. Similarly, HFNY conducts biennial analyses of the cultural responsiveness and the overall effectiveness of the CA.

HFNY also conducts analyses of the HFA Core Trainings provided by HFNY multi-site system trainers. HFNY uses the Kirkpatrick Model of Training Evaluation to evaluate the effectiveness of the HFA Core Trainings provided to home visitors.

Collaboration and Communication

Program performance is discussed at each CA meeting (held every other month). Each arm of CA reports back on QA or TA activities provided since the last meeting. Program challenges and strengths are assessed, and performance is reviewed. Additional TA or QA activities are planned as necessary to support program improvement. Statewide patterns in performance (both challenges and strengths) are identified during these discussions and provide the foundation for the development of statewide continuous quality improvement (CQI) or evaluation activities.

Evaluation & Research

HFNY engages in a variety of activities to understand specific aspects of program practice or impacts that are not part of our standard performance measures but are deemed to be particularly important to our various stakeholders (e.g., OCFS, program sites, families, etc.). Our evaluation and research activities generally focus on issues of implementation, effectiveness, cost effectiveness, and impact.

Reporting

Data from the HFNY MIS are analyzed and interpreted per the specific needs of the audience and the time-period of interest. Reporting serves many different functions in HFNY, ranging from monthly quality assurance reports to assess completion of required forms at the program level, to triennial reports of program services and outcomes to the New York State Legislature.

Monthly: Program Level Quality Assurance and Workload Reports, Ticklers and Lists

Quarterly: Performance Targets
Biannually: Performance Indicators
Annually: Annual Service Review, QA Analysis, TA Analysis
Biennially: Central Administration Analysis, Cultural Responsiveness Analysis
Triennially: New York State Legislature Report

Dissemination of Findings

Results from the performance management and evaluation activities conducted by HFNY are used to make decisions about policy or practice changes and to improve program effectiveness. Dissemination can take many forms, from presentations at HFNY state system meetings to published manuscripts. Results are discussed at state system meetings to get feedback and additional context and to determine any policy or practice implications.

Continuous Quality Improvement (CQI) Strategy: Child Welfare and Community Prevention Tracks

Collaborative Infrastructure

OCFS is in the process of developing a collaborative infrastructure to support on-going monitoring, CQI and evaluation of preventive services, other than HFNY, included in the state's Family First Prevention Services Plan. As describe in Section 3, CQI and evaluation activities will be shared tasks with OCFS central and regional office staff, LDSSs, preventive providers, families and youth, sister state agencies, advocate groups, and representatives from local communities brought together through the establishment of regional collaboratives and the CfE.

CQI Activities and Assessment Tools

As shown in the tables below, proposed CQI activities are organized around our logic model and are designed to solicit a rich array of timely information on each EBP's ability to effectively meet the needs of New York State's children and families. Outlined questions will be asked across each EBP, with specific metrics tailored to the requirements (e.g., training/educational level) and targeted outcomes of each individual program. As highlighted in Appendix A, OCFS has identified the specific outcomes anticipated to result from each EBP and where models share a common target, the CfE will be used to encourage the use of the same measurement strategy/tool across programs to facilitate cross model comparisons and learning opportunities. Findings from each of these research areas will be shared regularly across the state, LDSSs and provider partners, with the CfE acting as a liaison to regional collaboratives to help disseminate and discuss how findings can be used to improve implementation efforts.

Implementation Monitoring/Target Population

Table 2: Implementation Monitoring: Research Questions	**Potential Data Sources**	**Proposed Leads**
1. What #/% of children with a newly authorized preventive case are referred, decline, waitlisted, and/or enrolled in a Family First Parenting, Mental Health or Substance Abuse EBP?	Administrative Data: Connections/FASP; LDSS Records	OCFS; CfE, LDSS

1a. Are there differences in above by race/ethnicity, age, or other child demographics? By county/region?		
2. What #/% of pregnant/parenting youth in foster care are referred, decline, waitlisted, and/or enrolled in in a Family First Parenting, Mental Health or Substance Abuse EBP?		
2a. Are there differences in above by race/ethnicity, age, or other child demographics? By county/region?		
3. How does available service array compare to needs of eligible children and families?	Focus Groups, Case File Reviews	CfE; Regional Collaboratives
4. Do LDSSs have the supports/resources necessary to successfully identify, match and serve FFPSA candidates?		

Monitoring of Family First implementation efforts will take place across all levels. At the state level, OCFS will utilize administrative data to produce county-specific reports that provide an aggregate overview of local service provision patterns based on information captured in each candidate's prevention plan. Anticipated analyses will focus on comparing the potential candidate pool (e.g., all children with a preventive services case) to those enrolled in Family First services through both a race/equity and needs lens. Once formed, the CfE will be available to provide technical assistance to LDSSs interested in developing metrics specific to local implementation questions. CfE staff will also interface with regional collaboratives to collect qualitative data on stakeholders' perceptions of implementation strengths and challenges.

Interventions/Fidelity Monitoring

Table 3: Fidelity Monitoring/Process Evaluation: Research Questions	**Potential Data Sources**	**Proposed Leads**
1. Is selected EBP model implemented according to approved manual/blueprint?	Site visits/observations, local provider case records reviews; model specific adherence measures; provider accreditation status	CfE; LDSS, Preventive Providers
2. Do program staff have required education, credentials, training?		
3. For EBPS with built-in adherence measures/CQI procedures, are required tools utilized? What are the documented outcomes?		

3. Is treatment provided in a trauma-informed manner?		
4. Are children and families receiving the expected dosage/length of program participation?		

As stated in Section 3, LDSSs will be required to submit the *Family First Preventive Services Attestation Form* for each selected EBP that confirms each program's adoption of a trauma informed approach, manual adherence, and ability to provide program-specific fidelity and proximal outcome measures upon request. Once on board, the CfE will work with LDSSs to develop strategies and tools for verifying these attestations, such as site observation and case review tools that incorporate elements specifically tailored to each of the state's chosen EBPs. OCFS may also fund the CfE to complete site visits and reviews across providers on a rotating basis, with different models selected for review each year, and/or may incorporate recommended measures into OCFS's existing process for sampling and reviewing preventive cases.

Proximal Outcomes

Table 4: Proximal Outcomes: Research Questions	**Potential Data Sources**	**Proposed Leads**
1. Child social functioning	Outcomes will vary by model. OCFS intends to integrate CANS-NY into CONNECTIONS; caseworkers will be expected to update at minimum every six months. CfE will generate set of recommended tools/instruments for capturing well-being outcomes and assist LDSSs in including measurable outcomes in contractual agreements with providers. CfE will explore creation of child/family level data base for capturing subset of proximal outcomes across EBP providers/counties.	OCFS, CfE
2. Child behavioral and emotional functioning		
3. Child cognitive functioning		
4. Child physical development and health		
5. Decreased child delinquent behavior		
6. Decreased child substance use		
7. Improved child educational achievement and attainment		
8. Parent/caregiver mental or emotional health		
9. Parent/caregiver physical health		
10. Decreased parent/caregiver substance use		
11. Family Protective Factors		
12. Family/Child Satisfaction	Surveys, Focus groups	CfE; Regional Collaboratives

Responsibility for monitoring proximal outcomes will likely be shared by both OCFS and the CfE. As shown in Appendix A, proximal or targeted outcomes specific to each proposed EBP have been identified and will be used to monitor the immediate impacts achieved by each program. Many targeted outcomes (e.g., child behavioral and emotional health) are captured in specific items included in the Child and Adolescent Needs and Strengths (CANS) inventory. OCFS is in the process of redesigning the FASP and anticipates adding the New York State version of the CANS, (aka CANS-NY) into the required fields. This change would enable OCFS to map CANS-NY items to many of the proximal outcomes listed for both children and their targeted caregivers. A new CANS-NY would be required with every new FASP (30 days, 90 days, six months post-case initiation, and every six months thereafter), enabling OCFS research staff to monitor change in a universal way across programs throughout service delivery. At the local level, the CfE will be asked to create an inventory of recommended instruments for measuring each targeted outcome that can be incorporated into local procurement contracts for all EBPs linked to that outcome and used to document child and caregiver functioning over time. Funding permitting, the CfE may also develop and manage a web-based data portal for gathering pre- and post-service measures for Family First EBPs. A similar model is currently used for capturing uniform outcome data from CBCAP-funded programs and has yielded valuable outcome data. The CfE will also serve as the primary hub for collecting and analyzing stakeholder feedback and will collaborate with regional collaboratives to develop protocols and schedules for regularly gathering family's and youth's perceptions of EBP services.

Distal/Long-Term Outcomes: Child Welfare, HFNY and Community Prevention Tracks

The effectiveness of all Family First EBPs, including HFNY, at preventing future contact with the child welfare system will be monitored by OCFS staff using administrative records.

Table 5: Distal Outcomes: Research Questions	**Potential Data Sources**	**Proposed Leads**
1. #/% children/families receiving a Family First EBP reported to CPS within 12/24 months of service authorization and prevention plan start date	Administrative Data/CONNECTIONS/CPS and Foster Care Records	OCFS
2. #/% children/families receiving EBP with a substantiated CPS allegation within 12/24 months of service authorization and prevention plan start date		
3. #/% children/families receiving EBP entering foster care within 12/24 months of service authorization and prevention plan start date		
4. Are there differences in above by race/ethnicity, age, or other child/family demographics? By county/region?		

OCFS is well positioned to gather and routinely share annual feedback on the long-term outcomes associated with EBP participation. OCFS already produces annual, LDSS-specific data on the number of children newly enrolled in preventive services each year and their subsequent contact with CPS and foster care services at 12- and 24-months post service authorization. Under Family First implementation, OCFS anticipates expanding these analyses to incorporate breakouts by

EBP service type, specific EBP model, and dosage to the extent practicable. Aggregate information is distributed to LDSSs and made available on the OCFS website. In addition, LDSSs can obtain child-level outcome files upon request and are encouraged to utilize these files to dive deeper into the potential drivers of success and/or foster care admission. For LDSSs interested in engaging in such a process, CfE staff will be available to provide technical assistance.

For children served on the HFNY track, the HFNY CA team will provide bi-annual, child-level data files to the OCFS research team, for inclusion in long-term outcome monitoring efforts. State staff will match enrolled children to the CONNECTIONS system and record any formal child welfare system involvement occurring after the child's prevention plan start date. To facilitate data sharing, OCFS is incorporating the creation of a data exchange between CONNECTIONS New York State CCWIS) and the HFNY MIS into its CCWIS plan. OCFS owns both systems but they do not currently interface with each other. Once built this interface will support the exchange of information regarding eligibility for verification purposes, enable the assignment of a shared, state-level child identifier across systems, and provide ready access to service and outcome data.

Evaluation Strategy: Wave 2 Programs

Once the CfE and regional collaboratives have been fully implemented, OCFS will utilize these partners to determine what, if any, additional Family First EBPs, would be beneficial to add the menu of programs included in Wave 2. OCFS, CfE and regional collaboratives will work together to develop a plan that prioritizes the adoption and evaluation of regionally desired programs. While programs have yet to be definitively identified, feedback from stakeholders has identified several potential promising/supported models (e.g., Child Parent Psychotherapy, Trauma-Focused Cognitive Behavior Therapy, High Fidelity Wrap, Triple P) as well as a general call for building evidence for locally endorsed programs. Resources to support evaluation activities will likely be drawn from multiple sources, including state and federal Title IV-E administrative funds, with CfE, LDSSs and program providers also contributing on the ground resources to recruitment, data collection and CQI activities. Once required evaluation designs are in place, OCFS will submit an amended Title IV-E Prevention Plan for additional EBP approval as needed.

Section 7: Child Welfare Workforce Training and Support (pre-print Section 5)

Pregnant and Parenting Youth in Foster Care and Child Welfare Services Track

OCFS believes that one key support provided to the child welfare workforce was the development, distribution, and implementation of its Child Welfare Practice Model. It is through the implementation of the Practice Model that caseworkers are fully engaging families in the planning of the supports and services that the caregivers have identified as needing to keep their children safely in their home. This partnership clearly supports that the family knows best what they need, and that the child welfare system is there to provide the services and supports.

Through the Practice Model the following core competencies for all child welfare workers were delineated as being fundamental to the implementation of child centered, family-focused practice. The Practice Model is embedded throughout New York State in our culture, policies, trainings, practices, and aligns with the practices and principles at the core of Family First.

- Strength-based family engagement
- Written and verbal communication
- Collaboration
- Interviewing skills
- Assessment
- Service planning
- Intervention and trauma-informed practice
- Critical thinking
- Cultural competence
- Implicit Bias
- Facilitation skills
- Transitional supports

These core competencies and the following six principles of partnership have been embedded into our child welfare workforce training and technical assistance and will support the implementation of Family First.

- Everyone desires respect
- Everyone needs to be heard
- Everyone has strengths
- Judgments can wait
- Partners share power
- Partnership is a process

Additionally, as described above, training and support for the delivery of MI will be provided to the workforce. MI will be embedded within the Child Welfare Practice Model as part of this Family First plan. As a central component of the Child Welfare Practice Model, MI will equip the child welfare workforce to deliver a discrete Family First evidence-based service throughout the life of the Family First engagement, as a key strategy to improve family functioning and reduce the factors associated with risk of foster care entry. MI will also be used as a Family First prevention service alongside other Family First EBPs to promote uptake and completion of those services and other prevention supports in the service array, when indicated. By integrating MI into the

practice model, the workforce will be supported to acquire and maintain new skills to engage and motivate families.

Other Supports to LDSSs and VAs

OCFS also provides technical assistance and supports to LDSSs and VAs through our regional offices. This includes holding regional quarterly meetings, informational webinars, conducting case reviews related to key practices, providing data packets on key child welfare outcomes, and support from state data leaders on interpreting and understanding their LDSS data.

Child Welfare Workforce Training

OCFS has the responsibility for providing and supporting training or approving training provided by others (NYC ACS Satterwhite Academy) to child welfare workers across the state. With the recent creation of the new state of the art Human Services Training Center (HSTC), caseworkers across the state now have access to a cutting-edge training site that includes ample classroom space and simulation training rooms that replicate environments commonly encountered by child welfare caseworkers, such as a home setting, an emergency room, a day care center, and a court room. The simulation training rooms, with two-way mirrors for observation and feedback, provide caseworkers opportunities to practice key core practice competencies.

The cornerstone of the state's training is the Child Welfare Foundations Program (CWFP) training for caseworkers. This robust training, as described in Appendix B, provides caseworkers with the knowledge and skills needed to work with children, youth, and families, and fully aligns with the skills caseworkers will need in implementing Family First. OCFS will continue to provide cross-training of child welfare professionals and domestic violence service providers to promote the safety of all family members. OCFS expects the HSTC will be able to accommodate all the necessary additional training for caseworkers under Family First across the state.

Training provided to LDSS staff through the CWFP, and subsequent trainings promotes the following key child welfare practices:

- Conducting risk and safety assessments
- Engaging families in the assessment of strengths, needs and the identification of appropriate services
- Developing child-specific prevention plans
- Identifying and determining candidate eligibility
- Providing MI as a Family First service to promote improved family functioning and reduce risk of foster care entry
- Linking families with appropriate, trauma-informed, evidence-based services to mitigate risk and promote family stability and well-being
- Providing oversight and evaluation of the continuing appropriateness of the services

Recognizing the complexities of working with families, OCFS is currently transforming our training curriculum to better prepare our workforce to meet the needs of children and families and enhance a caseworker's competencies and skill set. Some of these trainings include:

- Implicit bias training
- Child and Adolescent Needs and Strengths (CANS)
- Signs of Safety (child protective services)

- SCR reform
- Safe and Together (domestic violence)
- LGBTQIA+ for caseworkers and foster parents
- ICWA

Training of new caseworkers is held throughout the year, with in-service trainings being offered to existing staff as well.

Key Components of CWFP

Conducting Risk and Safety assessments

Caseworkers receive pre-service and in-services training on the use of structured decision-making tools to assess safety and risk. These same tools will be used to assess the safety and risk of all candidates for Family First prevention services. These tools are embedded in the FASP and updated throughout the life of the case.

Engaging Families in the Assessment of Strengths, Needs, and the Identification of Appropriate Services

As part of the pre-service training caseworkers are trained on how to engage families on assessing family strengths, needs and identification of appropriate services. The caseworker considers the family's view of the situation, what they see as their most pressing needs and concerns, what the family believes needs to happen for them to meet the needs of their children for safety, permanency, and well-being, and what does the family want from the LDSS or other services they need. Caseworkers are also trained on solution-focus casework practices for empowering families and how family empowerment is useful in creating lasting change. This key component of the CWFP training will be critical in engaging families in determining if a Family First evidence-based service will best meet their needs.

Developing Child Specific Prevention Plans

Through pre-service training, caseworkers are trained on valuing the family's perspective of their needs, willingness, and ability to change. They are taught how critical thinking skills are applied in child welfare to gather, analyze, and evaluate information. They are taught how the Assessment Analysis component within the service plan is used, in partnership with the family to inform the formation of the service plan, detailing the activities and services to be offered and completed to each the desired outcomes of keeping the child safely in the home. In-service training on the referral process for families to receive the Family First EBPs will be done by LDSSs.

Identifying Candidate Eligibility

OCFS has developed and implemented a training for caseworkers on determining candidacy eligibility for foster care. A similar training will be provided to caseworkers on determining candidacy for Family First Preventive Services. A checklist will guide caseworkers in determining whether a child meets the eligibility criteria as noted in Section 2 of this Prevention Plan. Child specific eligibility will be documented in New York State's CONNECTIONS system. As part of OCFS's monitoring and oversight responsibilities, case reviews will be conducted to assess accurate determinations and additional training will be provided if warranted.

Providing Motivational Interviewing as a Family First Service

OCFS is planning on providing training to LDSSs on MI. Through this training caseworkers will learn the skills to better engage families in identifying their needs and accepting those Family First evidence-based services to meet those needs.

Linking Families with Appropriate, Trauma-informed, Evidence-Based Services

As part of the in-service training (which is usually done by the LDSS), caseworkers will be trained on newly implemented Family First evidence-based services available in the LDSS, as well as how to make referrals for the new services. OCFS will look to develop promotional materials on each of the new Family First evidence- based services and provide these materials to LDSSs for use with their staff and with families. LDSSs will be informed by OCFS of new Family First evidence-based services as they become approved on the Clearinghouse and how to access these services will be discussed during meetings held through OCFS's regional offices.

Pre-service training focuses on how the caseworker, working with the family identifies which services are needed, and makes the necessary referrals. When necessary, the caseworker will help set up the necessary appointments and work on arranging for or providing transportation. Caseworkers maintain oversight responsibility for the case and are responsible for collaborating with the service provider to assure the services are occurring as noted in the service plan, and that the child and/or caregiver are benefitting from the services. During casework contacts with the family, the caseworker seeks input from the child and/or caregiver on the success of the service provision and if any changes are needed or additional services warranted.

Providing Oversight and Evaluation of the Continuing Appropriateness of Services

The current CWFP training prepares caseworkers on gathering sufficient information through casework contacts with the child, youth, caregiver, and service providers to inform successes and challenges in service provision as well as assessing the child's, youth, or caregiver's eligibility for preventive services, and if the case can be safely closed. This same process will occur in determining Family First prevention services.

As noted in Section 4, the role of caseworker and case manager is key to providing oversight and evaluation of the continuing appropriateness of the services provided to the child, youth, and caregiver. With the development and frequent review of the FASP, the caseworker and case manager are continuously assessing the effectiveness of services being provided to the family and making modifications as necessary.

Supervisory Training

Ongoing coaching and support of the competencies taught in CWFP are provided by supervisors in the LDSS. Supervision of caseworkers is core to their professional development. To support on the job learning, OCFS provides to supervisors of the participating trainees an overview of the CWFP that includes an outline of the domains, tasks, and resources the supervisor can use with the worker to facilitate the skills-based practice on the job. Also, included in these sessions are the expectations of and the role of the supervisor in supporting the development of trainees. The supervisor session also includes a demonstration of the Supervisor Tool Kit and the accompanying resources supervisors can use in their coaching of new workers. In this online resource, supervisors will have access to consistent learning aids, skill assessment matrixes, and solution focused questions to improve casework critical thinking. It is expected that these resources will also enhance the learning of supervisors while simultaneously benefitting new

workers and the rest of the unit. Some of these online resource tools will be adapted to help supervisors in supporting the implementation of Family First evidence-based services. This will include adaptations to the solution focused questions aimed at assessing caseworkers critical thinking in making referrals to new evidence-based Family First services.

Supporting Strong Trauma Informed Practice by Contracted Providers

It should be noted that most evidence-based services will be provided by preventive agencies that LDSSs contract with and the training of the preventive agency staff on each of the EBPs will not be done by OCFS, but rather by the model developers or experts. Through the contracting and oversight process, LDSSs will require all preventive agencies to have policies and procedures in place to ensure that the staff providing the evidence-based services are certified in providing the service to the fidelity of the model, and capable of providing the required data elements for each child to meet the CQI and data reporting requirements. Additionally, contracts will require that preventive agencies provide training on trauma-informed care to all agency staff and deliver services in a trauma-informed manner.

Healthy Families New York Track

HFNY providers are required by HFNY policy to conduct background checks at hiring on all staff and ensure that requirements for HFNY Core and Wraparound trainings are met. Similarly, HFNY home visitors are required to receive regular observations of home visits to ensure effective practices. All home visitors receive weekly individual supervision (1.5 to 2 hours per week) that includes administrative, clinical, and reflective components.

HFNY Core Training and Wraparound Topics

<table>
<tr><td colspan="4">Required training for all staff</td></tr>
<tr><td colspan="4">All staff receive orientation training regarding their role, HFA goals and home visiting philosophy, the site's relationship with community resources, child abuse and neglect indicators, confidentiality, ethical practice, boundaries, and staff safety prior to direct work with families.</td></tr>
<tr><td colspan="4">Screening and assessment tools (ASQ, ASQ-SE, PHQ-2, PHQ-9, HITS, Audit-C, CHEERS Check In) – prior to administration</td></tr>
<tr><td>Within 3 months</td><td>Within 6 months</td><td>Within 12 months</td><td>Ongoing training (annually)</td></tr>
<tr><td>• Infant care
• Sleeping
• Feeding/Breastfeeding
• Physical care of baby
• Crying and comforting baby</td><td>• Infant and child development
• Language and literacy
• Physical and emotional
• Identifying developmental and intellectual delays
• Brain development</td><td>• Child abuse and neglect
• Etiology of child abuse and neglect
• Working with survivors of abuse</td><td>• The staff and supervisors identify training needs and determine what additional training topics would be most beneficial in enhancing job performance, and training is offered</td></tr>
</table>

• Child health and safety • Home safety • Abusive head trauma/Shaken baby syndrome • SUIDS • Seeking medical care • Well-child visits and immunizations • Seeking appropriate child care • Car seat safety • Failure to thrive	• Supporting the parent-child relationship • Supporting attachment • Positive parenting strategies • Discipline • Parent-child interactions • Observing parent-child interactions • Strategies for working with difficult relationships	• Intimate Partner Violence (IPV) • Indicators of IPV • Dynamics of IPV • Intervention protocols • Strategies for working with families with IPV issues • Effects of IPV on children • Referral resources for IPV	• Annual child abuse training • Updates on child welfare policies, practices, trends in the community
• Maternal and family health • Family planning • Nutrition • Pre- and post-natal health care • Pre-natal and post-partum depression • Warning signs for when to call the doctor	• Staff-related issues • Stress and time management • Burnout prevention • Personal safety of staff • Ethics • Crisis intervention • Emergency protocols	• Substance abuse • Etiology for substance abuse • Culture of drug use • Strategies for working with families with substance abuse issues • Smoking cessation • Alcohol use/abuse • Fetal Alcohol Spectrum Disorders • Street drugs • Referral resources for substance abuse	• Annual Cultural Sensitivity Training
• HFNY Family Goal Plan training • Purpose and importance of the FGP process • Helping families identify strengths and needs • Supporting the family to set and achieve meaningful, measurable	• Mental health • Promotion of positive mental health • Behavioral signs of mental health issues • Depression • Strategies for working with families with	• Family issues • Life skills management • Engaging fathers • Multigenerational families • Teen parents • Relationships • HIV and AIDS	

goals, and build independence • Development of FGPs based on the FSSs' knowledge about the family (including the Parent Survey Assessment) as well as tools completed by the family • Practice writing family goals in ways that help families create measurable goals	mental health issues • Referral sources for mental health		
	• HFNY prenatal training • Fetal growth and development during each trimester • Warning signs: When to call the doctor • Activities to promote the parenting role during pregnancy and the parent child relationship during pregnancy • Preparing for baby • Promoting parental awareness of and sensitivity to the baby's needs with a connection to what the parent is doing (reflection)	• Role of culture in parenting • Working with diverse populations (age, religion, gender, sexuality, ethnicity, poverty, fathers, teens, gangs, disabilities, etc.) • Culture of poverty • Values clarification • Multi-Site System/Central Administration • Goals, objectives, policies and functions of Multi-Site System and Central Administration • All staff hired since January 1, 2018 are required to be oriented to this.	

Section 8: Preventive Services Caseloads (pre-print section 7)

Pregnant and Parenting Youth in Foster Care and Child Welfare Services Track

OCFS does not have the legal authority to set specific caseload standards. However, during the spring of 2006, the New York State Legislature directed OCFS to "contract with a national child welfare expert to review and recommend manageable workloads for child protective services, foster care and preventive services in order to allow sufficient time for each worker to meet all requirements and allow for comprehensive assessment of services for children and families."

In response to the legislative mandate, OCFS contracted with Walter R. McDonald & Associates, Inc. (WRMA), and its partner, the American Humane Association (AHA) to conduct the study and prepare a report for submission to the legislature. Through that study, OCFS did make case ratio recommendations for LDSSs and VAs to use when providing preventive services. The recommendation was a goal of 12-16 families per caseworker per month. It should be noted that this recommendation is in line with recommended caseload standards as prescribed by the Child Welfare League of America.

The preventive services caseload standard recommendation was shared with LDSSs and VAs via an Informational Letter, dated December 20, 2006, and will be maintained for Family First. A copy of it can be accessed on the link listed below.

https://ocfs.ny.gov/main/policies/external/ocfs_2006/INFs/06-OCFS-INF-08%20New%20York%20State%20Child%20Welfare%20Workload%20Study.pdf

OCFS has made available to LDSSs management reports through the Data Warehouse that provide each worker and their supervisor with a list of the cases assigned to the worker and aggregate counts. The caseload reports, along with other data reports are used by LDSSs to support their CQI efforts with the goal of maintaining caseloads at or below the recommendation. These caseload reports are also systematically reviewed by OCFS and are a core component of our oversight and monitoring of the LDSSs.

Additionally, through the support of OCFS's data leaders, LDSSs can consult with OCFS on accessing their data from the state's Data Warehouse, data analysis, and the development of plans for improvement.

Healthy Families New York Track

HFNY home visitors have limited caseloads with caseload size determined by the number of hours worked, the experience and skill level of the home visitor, the number of families served at each level, and any additional resource requirements of the family (e.g., families involved with child welfare, families with multiple births, etc.). Typical caseloads range between 10 to 20 families, with an average caseload size of 15 families. Caseloads are limited to ensure that home visitors have sufficient time and resources to deliver the HFNY model with fidelity and to serve families most effectively. Home visitor caseloads may not exceed a caseload weight of 30 for a 40-hour work week.

Section 9: Assurance on Prevention Program Reporting (pre-print 8, Attachment 1)

Appendix A

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Brief Strategic Family Therapy (BSFT); Manual: 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	**Well-Supported;** Mental Health, Substance Abuse, Parenting	BSFT is designed for 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.	• Improved child emotional and behavioral functioning • Decreased child delinquent behavior • Decreased child substance use • Decreased parent/caregiver substance use • Improved family functioning	BSFT was selected because it is appropriate for use with a wide range of children and families with a variety of needs, including adolescents with mental health needs. While there is not currently a large existing infrastructure for BSFT across the state, New York City plans to invest in this program under FFPSA, which is a significant proportion of children served within the state. We believe that this program will grow throughout the state over the next five years.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Familias Unidas; Manual: Estrada, Y., Pantin, H. M., Prado, G., Tapia, M. I., & Velazquez, M. R. (2020). UM-Familias Unidas Program: For the families of Hispanic adolescents: Intervention manual. University of Miami.	**Well-Supported;** Mental Health, Substance Abuse; Parenting	Familias Unidas is designed for Hispanic adolescents ages 12 to 16 and their families.	• Improved child behavioral and emotional functioning • Decreased child substance use • Improved positive parenting practices • Improved family functioning	Familias Unidas was selected for inclusion because it is appropriate for use with families with mental health, substance abuse and parenting needs. Additionally, it can be delivered in a variety of settings, including homes, community-based organizations, and schools. Finally, this program is culturally sensitive and specifically designed to serve Hispanic youth and their families, which is a sizeable population across New York State.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Family Check-Up (FCU); Manuals: Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019). Family Check-Up in early childhood: An Intervention Manual (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon	**Well-Supported;** Mental Health, Parenting	FCU is designed for families with children ages 2-17 who would like to improve parenting and family management skills.	• Improved child behavioral and emotional functioning • Improved child cognitive functions and abilities • Improved child educational achievement and attainment • Increased positive parenting practices • Improved parent/caregiver mental or emotional health	FCU was selected because of the large age range of the target population and because it is approved for mental health and parenting needs. FCU can also be delivered in a variety of settings, including homes, schools, and health offices, which is a characteristic that our LDSSs indicated was important.
Functional Family Therapy (FFT); Manual: Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association	**Well-Supported;** Mental Health	FFT is intended for 11- to 18-year-old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.	• Improved child behavioral and emotional functioning • Decreased child substance use • Decreased child delinquent behavior • Increased positive parenting practices • Improved family functioning	FFT was selected because it targets adolescent mental health and already has a large existing infrastructure in NYS, including existing programs in NYC. LDSSs cited cost as one of the main reasons that this program is not utilized more throughout the state, which makes it an ideal program to expand under FFPSA.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Healthy Families America (HFA); Manuals: Healthy Families America. (2018) Best Practice Standards. Prevent Child Abuse America. Healthy Families America. (2018). *State/Multi-Site System Central Administration Standards*. Prevent Child Abuse America.	**Well-Supported;** Parenting	Families are eligible to receive HFA services beginning prenatally or within three months of birth. Families may be referred by the local child welfare agency if the child is less than 24 months of age if the program has been approved to implement HFA's child welfare protocols. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences.	• Reduced child welfare administrative reports • Reduced self-reports of maltreatment • Lower scores on maltreatment risk assessments • Lower scores on medical indicators of maltreatment risk • Reduced out-of-home placements • Improved child social, behavioral, emotional, and cognitive functioning • Improved child physical development and health • Decreased child delinquent behavior • Improved child educational achievement and attainment • Improved positive parenting practices and family functioning • Improved parent/caregiver mental or emotional health • Decreased parent/caregiver substance use • Improved economic and housing stability	New York State already has a strong HFA program with 44 Healthy Families New York (HFNY) sites located across the state. The HFNY program has a documented history of success in achieving intended outcomes with the target population. This program was selected with plans to expand by adding the HFA child welfare protocol which will expand the eligible child population to those less than 24 months of age and adding additional HFNY sites.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Homebuilders; Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping Families Together: The HOMEBUILDERS Model*. New York, NY: Taylor Francis.	**Well-Supported;** Parenting	Homebuilders serves families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services.	• Reduced child welfare administrative reports • Reduced out-of-home placement • Improved child permanency outcomes • Improved parent/caregiver mental or emotional health • Improved economic and housing stability	Homebuilders was selected for inclusion because it covers a wide population of children and families for parenting services, which came out in the needs assessment as the largest need category.
Motivational Interviewing (MI); Manual: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping People Change* (3rd ed.). Guilford Press	**Well-Supported;** Substance Abuse	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas and will be provided if the child/family is receiving preventive services and therefore per New York State's definition a candidate for foster care. New York State is seeking approval to use MI across all three services areas: Substance Abuse, Mental Health and Parenting.	• Decreased child substance use • Increased parent/caregiver mental and emotional health • Decreased parent/caregiver substance use • Decreased parent/caregiver criminal behavior • Improved family functioning • Improved parent/caregiver physical health • Improved economic and housing stability	MI was selected in the prevention plan because of its potential for wide application with a variety of populations. New York State, along with New York City, plans to invest in MI for use throughout the preventive services array.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Multisystemic Therapy (MST); Manual: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (2nd ed.). Guilford Press.	**Well-Supported;** Mental Health, Substance Abuse	This program provides services to youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.	• Decreased out-of-home placement • Improved child behavioral and emotional functioning • Improved child social and cognitive functioning • Decreased child substance use • Decreased child delinquent behavior • Improved positive parenting practices • Improved parent/caregiver mental or emotional health • Improved family functioning	MST was selected in the prevention plan because it has already been widely used in New York State, including New York City, and there is a strong existing infrastructure that can be expanded to previously unserved counties. Additionally, MST specifically targets adolescents and their families with mental health and substance abuse needs, which came out in the regional meetings as a significant need.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Nurse-Family Partnership (NFP); Manual: *Nurse-Family Partnership (2020) Visit-to-visit guidelines.* New nurses also learn the visit-to-visit guidelines, which provide a consistent content and structure for each of the 64 planned home visits. (CEBC).	**Well-Supported;** Parenting	NFP is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members.	• Decreased child welfare administrative reports • Decreased maltreatment risk assessment • Decreased medical indicators of maltreatment risk • Improved child behavioral, emotional, and cognitive functioning • Improved child physical development and health • Improved educational achievement and attainment • Improved positive parenting practices and family functioning • Improved parent/caregiver mental, emotional, and physical health • Decreased parent/caregiver substance use • Improved economic and housing stability	NFP was selected in the prevention plan because it already has a strong existing infrastructure in New York State with successful outcomes.

Service, Description, and Version	Clearinghouse Rating and Categories	Target Population	Intended Outcomes/Proximal Outcomes Monitored for CQI	Rationale for Selection
Parent-Child Interaction Therapy (PCIT); Manual: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol*: 2011. PCIT International, Inc.	**Well-Supported;** Mental Health	PCIT is typically appropriate for families with children who are between 2 and 7 years old and experience emotional and behavioral problems that are frequent and intense.	• Improved child behavioral and emotional functioning • Improved child social functioning • Improved positive parenting practices • Improved parent/caregiver mental or emotional health • Improved family functioning	PCIT was selected because it is designed to meet for children with mental health and behavioral needs and their families. A number of counties within New York State have expressed an interest in contracting for this program.
Parents as Teachers (PAT); Manual: *PAT Foundational Curriculum* is Parents as Teachers National Center, Inc. (2016), *Foundational curriculum; and* Parents as Teachers National Center, Inc. (2014), *Foundational 2 curriculum: 3 years through kindergarten*	**Well-Supported;** Parenting	PAT offers services to new and expectant parents, lasting until kindergarten. Many PAT programs target families in possible high-risk environments.	• Decreased child welfare administrative reports • Decreased medical indicators of maltreatment risk • Decreased out-of-home placements • Improved social and cognitive functioning • Improved child physical development and health • Improved positive parenting practices and family functioning • Improved economic and housing stability	PAT was selected because it targets families with young children with a parenting need. While there is not currently a large infrastructure for PAT in the state, numerous counties expressed an interest in contracting for this program in the future.

Appendix B

This document lists the Learning Objectives (LO) for the following Child Welfare Foundations Program Domains:

- Strengths-Based Family Engagement
- Assessment
- Interviewing
- Intervention
- Service Planning

Each domain may have one or all of the following components:

- WBT: Synchronous web-based trainings
- Classroom
- Skills clinic
- On-the-Job Learning (OJL)

Strengths-Based Family Engagement Domain

Strengths-Based Family Engagement WBTs:

Introduction to Strengths-Based Practice:

- Define strengths-based practice
- Describe the categories of strengths
- Explain the role of strengths-based practice in promoting family engagement and a working partnership with families
- Appreciate the purpose and value of strengths-based practice in child welfare

Introduction to Family Engagement:

- Describe the benefits of family engagement
- Identify challenges to family engagement
- Articulate various strategies for engaging families at the practice level

Strengths-Based Family Engagement Classroom:

- Define the characteristics of the professional casework relationship
- describe the role of the professional casework relationship in family engagement
- Explain how caseworkers' and families' efforts to meet their individual needs might impact the development and maintenance of a professional casework relationship
- Associate the Principles of Partnership with the establishment and maintenance of a professional casework relationship with all family members
- Determine the roots of resistance in the professional casework relationship and how resistance can impact the casework process
- Recognize the influence of caseworkers' own needs, values, perceptions, and behaviors on their professional practice
- Appreciate that initiating and maintaining change can be a difficult process for individuals and families
- Articulate family strengths
- Define "solution-focused casework"

- Differentiate characteristics of and obstacles to effective communication
- Explain the functions and characteristics of attending behaviors
- Describe the elements of nonverbal communication
- Distinguish effective and ineffective questions
- Describe the purpose for and construction of open, closed, indirect, circular, solution-based, and scaling questions
- Develop strengths-based questions
- Define the components of reflecting
- Describe the qualities of effective feedback
- Explain how to give and receive feedback
- Describe the purpose of summarization
- Identify the purpose of confrontation
- Distinguish the types of confrontation that can be used in casework practice to resolve inconsistencies; maintain an honest relationship between themselves, families, and colleagues; and influence needed change
- Assess their comfort level using confrontation as a part of child welfare practice
- Confront facts and information, inconsistencies, capacity for action, strengths, and limitations
- Explain the strategic use of skills
- Appreciate the value of effective communication in building the relationships that are necessary to aid the casework process
- Distinguish solution-focused casework practices for empowering families
- Articulate the rights and responsibilities of parents involved in the child welfare system
- Explain how to invite and provide feedback with families
- Describe the requirement for locating parents and relatives
- Explain how to locate missing or absent parents and relatives
- Recognize the important role fathers play in the lives of their children
- Identify tools and strategies, including family maps, for widening the family circle
- Value family empowerment as necessary and useful in creating lasting change
- Identify the purposes of confidentiality

Strengths-Based Family Engagement Skills Clinic:

- Demonstrate the use of reflections of feeling and content
- Use strengths-based questions to engage family members in recognizing and utilizing their strengths in response to child welfare concerns
- Disclose information to families about their rights and responsibilities in the child welfare system
- Apply the system of confrontation to support families in making needed changes
- Create a family map
- Provide effective feedback
- Use summarization to share information succinctly

Strengths-Based Family Engagement OJL: (all LO are met in classroom and reinforced through OJL)

<u>Assessment Domain</u>

Assessment WBTs:

Overview of Assessment:
- Define assessment
- Explain the basic principles of all assessments
- List the different types of assessments that caseworkers may be required to conduct
- Identify various conceptual frameworks that support assessment and decision-making related to the child welfare outcomes

Child Development:
- Differentiate stages of child and youth development
- Describe the typical characteristics of each stage of child development
- Explain the domains of child development
- Value the myriad changes that take place (physical, emotional, mental, social, and spiritual) as humans grow and develop
- Understand the relationship between human needs, human behavior, and developmental stages
- Use the *Child Development Guide* when observing and interviewing children and families
- Determine whether there are discrepancies between the child's behavior and the development tasks or milestones associated with the child's stage of development
- Appreciate the importance of gathering information about a child's development from a variety of resources
- Offer suggestions for effective parenting based on the observed behaviors and developmental status of a child

Introducing Developmental Disabilities:
- Value the experiences of children and parents who are living with developmental disabilities in their families
- Define the term developmental disability
- Explore the connection between developmental disabilities and child abuse/maltreatment
- Differentiate developmental disability and developmental delay
- Explain the federal and New York State definitions of developmental disability

Introduction to Documentation:
- Understand the purpose of documentation in child welfare work
- Identify the components of the Uniform Case Report
- Describe what information child welfare workers must document
- Write frequent, effective, and contemporaneous progress notes
- Value how effective case documentation supports the achievement of child welfare outcomes

Assessment Classroom:

- Distinguish maltreatment from abuse
- Describe the concept of minimum degree of care
- Explain how poverty may contribute to maltreatment but is not equated with maltreatment
- Identify possible physical, behavioral, and environmental indicators of child maltreatment
- Articulate how parent/caretaker action or inaction can result in abuse or maltreatment
- Identify legal criteria for determining whether a situation constitutes maltreatment or abuse
- Value the challenge of deciding whether children's needs are being met to the standard of minimum degree of care
- Apply critical-thinking skills to determine whether indicators of abuse or maltreatment exist
- Assess for physical and behavioral indicators of child abuse

- Define safety
- Describe the safety factors and safety criteria
- Determine the presence or absence of safety factors in case situations
- Decide whether safety factors and safety criteria interact to create a situation of immediate/impending danger of serious harm
- Comprehend the importance of assessing safety throughout the life of a case during all casework contacts and review of case-related documents
- Make safety decisions, in concert with the family whenever possible
- Describe the safety-planning process
- Assess the presence of any safety issues that are not a result of parent actions or inactions and identify ways to support the family in addressing those concerns
- Value the use of critical-thinking skills to assess child safety
- Define risk and risk assessment
- Explain the purposes of risk assessment in child welfare work
- Describe the risk-assessment process
- Identify dynamics, behaviors, and experiences of families as well as conditions that contribute to risk and the strengths that offset risk
- Determine what information is known about a family's presenting situation as well as information that still needs to be gathered to inform decision-making
- Identify appropriate sources from which to gather information to develop a fuller understanding of a family's situation
- Distinguish safety from risk
- Identify the conceptual frameworks related to assessment in child welfare practice
- Determine what information is needed from the family and collaterals to assess child and parental strengths and needs related to safety, permanency, and well-being
- Identify which collaterals for each unique family are the best resources to assist the caseworker and family in assessing child and parental strengths and needs related to safety, permanency, and well-being
- Demonstrate the use of interpersonal skills to gather information from parents, children, and collaterals in a trauma-informed manner
- Explain how applying critical-thinking skills yields more accurate assessments while gathering information from families and all relevant collaterals
- Value the role of a comprehensive assessment in identifying what children and families need and in laying the foundation for a plan of action to meet those needs and make changes
- Determine a child's developmental strengths and needs while considering the effects of trauma on the child
- Assess family dynamics, family strengths (including cultural strengths), needs, underlying conditions, and contributing factors leading to or sustaining behaviors in families that affect achievement of child welfare outcomes

Assessment Skills Clinic:

- Value the role of a comprehensive assessment in revealing the level of child and family functioning
- Employ the strategic use of interpersonal skills to assess the family's system; their family and cultural strengths; underlying conditions, including needs; and contributing factors leading to or sustaining behaviors that create safety or risk concerns
- Apply critical-thinking skills to identify appropriate collaterals for information gathering and assessment

- Document information related to the assessment of child safety
- Synthesize assessment information to begin deciding what needs to change to achieve child welfare outcomes
- Utilize the *Child Development Guide* to assess the children's developmental needs and strengths, including any effects of trauma

Assessment OJL: (*Learning objectives solely achieved through OJL)*

- Document a safety assessment and safety decision in CONNECTIONS in a timely, clear, and thorough manner
- Record a progress note thoroughly, concretely, and contemporaneously

Interviewing Domain:

Interviewing WBTs:

Overview of Motivational Interviewing:
- Some background on the theories behind MI
- An overview of the Stages of Change and what they might look like
- An idea of what Resistance and Ambivalence to Change might look like and some strategies to overcome them
- Ways to recognize Change Talk, and how to encourage it
- Some Engagement Strategies to use during MI

Interviewing Classroom:

- Define *interviewing* in the context of child welfare work
- Describe the steps of the Child Welfare Interview Protocol
- Identify caseworker tasks related to each step of the Child Welfare Interview Protocol
- Value the use of an interview protocol to engage families in the information-gathering and decision-making processes
- Explain the principles of motivational interviewing
- Articulate the strategic use of skills in a motivational interview
- Explain how motivational interviewing supports change in families
- Identify age-appropriate expectations for children who are being interviewed
- Explain how to modify interviewing skills and techniques for use with children
- Describe how to interview/observe an infant and a toddler
- Describe how to use the Three Houses tool to interview children
- Associate being trauma-informed with considering the needs of children and parents with trauma histories, during an interview
- Describe gatekeeping skills
- Value the personal information that families share during a child welfare interview
- Conduct the four stages of the interview protocol with a family using a trauma-informed approach
- Employ the Principles of Partnership and interpersonal skills as well as strategies such as motivational interviewing with a family
- Develop mutual understanding with the family on the conditions and behaviors that are placing children at risk of harm and/or compromising their development
- Provide effective feedback

Interviewing Skills Clinic:

- Use the stages of the Child Welfare Interview Protocol as a tool to structure a child welfare interview
- Appreciate the importance of using interpersonal skills to interview children who have been harmed or are at risk of being harmed
- Employ interpersonal skills to enable children of varying ages and developmental abilities to talk about their experiences
- Value the use of an interview protocol to engage families in the information-gathering and decision-making processes
- Demonstrate gatekeeping skills to meet the needs of all family members engaged in an interview
- Engage children, parents, and the family in an interview for the purpose of assessing child safety

Interviewing OJL: (all LO are met in classroom and reinforced through OJL)

Intervention Domain:

Intervention WBT:

Understanding the Legal System:

- Identify the impact of the legal system on child welfare practice in New York State
- Describe the role of various professionals within the legal system
- Explain how to effectively utilize family court intervention, when necessary, to promote child safety, permanency, and well-being
- Describe the constitutional rights of parents

Intervention Classroom:

- Explain a caseworker's responsibility to balance protection of children within a family while empowering the family in the casework process
- Describe the safety planning process
- List various controlling interventions that protect children
- Explain the rationale for engaging the family in the assessment of safety
- Appreciate the importance of informed and appropriate safety decision-making to protect children from danger and risk of harm
- Decide when it is necessary to use the court system to support the safety, permanency, or well-being of the child
- Determine which, if any, safety factors present in a family scenario place any child in immediate or impending danger of serious harm
- Exhibit respect for the uniqueness of the family and the differences between individuals
- Use confrontation, various types of questions, and management of authority to identify gaps and inconsistencies in information and gather sufficient information to assess safety and make a safety decision
- Apply critical-thinking skills to the safety-assessment decision-making process
- Determine which, if any, safety factors present in a family scenario place any child in immediate or impending danger of serious harm
- Make a safety decision based on case circumstances
- Use effective strategies for communicating to a parent the need for a safety plan
- Engage the parent in making decisions about child safety and in creating and implementing a safety plan to protect children

- Apply critical-thinking skills to the safety-assessment decision-making process
- Determine which, if any, safety factors present in a family scenario place any child in immediate or impending danger of serious harm
- Make a safety decision based on case circumstances
- Document a safety assessment and safety plan, including parent and caretaker actions and caseworker actions that must be taken to fully protect children, as well as other necessary controlling interventions

Intervention Skills Clinic:

- Demonstrate the Principles of Partnership
- Employ summarization, confrontation, various types of questions, and other interpersonal skills to mutually arrive at a safety decision with families
- Apply critical-thinking skills to the safety decision-making and safety planning processes
- Utilize effective strategies for communicating to a parent the need for a safety plan
- Engage the parent in creating and implementing a safety plan that will protect the children from immediate or impending danger of serious harm and, when possible, preserve the family
- Document a safety plan

Intervention OJL: (*Learning objectives solely achieved through OJL)*

- Identify whom to seek guidance from when confronted with ethical dilemmas, conflicts, or uncertainty about confidentiality protocols
- Record a progress note thoroughly, concretely, and contemporaneously

Service Planning Domain

Service Planning Classroom:

- Identify how family strengths can be utilized to support achievement of outcomes
- Explain the links between parent involvement, empowerment, and effective service plan outcomes
- Explain how the assessment analysis is used, in partnership with the family, to inform the formulation of a service plan
- Describe the relationship between change and service planning
- Value the family's perspective of their needs, willingness, and ability to create change
- Explain the purpose of a statement of problem/concern
- Identify the criteria of effective statements of problem/concern
- Define outcomes as they relate to New York State service plans
- Describe activities in the service plan
- Identify the criteria for effective outcomes and activities

Service Planning OJL: (all LO are met in classroom and reinforced through OJL)

Integrative Skills Clinic:

- Apply critical-thinking skills to gather, analyze, and evaluate information related to indicators of abuse and maltreatment, assessing safety, and making a safety decision
- Demonstrate an awareness of personal bias and the importance of being able to manage personal bias when working with children and families
- Operationalize the Principles of Partnership with families and members of the families' support networks

- Demonstrate the interpersonal skills of attending, reflection, concreteness, confrontation, and summarization to engage family members during child welfare interviews
- Utilize strengths-based questions and motivational interviewing techniques with families to develop or maintain a safety plan
- Identify appropriate stakeholders when planning, coordinating, and conducting assessments
- Employ solution-focused and trauma-informed techniques to facilitate discussions with individuals, families, and groups to develop and work toward reasonable shared goals that align with child welfare outcomes assess safety on an ongoing basis

ADMINISTRATION FOR
CHILDREN & FAMILIES
330 C Street, S.W., Washington, D.C. 20201 | www.acf.hhs.gov

August 2, 2022

Sheila J. Poole
Commissioner
New York State Office of Children & Family Services
52 Washington Street
Rensselaer, New York 12144

Dear Commissioner Sheila Poole:

Thank you for submitting New York State's title IV-E prevention program five-year plan for fiscal years (FYs) 2022-2026. The title IV-E prevention program is authorized under the Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115-123, which amended titles IV-B and IV-E of the Social Security Act (the Act). The FFPSA is an important tool that, if utilized effectively, will help move child welfare in the United States to a more preventative system that works to strengthen families and reduce unnecessary family disruption.

Plan Approval

New York State submitted a title IV-E prevention program five-year plan to the Children's Bureau (CB) Regional Office on February 25, 2022. We completed a review of this submission and identified areas requiring further documentation to support compliance with state plan requirements. On July 29, 2022, New York State provided a final revised plan that addressed all the identified provisions.

We are pleased to notify you that we reviewed New York State's title IV-E prevention program five-year plan submitted July 29, 2022 and find it to be in compliance with applicable federal statutory and regulatory requirements. New York's title IV-E prevention program five-year plan for FYs 2022-2026 is approved as outlined below. An amendment must be submitted any time there is a substantial change to information in the approved plan.

The effective date of New York's plan is January 1, 2022. Please maintain this approval letter as a part of the final, approved plan.

Approval of Services under the Title IV-E Prevention Program
Pursuant to sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, only services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse or a state's designation based on an independent systematic review approved for transitional payments as part of the title IV-E prevention program five-year plan by the U.S. Department of Health and Human Services (HHS) are

permitted. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse). The title IV-E agency must also provide an assurance each program or service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and that the state will use information gleaned from the continuous monitoring efforts to refine and improve practices. CB has approved the following allowable programs and services as part of New York's plan:

Brief Strategic Family Therapy (BSFT)
Familias Unidas
Family Check-up
Functional Family Therapy (FFT)
Healthy Families America (HFA)
Homebuilders
Motivational Interviewing (MI)
Multisystemic Therapy (MST)
Nurse Family Partnership (NFP)
Parent Child Interaction Therapy (PCIT)
Parents as Teachers (PAT)

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in an approved public assistance cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative costs in accordance with applicable regulations at §95.509(a)(3).

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

Brief Strategic Family Therapy (BSFT)
Familias Unidas
Family Check-up
Functional Family Therapy (FFT)
Healthy Families America (HFA)
Homebuilders
Motivational Interviewing (MI)

Multisystemic Therapy (MST)
Nurse Family Partnership (NFP)
Parent Child Interaction Therapy (PCIT)
Parents as Teachers (PAT)

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

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

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

For any question or concerns you may have, please contact, Shari Brown, Child Welfare Regional Program Manager in Region 2, at (215) 861-4030 or by e-mail at shari.brown@acf.hhs.gov. You also may contact Shaniece Edwards, Children and Families Program Specialist, at (202) 838-3328 or by e-mail at Shaniece.Edwards@acf.hhs.gov.
We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,

Aysha E. Schomburg, Esq.
Associate Commissioner
Children's Bureau

Enclosures: Plan Submisssion Certification, Program Reporting Assurance, Requests for Waiver of Evaluation Requirements, Assurance of Trauma Informed Delivery

cc: Shari Brown, Child Welfare Regional Program Manager, CB, Region 2
Shaniece Edwards, Children and Families Program Specialist, CB, Region 2
Lisa Ghartey-Ogundimu, Deputy Commissioner, NYS OCFS
Gail Geohagen-Pratt, Associate Commissioner, NYS OCFS
Renee Hallock, Associate Commissioner, NYS OCFS
Janice Davis Caldwell, Director of Family Protection & Resilience Portfolio, ACF Office of Grants Management
George Barnwell, Grants Management Officer, Eastern Region

Endnotes

[1] Child Welfare Information Gateway (n.d.). *Framework for prevention of child maltreatment.* https://www.childwelfare.gov/topics/preventing/overview/framework/#two

[2] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021). *Child Maltreatment 2019*. https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment.

[3] NYS Monitoring and Analysis Profiles: Children Admitted to Foster Care by District, 1995-2020; available at https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp

[4] Ibid

[5] Preventive Services Data Report for NYS, CY 2020 available at https://ocfs.ny.gov/main/sppd/docs/ffpsa-regional-data/psar/2020-NYS-Statewide-Preventive-Services-Annual-Report.pdf

[6] NYS Monitoring and Analysis Profiles: Aggregate CPS Reports Received by District, 1995-2020; available at https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp

[7] NYS Monitoring and Analysis Profiles: Children Admitted to Foster Care by District, 1995-2020; available at https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp

[8] NYS Monitoring and Analysis Profiles: Aggregate CPS Reports Received by District, 1995-2020; available at https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp

NYS Monitoring and Analysis Profiles: Children Admitted to Foster Care by District, 1995-2020; available at https://ocfs.ny.gov/main/reports/maps/defaultAgg.asp

[9] Preventive Service Authorizations and Subsequent Foster Care Admissions, available at https://ocfs.ny.gov/reports/custody/fc-biannual/Preventive-Service-Authorization.pdf

[10] 2020 Monitoring and Analysis Profiles with Selected Trend Data: 2016-2020; available at https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20State.pdf

[11] 2020 Monitoring and Analysis Profiles with Selected Trend Data: 2016-2020; available at https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20State.pdf

[12] Child Welfare Information Gateway. (2018). *Working with kinship caregivers.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/kinship.pdf

[13] Richmond-Crum, M., Joyner, C., Fogerty, S., Ellis, M. L., & Saul, J. (2013). Applying a public health approach: The role of State health departments in preventing maltreatment and fatalities of children. *Child Welfare, 92(2)*, 99–118.

[14] FRIENDS National Center for Community-Based Child Abuse Prevention (CBCAP) and the New York State Office of Children and Family Services. (n.d.). *2021 New York Evaluation Brief.* https://friendsnrc.org/wp-content/uploads/2021/03/2021-New-York-Evaluation-Brief-FINAL.pdf

[15] Raissian, K.M. & Bullinger, L.R. (2017). *Money matters: Does the minimum wage affect child maltreatment rates? Children and Youth Services Review, Vol. 72*, pp. 60-70, https://doi.org/10.1016/j.childyouth.2016.09.033.

[16] Ibid

[17] Kim, H., Wildeman, C., Jonson-Reid, M., & Drake, B. (2017). Lifetime prevalence of investigating child maltreatment among US children. *American Journal of Public Health*, *107(2)*, 274-280.

[18] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children Youth and Families, Children's Bureau. (2020). *The AFCARS Report*. https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf

[19]. National Kids Count. (2021). *Child population by race | KIDS COUNT Data Center*. Datacenter.Kidscount.Org. https://datacenter.kidscount.org/data/tables/103-child-population-by-race#detailed/1/any/false/1729,37,871,870,573,869,36,868,867,133/68,69,67,12,70,66,71,72/423,424

[20] Conrad-Hiebner, A., & Byram, E. (2020). The temporal impact of economic insecurity on child maltreatment: A systematic review. *Trauma, Violence, & Abuse*, *21*(1), 157-178.

[21] Courtney, M. E., Dworsky, A., Piliavin, I., & Zinn, A. (2005). Involvement of TANF applicant families with child welfare services. Social Service Review. *79*(1):119-157

[22] U.S. Department of Health & Human Services, Administration for Children and Families, & Administration on Children, Youth and Families Children's Bureau. (2021). *Child Maltreatment 2019*. Www.Acf.Hhs.Gov. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf

[23] Family and Child Well-being System: Economic & Concrete Supports as a Core Component. (2021, June). www.chapinhall.org. https://www.chapinhall.org/wp-content/uploads/Economic-Supports-deck.pdf

[24] Cancian, M., Yang, M.-Y., & Slack, K. S. (2013). The Effect of Additional Child Support Income on the Risk of Child Maltreatment. *Social Service Review*, *87*(3), 417–437. https://doi.org/10.1086/671929

[25] Rostad, W. L., Rogers, T. M., & Chaffin, M. J. (2017). The influence of concrete support on child welfare program engagement, progress, and recurrence. *Child and Youth Services Review*, *72:* 26-33.

[26] Duncan, G. J., Morris, P. A., & Rodrigues, C. (2011). Does money really matter? Estimating impacts of family income on young children's achievement with data from random-assignment experiments. *Developmental Psychology*, *47*(5), 1263–1279. https://doi.org/10.1037/a0023875

[27] Wilson, S. J., Price, C., Kerns, S. E. U., Dastrup, S. R., & Brown, S. R. (2019, April). *Handbook of Standards and Procedures*. Www.Preventionservices.Abtsites.Com.

[28] State Fact Sheets: Trends in State TANF-to-Poverty Ratios. (2020, November 30). Center on Budget and Policy Priorities. https://www.cbpp.org/research/family-income-support/state-fact-sheets-trends-in-state-tanf-to-poverty-ratios

[29] Ibid

[30] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[31] Ibid

[32] 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

[33] Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015b). 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

[34] 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

[35] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[36] Perrino, T., Pantin, H., Huang, S., Brincks, A., Brown, C. H., & Prado, G. (2016). Reducing the risk of internalizing symptoms among high-risk Hispanic youth through a family intervention: A randomized controlled trial. *Family Process, 55(1),* 91-106. https://doi.org/10.1111/famp.12132

[37] Prado, G., Cordova, D., Huang, S., Estrada, Y., Rosen, A., Bacio, G. A., Leon Jimenez, G., Pantin, H., Brown, C. H., Velazquez, M.-R., Villamar, J., Freitas, D., Tapia, M. I., & McCollister, K. (2012). The efficacy of Familias Unidas on drug and alcohol outcomes for Hispanic delinquent youth: Main effects and interaction effects by parental stress and social support. *Drug and Alcohol Dependence, 125 (Suppl 1)*, S18-S25. https://doi.org/10.1016/j.drugalcdep.2012.06.011

[38] Molleda, L., Estrada, Y., Lee, T. K., Poma, S., Quevedo Teran, A. M., Tamayo, C. C., Bahamon, M., Tapia, M. I., Velazquez, M. R., Pantin, H., & Prado, G. (2017). Short-term effects on family communication and adolescent conduct problems: Familias Unidas in Ecuador. *Prevention Science, 18, 783-792*. https://doi.org/10.1007/s11121-016-0744-2

[39] Estrada, Y., Lee, T. K., Huang, S., Tapia, M. I., Velazquez, M.-R., Martinez, M. J., Pantin, H., Ocasio, M. A., Vidot, D. C., Molleda, L., Villamar, J., Stepanenko, B. A., Brown, C. H., & Prado, G. (2017). Parent-centered prevention of risky behaviors among hispanic youths in Florida. *American Journal of Public Health, 107(4),* 607-613. https://doi.org/10.2105/AJPH.2017.303653

[40] Lee, T. K., Estrada, Y., Soares, M. H., Sanchez Ahumada, M., Correa Molina, M., Bahamon, M. M., & Prado, G. (2019). Efficacy of a family-based intervention on parent-adolescent discrepancies in positive parenting and

substance use among Hispanic Youth. *Journal of Adolescent Health, 64(4),* 494-501. https://doi.org/10.1016/j.jadohealth.2018.10.002

[41] Pantin, H., Prado, G., Lopez, B., Huang, S., Tapia, M. I., Schwartz, S. J., Sabillon, E., Brown, C. H., & Branchini, J. (2009). A randomized controlled trial of Familias Unidas for Hispanic Adolescents with behavior problems. *Psychosomatic Medicine, 71(9),* 987-995. https://doi.org/10.1097/PSY.0b013e3181bb2913

[42] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[43] Hiscock, H., Gulenc, A., Ukoumunne, O. C., Gold, L., Bayer, J., Shaw, D., Le, H., & Wake, M. (2018). Preventing preschool mental health problems: Population-based cluster randomized controlled trial. *Journal of Developmental and Behavioral Pediatrics, 39(1),* 55-65. https://doi.org/10.1097/DBP.0000000000000502

[44] Lunkenheimer, E. S., Dishion, T. J., Shaw, D. S., Connell, A. M., Gardner, F., Wilson, M. N., & Skuban, E. M. (2008). Collateral benefits of the Family Check-Up on early childhood school readiness: Indirect effects of parents' positive behavior support. *Developmental Psychology, 44(6),* 1737-1752. https://doi.org/10.1037/a0013858

[45] Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-Year effects of the Family Check-Up in early childhood. *Journal of Consulting and Clinical Psychology, 74(1),* 1-9. https://doi.org/10.1037/0022-006x.74.1.1

[46] Shelleby, E. C., Shaw, D. S., Cheong, J., Chang, H., Gardner, F., Dishion, T. J., & Wilson, M. N. (2012). Behavioral control in at-risk toddlers: The influence of the Family Check-Up. *Journal of Clinical Child and Adolescent Psychology, 41(3*), 288-301. http://dx.doi.org/10.1080/15374416.2012.664814

[47] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[48] 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.

[49] 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

[50] 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

[51] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[52] New York State Child Fatality Report, 2010-2014. Available at: https://ocfs.ny.gov/main/reports/2010-2014-Child-Fatality-Report.pdf

[53] 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

[54] Mitchell-Herzfeld, S., Izzo, C., Greene, R., Lee, E., & Lowenfels, A. (2005). *Evaluation of healthy families New York (HFNY): First year program impacts*. New York State Office of Children and Family Services. https://www.healthyfamiliesnewyork.org/Research/Publications/HFNYEvalReport.pdf

[55] 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.

[56] Duggan, A., Caldera, D. L., Rodriguez, K., Burrell, L. D., & Shea, S. K. (2005*). Evaluation of the Healthy Families Alaska Program: Final report*. Johns Hopkins University. http://www.hss.state.ak.us/ocs/Publications/JohnsHopkins_HealthyFamilies.pdf

[57] DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., Layne, C. & Greene, R. (2010). *A randomized trial of Healthy Families New York (HFNY): Does home visiting prevent child maltreatment*. New York State Office of Children and Family Services. https://www.ojp.gov/pdffiles1/nij/grants/232945.pdf

[58] Kirkland, K., & Mitchell-Herzfeld, S. (2012). *Evaluating the effectiveness of home visiting services in promoting children's adjustment in school.* New York State Office of Children and Family Services. https://www.healthyfamiliesnewyork.org/Research/Publications/EvaluatingEffectivenessofHomeVisitingServicesinPromotingChildrensAjustmenttoSchool.pdf

[59] 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

[60] 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

[61] 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

[62] 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.

[63] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[64] 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.

[65] 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

[66] Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). Evaluation of Family Preservation and Reunification Programs: Final Report. U.S. *Department of Health and Human Services* https://files.eric.ed.gov/fulltext/ED480610.pdf

[67] Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91-111.

[68] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021

[69] 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

[70] 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

[71] 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.

[72] 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.

[73] 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

[74] 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

[75] Kay, E., Vascott, D., Hocking, A. et al. (2016). Motivational interviewing in general dental practice: A review of the evidence. *British Dental Journal 221*, 785–791; Colvara, B. C., Faustino-Silva, D. D., Meyer, E., Hugo, F. N., Hilgert, J. B., & Celeste, R. K. (2018). Motivational Interviewing in Preventing Early Childhood Caries in Primary Healthcare: A Community-based Randomized Cluster Trial. The Journal of pediatrics, 201, 190–195. https://doi.org/10.1016/j.jpeds.2018.05.016

[76] Song, D., Xu, T. Z., & Sun, Q. H. (2014). Effect of motivational interviewing on self-management in patients with type 2 diabetes mellitus: a meta-analysis. *International Journal of Nursing Sciences, 1(3),* 291-297; Chen, S. M., Creedy, D., Lin, H. S., &

Wollin, J. (2012). Effects of motivational interviewing intervention on self-management, psychological and glycemic outcomes in type 2 diabetes: a randomized controlled trial. *International journal of nursing studies, 49(6),* 637-644.

[77] Martins, R. K., & McNeil, D. W. (2009). Review of motivational interviewing in promoting health behaviors. *Clinical psychology review, 29(4),* 283-293.

[78] Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence and victims, 23(5),* 558-570.

[79] Snyder, E. H., Lawrence, C. N., Weatherholt, T. N., & Nagy, P. (2012). The benefits of motivational interviewing and coaching for improving the practice of comprehensive family assessments in child welfare. *Child Welfare, 91(5),* 9.

[80] Doran,N., Hohman, M., & Koutsenok, I. (2013). Motivational interviewing training in juvenile corrections: A comparison of outside experts and internal trainers. Legal and *Criminological Psychology*, *18(2),* 262. https://doi-org.avoserv2.library.fordham.edu/10.1111/j.2044-8333.2011.02036.x

[81] Forrester, D., McCambridge, J., Waissbein, C., Emlyn-Jones, R., & Rollnick, S. (2008). Child risk and parental resistance: Can motivational interviewing improve the practice of child and family social workers in working with parental alcohol misuse?. *British Journal of Social Work, 38(7),* 1302-1319.

[82] Higgins, M. M. (2015). *Application of Motivational Interviewing Techniques in Child Welfare Practice.* Minneapolis, MN; Center for Advanced Studies in Child Welfare, University of Minnesota.

[83] Shah, A., Jeffries, S., Cheatham, L. P., Hasenbein, W., Creel, M., Nelson-Gardell, D., & White-Chapman, N. (2019). Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society, 100(1), 52–67. https://doi.org/10.1177/1044389418803455

[84] Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *Journal of consulting and clinical psychology, 71(5),* 843.

[85] Hettema, J., Steele, J., & Miller, W. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91-111.

[86] Vasilaki, E. I., Hosier, S. G., & Cox, W. M. (2006). The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism, 41(3),* 328-335.

[87] Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on social work practice, 20(2),* 137-160.

[88] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[89] 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

[90] 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.

[91] 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.

[92] 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.

[93] 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

[94] 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.

[95] 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

[96] 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

[97] 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

[98] 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.

[99] 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

[100] 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

[101] 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.

[102] 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

[103] 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.

[104] 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.

[105] 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

[106] Borduin et al (1995); Fonagy et al. (2018).

[107] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.

[108] 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

[109] 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

[110] 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.

[111] 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

[112] 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

[113] Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: a randomized, controlled trial. *Pediatrics, 110(3),* 486-496.
[114] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.
[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.
[116] 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
[117] 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*.
[118] Wagner, M. M., & Clayton, S. L. (1999). The Parents as Teachers program: Results from two demonstrations. The Future of Children, 9(1), 91-115.
[119] Bureau of Research, Evaluation and Performance Analytics. FFPSA Needs Assessment. Internal Analysis. Data as of 6/2/2021.
[120] 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
[121] 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.
[122] 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
[123] 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.
[124] 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.
[125] 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.
[126] 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.
[127] 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.
[128] Bagner et al. (2007); Bagner et al. (2010); Bjorseth et al. (2016); Leung et al. (2015): Leung et al. (2017); Thomas & Zimmer-Gembeck (2011).
[129] 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
[130] Leung et al. (2017), Leung et al. (2015).