

**Kentucky Cabinet for  
Health and Family  
Services, Department for  
Community Based  
Services**

**TITLE IV-E  
PREVENTION  
PLAN**



KENTUCKY  
Cabinet *for Health and*  
Family Services

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## Introduction

The Kentucky Department for Community Based Services (DCBS), within the Cabinet for Health and Family Services (CHFS), is leading the State's child welfare system through a radical transformation focused on the achievement of three priority outcomes:

1. Safely reduce the number of children entering out of home care
2. Improve timeliness to appropriate permanency
3. Reduce staff caseloads

Committed to making the Kentucky child welfare system a national model, DCBS was joined in these efforts by then Governor Bevin, First Lady Bevin, and a wide range of private and community agency partners, child welfare advocates, and key stakeholders. State legislators expressed their investment in transforming Kentucky's child welfare system through the 2018 passage of House Bill 1, landmark state child welfare legislation creating a statewide Child Welfare Oversight & Advisory Committee; increased attention to child welfare caseloads; improved quality and access to family preservation services for vulnerable families; increased supports for kin caregivers; streamlined processes for prospective foster and adoptive parents; and the requirement for the State to implement performance based contracting with its provider network.



Key accomplishments thus far in the transformation include a statewide commitment to establishing a culture of safety within the child welfare system; a recently codified Foster Child Bill of Rights; expanded supports for relative caregivers and the addition of a fictive kin placement option; a substantial increase in the number of licensed family foster homes; an increase in the number of children exiting to reunification and adoption; and a decrease in the number of children exiting care without achieving permanency.

DCBS and its partners are equally committed to early implementation of the Family First Prevention Services Act (Family First). Family First's key provisions around prevention and ensuring appropriate placements reflect Kentucky's commitment to reorienting around prevention and family preservation and utilizing foster care as an intervention of last resort. When foster care is needed, DCBS and its network of private partners are invested in creating a

placement array that best meets the needs of children and youth, includes relative and fictive kin placements whenever possible, and reserves residential care as a temporary placement only for youth with a clinical need to receive the treatment available in these settings.

Kentucky's child welfare transformation is building off successes and lessons learned within its title IV-E waiver demonstration, focused on addressing substance use disorders among child-welfare involved families through the implementation of Sobriety Treatment and Recovery Teams (START) and Kentucky Strengthening Ties and Empowering Parents (K-STEP). Both of these programs represent important dimensions of Kentucky's preventive service array and have demonstrated considerable success in helping families overcome substance use disorders and safely care for their children. Substance use disorders, especially opioid use, are a significant problem in Kentucky and represent a major contributing factor for many families' child welfare system involvement.

Building upon the successes of the title IV-E waiver demonstration, Kentucky is dedicated to developing a full continuum of preventive services that addresses not only substance abuse prevention and treatment, but the full array of needs present in families with children at risk of entering foster care. This effort represents a substantial increase in the State's investment in and commitment to preventive services. In State Fiscal Year 2019, DCBS spent \$476,176,222 on out of home care costs relative to its \$18,443,365 investment in preventive services designed to mitigate risk factors, promote child safety, and avoid the need for foster care (Sammons, 2019). DCBS believes that this misalignment of resources between preventive and foster care services is not in the best interest of families and does not reflect the values of the Kentucky child welfare system. DCBS intends to build on the programs that are successfully strengthening families and preventing children from entering out of home care. In SFY19 96% of the children served through in-home services under the Family Preservation Program (FPP) remained safely in their home at the end of the intervention. Family First will be used as a lever to increase the capacity of the Evidence-based Programs (EBP) utilized by FPP.

To inform the development of this Title IV-E Prevention Plan and the selection of proposed interventions, DCBS conducted a rigorous analysis of its child welfare data to understand the reasons children were entering care, risk factors for maltreatment present in families, and their geographic representation across the State and its nine regions. Complementing this analysis of the child welfare population, DCBS engaged its provider network in a readiness assessment for Family First to better understand, among many factors, the array of evidence-based interventions in place around the State, provider capacity to serve children and families, and capacity to monitor fidelity and assess program impact on outcomes. DCBS will leverage these survey findings in partnership with state sister agencies and the provider community to inform

the development of a full continuum of preventive services in Kentucky and expand access to services for families at risk of experiencing child maltreatment. Please see Appendix A for DCBS' overarching theory of change for its Title IV-E Prevention Plan.

### ***Stakeholder involvement in Title IV-E Prevention Plan development***

DCBS welcomed the opportunity to create the Title IV-E Prevention Plan in partnership with its stakeholders. Efforts related to the development of the provider readiness assessment and analysis of the data represent just one mechanism in which stakeholders contributed to the development of this Title IV-E Prevention Plan. DCBS has created a broad governance structure to guide its transformation, inclusive of a steering committee, a stakeholder advisory committee, and nine transformation workgroups. Family First implementation represents a fundamental part of the broader child welfare transformation, and the Preventive Supports transformation workgroup was specifically charged with developing the Title IV-E Prevention Plan. Workgroup members represent a broad cross-section of internal and external stakeholders, including sister agency partners and child welfare advocates. DCBS leadership and staff also integrated the readiness assessment results and preventive planning into a number of stakeholder meetings. Specifically, DCBS partnered with Kentucky Youth Advocates and other stakeholders to host nine regional forums specifically focused on Family First education, engagement, and planning.

In addition, DCBS has ensured that legal and judicial partners have been meaningfully included in the development of the Title IV-E Prevention Plan. The Family First Judicial Workgroup, chaired by Supreme Court Justice Debra Lambert, was developed and began meeting in March 2019. DCBS and the Administrative Office of the Courts (AOC) have worked jointly to prepare the courts and DCBS staff for Family First implementation. An overview of Family First and the provider readiness assessment results were presented to the workgroup comprised of judges and AOC staff. Judges provided integral input to inform the provision of prevention services throughout the State. Additionally, DCBS and AOC are working collaboratively to present on Family First at the annual judicial college with district and circuit court staff. AOC staff were part of the planning and agenda for the Family First regional forums. Additionally, AOC presented on the impact of Family First to the courts during the forums. There was a substantial presence from the courts at each forum. In one region, the courts canceled all activities that day to attend and participate in the forum. AOC has engaged DCBS in the changes to the family court rules to reflect Family First requirements.

All in all, DCBS engaged with 1150 stakeholders across the State in Family First planning and Prevention Plan development. In addition to talking with stakeholders specifically about the

opportunities inherent in Family First and their interconnection with the larger transformation, the child welfare data and provider readiness assessment findings were also presented and discussed. Stakeholder input was gathered and ultimately informed the development of this submission. DCBS is very grateful for the amount of time and efforts its partners invested in the development of this Title IV-E Prevention Plan and the child welfare transformation more broadly.

## **Section 1: Eligibility and Candidacy Definition**

There are two populations eligible for Family First preventive services: 1) Children who are determined to be candidates for foster care, and 2) Pregnant and parenting youth.

DCBS used calendar year (CY) 2018 data to get a sense of the size and scope of children already known to DCBS that are likely to meet the candidacy criteria. Through that analysis, Kentucky identified 27,522 children who could potentially be identified as candidates under Family First. Potential Family First candidates include children involved in a substantiated or family in need of services finding. This identifies children at risk for future or immediate removal from their home. See Appendix B for further detail about the CY2018 candidacy estimates and the pathways by which candidates and their families are involved with the Kentucky child welfare system. Further detail is available in Appendix C, which includes a geographical representation of the potential candidates as represented in the CY2018 data. Children newly coming to the attention of the department will be assessed for candidacy eligibility using the criteria and processes identified in the subsequent subsection of this report.

Of the potential Family First candidate pool identified in the CY2018 data, data suggest only one in five is receiving contracted in-home service intervention highlighting an opportunity to expand service provision. Regionally, the Eastern Mountain Service Region utilizes more in-home services than any other region in the State. When considering the rate of youth entering out of home care in comparison to the rate of youth utilizing in-home services, regional service needs have been identified in Kentucky's eight remaining regions, with the greatest need occurring in the Cumberland, Jefferson, Northern Bluegrass, Salt River Trail, and Southern Bluegrass Service Regions.

### ***Identifying candidates***

A child meets the criteria for foster care candidacy when they are determined to be at imminent risk for removal, but the identified risk and safety issues can be mitigated through the provision of child-specific preventive services, including one or more of the evidence-based



interventions designed to build parents' skills and protective capacities, treat mental health issues, and/or prevent or treat substance abuse.

The majority of the candidates for foster care who will receive prevention services as described in the Act will be identified during the investigative phase utilizing the agency's existing safety and risk assessment procedures. These children and families will come to the attention of the agency via a referral that meets acceptance criteria for investigation. Additional candidates for foster care will include children who have recently exited foster care whose families are in need of services to prevent further maltreatment and re-entry into care, with identification of these children occurring prior to reunification. Children identified as candidates for foster care will meet one of the following criteria:

1. A victim of substantiated maltreatment in which existing safety and risk factors can be mitigated by provision of in-home services;
2. A child for whom maltreatment has not been substantiated, however, moderate to severe risk factors for maltreatment are present and services are necessary to prevent maltreatment and subsequent entry into foster care;
3. A child who has recently been reunified for whom services to the family will mitigate identified risks, preventing further maltreatment and re-entry into care; or

### ***Identifying pregnant and parenting youth***

The agency will identify pregnant and parenting youth in out of home care through a variety of methods. Enhancements to the state's CCWIS system are currently underway to assist with identification of this population. These enhancements will be in place by October 1, 2019.

There are multiple opportunities in routine casework for Social Service Workers (SSWs) to identify pregnant or parenting youth through routine casework including monthly home visits, ongoing assessments, supervisory consultation, case planning meetings, as well as youth transition planning meetings. Additionally, the enhancements to the data system will allow reports to be generated on a monthly basis to embed a quality assurance measure regarding referral and provision of prevention services as appropriate to this population.

The SSW will determine foster care candidacy in consultation with the candidate's family and the Family Services Office Supervisor. During the investigation, SSWs will identify high-risk behaviors of family members or case circumstances, which will result in removal of the child from the home, immediately or in the future, if intervention does not occur. A comprehensive prevention strategy for each identified candidate or pregnant/parenting youth will be

developed in partnership with the candidate's family. SSWs will utilize the EBP Selection document to identify appropriate Evidence-based Practice interventions to mitigate the specific, identified risk(s) for the family. EBPs will be selected methodically, reviewing the appropriate target population and outcomes associated with each EBP.

Please see Section 2, Title IV-E Prevention Services, for the referral process for services and child specific prevention plans.

## **Section 2: Title IV-E Prevention Services**

To inform the development of this Title IV-E Prevention Plan and the selection of proposed interventions, DCBS conducted a rigorous analysis of its child welfare data to understand the reasons children were entering care, risk factors for maltreatment present in families, and their geographic representation across the State and its nine regions. DCBS analysts specifically examined the prevalence of needs that could be addressed through preventive programs contained within the three categories of allowable services under Family First: 1) In-home, skill-based parenting programs; 2) Substance abuse treatment and prevention; and 3) Mental health treatment. The prevalence of those needs was then geographically mapped across Kentucky's nine regions and discussed with the relevant Transformation workgroups who helped make meaning of those findings.

### ***Substance abuse treatment and prevention***

Substance abuse disorders, by youth or caretaker, are prevalent among Kentucky's child welfare population and represents a specific area DCBS intends to target through this prevention plan. Kentucky has existing infrastructure to address a portion of the needs of this population with the Title IV-E Waiver programs, START, and KSTEP. When considering Kentucky's potential Family First candidates, 17,471 children are involved in a case with substance abuse as an identified risk factor within the family. The more vulnerable population of Family First potential candidates under 10 years of age, with substance abuse as a case characteristic, totals 12,164 in the CY2018 cross-section. Sixty-six percent of the potential candidates are under 10 years old. When considering potential Family First candidates, under 10 years of age, with a case characteristic of substance abuse in comparison to the current population being served by in-home services, Kentucky has identified regions where a gap exists in service delivery. The need for additional substance abuse interventions is indicated for one county in the Eastern Mountain service region, four counties in the Northeastern Service Region, six counties in the Northern Bluegrass service region, four counties in the Cumberland service region, three counties in the Salt River Trail Service Region, three counties in the

Southern Bluegrass Region, seven counties in the Lakes Service Region, and one county in the Two Rivers Service Region. See Appendix D, Potential Family First Candidates with Substance Abuse as a Case Characteristic map, and Appendix E, Potential Family First Candidates Under 10 with Substance Abuse as a Case Characteristic map.

### ***Addressing family violence***

The presence of family violence is another significant risk factor for entry into foster within Kentucky's child welfare population. While family violence is not one of the three service categories supported within the Family First legislation, recent State data indicate that 12,280 families experience challenges with family violence. Therefore, addressing family violence remains a key priority area for DCBS as efforts continue to expand and align the State's service array with the needs of the families served by the agency. Some examples of current services and interventions include EBPs that embed strategies to address underlying contributing factors of violence within the family. Additionally, there are 5,369 potential Family First candidates known to DCBS with co-occurring substance abuse and family violence as case characteristics (See Appendix F). Existing programs have the ability to serve both needs.

### ***Provider readiness assessment***

Complementing this analysis of the child welfare population, DCBS engaged its provider network in a readiness assessment for Family First. DCBS conducted a comprehensive survey of providers, targeting agencies both with a current contract with DCBS as well as providers who could potentially contract with DCBS following implementation of Family First. Sister agency partners (e.g. Medicaid, Department for Behavioral Health Developmental and Intellectual Disabilities) were consulted to identify additional providers to which DCBS should outreach beyond their current network.

The provider assessment addressed both the preventive and congregate care provisions of Family First and contained a number of domains: Trauma-Informed Care, Implementation of Evidence-Based Practice, Federal Qualified Residential Treatment Program Criteria, and Continuous Quality Improvement and Data Use. With regard to evidence-based practices, the survey specifically asked which interventions provider agencies were implementing and assessed their current capacity to monitor model fidelity and impact on intended outcomes. In addition, the survey inquired about provider capacity, specifically the number of children and families that could be served within each program on an annual basis.

Leveraging the Transformation workgroups and stakeholders as key decision-making partners, DCBS examined the target population analyses alongside the provider readiness assessment findings and developed Kentucky’s proposed list of interventions for the Title IV-E prevention plan. The proposed list was informed by Kentucky’s waiver demonstration efforts as well as the EBPs currently reviewed and rated by the Title IV-E Prevention Services Clearinghouse.

### ***Proposed Evidence-Based Preventive Services***

The information detailed below represents the array of preventive programs that best aligns with the needs of children and families involved with Kentucky’s child welfare system.

Table 1 represents the evidence-based programs that are currently rated by the Title IV-E Prevention Services Clearinghouse as having achieved a promising or well-supported rating. These services align with the needs of Kentucky’s child welfare population and we submit them to the Children’s Bureau for approval.

Table 1: DCBS proposed prevention programs with a Title IV-E Prevention Services Clearinghouse rating

<b>Prevention Program categories</b>	<b>DCBS Proposed Evidence-Based Programs</b>	<b>Title IV-E Prevention services Clearing-House Rating</b>
<b>Mental health treatment</b>	<b>Functional Family Therapy</b>	<b>Well-Supported</b>
	<b>Multisystemic Therapy</b>	<b>Well-Supported</b>
	<b>Parent-Child Interaction Therapy</b>	<b>Well-Supported</b>
	<b>Intensive Care Coordination Using High-Fidelity Wraparound</b>	<b>Promising</b>
	<b>Trauma Focused-Cognitive Behavioral Therapy</b>	<b>Promising</b>
<b>Substance abuse treatment and prevention</b>	<b>Motivational Interviewing</b>	<b>Well-Supported</b>
	<b>Multisystemic Therapy</b>	<b>Well-Supported</b>
	<b>Sobriety Treatment and Recovery Teams</b>	<b>Promising</b>
<b>In-home, skill-based parenting programs</b>	<b>Homebuilders</b>	<b>Well-Supported</b>
	<b>Intercept®</b>	<b>Well-Supported</b>
	<b>Sobriety Treatment and Recovery Teams</b>	<b>Supported</b>

This next set of interventions, Table 2, are not currently rated by the Title IV-E Prevention Services Clearinghouse, but they have been rated by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare and they align with the needs of Kentucky’s child welfare population. Many represent important elements of Kentucky’s service array that would

be beneficial to expand. In particular, the Commonwealth has invested significant effort in implementing and evaluating START to the benefit of Kentucky children and families. Ideally, Kentucky seeks the Children’s Bureau’s approval of these preventive programs as well, and the State is exploring mechanisms for conducting independent systematic reviews per federal guidance. Given the significant level of effort and capacity such an independent review requires, Kentucky respectfully requests that the Title IV-E Prevention Services Clearinghouse review and rate these programs as soon as possible so that DCBS can meet the needs of families in a timely manner.

Table 2: DCBS proposed prevention programs rated by the CEBC

<b>Prevention Program categories</b>	<b>DCBS Proposed Evidence-Based Programs</b>	<b>CEBC Rating</b>
<b>Mental health treatment</b>	<b>Motivational Interviewing for motivation and Engagement programs</b>	<b>Well-Supported</b>
<b>In-home, skill-based parenting programs</b>	<b>Motivational Interviewing for Motivation and Engagement Programs</b>	<b>Well-Supported</b>

Please see Appendix G for a summary of all proposed evidence-based interventions, including the evidence ratings, a brief description of the program and target population, intended outcomes, and the evaluation strategy.

### ***Brief narrative summary of evidence-based programs***

#### **➤ Functional Family Therapy**

Functional Family Therapy (FFT) is a family intervention program for youth experiencing dysfunction with disruptive, externalizing problems. The target population is 11-18 year olds with serious concerns such as conduct disorder, violent acting-out and substance abuse. FFT is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will utilize FFT manual, Family Therapy for Adolescent Behavioral Problems, and will not use any adaptations to the FFT model (Alexander, Waldron, Robbins, & Need, 2013).

#### **➤ High Fidelity Wraparound**

The High-Fidelity Wraparound model exists as an acknowledgement that young people with severe emotional and behavioral disturbances often receive services from multiple care providers, (e.g., psychotherapists, psychiatrists, applied behavioral analysts, etc.). When such

multidimensional care is provided for complex needs, the presence of so many providers creates the tendency towards poor coordination of services. High-Fidelity Wraparound aims to address this tendency through a regimented approach to care-coordination as a means of ensuring that children's needs are attended to in a synchronized manner.

According to the CEBC, the High-Fidelity Wraparound intervention model is described as:

"... a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.), who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal Wraparound process is no longer needed".

The values associated with Wraparound require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent, and community-based. Additionally, the Wraparound process should increase the "natural support" available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. Finally, Wraparound should be "strengths-based", helping the child and family recognize, utilize, and build talents, assets, and positive capacities." (California Evidence Based Clearinghouse for Child Welfare)

The California Evidence-Based Clearinghouse for Child Welfare categorizes High-Fidelity Wraparound as a *promising* intervention; with a *high* relevance to child welfare practice. While there have been many studies that have tested its efficacy with children and youth, comparably fewer have tested whether it is effective in child welfare/child protection settings (Browne, Puente-Duran, Shlonsky, Thabane, & Verticchio, 2016). This is especially true in terms of questions related to whether High-Fidelity Wraparound is an effective means of preventing out of home care placements. High-Fidelity Wraparound is currently utilized by prevention providers in Kentucky to improve child and family functioning, and to decrease out-of-home care (OOHC) placements. High-Fidelity Wraparound is used in 4.5 service regions, approximately half of the Commonwealth, with a success rate of 96% of maintaining children in their homes at closure for CY19. Kentucky utilizes High-Fidelity Wraparound in these regions of

the state in conjunction with the Wraparound manual, *The Wraparound Implementation Guide: A Handbook for Administrators and Managers*, including children with mental health or behavioral needs and with families with needs outside of this scope (Miles & Brown, 2011). This consists of Wraparound utilization as a “planning process to help children and families realize a life reflecting their hopes and dreams” and bringing “people together from different parts of the family’s life” to “coordinate activities and move closer together in view of the family situation” (Miles & Brown, 2011). In a recent meta-analysis, preliminary evidence was also found suggesting Wraparound “may help programs to achieve better outcomes for youths who have not been well served by traditional mental health services, particularly youths of color” (Olsen et al., 2021). This is relevant as Kentucky pursues service provision supporting equity and ensuring further disproportionality does not result from Family First implementation. Kentucky will not use any adaptations to the model. Kentucky is requesting approval to claim transitional payments for High Fidelity Wraparound due to it not currently being reviewed or rated by the Title IV-E Prevention Services Clearinghouse. Public Consulting Group (PCG) completed an independent systematic review of High Fidelity Wraparound to support this request, proposing a promising designation. The independent systematic review is attached.

➤ **Homebuilders®**

Homebuilders is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports, or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.

Homebuilders is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will utilize the Homebuilders manual, *Keeping families together: The Homebuilders® Model*, and will not use any adaptations to the Homebuilders® Model (Kinney, Haapala & Booth, 1991).

➤ **Intercept®**

Intercept®, developed by Youth Villages, is an integrated, intensive, in-home parenting skills program used to safely prevent children from entering OOHC; or reunify children with family as quickly as possible if a period of OOHC is necessary (this includes, but is not limited to foster care, residential treatment, or group home settings). Intercept® is appropriate for children ranging in age from birth to 18, with services lasting four to nine months depending on referral type. Family intervention specialists work with both the child and caregivers to address issues impacting the stability of the family, meeting an average of three times weekly in the home or community (depending on family need) and providing 24-hour on-call crisis support. Trauma-informed care is provided.

Youth Villages' Intercept® uses an integrative process combining evidence-based, clinical content and consultation with a program expert to address referral issues and presenting concerns for children and families.

Family intervention specialists have small caseloads of four to six families. They work in all areas that surround the child - family, school, peer group, community/neighborhood -providing evidence-based and research-informed interventions. Following a detailed case conceptualization process, family intervention specialists collaborate with other providers, schools, case workers, courts, and other community supports to formulate individualized treatment plans. The treatment plans are reviewed bi-weekly with licensed program experts, assuring fidelity with the program model. Family intervention specialists receive extensive, ongoing training from the licensed program experts to continually improve their skills. Progress with children and families is measured through ongoing assessment and review. The comprehensive treatment approach includes advocating extensively to access community resources and linking to long-term, ongoing support.

The target population for Intercept® are children and youth at risk of entering foster care or other out-of-home placements or returning home following an out-of-home placement. Intercept® provides services to children and youth from birth to age 18 who (1) have emotional and/or behavioral problems, and/or (2) have experienced abuse and/or neglect.

Intercept® family intervention specialists meet the child and family an average of three times weekly in the home and community for four to nine months. Intercept® services to prevent children from entering out-of-home placements average four to six months. Intercept® services to reunite children with their family after a period of foster care or out-of-home placement average six to nine months.



Intercept® includes multiple components to assess and address the impact of trauma, both acute and chronic, throughout the program. This begins with a risk trauma assessment that considers both child/youth and family trauma exposure history. The assessment is completed at admission, and then updated monthly and after serious incidents throughout treatment. Assessments include a trauma-sensitive component, which focuses on current and past trauma episodes, but also considers both protective and restorative factors. Multiple trauma-informed intervention strategies are utilized throughout treatment to address traumatic stress and related mental health issues. Staff training materials include how trauma can impact brain development and related strategies to address these issues. Staff development tools focus on secondary traumatic stress symptoms and interventions for individuals who may be affected through their work with children/youth and families.

Intercept® is rated Well-Supported in the Title IV-E Prevention Services Clearinghouse. Kentucky will utilize the Intercept® manual, Youth Villages clinical protocols treatment manual, and will not use any adaptations to the Intercept Model® (Goldsmith, 2007).

➤ **Motivational Interviewing**

Motivational Interviewing (MI) is a client-centered, directive method designed to enhance a person's internal motivation to change, to reinforce this motivation, and develop a plan to achieve change. MI is rated Well-Supported with Medium child welfare relevance, for both substance abuse treatment and for use with motivation and engagement programs, per the CEBC, and it is rated Well-Supported for substance abuse treatment and prevention, per the Title IV-E Prevention Services Clearinghouse.

MI will be used in Kentucky consistent with the Miller & Rollnick (2012) MI manual, Motivational interviewing: Helping people change, and in four ways to produce positive outcomes for families:

1. To increase motivation to change for adult caregivers and adolescents with substance use disorder;
2. To enhance familial collaboration with child welfare workers;
3. To enhance familial collaboration with prevention service providers; and
4. To enhance EBP intervention completion and success.

The target population for MI includes caregivers of children referred to the child welfare system and adolescents, in enhancing their motivation to change as relevant to substance use disorder. The target population for MI use for adolescents with substance use disorder is identified for use by contracted providers and will be identified for use by child welfare workers. For child welfare worker and provider's use of MI with adolescents with substance use disorder, youth

are identified by the child welfare worker as being at risk of entry or re-entry into foster care due to risk factors related to substance use disorder, for use within the category of substance use prevention and treatment. For contracted provider use of MI, candidacy establishment and EBP selection for risk mitigation is identified on the Family First Prevention Services Referral form. Once the family's referral is accepted by the contracted provider, the provider completes clinical assessments, such as the Substance Abuse Subtle Screening Inventory (SASSI), and if MI is warranted the contracted provider enters a start date for MI for use in the category of substance use prevention and treatment in Kentucky's CCWIS system. For child welfare worker use of MI, risk factors for adolescent substance use disorder and use of MI to mitigate foster care, are identified through child welfare worker assessment in investigative or ongoing functions, as documented in the investigative Assessment and Documentation Tool and in service recordings.

The broadened target population for expansion of MI across all three categories, substance abuse prevention and treatment, mental health treatment, and in-home skill-based parenting, includes all children meeting the criteria for a candidate for foster care in Kentucky. Within the category of substance abuse prevention and treatment, eligible children includes children at risk of entry or re-entry into foster care with parental substance use as the risk factor mitigated by MI use. Within the category of Mental Health Prevention and/or Treatment Services, eligible children includes children at risk of entry or re-entry into foster care with parental mental health needs as the risk factor mitigated by MI use, to increase service uptake and completion of necessary EBPs to meet parental mental health needs. Within the category of In-home, Skill-Based Parenting Programs, eligible children includes children at risk of entry or re-entry into foster care with caregiver parenting needs as the risk factor mitigated by MI use, to increase service uptake and completion of necessary EBPs to meeting parenting capacity needs.

For adults receiving MI at the point of investigation, the state will ensure MI is being provided within the allowable categories. For child welfare worker and provider's use of MI with adults with substance use disorder, children are identified by the child welfare worker as being at risk of entry or re-entry into foster care due to risk factors related to substance use disorder, for use within the category of substance use prevention and treatment. For contracted provider use of MI, candidacy establishment and EBP selection for risk mitigation is identified on the Family First Prevention Services Referral form. Once the family's referral is accepted by the contracted provider, the provider completes clinical assessments, such as the Substance Abuse Subtle Screening Inventory (SASSI), and if MI is warranted the contracted provider enters a start date for MI for use in the category of substance use prevention and treatment in Kentucky's CCWIS system. For child welfare worker use of MI, risk factors for adolescent substance use disorder and use of MI to mitigate foster care, are identified through child welfare worker assessment in

investigative or ongoing functions, as documented in the investigative Assessment and Documentation Tool and in service recordings.

For child welfare worker and provider's use of MI with mental health prevention and treatment, children are identified by the child welfare worker as being at risk of entry or re-entry into foster care due to risk factors related to mental health needs, for use within the category of mental health prevention and treatment. For contracted provider use of MI within mental health prevention and treatment, candidacy establishment and EBP selection for risk migration is identified on the Family First Prevention Services Referral form. Once the family's referral is accepted by the contracted provider, the provider completes appropriate mental health assessments, identifies MI is warranted to enhance uptake, participation, and the completion of other EBPs. For child welfare worker use of MI, risk factors for adult mental health and use of MI to mitigate foster care, are identified through child welfare worker assessment in investigative or ongoing functions, as documented in the investigative Assessment and Documentation Tool (ADT) and service recordings. For child welfare worker and provider's use of MI with in-home parent skills training, children are identified by the child welfare worker as being at risk of entry or re-entry into foster care due to risk factors related to parenting needs, for use within the category of in-home parent skills training. For contracted provider use of MI within in-home parent skills training, candidacy establishment and EBP selection for risk migration is identified on the Family First Prevention Services Referral form. Once the family's referral is accepted by the contracted provider, the provider completes appropriate parenting assessments, identifies MI is warranted to enhance uptake, participation, and the completion of other EBPs. For child welfare worker use of MI, risk factors for adult parental capacity and use of MI to mitigate foster care, are identified through child welfare worker assessment in investigative or ongoing functions, as documented in the investigative Assessment and Documentation Tool (ADT) and service recordings.

Use of MI to enhance familial collaboration with child welfare workers, occurs with the target population at the point of investigation and assessment of needs, and through ongoing case service provision. Use of MI to enhance familial collaboration with prevention service providers occurs with the target population at provider receipt of a Family First Prevention Services referral, with regard to uptake of the prevention service program and ongoing assessment of familial readiness to change. Use of MI to enhance EBP intervention completion and success occurs when the target population receives an IV-E EBP through Family First Prevention Services. MI may be used in conjunction with all IVE EBPs on the Kentucky IVE Prevention Plan. Exceptions to this include IVE EBPs, which already have MI imbedded in service provision, such as Homebuilders and START.

Implementation of MI with child welfare workers will occur through state wide training of all frontline child welfare workers and staff specified to providing coaching and supervision. All frontline workers will complete basic MI training, as provided by a Motivational Interviewing Network of Trainers (MINT) or equivalent trainer. Frontline child welfare workers will use motivational interviewing with families through investigation and assessment of needs, and through ongoing case service provision. Specified child welfare staff will complete basic and advanced motivational interviewing training, as provided by a MINT or equivalent trainer, as well as necessary coding and coaching trainings. This will allow for child welfare staff to provide coaching, utilize fidelity monitoring for frontline child welfare workers, including the use of manual congruent fidelity monitoring tools, such as the Motivational Interviewing Treatment Integrity (MITI) or Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP), and assess frontline worker proficiency level and needs.

The use of MI is already deeply embedded in the agency's service array, through both addressing the opioid epidemic and other substance use disorders challenging families within the Commonwealth. Several studies have been conducted to determine the efficacy of MI, leading the CEBC to give it a Well-Supported rating. Specific to substance abuse treatment, studies report that when compared to other active treatments such as 12-step and cognitive behavioral therapy (CBT), the MI interventions took over 100 fewer minutes of treatment on average, yet produced equal effects. A study examined the efficacy of Motivational Interviewing (MI) as an enhanced treatment initiation with substance abusers. Participants were randomly assigned to receive either standard treatment or standard treatment with MI. Measures utilized include the rates of participants who attended one or three subsequent drug abuse treatment sessions after the evaluation, as well as basic demographic data and substance abuse history. Results showed that significantly more participants in the MI group went on to attend treatment sessions than in the standard group (59.3% versus 29.2%). However, this advantage did not persist beyond treatment initiation. Limitations include small sample size, lack of follow up, and generalizability of findings due to ethnicity (Carroll, Libby, Sheehan, & Hyland, 2001). The evidence base for MI is strong in the areas of addictive and health behaviors.

The use of MI in increasing family involvement and collaboration in prevention services lends Kentucky to increasing service uptake, ongoing familial partnership to achieve the Child Specific Prevention Plan, ensuring continuity of services between child welfare and prevention services, and reducing child welfare recidivism through enhanced success of other EBP completion (Hall, Sears, & Walton, 2020; Shah et al., 2019). In Kentucky, 237 families' experienced incomplete or unsuccessful closures in CY 19, including families where children entered OOHC, families declining to participate initially or ending prevention services prior to completion, highlighting

barriers to meaningful engagement, EBP intervention success, and child-specific prevention plan goal completion. Prevention provider and child welfare worker use of MI will enhance familial engagement in prevention service and EBP interventions, and will maximize positive outcomes for families and youth served. MI is likely to lead to client improvement when directed at increasing healthy behaviors and/or decreasing risky or unhealthy behaviors as well as increasing client engagement in the treatment process (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Useful as a brief intervention in itself, MI also appears to improve outcomes when added to other treatment approaches (Hettema, Steele, & Miller, 2005). The use of MI assisted in the uptake of services specific to another Title IV-E Prevention Clearinghouse EBP, PCIT (Chaffin et al. 2009), and maltreatment was found to be decreased when MI and PCIT were used together, than either alone (Chaffin et al. 2009). Kentucky will utilize the MI manual, *Motivational interviewing: Helping people change* (Miller & Rollnick, 2012). Kentucky will not use any adaptations to the MI model.

➤ **Multisystemic Therapy**

Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The target population is 12 to 17 year olds who are at risk of out-of-home placement due to delinquent behavior. MST is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will use the MST manual, *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents* (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Kentucky will not use any adaptations to MST.

➤ **Parent-Child Interaction Therapy**

Parent and Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children and their parents or caregivers that focuses on decreasing externalizing child behavior problems, increasing child social skills and cooperation, and improving the parent child attachment relationship. The target population is children ages two to seven years of age and their caretakers. PCIT is rated Well-Supported with the Title IV-E Prevention Services Clearinghouse. Kentucky will use the PCIT manual, *Parent-Child Interaction Therapy Protocol* (Eyberg, & Funderburk, 2011). Kentucky will not use any adaptations to PCIT.

➤ **Trauma Focused-Cognitive Behavioral Therapy**

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The target age is three to 18 years old. TF-CBT is rated Well-Supported and “High” for child welfare relevance per the CEBC. TF-CBT is rated

promising with the Title IV-E Prevention Services Clearinghouse. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

The majority of Kentucky providers in community mental health centers, private foster care agencies, and residential programs utilize TF-CBT. There are several journal reviews discussing the efficacy of TF-CBT (Cohen, Mannarino, & Iyengar, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Results indicated that TF-CBT, regardless of the number of sessions or the inclusion of a Trauma Narrative (TN) component, was effective in improving participant symptomatology as well as parenting skills and the children's personal safety skills. The eight-session condition that included the TN component seemed to be the most effective and efficient means of reducing parents' abuse-specific distress as well as children's abuse-related fear and general anxiety (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). The study evaluated the effectiveness of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) in a sample of children with histories of sexual abuse trauma and posttraumatic stress disorder (PTSD). Among treatment completers, TF-CBT resulted in significantly greater improvement in anxiety, depression, sexual problems, and dissociation at six-month follow-up and in PTSD and dissociation at 12-month follow-up. Intent-to-treat analysis indicated group x time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems (Cohen, Mannarino, & Knudsen, 2005). Kentucky will use the TF-CBT manual, *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Mannarino, & Deblinger, 2006). Kentucky will not use any adaptations to TF-CBT.

#### ➤ **Sobriety Treatment & Recovery Team**

Sobriety Treatment and Recovery Team (START) is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START serves families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. Families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-

mentor dyad has a capped caseload of 15 families, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity. START is rated promising with “High” child welfare relevance per the CEBC. START is rated supported on the Title IV-E Prevention Services Clearinghouse as well. Kentucky first implemented START in 2007 and has gradually expanded since that time, investing in the staff, collaboration, infrastructure, and outcome studies of START.

START is listed on the California Evidence-Based Clearinghouse (CEBC) site as a promising practice. An impact study (Huebner, Willauer, & Posze, 2012) found that 21% of children in families who received START (n=451) entered out-of-home care (OOHC) compared to 42% of children from a matched comparison group (n=359) who received usual child welfare services ( $\chi^2(1) = 42.63$ ;  $p < .01$ ) had a medium effect size (0.23). In a subsequent impact study (Hall et al, 2015) with a matched comparison in a rural Appalachian County, findings indicated no significant differences in OOHC placement rates, but significantly less recurrence of child maltreatment within six months, and reentry into foster care within 12 months (0% vs. 13.2%). Finally, an evaluation of START as part of the Children’s Bureau Regional Partnership Grant Round II found that 21% of children in families served by START entered out-of-home care within 12 months compared to 31% of a propensity score-matched comparison group. In summary, two independent evaluations of START report that 21% of children in families served by the program enter out-of-home care within 12 months, a rate that is significantly lower than similar children receiving usual child welfare services.

Although not designed specifically as impact studies, outcomes research (Huebner, Posze, Willauer, & Hall, 2015) shows that stronger adherence to the START timeline (measuring quick access to treatment), results in children (n = 717) remaining with their parents throughout treatment (31.7% to 47.4% with stronger fidelity) without any time placed with relatives or in OOHC. Both mothers (n=331) and fathers (n=219) achieved higher rates of sobriety and early recovery (as measured by drug tests, engagement in treatment and community recovery supports and progress on CPS goals with 66.3% of mothers achieving sobriety - far above the 37% of CPS mothers completing one treatment modality in Treatment Episode Data Set (TEDS) data. Published studies on non-waiver Kentucky START families (Huebner, Willauer, Posze, Hall, & Oliver, 2015) explored rates of recurrence among START-served children (n=866) and found rates far below the state rate of recurrence. Studies have explored the outcome of the family mentor in START (Huebner, Hall, Smead, Willauer, & Posze, 2018) and aligned the practices of START with family-centered practices and outcomes (Huebner, Young, Hall, Posze, & Willauer, 2017).



With two additional impact studies in progress and multiple outcome studies that demonstrates START effects, we anticipate that START will be rated as a well-supported intervention in the future. Building a solid evidence base of impact studies that match the Clearinghouse Standards takes time and commitment. Kentucky is committed to sustaining that effort through fruition. START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.

Kentucky will use the START implementation manual, Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual (Willauer, Posze, & Huebner, 2018). Kentucky will not use any adaptations. Public Consulting Group (PCG) completed a systematic review of START, proposing a promising rating. As approved, Kentucky will claim transitional payments for START during the time it was not rated by the Title IV-E Prevention Services Clearinghouse.

Table 3: All DCBS Proposed Prevention Services

Prevention Program Category	Intervention	Title IV-E Prevention Services Clearinghouse Rating/Systematic Review Rating	Target Population	Book, Manual, Program Documentation	Relevant Past Research
In-Home Skill-Based Parenting Programs	Homebuilders®	Well-Supported	Families with children (birth to 18) at imminent risk of placement into foster care (or recently reunified from foster care)	Kinney, J., Haapala, D. A., & Booth, C. (1991). <i>Keeping Families Together: The HOMEBUILDERS Model</i> . New York, NY: Taylor Francis.	Walton (1998)



In-Home Skill-Based Parenting Programs		Intercept®	Well-Supported	Families with children (birth to 18) at risk of OOHC (foster care, residential treatment, or group home settings).	Goldsmith, T. (Ed.). (2007). Youth Villages clinical protocols treatment manual. Youth Villages.	Huhr & Wulczyn (2020a) Huhr & Wulczyn (2020b) Huhr & Wulczyn (2021) Huhr & Wulczyn (2022)
In-Home Skill-Based Parenting Programs	Substance Abuse Treatment and Prevention	START*	Supported	Caregivers with substance use disorders; households with young children (birth – 6 years) at risk of placement into foster care	Willauer, T., Posze, L., & Huebner, R.A. (Eds.). (2018). <i>The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual</i> . Forest Park, CA. Children and Family Futures.	Huebner, Willauer, & Posze (2012)
Mental Health Treatment		FFT	Well-Supported	Youth (ages 11 to 18 years old) with behavioral or emotional problems and their families	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). <i>Functional Family Therapy for Adolescent Behavioral Problems</i> . Washington, D.C. American Psychological Association.	Humayun et al. (2017)
Mental Health Treatment		TF-CBT	Promising	Children and adolescents who have experienced severe trauma and their families	Cohen, J. A., Mannarino, A.P., & Deblinger, E. (2006). <i>Treating Trauma and Traumatic Grief in Children and Adolescents</i> . New York, NY. Guilford Press.	Smith et al. (2007)

Mental Health Treatment		PCIT	Well-Supported	Families with children between two and seven years old; children with emotional and behavioral problems that are frequent and intense.	Eyberg, S. & Funderburk, B. (2011) <i>Parent-Child Interaction Therapy Protocol: 2011</i> . PCIT International, Inc.	Bjørseth & Wichstrøm (2016)
Mental Health Treatment	Substance Abuse Treatment and Prevention	MST	Well-Supported	Youth between the ages of 12 and 17 who are at risk for delinquent behavior/out of home care placement and their families.	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). <i>Multisystemic Therapy for Antisocial Behavior in Children and Adolescents</i> (2 <sup>nd</sup> ed.). New York, NY. Guilford Press.	Vidal et al. (2017)
Mental Health Treatment		High-Fidelity Wraparound	Promising	Children and their families where the child is at risk of OOHC placement and involved in multiple child and family-serving systems	Bruns, E. J., & Walker, J. S. (Eds.) (2015). The resource guide to Wraparound. National Wraparound Initiative.  Miles, P., Brown, N., & The National Wraparound Initiative Implementation Work Group. (2011). The Wraparound Implementation Guide: A	Puente-Duran et al. (2016)

						Handbook For Administrators And Managers. Portland, OR: National Wraparound Initiative.	
In-Home Skill-Based Parenting Program	Mental Health	Substance Abuse Treatment and Prevention	MI	Well-Supported	Adults (18+ years) involved in child welfare prevention services; has shown promising evidence with adolescents	Miller, W. R., & Rollnick, S. (2012). Motivational interviewing: Helping people change. New York, NY. Guilford press.	Shah et al. (2019)

### ***Interventions for future consideration***

#### **➤ Kentucky Strengthening Ties and Empowering Parents (KSTEP)**

KSTEP, developed as part of Kentucky's Title IV-E Waiver, is not included in Kentucky's first submission of our State Prevention Plan. However, due to KSTEP's demonstrated success in recent years, Kentucky plans to pursue steps necessary to submit KSTEP in future Prevention Plan revisions as its manual is developed and evaluation efforts continue. Participation in KSTEP yielded significant improvement for families and individuals in both the Addiction Severity Index (ASI) and North Carolina Family Assessment Scale (NCFAS) at the submission of the Waiver Interim Evaluation Report (May, 2018). KSTEP also maintains a 90% success rate in maintaining children safely in their home of origin. The KSTEP intervention uses quick access to substance abuse treatment, intensive in-home services, client transportation, weekly contact between the child welfare agency, treatment provider, and in-home service provider, and joint decision making with all partners. KSTEP is a multi-faceted model that includes within its service delivery approach several distinct EBPs, including PCIT and MI. Taken together, this integrated approach to service delivery is designed to achieve a discrete set of outcomes including reducing the number of children entering care, increasing parental sobriety and improving parental protective capacities.

### ***Kentucky's in-home service delivery model***

Kentucky's contracted prevention services are primarily provided through the Family Preservation Program (FPP), an in-home services program. There are seven FPP service providers throughout the State who utilize various EBPs in their work with families. In SFY2019, 96% of the children serviced through an FPP provider were maintained safely in their homes at the end of the intervention. A performance outcome of 75% of children maintained safely in their home at the end of an FPP intervention has been embedded in the FPP contracts for many years. This outcome standard has been exceeded by all providers, with most recent years exceeding a 90% success rate of families remaining safely intact together in their homes. Kentucky will be utilizing Family First as a lever to continue the impressive work of the FPP program by expanding services and the provider network. Current FPP providers offer a varied array of EBPs proposed in this five-year prevention plan. Additionally, a variety of intensity and duration exist within FPP programs that have the opportunity adjusted based on the strengths and needs of the family.

In addition to FPP, DCBS has funded two in-home and community based prevention programs through its Title IV-E waiver demonstration project (START and K-STEP) to address the needs of families struggling with substance use disorders. Those programs utilize a variety of EBPs throughout the State as well.

Table 4 reflects a summary of EBPs administered by DCBS' in-home service providers. This includes the FPP providers as well as START and K-STEP. While START and KSTEP each represent a comprehensive and unified program model, discrete EBPs are made available to families as part of the models' service delivery approach.

Table 4: Evidence-Based Practices administered by DCBS in-home service providers

	FFT	Homebuilders	Intercept®	MI	MST	PCIT	TF-CBT	START	Wraparound
FPP	X	X		X		X	X		X
KSTEP	X			X		X	X		
START				X			X	X	
MST					X				
Intercept®			X						

## ***Ensuring trauma-informed service provision***

All evidence-based interventions included in Kentucky's array of in-home services are administered within a trauma-informed framework. All new evidence-based interventions that Kentucky plans to implement under Family First will also be administered within a trauma-informed framework. This is a requirement in current contracts, and will remain a requirement in all future contracts.

Additionally, DCBS has worked closely with the Department for Behavioral Health and Developmental and Intellectual Disabilities (BHDID) to support the provider network with additional trauma informed care (TIC) training. TIC training provides a foundational understanding of the knowledge and skills needed to deliver trauma informed, family preservation services. This includes understanding and recognizing traumatic stress; the impact of trauma on brain development and subsequent functioning; how traumatic stress manifests in social, emotional and cognitive functioning and behaviors; the importance of the caregiving relationship; strategies FPP workers can model and teach caregivers to help them support youth who have experienced trauma; and the impact of working with trauma exposed youth on staff. BHDID has served on several workgroups in preparation for Family First and will be supporting providers as needed to ensure training and ongoing support for a trauma informed framework within each agency.

FPP also ensures all Master's level staff have received training in Trauma Affect Regulation Guide for Education and Therapy for Adolescents (TARGET), a promising intervention. TARGET is an educational and therapeutic intervention designed to prevent and treat traumatic stress disorders, co-occurring addictive, personality, or psychotic disorders, and adjustment disorders related to other types of stressors, for youth 10 to 18 years of age.

Elements of START's trauma-informed framework are particularly notable. Each staff-person in START is trained on how trauma impacts the families served knowing that trauma is strongly correlated with substance use disorders (SUD) and that treating trauma and SUD concurrently is best practice. START Service Coordinators assess for trauma and SUD in both mothers and fathers and link clients with SUD treatment that addresses trauma when needed. START funds have been used to provide training for clinicians in each START community on trauma-specific treatments such as Seeking Safety. START behavioral health providers utilize trauma specific evidence-based practices as indicated. Families are provided Seeking Safety, Child Parent Psychotherapy, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) as clinically indicated.

START utilizes shared decision-making, collaborating with families and empowering them to be active participants in decision-making and plan development for their family. As a family-centered model, START children are screened for social-emotional delays, which are often a result of the trauma experienced by children who are abused or neglected. With its two-generation approach, START attempts to break the cycle of trauma, knowing that keeping families intact and providing early intervention for children's mental health issues can help prevent those children from developing adulthood substance use and mental health disorders.

DCBS is committed to furthering the extent to which the agency is promoting a trauma-informed and trauma-responsive child welfare system. As Kentucky moves forward with Family First implementation, including its expansion of prevention services, all agencies will be required to operate within a trauma-informed framework in order to contract with DCBS.

See Appendix H for DCBS' signed assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma informed organizational structure and treatment framework.

### ***Implementation approach***

Responsibility for the development and implementation of the Title IV-E Prevention Plan rests with the Prevention Supports Workgroup within the broader DCBS Child Welfare Transformation Governance Structure. This group is comprised of key internal and external stakeholders and subject matter experts who guide the planning and decision-making process, including an Evidence-Based Practice Subgroup. The Evidence-Based Practice Subgroup led the process to identify the EBPs included in this Title IV-E Prevention Plan and they will retain responsibility for overseeing their implementation and/or expansion.

Kentucky will implement Family First initially utilizing existing contracted prevention providers. Kentucky will expand relationships and provider contracts with existing private agency partners, to also include congregate care providers expanding their business models to include preventive services. Current prevention providers have identified additional capacity and more importantly, a willingness and interest in expanding their services to meet the identified needs of the candidate population as increased resources become available.

Current contracted providers have established relationships with trainers and purveyors of current EBPs. Kentucky will examine and modify these existing relationships as necessary to accommodate additional training needs moving forward. In addition, Kentucky will utilize Learning Collaboratives to strengthen the quality of implementation and provide peer-learning

opportunities for contracted agencies. Experienced providers may serve as facilitators and mentors in quarterly provider meetings to coach and mentor newly contracted agencies.

DCBS staff will provide support and technical assistance to provider agencies related to recruitment; training; coaching; outcomes management, and fidelity monitoring. Strengthening the infrastructure and quality of service provision with existing providers will well-position DCBS to expand contracts and build even greater EBP service delivery capacity within the Commonwealth.

Kentucky will continue to conduct regular gap analyses between the services available in the Commonwealth and the needs indicated within the candidacy population. The EBP and Evaluation subcommittees of the Prevention Supports workgroup will continue to review data on service availability, gaps, family risk factors, and community readiness to determine geographic areas for service expansion. Using that data, Kentucky will expand contracts or issue new RFPs to continually expand service capacity. A staged approach to service expansion will allow time for continuous quality improvement processes to be developed, tested, and modified for each EBP before going to scale.

Family First liaisons represent another strategy for promoting sound implementation of this prevention plan. Family First liaisons will be regional experts with specialized knowledge of the Family First legislation and the implications for implementation within the Kentucky child welfare context. The Family First liaisons will be available to provide consultation and support to regional child welfare staff across a wide range of policy and practice issues, including candidacy determination or redetermination of candidacy, model selection, model fidelity, and performance monitoring.

Additionally, the Division of Protection and Permanency (DPP) through its Prevention branch will provide policy, procedure and consultation supports statewide through its branch manager and social services specialists.

To ensure tracking of prevention services for appropriate Title IV-E claiming, information technology staff have been an integral part of preparation for Family First implementation. System enhancements for candidacy identification, EBP selection, and billing processes are occurring to support workforce both in the public and private agencies. Kentucky's contracted providers will provide monthly invoices to both programmatic and financial staff for review. Kentucky is collaborating with Public Consulting Group (PCG) to develop an invoice template to include the potential candidate, date of service, EBP utilized, and amount billed with each EBP,

for Family First funds. An accounting code will be assigned for each EBP billed and for each agency. This will assist financial management staff in managing funds appropriately.

To monitor implementation fidelity, CHFS will use its existing Continuous Quality Improvement (CQI) process, CQI process specific to well-supported interventions, and contract monitoring staff within the Division of Protection and Permanency to engage providers in a standardized quality assurance process. This fidelity monitoring will include regular contact and communication between CHFS staff and providers; standardized reporting of performance measures for fidelity by each provider; and establishing provider outcome goals. In addition to measuring progress on the outcomes that the EBPs are designed to impact, outcomes monitoring will also include the retention of clients in the services, the count/proportion of clients completing service treatment plan, tracking of referrals of clients to additional needed services, and tracking of clients who have change of status either from out of home care to parent or parent to out of home care.

To implement Family First in Kentucky, DCBS will continue to communicate and collaborate with other partner agencies, both governmental and community. Resources will be used to develop and implement training and educational opportunities for all agencies working with child welfare families (Courts, Department of Juvenile Justice, Education, Behavioral Health, Private Child Care, Foster Care, etc.). The transformation occurring within the child welfare system is not led in isolation by DCBS, the child welfare agency. From a macro statewide approach, support will also be provided by the State Interagency Council for Services and Supports to Children and Transition-age Youth (SIAC) in the form of continued policy development related to community needs assessments and provisions. This council serves to enlist the input of a statewide group of stakeholders including youth, biological parents, service providers, and other professionals to ensure the most robust and appropriate system of care within the Commonwealth. All Regional Interagency Councils (RIAC) and the SIAC have received training on Family First and play an integral role in the support of its implementation.

### **Section 3: Developing the Prevention Plan**

The development of the child specific prevention plan will follow a specified process. First, the SSWs will complete the Preventative Services Referral Form, identifying the date of candidacy determination for each child, the high-risk behaviors or circumstances which could lead to removal and the appropriate EBP intervention(s) needed to mitigate the risk. Upon approval, the referral form will populate the identified risk factors and identified EBP into an in-home case plan within TWIST, Kentucky's child welfare information system. The in-home case plan will include candidates' child specific prevention plans embedded within the broader case



planning platform. In addition, the child-specific prevention plans (within the in-home case plan) will include the date that candidacy was established, along with a child specific prevention strategy, known as an objective within DCBS case planning parlance. Each objective will be accompanied by several tasks outlining the identified family strengths and strategies for keeping the foster care candidates in their home. The objective will also reference the risk factors identified and link to the appropriate EBP(s) needed to mitigate the risk factors for maltreatment. This process, together with the expectations for SSWs casework practice, will be clearly outlined in DCBS' standard operating procedures (SOP), issued to the in-home workforce, and incorporated into child welfare policy and training curricula.

### ***Motivation Interviewing Implementation and the Prevention Plan***

For contracted provider implementation of motivational interviewing, the existing aforementioned process is used to identify the child specific prevention plan. This includes date of candidacy determination, risk factors which could lead to foster care entry or re-entry, and the selection of MI as the appropriate EBP intervention to mitigate the identified risk on the Family First Prevention Services Referral form, provider entry of MI intervention start and end dates in Kentucky's CCWIS system, and the interface between these two areas of data entry and the child specific prevention plan captured on the family's case plan. For child welfare worker use of motivational interviewing, the child specific prevention plan will also be captured on the family case plan. This includes the date of candidacy determination for eligible children at risk of entry or re-entry into foster care with parental substance use, parental mental health needs, and caregiver parenting needs as the risk factor mitigated by MI use. This also includes identification of dates of MI use, as captured through similar processes used to capture Targeted Case Management (TCM) claiming, utilizing child welfare worker service recordings within Kentucky's CCWIS system. Data entry for candidacy establishment and dates of intervention use will interface and populate on the child specific prevention plan capture on the family's case plan. Specific to capturing the child specific prevention plan during investigations and in advance of the family case plan, processes will include child welfare worker entry of candidacy start and end dates, risk factor mitigation to maintain the child in their home, and evidenced based practice start and end dates into service recordings into the Kentucky's CCWIS system. The aforementioned data entry will then populate on a child specific prevention plan separate from the family's case plan and specific to Motivational Interviewing during the investigation.

### ***Prevention plan for pregnant and parenting youth***

Upon identification of a pregnant or parenting youth and assessment of the need, a service referral will be made for prevention services. The services to be provided will be outlined on the youth's foster care case plan. The services will be listed on the case plan and specifically

targeted to ensure that the youth is prepared and able to parent successfully. The foster care prevention strategy for any child born to a youth in out of home care will be clearly identified within the youth's case plan. The prevention plan will be developed in partnership with the pregnant or parenting youth, services providers, and natural supports during case planning conferences and/or youth transition planning meetings. The CCWIS and SOP enhancements will ensure identification of parenting fathers as well to be included in these prevention efforts.

### ***Assessment and consultation processes***

The process for assessing families' strengths, needs, and the services needed to mitigate risk factors for maltreatment will occur using structures that are already in place. DCBS already uses a collaborative and ongoing assessment model that includes contributions from the investigator, in-home services worker, and the supervisor and is continually revisited during ongoing case consultation. All case types receive monthly consultation between supervisor and worker. Within these consultations, workers and supervisors will consider together at a minimum, safety and risk issues, candidacy status, appropriateness of prevention strategies, and progress toward case plan goals. High-risk investigation consults occur with the worker, supervisor, and regional staff within 72 hours, with a follow-up within 14 days.

Case planning processes already in place will continue with the implementation of the Title IV-E Prevention Plan. Case plan meetings, and task negotiation and development occur initially when a case is opened and every six months thereafter. A formal review of candidacy and continued eligibility will occur every six months. Candidacy redetermination will occur at 12 months if needed. Case plan modifications will also occur when candidacy ends, due to a candidate completing the course of treatment/service delivery associated with the assigned EBP or due to a candidate's removal from the home.

Children will be assessed on an ongoing basis to determine if risk factors are still present or if they have been reduced and parental capacity has been enhanced, negating the need for prevention services. This will be achieved through ongoing provider consultation utilizing assessment tools, such as the NCFAS, and ongoing frontline worker assessment and periodic case plan assessment.

### ***Supervision and oversight strategies to promote quality practice***

Supervisors assess the appropriateness of the risk level assigned by their staff and support workers in making that decision. They also provide support and oversight in ensuring that the preventive strategies and EBPs identified in the child-specific plans are appropriate and effective.

Workers will consult with their supervisor regarding child-specific candidacy determinations and associated service need(s) based upon identified risk factors. Workers will begin the referral process to evidence-based interventions following supervisor consultation. A description of services/target population resource form will be provided to workers and regional in-home services gatekeepers to utilize as a reference and to guide decision-making regarding referral to appropriate services. It will also be available for access within standards of practice (SOP). The form is designed as a resource that guides decision-making to ensure referrals are made to the most appropriate program to meet the family's needs.

Workers provide ongoing oversight during monthly home visits to assess and monitor family progress in mitigating risk factors. This is also assessed during the consultative process between workers and supervisors to assess case plan progress. DPP central office will also serve as oversight by providing consultation as needed and developing a case review process with random selection of cases for review as part of DCBS' ongoing CQI processes.

Regional gatekeepers play a critical role in the decision-making and oversight processes related to service provision and monitoring. Gatekeepers are experienced child welfare staff with a knowledge of risk and safety assessments along with evidence-based practices. They also have an established professional relationship with the prevention services provider network. They serve as a support to frontline workers and supervisors for consultation related to prevention services selection and act as a liaison between field staff, families, and service providers. Regional gatekeepers for preventative services will also promote quality preventive casework practice by performing quality assurance measures on candidacy selections and referrals to services. Gatekeepers will review the risk identified to ensure candidacy determinations are appropriate. Gatekeepers will have the ability to send referrals back to workers for changes and are assigned the responsibility for ultimately sending referrals to contracted providers. The referral for services requires consent from family, supervisor approval, and regional gatekeeper oversight and approval. Referrals for services and candidacy status will be captured in the state CCWIS system for data collection and monitoring.

See Appendix I for an illustration of the business process and roles associated with determining candidacy and linking families to the appropriate EBP.

### ***Coordinating Title IV-B and Title IV-E Funded Services***

Kentucky's Title IV-B funded preventative services, Families & Children Together Safely (FACTS) and Family Reunification Services, will be implemented in conjunction with Family First funded preventative services. Both the Families and Children Together Safely (FACTS) and Family Reunification Program are partially funded by IV-B funds and will continue to be. Title IV-B

funding accounts for 25.51% of the current Family Preservation budget. Interventions used when programs are funded by IV-B will not be included in the tracking of Kentucky's well-supported interventions and will not be claimed to IV-E. SSWs will ensure families' case plans, and the child-specific prevention plans contain the right constellation of services needed to address risk factors for maltreatment and maintain the child safely in their home. This preventive service package in its entirety will likely be funded by a variety of federal, state, and local funding streams, including Title IV-B and Title IV-E. SSWs will ensure that all services for the child and family, regardless of funding stream, are well-coordinated, mutually reinforcing, and appropriate for achieving the case plan goals for the family.

Kentucky has collaborated with many entities in the development of this plan, including the close involvement of the CFSP Stakeholder Continuous Quality Improvement (CQI) group, which is charged with the writing of the CFSP to support IV-B funded services. The CFSP was recently submitted, including CFSP Goal 2, Ensure that appropriate services are available that expand the prevention continuum and are provided to meet the needs of families and children in Kentucky and Objective 2.1, Expand prevention services statewide 12% by 2024, specific to prevention services, to include eligible candidates. The stakeholder's group meets quarterly, with attendance including department staff, frontline staff and supervisors, program staff, and leadership; the Administrative Office of the Courts (AOC); Department of Medicaid Services (DMS); Court Appointed Special Advocates (CASA); Division of Family Support (DFS); Prevent Child Abuse Kentucky (PCAK); the Department of Juvenile Justice (DJJ); the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID); Orphan Care Alliance (OCA); the Children's Alliance; Family Resource and Youth Services Centers (FRSYC); parent representatives; Children's Justice Act (CJA); various service providers including those receiving Community-Based Child Abuse Prevention Program (CBCAP) funding; various partners from different universities, including the training resource consortium; Early Childhood Education; and the Department for Public Health (DPH). During CFSP meetings, DCBS and our partners are reviewing Family First planning and making decisions together regarding actions necessary for implementation. At the last meeting on 10/31/19, implementation strategy development included a working session to identify how DCBS will better support providers and field staff in implementation.

In addition to CFSP specific collaboration, Kentucky has also, DCBS engaged its provider network in a readiness assessment, participated in an agency collaboration survey, held regional forum presentations in each region or the state, and held statewide meetings with providers, gatekeepers, Family First liaisons, and regional leadership on an ongoing basis. Family First is discussed during both KSTEP and START pilot program direct line and workgroup

meetings. Kentucky has developed a 7 module web-based training for DCBS frontline and regional staff, which has been shared with our private providers to further support them. Kentucky has also developed an EBP workgroup to address capacity building of well-supported interventions and CQI processes. Every private in-home provider agency in the state is represented in this group.

## **Section 4: Monitoring Child Safety**

Safety and risk will be assessed on an initial and ongoing basis for all foster care candidates without exception.

The Department trains and provides SOP guidance to field personnel in completing a thorough risk assessment with each case. Workers are required to fully assess a family for high-risk patterns of behavior and needed services with each intake accepted whether the intake is accepted for physical abuse, sexual abuse, neglect, or dependency. This assessment includes face-to-face interviews with all household members, interviews with children's school collaterals if appropriate, and other collateral interviews to assist in fact-finding and assessment of the incident that led to referral. Workers also collect evidence and documentation from photographs, medical records, criminal history, and child abuse and neglect history.

Workers continuously evaluate risk throughout each phase of a case to determine if risk and safety issues require intervention, and consult with supervisors to discuss any concerns or barriers presented. This practice considers the totality of the family's situation, overall safety threats to the child, protective capacity of the parent/caregiver, perpetrator access, and prediction of recurrent maltreatment.

Workers provide appropriate service matching to the family's needs in order to mitigate the safety threats and risk at both the initial assessment and throughout the life of the case. This is discussed in SOP 2.11 Investigation Protocol and SOP 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding. Please see Appendix O.

The Department is also currently in the process of negotiating a contract to purchase a national safety model, Structure Decision Making (SDM), for implementation in 2020. SDM will help guide the decision making process and prioritize the delivery of services to families across the State. The model will be utilized throughout all phases of the case to assist workers in monitoring safety and risk. The tools being evaluated for purchase are the intake screening tool known as the base assessment, the safety assessment, and risk assessment. The base assessment will assist workers from the start of the case by providing consistency to acceptance determination. The safety assessment will help guide decisions about current danger to the

child and acceptable interventions for families. The risk assessment will assist workers in making a determination regarding the appropriate level of care along the prevention and intervention continuum. These tools will be utilized during major case decision points throughout the life of the case from intake to reunification. Title IV-E Prevention Plan updates will be submitted to the Children's Bureau if the implementation of the national safety model influences or changes the information reflected in this initial submission.

Each unique in-home service program, employed during the investigative phase of each case, also implements different levels of familial contact based upon the risk and family's level of need. All in-home service programs require collaboration with DCBS, this may include joint meetings with the family in the home, joint treatment planning meetings with the family, weekly contact between providers for progress updates, etc. All in home services also utilize the North Carolina Family Assessment Scale (NCFAS) consistently. The use of the NCFAS supports the assessment of family functioning during the intervention, through domains, such as safety, environment, and parental capacity. NCFAS use allows the continuity of safety assessment throughout the assessment. Pre and post-scored domains are also provided to the worker to aid in their ongoing safety assessment of the family.

All case types receive monthly consultation between supervisor and worker to assess for safety and necessary case provision/goals. For in-home cases with candidate children, in home case consultation standard operating procedures and the In Home Services Case Consultation Form have both been updated to capture and prompt discussion regarding what prevention services are being offered to the family, when services began, the date the child(ren) were identified as candidates for foster care, and identifying the EBPs utilized with the family to mitigate high risk behavior. Please see Appendix O for Standards of Practice 1.5 Supervision and consultation.

Additionally, DCBS staff complete at least monthly home visits with all family members, receiving in-home services, unannounced if necessary. Workers also meet with children privately in their home during monthly home visits to assess safety. During home visits the worker:

1. Assesses for new immediate safety issues, high-risk behaviors, or unaddressed risk factors;
2. Evaluates the family's progress toward reducing the immediate safety issues and/or reducing the risks that necessitated case action;
3. Reviews the family's progress toward accomplishment of their case planning tasks;
4. Reviews the tasks of other service providers and progress toward accomplishment of these;
5. Identifies and resolves barriers to completing case objectives; and

6. Prepares for the next ongoing assessment, case planning conference/periodic review and court hearing.

An ongoing case plan and ongoing comprehensive assessment, including assessment for risk, is completed at least every six months, and with greater frequency if there are major changes. A periodic risk assessment is completed along with the ongoing comprehensive assessment every 6 months, in addition to consultations and assessments completed during home visits. During ongoing assessments, the progress for each objective related to high-risk behavior is discussed, with regard to progress made and objective achievement. Safety and risk are also addressed, with regard to identifying if the risk and safety has been reduced, which prompted the opening of the family's case. Any new incidents are documented and addressed, along with a description of how the family handles daily life situations, stressors, caregiver protective capacity, and methods of behavior management. Please see Appendix O for review of Standards of Practice 3.12 Case Plan Evaluation/Ongoing Assessment.

## **Section 5: Evaluation Strategy and Waiver Requests**

Kentucky's evaluation strategy for Family First implementation will apply an evaluation model that includes process, outcome, and impact measures. While DCBS is contemplating an overarching evaluation strategy for Family First implementation as a whole within the State, the agency will be working with Cabinet for Health and Family Services (CHFS) evaluators and an internal CQI team to administer a discrete, well-designed, and rigorous evaluation or CQI strategy for each EBP proposed within this Title IV-E Prevention Plan.

An evaluation/CQI team of CHFS Family First research/evaluation staff, program leadership, front line staff, community stakeholders, and client stakeholders has been developed for this effort. The evaluation team will be led by Matthew Walton, PhD, MSSW and Dana Quesinberry, JD, DrPH from the Division of Analytics in the Office of Health Data and Analytics at the Cabinet for Health and Family Services. Dr. Walton's research interests involve the intersection of behavioral health and child welfare; he was on the team that conducted the evaluation of the START program under Kentucky's Title IV-E Waiver Demonstration project (included in the promising strategies to be implemented under this plan). Additionally, Dr. Walton has direct social work practice experience in psychiatric and general hospital settings. Dr. Quesinberry practiced law for 15 years with a focus in child abuse and neglect cases. Under multiple federal grants, Dr. Quesinberry has conducted evaluations of existing public health prevention programs, the implementation of new programs, and health policy.



While DCBS is proposing that a formal evaluation will apply to some EBPs and CQI strategies will apply to others, this evaluation/CQI team will work in partnership to ensure a shared conceptual framework, promote collaboration and information sharing, and create a sound foundation for DCBS' broader Family First implementation.

### ***Evaluation waiver request for well-supported interventions***

Pursuant to Section 471(e)(5)(C)(ii), states may submit a request to waive the evaluation requirement for allowable programs or services that have been deemed well-supported by the Title IV-E Prevention Services Clearinghouse. Specifically, this section reads:

*“(ii) WAIVER OF LIMITATION.—The Secretary may waive the requirement for a well-designed and rigorous evaluation of any well-supported practice if the Secretary deems the evidence of the effectiveness of the practice to be compelling and the State meets the continuous quality improvement requirements included in subparagraph (B)(iii)(II) with regard to the practice.”*

Kentucky will be seeking a waiver request for the evidence-based practices included in this plan that are rated as *well-supported* by the Title IV-E Prevention Services Clearinghouse. Those EBPs include parent child interaction therapy (PCIT), motivational interviewing (MI), multisystemic therapy (MST), Homebuilders®, Intercept®, and functional family therapy (FFT). See Appendix J for the signed waiver requests.

### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Parent-Child Interaction Therapy***

The evidence in favor of the use of Parent Child Interaction Therapy (PCIT) as a means of promoting positive family dynamics and reducing the risk of foster care placements in Kentucky is compelling. Moreover, the weight of the evidence is sufficiently compelling to warrant a waiver to the Kentucky Department of Community Based Services for the Family First evaluation requirements for PCIT. This request for a waiver of the evaluation requirement for Parent Child Interaction Therapy is based on the following:

- (1) It has been shown to be efficacious in a wide variety of locations and has universal application,
- (2) It has demonstrated flexibility and favorable outcomes with children of various cultural backgrounds and underlying problems and
- (3) It can be adapted for Kentucky's target population without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse; moreover, PCIT has been successfully tailored for use with Appalachian children and families



### ***Efficacious in Variety of Locations and Broad Contextual Applications***

There are several well-designed studies identified by the Title IV-E Prevention Services Clearinghouse literature review of PCIT that demonstrate its ability to reduce child maltreatment and disruptive behavior across a wide variety of contexts and populations (e.g., Thomas & Zimmer-Gembeck, 2011; Bjørseth & Wichstrøm, 2016). Among the six highest-rated studies in the review, half were performed internationally (two in Hong Kong, one in Norway). PCIT's consistent success with diverse racial and ethnic groups in multiple cultural contexts suggests the intervention would be successful with Kentucky children and families as well (McCabe, Yeh, Lau, & Argote, 2012). The body of evidence describes that the core components of PCIT have a degree of universal application, and therefore PCIT will have the same desired effects in Kentucky that have been demonstrated elsewhere.

### ***Favorable Outcomes and Flexibility Across Cultural Backgrounds and Underlying Problems***

Not only has PCIT demonstrated favorable outcomes in multiple locations with various ethnicities (and languages), but it has also demonstrated flexibility in terms of the particular diagnostic presentations of children. For example, a randomized controlled trial conducted by Leung, Tsang, Ng, and Choi (2017) found that PCIT promoted positive outcomes for children with ADHD diagnoses. A similar investigation by Solomon, Ono, Timmer, and Goodlin-Jones (2008) found comparable favorable results for children on the autism spectrum. Finally, yet a third study authored by Bagner, Sheinkopf, Vohr, and Lester, (2010) found PCIT to be effective in children who were born premature. ADHD, Autism, and prematurity are common problems in the child welfare population broadly, but are particularly present in Kentucky's CPS caseloads. According to the March of Dimes *2018 Premature Birth Report Card*, Kentucky received a grade of "D", with an 11.1% rate of all live births being born preterm. This is likely related to epidemic levels of drug use in the state affecting prenatal circumstances for pregnant women. Studies authored by the Medical Director of Kentucky's Department for Community Based Services suggests that each of these diagnostic presentations will be common in the eligible pool of Kentucky foster care candidates that will receive PCIT (Lohr et al., 2018; Lohr et al., 2018). Therefore, the literature suggests that PCIT is capable of flexibility in terms of the particular national/cultural background where it is provided *and* the particular medical or behavioral problems experienced by the children who benefit from it.

### ***Adaptability without Altering PCIT, and Prior Success in Appalachian Context***

Most compellingly, the evidence suggests that PCIT can be successfully adapted to the particular context where it is being delivered without materially altering the practice or diminishing its efficacy. Indeed, evidence of successful adaptation of PCIT to rural Appalachian contexts has been described in Taubenheim and Tiano (2012), which found several meaningful strategies to tailor the intervention in ways that will be instructive for DCBS in Kentucky. These include:

- Granting Appalachian families the opportunity to talk about other concerns beyond parent training and child behavior problems appears to increase the likelihood of retention in treatment.
- Much of Kentucky is either sparsely populated, mountainous, or both. This is especially true in most of Eastern Kentucky, where poverty, underdeveloped infrastructure, and distance to treatment facilities make transportation a particular hardship for families. Taubenheim and Tiano (2012) recommend finding innovative ways to provide transportation as a means of promoting retention in PCIT.
- There is often a distrust of government authority figures and professionals in Appalachian culture. This may be a barrier to engaging in treatment. Enlisting the assistance of trusted local leaders, such as religious figures, is likely to increase retention.
- Taking a strengths-based approach to local culture is likely to help build rapport. “Strengths of Appalachians include persevering through hard times, making do with limited resources, having pride, being close-knit and protective, and caring about friends and families” (p. 22).

Just as PCIT has been successfully adapted for Spanish-speaking Mexican-Americans in California or high-risk families in Australia (e.g., Thomas & Zimmer-Gembeck, 2011); DCBS believes that it can be adapted for Appalachian residents of Eastern Kentucky or urban families in Louisville without altering its beneficial effects on parent-child relationships, as described in Taubenheim and Tiano (2012). This particular dimension of EBP adaptation and implementation is mentioned in the Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures (2019, p. 15):

**Exhibit 4.1. Examples of Program and Service Adaptations within a Study for the Purpose of Study Review**

Eligible Adaptations	Adaptations that Result in Different Program or Service
<ul style="list-style-type: none"> <li>• Modestly changing session frequency or duration</li> <li>• Delivering the intervention in the home compared to office-based delivery</li> <li>• Making small changes to increase the cultural relevancy of the intervention (e.g., changing examples to match the cultural background of subjects; providing the intervention in a different language) without changing program components</li> <li>• Delivering the program by slightly different types of professionals than described in the manual or original research on the program or service (e.g., using social workers instead of counselors to deliver the program)</li> </ul>	<ul style="list-style-type: none"> <li>• Changing from individual to group therapy</li> <li>• Adding any new modules or session content</li> <li>• Subtracting any modules or session content that was part of the original intervention</li> <li>• Radically changing content for different cultural groups, such as to reflect particular issues experienced by those groups</li> <li>• Delivery of the program by substantially different providers than described in the manual (e.g., using para-professionals instead of nurses to deliver the program)</li> </ul>

### ***Evaluation Waiver Request – Parent Child Interaction Therapy***

The evidence described above is sufficiently compelling that an evaluation of PCIT, a well-supported evidence-based practice, is not necessary for Kentucky’s 5-year prevention plan. The evidence-base is already strong for this practice, the resources that Kentucky has available for evaluation would be most prudently applied to another prevention service that has an evidence-base that is less robust (i.e., a promising or supported EBP). Based on previous studies and evaluation reports that were identified by the Title IV-E Prevention Services Clearinghouse from similar contexts, DCBS feels that CQI measures will suffice in this case.

### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Motivational Interviewing***

The evidence in favor of the use of Motivational Interviewing (MI) as a means of promoting positive family dynamics and reducing the risk of foster care placements in Kentucky is compelling. Moreover, the weight of the evidence is sufficiently compelling to warrant a waiver to the Kentucky Department of Community Based Services of the Family First evaluation requirements for MI. This request for a waiver of the evaluation requirement is based on the following:

- (1) It has been shown to be efficacious in a wide variety of locations and settings,
- (2) It has demonstrated flexibility and favorable outcomes with youths and families of various cultural backgrounds and underlying problems and

(3) Because MI is designed to peak a client's motivation for behavioral change, it has been shown to be an especially effective intervention to pair with other child welfare programs to reduce risk of maltreatment and placement into out of home care

### ***Efficacious in Variety of Locations and Broad Scope of Application***

There are several well-designed studies that have demonstrated MI's benefit to people who receive it. The usefulness of MI has been demonstrated in outpatient clinic settings, correctional institutions, hospitals, schools, and several other environments where child welfare-involved families receive services. Because MI is used to help people identify their core values and assist them to understand how their behavior is inconsistent with those values, it is a versatile intervention. Broadly speaking, child welfare authorities operate under the assumption that parents love their children and want them to grow and develop in healthy ways. Indeed, this is among the most powerful values that a parent can have, and does not significantly vary based on culture, language, ethnicity, or religious affiliation. With this in mind, practitioners of MI in Kentucky will be able to use it to connect their work with clients to this underlying set of values about the well-being of their children.

### ***Favorable Outcomes and Flexibility Across Cultural Backgrounds and Underlying Problems***

MI has demonstrated favorable outcomes in multiple locations with people of various ethnicities, but it has also demonstrated flexibility in terms of the particular diagnostic presentations that it can help treat. Though it was initially developed as a means of helping patients engage in addiction treatment, MI has been found to be useful in a host of behavioral health settings where people may be reluctant to participate. Specifically, it appears to be most applicable to Family's First's emphasis on treating addiction and severe mental illness (. As described in a literature review by Shah and colleagues (2019), there is an emerging body of evidence that MI is also specifically useful for child welfare professionals in a range of settings and for certain targeted family outcomes.

### ***MI Appears to be Especially Valuable as an Adjunctive Intervention***

Motivational interviewing is unique from other identified prevention services for a few meaningful reasons. Chief amongst these reasons is that MI can be provided as a stand alone intervention, but is commonly provided as a means of addressing hesitancy or resistance to behavior change *in advance of some other intervention*. Notably, there is evidence that MI is particularly beneficial when it is offered as an adjunct to PCIT (Chaffin et al., 2009; Chaffin, Funderburk, Bard, & Valle, 2011) – another service included in Kentucky's plan. Using a 2 x 2 sequential random assignment design, Dr. Mark Chaffin's research group in Oklahoma noted

that a combination of MI and PCIT improved parents' retention in PCIT treatment, which then in turn improved child welfare outcomes after a period of 2.5 years. Similarly, in a review of the clinical literature, Randall and McNeil (2017) noted:

*"Limitations and the preliminary nature of the work in this area notwithstanding, it appears that it is feasible to supplement or integrate with MI and that doing so has the potential to improve treatment initiation and engagement, as well as clinical outcomes."*  
(p. 1)

### ***Evaluation Waiver Request – Motivational Interviewing***

The evidence described above is sufficiently compelling that an evaluation of MI, a well-supported evidence-based practice, is not necessary for Kentucky's 5-year prevention plan. The evidence-base is already strong for this practice, and the resources that Kentucky has available for evaluation would be most prudently applied to other prevention services that have an evidence-base that is less robust (i.e., a promising or supported EBP). Based on previous studies and evaluation reports that were identified by the systematic review attached to this document, DCBS feels that CQI measures will suffice in this case.

### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Multisystemic Therapy***

The evidence in favor of the use of Multisystemic Therapy (MST) as a means of promoting positive youth behavior change and reducing the risk of foster care placements in Kentucky is compelling. Moreover, DCBS believes the weight of the evidence is sufficiently compelling to warrant a waiver of the evaluation requirements for MST. This request for a waiver of the evaluation requirement for Multisystemic Therapy is based on the following:

- (1) It has been shown to be effective in a wide variety of locations, in a variety of client populations, and with multiple target outcomes
- (2) There is evidence that MST can be adapted for the Kentucky's population at a statewide scale without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse

### ***Efficacious in Variety of Locations and Broad Scope of Application***

There are numerous examples in the literature where MST has been shown to be more effective than usual services at reducing out of home care placements and conduct problems in children and adolescents (e.g., Vidal, Steeger, Caron, Lasher, & Connell, 2017; Butler, Baruch, Hickey, & Fonagy, 2011). The MST intervention has now been implemented and evaluated over

several decades and in multiple locations around the world; and many families have demonstrably benefited from receiving it.

A program of research on MST led by Dr. Scott Henggeler at the Medical University of South Carolina has demonstrated its capacity to positively affect a number of outcomes for youths and their families in South Carolina (e.g., Henggeler et al., 2003). Among these outcomes are: reduced out of home care placements, reduced suicide attempts in emotionally disturbed youths, and improvements in measures of family cohesion. A set of similar favorable outcomes were also observed in Rhode Island, when the intervention was taken to scale across the state, by a team of researchers from Westat, the University of Washington, and Yale University (Vidal et al., 2017). While Kentucky, South Carolina, and Rhode Island are undoubtedly different from one another in meaningful ways, DCBS believes that South Carolina and Rhode Island are suitable comparison states to conclude that MST will have similar beneficial effects when scaled up in Kentucky. For example, according to the National Institute on Drug Abuse (NIDA), Kentucky and Rhode Island appear to be facing a similar burden from the opioid crisis. In Rhode Island, there were 26.9 overdose deaths per 100,000 residents in 2017; for that year in Kentucky, that number was 27.9. Additionally, according to data reported in Radel, Baldwin, Crouse, Ghertner, and Waters, (2018), Rhode Island and Kentucky appear to be struggling with comparable proportions of counties reporting rates of drug overdose deaths and foster care entries that are both simultaneously above their respective national medians.

Important conclusions were drawn in Vidal and colleagues (2017):

*“Consistent with findings from efficacy and effectiveness studies, our findings support the promise of taking MST to scale.” (p. 861)*

*“Taken together, our findings underscore the potential benefits of taking evidence-based programs such as MST to scale to improve the well-being and functioning of high-risk and high-need youth.” (p. 863)*

### ***MST is a Scalable Intervention***

These findings came from studies with diverse samples of several hundred youths. The Vidal and colleagues (2017) study reported on a statewide scale-up of MST in Rhode Island that describes an implementation process that is comparable to Kentucky’s FFPSA prevention plan in several important ways. There now exists several precedents and resources that can be used to guide Kentucky’s large scale implementation of the MST and adaptation of the practice to suit Kentucky’s unique needs. Importantly, because MST has been implemented around the United States (as well as Chile and the United Kingdom), a method of transfer, implementation, and continuous quality improvement has been established for agencies that elect to provide the practice to their population. This method is outlined in Henggeler (2011), which states:

“The effectiveness trials with serious juvenile offenders have demonstrated the capacity of MST to achieve key ultimate outcomes in real-world clinical settings, and the hybrid efficacy-effectiveness studies have supported the promise of several MST adaptations and shown that second- and third-generation MST experts can provide a level of quality assurance needed to achieve key outcomes.” (p. 366)

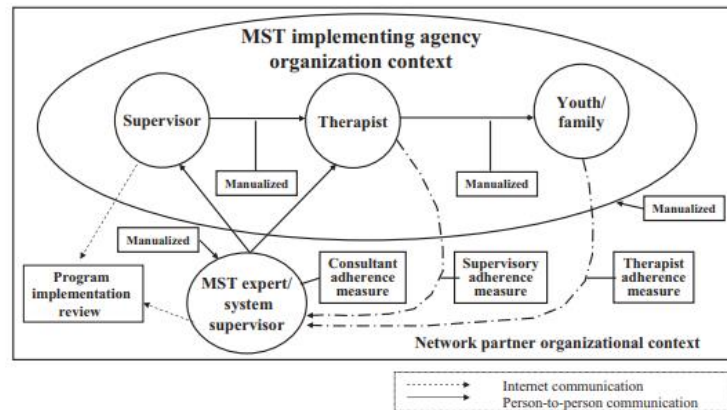


Figure 3

Multisystemic therapy (MST) quality improvement system. Note that linkage between therapist adherence, as reported by caregivers, and child outcomes has been empirically supported in clinical trials. Additionally, the linkages between supervisor adherence and therapist adherence as well as consultant adherence and therapist adherence have been empirically demonstrated in research studies of MST. Current research efforts are directed at evaluating this model and identifying possible barriers to successful implementation of MST.

\*Henggeler (2011, p. 370)

### ***Evaluation Waiver Request – Multisystemic Therapy***

The evidence described above is sufficiently compelling that an evaluation of MST is not necessary for Kentucky’s 5-year prevention plan. The systematic review performed by the Title IV-E Prevention Services Clearinghouse suggests that Kentucky would be best served by allocating its evaluation resources to other prevention services with a less well-developed evidence base. DCBS must use its available resources to strike a balance between monitoring the quality of existing well-supported practices and providing well-designed, rigorous evaluations for the remaining practices. It is DCBS’ position that the marginal added value of a full evaluation of MST in this case simply does not warrant the projected cost. Therefore, DCBS feels that CQI measures will suffice as Kentucky implements Family First.

### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Functional Family Therapy***

The evidence in favor of the use of Functional Family Therapy (FFT) as a means of reducing the risk of foster care placements in Kentucky is compelling. Moreover, DCBS believes the weight of the evidence is sufficiently compelling to warrant a waiver of the evaluation requirements for FFT. This request for a waiver of the evaluation requirement for Functional Family Therapy is based on the following:



- (1) It has been shown to be effective in a wide variety of locations, in a variety of client populations, and with multiple target outcomes
- (2) There is evidence that FFT can be adapted for Kentucky's target population without materially altering the EBP as reviewed by the Title IV-E Prevention Services Clearinghouse

### ***Efficacious in Variety of Locations and Broad Scope of Application***

There are numerous examples in the literature where FFT has been shown to be more effective than usual services at reducing conduct problems in older children and adolescents across a wide range of sites and contexts, suggesting universal applicability. These results are described for young people in (among other locations) Washington State, the United Kingdom, and New York City. Specifically, the highly rated studies by the Title IV-E Prevention Services Clearinghouse most commonly describe the capability of FFT to reduce youth substance abuse and criminal behavior (e.g., Humayun et al., 2017). This is particularly relevant to Kentucky, a state that ranked 7<sup>th</sup> highest in the nation for drug overdose deaths among 12-25 year olds and 35<sup>th</sup> lowest in the nation for overall child wellbeing (Cole, Logan, & Scrivner, 2017). Early versions of FFT were found to be effective at promoting favorable child welfare outcomes (see Barton, Alexander, Waldron, Turner, & Warburton, 1985). DCBS believes that the wide variety of settings, localities, and client populations that have successfully used FFT to address disruptive behavior in families is evidence of its ability to be successfully implemented in Kentucky. Further evidence of this can be found in the endorsement of the practice by the U.S. Centers for Disease Control and Prevention, which identifies FFT as an effective means of addressing youth violence (see David-Ferdon et al., 2016). A review of the literature identified by the Title IV-E Prevention Services Clearinghouse as well as additional publicly available material leaves DCBS to conclude that there exists no reason to believe that the population of Kentucky is materially distinct from the populations who have documented accounts of responding favorably to FFT. Therefore DCBS feels confident that similar benefits will be realized in the child welfare-involved families in Kentucky.

### ***Evaluation Waiver Request – Functional Family Therapy***

The evidence described above is sufficiently compelling that an evaluation of FFT is not necessary for Kentucky's 5-year prevention plan. The systematic review performed by the Title IV-E Prevention Services Clearinghouse suggests that, rather than conducting a rigorous evaluation of FFT as a component of Kentucky's Family First implementation, its evaluation-related resources are best allocated to other prevention services that do not have the same evidence base. Therefore, DCBS feels that CQI measures will suffice in this case.



### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Homebuilders®***

The Title IV-E Clearinghouse has recently given a *Well-Supported* designation to the Homebuilders® intervention program. In light of this designation for the level of research support for Homebuilders®, DCBS submits this request for a waiver of the Family First evaluation requirement for consideration. The evidence in favor of the use of Homebuilders® as a means of promoting successful family reunification and reducing the risk of out of home care placements in Kentucky is compelling. Moreover, DCBS believes the weight of the evidence is sufficiently compelling to warrant a waiver of the evaluation requirements for Homebuilders® as it pertains to this prevention plan. This request for a waiver of the evaluation requirement for Homebuilders® is based on the following:

- (1) Among the many studies identified by the Clearinghouse, there are six favorable studies – each rated at the ‘moderate’ level of support of causal evidence – that establish the efficacy of Homebuilders®.
- (2) Specifically, Homebuilders® has a demonstrated history of success in Utah and North Carolina; with effects on study samples that DCBS believes are generalizable to Kentucky’s population

### ***Demonstrated Efficacy & Relevance to the Goals and Aims of Family First***

The Homebuilders® intervention has demonstrated efficacy in several past studies: especially in terms of family reunification, post-permanency outcomes, and family stabilization (see Walton, Fraser, Lewis, & Pecora, 1993; Walton, 1996; Fraser, Walton, Lewis, Pecora, & Walton, 1996). While DCBS plans to make Homebuilders® available to any Family First candidate in the target population where the service is offered, evidence suggests it is especially useful immediately post-permanency. Based on insights from the literature, DCBS is led to conclude that Homebuilders® is especially pertinent and effective for families in the early days after reunification. Moreover, these favorable findings appear to persist at least one year after discharge from services. In their discussion of a quasi-experimental investigation of Homebuilders® in Utah, Fraser and colleagues (1996) stated:

“On the positive side, it is clear that the bulk of children in the FRS [Homebuilders®] condition were re-established safely in the custody of their birth parents. And included in this group is a sub-group of children who, without FRS [Homebuilders®], may never have reunified with their families. Across the 455 day study period, the FRS [Homebuilders®] children spent more time - the mean difference was 175 days - in their homes when compared to the children in the control group.”

DCBS finds these results encouraging, especially given that the sample reported on in this study was similar in many ways to the prospective population in Kentucky (e.g., primarily Caucasian,

history of past out of home care placements, primarily female heads of household, low-income, etc.).

### ***Further Evidence of Success from Utah and North Carolina***

Though most of this evidence appears to come from studies conducted in Utah, these results have been found in more than one state. Moreover, the results from Utah were discovered using a variety of study methodologies and over long periods of time. In a randomized controlled trial of Homebuilders® vs. routine reunification services, Walton (1998) found compelling results well beyond conventional follow-up periods. Specifically, at a one-year follow-up, 75% of children in the experimental condition receiving Homebuilders® were reunified with their families, whereas this outcome was only true for 49% of children in the control condition. Additionally, at six years post-discharge, approximately two-thirds of experimental condition families were considered *stabilized* vs. one-third of control condition families (Walton, 1998).

Furthermore, in a large quasi-experimental study of Homebuilders in North Carolina, Kirk and Griffith (2004) concluded that Intensive Family Preservation Services (IFPS; i.e. Homebuilders®) was an effective intervention for the prevention of out of home care placement. Specifically, their analyses found that the 542 high-risk children who received the intervention were 21% less likely to experience a placement than the 25,722 high-risk children who did not receive it. In their discussion of their findings, Kirk and Griffith (2004) state:

*“The results of this study contradict previous research on the effectiveness of IFPS. By studying a population of cases that fits the intended client definition (CPS high-risk children), by ensuring a high degree of treatment fidelity among service providers (using quality assurance statistics on 100% of providers and cases), by controlling for risk factors that affect placement rates (CPS risk rating, prior placements, prior substantiations, prior high-risk substantiations), and by using an analytic strategy that accounts for time by treating the dependent variable as dynamic rather than static (event history analysis), IFPS is shown to outperform traditional child welfare services when success is defined as placement prevention. Furthermore, when a Cox model is developed based on the aforementioned risk factors, as well as other factors at work in the treatment environment and an adjusted placement curve is constructed on the basis of the IFPS variable, IFPS is shown to be superior to traditional services when all variables are held constant at their respective means.” (p. 14).*

As Southeastern US states, both Kentucky and North Carolina share some common cultural and familial practices that lend credence to DCBS’ argument that what works in North Carolina will work in Kentucky. These include the prevalence of the Scots-Irish cultural identity, the

influence of Protestant Christian heritage on community life, beliefs about child rearing and disciplinary practices, etc.). In addition, Both Kentucky and North Carolina also contain regions of Central Appalachia within their borders – a region that Radel, Baldwin, Crouse, Ghertner, and Waters (2018) identify as being particularly negatively affected by increasing rates of substance use and foster care entries.

### ***Evaluation Waiver Request***

The evidence described above is sufficiently compelling that an evaluation of Homebuilders<sup>®</sup>, a newly designated *Well-Supported* evidence-based practice, is not necessary for Kentucky's 5-year prevention plan. The evidence-base is already adequate for this practice such that Kentucky believes that the resources available for evaluation would be most prudently applied to other prevention services that have an evidence-base that is less robust (i.e., a promising or supported EBP). Therefore, DCBS feels that CQI measures will suffice for Homebuilders<sup>®</sup> in this case.

### ***Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Intercept<sup>®</sup>***

The evidence in favor of the use of Intercept<sup>®</sup> as a means of promoting positive family dynamics and reducing the risk of foster care placements is compelling. Moreover, the weight of the evidence is sufficiently compelling to warrant a waiver of Family First evaluation requirements for this intervention. This request for a waiver of the evaluation requirement for the utilization of the Intercept<sup>®</sup> in Kentucky is based on the following:

- (1) It has been shown to be efficacious in a state that borders Kentucky (Tennessee), which shares several important demographic, cultural, and economic factors that influence family life and the experiences of children (Huhr & Wulczyn, 2021; Huhr & Wulczyn, 2022).
- (2) The studies identified by the Title IV-E Prevention Services Clearinghouse used very similar evaluation methods and data sources compared to what has been outlined within Kentucky's program evaluation plan for other EBPs. Therefore, unless one assumes that Kentucky's population and child welfare apparatus will respond to the intervention in a way that is incomparable to Tennessee, it is reasonable to assume that a program evaluation of Intercept<sup>®</sup> in Kentucky will find similar results as Huhr and Wulczyn (2022). While replication of published research is valuable, it is likely that Kentucky's resources would be better allocated elsewhere.
- (3) In a recent meta-analysis of 33 studies, Intensive Family Preservation Services (IFPS), broad category of interventions similar in spirit and implementation to Intercept<sup>®</sup> were demonstrated to significantly reduce the relative risk (RR) of a child's OOHC placement (Bezczky et al., 2020). Bezczky and colleagues (2020) noted that these significant

differences were observed at multiple points of follow-up: three-months post-intervention (RR = 0.57; 95% CI = 0.35-0.93); six-months post-intervention (RR = 0.51; 95% CI 0.27-0.96); 12-months post-intervention (RR = 0.60; 95% CI = 0.48-0.76); and 24-months post-intervention (RR = 0.51; 95% CI = 0.30-0.87).

*Intercept® Was Found to Be Efficacious in Tennessee, a Comparable State to Kentucky*

In two professional reports and one peer-reviewed article, Scott Huhr and Fred Wulczyn describe quasi-experimental studies that estimated the impact of Intercept® on OOHC placement rates among large samples of families in Tennessee (Huhr & Wulczyn, 2020; Huhr & Wulczyn, 2021; Huhr & Wulczyn, 2022). In each analysis, children who received the Intercept® intervention were significantly less likely to be placed in OOHC. Tennessee and Kentucky are similar for several important reasons. Primarily, both states belong to the same region of the United States and have comparable demographic features (see Table 5 below). Also, according to the most recently available data, Kentucky's rates of children receiving CPS investigations display a trend similar to Tennessee's rate (see Table 6 below). The fact that these rates have grown closer to one another in recent years suggests a comparable degree of children becoming involved with CPS in the two states.

Table 5.

*State Population Demographics (Kentucky and Tennessee)*

	Persons Under 5 Years	Persons Under 18 Years	White Alone	Per Capita Income	Persons in Poverty
Kentucky	6.1%	22.4%	87.5%	\$29,123	14.9%
Tennessee	6.0%	22.1%	78.4%	\$30,869	13.6%

Source: U.S. Census Quick Facts. <https://www.census.gov/quickfacts/fact/table/TN,KY,US/PST045221>

Table 6.

*Children who Received an Investigation or Alternative Response (Kentucky and Tennessee)*

	2018	2019	2020
Kentucky	83.2	77.2	66.9
Tennessee	57.9	62.8	56.9

Source: U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). *Child Maltreatment 2020*. Available from <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.

Note: Expressed as the number of investigations or alternative responses per 1,000 children in the state's population.

*A Full Program Evaluation of the Intercept® Program Would Effectively be a Replication Study*

The Huhr and Wulczyn analyses share three important features with the evaluation methods outlined in Kentucky's Family First Prevention Plan: (1) administrative child welfare data as the primary source of information; (2) retrospective quasi-experimental study methods that utilized theory-driven matching techniques to address selection bias; and (3) the risk of OOHC placement as the primary outcome variable (Huhr & Wulczyn, 2020; Huhr & Wulczyn, 2021; Huhr & Wulczyn, 2022). Furthermore, as these studies utilized an intent-to-treat approach for the creation of their treatment groups (which did not consider treatment program fidelity or heterogeneity in levels of family engagement), Intercept® demonstrated favorable outcomes even without accounting for important program dynamics. Lastly, the inclusion criteria for the Tennessee studies were virtually identical to Kentucky's foster care candidacy definitions, (i.e., the criteria that a child be reported to CPS essentially renders the entire population of children at risk for placement eligible to receive Intercept®).

### *A Systematic Review and Meta-Analysis of Similar Interventions Found Them to be Effective*

Huhr & Wulczyn (2022) state that Intercept® falls within a broader category of child welfare interventions known as IFPS. In a systematic review and meta-analysis of the impact of IFPS on OOHC placement rates, Bezeczký and colleagues (2020) write: "This comprehensive systematic review of the international published literature shows that at child level, IFPS significantly decreased the likelihood of out-of-home placement up to two years after the intervention. For studies that measured outcomes at family level, IFPS did not statistically decrease the likelihood of placements." (p. 7). The Bezeczký and colleagues (2020) article outlines a literature review process that involved screening 1,948 articles identified from 12 databases and 16 websites with 37 articles meeting the final inclusion criteria for the meta-analysis. In addition to the relative risk statistics reported earlier in point (3), the study authors reported emerging evidence that IFPS may be cost-beneficial or otherwise economically efficient. Given the weight of evidence described by the meta-analysis published by Bezeczký and colleagues (2020), Kentucky feels that a full program evaluation effort of Intercept® is not necessary.

### *Evaluation Waiver Request – The Intercept® Program*

The evidence described above is sufficiently compelling that an evaluation of Intercept®, a well-supported EBP, is not necessary for Kentucky's Family First Prevention Services Act Prevention Plan. The evidence-base is already strong for this practice and the resources that Kentucky has available for evaluation would be most prudently applied to another prevention service that has a less robust evidence base. Based on previous studies and evaluation reports that were identified by the Title IV-E Prevention Services Clearinghouse from similar contexts, DCBS feels that CQI measures will suffice.

### ***CQI strategy for Well-Supported Interventions***

A consistent, statewide CQI strategy will be utilized to monitor fidelity to the interventions and achievement of intended outcomes by those well supported EBPs. CQI processes may also measure additional performance outcomes to the extent possible, like families' experiences and/or satisfaction with the programs or treatment models included in the candidates' child-specific prevention plan. Kentucky is building CQI capacity and integrating CQI activities into existing practice in several ways. In addition to including CQI processes within Standards of Practice (SOP), DCBS is also hiring a Family First program specialist within the Prevention Branch of the Division of Protection and Permanency (DPP) to support statewide CQI activities and provide additional contributions and oversight to regional Family First liaisons as well as gatekeepers. The continuous monitoring processes and systems described in this section will also extend to be tailored to all interventions, in addition to well-supported interventions.

CQI processes will include quality periodic case reviews conducted with providers to ensure alignment with the practice models. Data will be collected and stored in model specific databases, the state CCWIS system, as well as an in-home provider database. Data will also be collected utilizing a screening tool to ensure data are collected consistently and accurately. Quality Control Analysts within the Information and Quality Improvement Unit will assist with regard to any data issues encountered. The sample size reviewed will be large enough to make statistical inferences and reviewed with regard to geographical location and population. Specific caseload data will be screened to provide context and address agency performance. Quarterly CQI meetings will be held with a variety of providers reviewing administrative reports consisting of key data points, assessing challenges to successful implementation and planning for solutions to eliminate the barriers identified by stakeholders. Data collected during the case review process will also be shared with providers during quarterly meetings. This will allow for providers to inform analysis and to increase collaborative efforts. Furthermore, focus groups with families and providers will be conducted annually.

Intervention fidelity will be monitored at several levels to determine outcomes achieved:

1. Provider level-adherence to intervention model purveyor fidelity activities;
2. DCBS Central Office administered case reviews to ensure intervention specific fidelity;  
and
3. State level interagency collaboration to refine and improve processes.

Executing all necessary protocols to monitor and promote fidelity, and collaborating with DCBS, for well-supported interventions, in the implementation of case reviews, quarterly meetings, and focus group participation, will be added to provider contacts during this state fiscal year (SFY) or at the latest, SFY 21. Providers are expected to complete intervention specific fidelity monitoring, as prescribed by each individual implementation manual. All Kentucky providers

participate in a workgroup formed to develop Kentucky's CQI process for well-supported interventions. Providers are engaged in the developing of case review screening tools and collection methods. This provides additional awareness of state monitoring and fidelity expectations, such as utilizing intervention model specific databases, collaborating with model purveyors to examine client outcomes or ongoing trainings. A Family First Specialist in DCBS Central Office will complete administration of the case review. Case reviews will be administered yearly, by region and intervention specific. Case reviews will assess if interventions are completed per model implementation manual, familial outcomes, if clinician training or certification is appropriate, if consultation occurs as prescribed, etc. Regional focus groups will also occur at the time of regional case review completion, with program recipients as participants. This will allow for the collection of additional performance measures to assess for program and intervention satisfaction, and familial experience. Focus groups will be facilitated by the Family First Specialist in DCBS Central Office to ensure objectivity, in that recipients answer without fear for repercussion or influence to answer favorably towards the agency.

Data collected through model specific databases, Kentucky's CCWIS system, the in-home provider database, case reviews, and focus groups, will be used to determine intervention-specific outcomes by region and provider, as well as statewide aggregate findings on key outcomes, such as rates of entry foster care and sustained reunification. This data will also be shared with each private provider regionally, following the completion of their regional/agency case reviews and focus groups. Areas in need of improvement identified will help to identify systematic issues requiring refinement, along with improving practices where growth is indicated for intervention implementation. Both areas of need and areas of success will be share with at quarterly statewide provide meetings. This feedback will assist in achieving fidelity statewide and identifying areas of growth for agencies, prior to them becoming problematic. Kentucky's development of processes and systems for CQI strategy for well-supported interventions largely compliments the revitalization of the department wide CQI process, with similar opportunities for regional meetings, stakeholder engagement, and a feedback loop. This also includes a forthcoming partnership with the Center for States and Chapin Hall. Three separate but closely aligned and integrated components will be included in the overall approach to the statewide CQI, Family First CQI, and Family First evaluation processes. These processes will work in tandem, by the engagement of service providers, along with the feedback loop of any necessary communication to field staff.

Specific to MI, MI will be used in Kentucky to enhance outcomes for families through increased collaboration with child welfare workers and prevention service providers, increased motivation to change for adults and adolescents with substance use disorder, and the enhance



to the uptake and completeness of other IVE EBPs, which will be monitored through Kentucky's Family First CQI process. Data specific to MI implementation will be collected and monitored through both a Reach Reporting Dashboard and fidelity monitoring case reviews. Reach reporting data measures provide insight into the numbers and characteristics of potential Family First candidates, and the numbers and characteristics of candidates actually referred to a prevention service, allowing for observation of changes over time and after implementation of MI by child welfare workers. Candidate level data is also collected by prevention provider response to prevention service referrals, which will also allow for analysis of any changes in the service uptake for candidates. This data is further measured by the EBP(s) referred by the child welfare worker, and the EBP(s) ultimately delivered by the prevention provider.

Fidelity monitoring case reviews are completed by specialists on the DPP Prevention Branch to monitor prevention provider adherence to EBP fidelity. Specific to MI, this includes educational and training requirements, supervision, clinical assessments, appropriateness of the client, and practitioner competence. Fidelity monitoring case reviews will also be extended to the monitoring of frontline child welfare worker and supervisors in their implementation of MI. Similar to the training of prevention provider staff, specified child welfare staff will have basic and advanced motivational interviewing training, as well as necessary coding and coaching trainings. This will allow for child welfare staff to provide coaching, utilize fidelity monitoring for frontline child welfare workers, including the use of manual congruent fidelity monitoring tools, such as the Motivational Interviewing Treatment Integrity (MITI) or Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA:STEP), and assess frontline worker proficiency level and needs. The case review tool also captures data regarding the completeness of the intervention, whether the EBP has been completed, the service end date, and the reason the EBP was not completed if it ended prematurely, allowing for measurement of enhanced EBP completion for EBPs used in conjunction with MI for prevention provider case reviews. Information learned from CQI activities for Motivational Interviewing will be presented to stakeholders during quarterly Family First Prevention CQI meetings to allow for collaborative work to address identified needs. Regional child welfare staff, such as referral gatekeepers, Family First liaisons, and CQI Specialist attend the stakeholder group meeting, making the dissemination of information and engagement of necessary professionals in planning, a seamless process.

Information learned from the aforementioned CQI activities will be used to improve practice at multiple levels. Specific to MI use by child welfare workers, this will occur at the level of child welfare staff monitoring fidelity, child welfare staff utilizing MI with families, at a regional or county level, and a statewide level. Child welfare staff monitoring fidelity will receive basic, advanced, and in a clinical supervisory fidelity assessment tool. Child welfare staff monitoring



fidelity of individual child welfare case managers will be monitored and assessed until reaching proficiency in MI. Child welfare staff utilizing MI will be assessed for fidelity to MI during monthly individual case consultation, such as assessment of their use of global skills, change talk, sustain talk, partnership and empathy, and behavioral skills, giving information, questions, affirmations, etc. present within the MITI assessment tool. During case consultation coaching and feedback will occur, including MI skills targeted for improvement as assessed through a clinical tool, such as the MITI assessment tool. Fidelity monitoring case reviews of MI use by child welfare workers will then occur as part of the statewide process of fidelity monitoring case reviews, randomly selected by case. Fidelity monitoring case reviews will include review of staff training records, consultation and coaching documentation, clinical assessments, appropriateness of the client, the use of MI skills, consistency with the spirit of MI, and the use of change talk. Debriefings from state level fidelity monitoring case reviews will occur at a county or regional level, depending on the case location of cases randomly selected for review. Debriefings will include the child welfare worker, child welfare staff monitoring fidelity at a local level, reviewers, and prevention branch staff. Regional or county debriefings will also include invitations of appropriate MI trainers for attendance. Debriefings allow reviewers to speak directly to child welfare staff and trainers regarding the information produced from the case review process. This allows for discussion to occur regarding any concerns or identified needs to ensure that services are being provided to fidelity to improve practice. Lastly, statewide Family First CQI Stakeholder meetings occur at the highest level of the feedback loop for fidelity monitoring. With regional child welfare staff in attendance, data on trends in fidelity to MI specific to use by child welfare workers will be shared with the stakeholder group, identification of needs, and relevant planning to occur to improve practice.

Specific to High-Fidelity Wraparound will also include data collection activities through the Reach Dashboard and fidelity monitoring case reviews. The Reach Dashboard allows for assessment of family access to necessary services, and of services referred and then actually received. High-Fidelity Wraparound will also be added to fidelity monitoring case reviews, including case review sections monitoring practitioner education and training, intervention appropriateness to the clients, and service activities. Within the section on education and training, use of wraparound specific fidelity monitoring tools will be included, such as assessment systems or supervisory/program checklists to monitor implementation and wraparound principles (Miles, 2011). Monitoring of supervisory activities congruent with wraparound supervision guidelines implemented by prevention providers will also be included in the education and training section. (Miles, 2008). With regard to service activities and in addition to wraparound principle adherence, monitoring of the types of services included in wraparound plans and information preventing plans from being implemented, will be included in the service activities section of the tool (Miles, 2011). Typical Wraparound outcomes

measured, include the child remaining in their home, increased well-being, and cost monitoring, which are complimentary to Kentucky's Theory of Change in Appendix A, through decreased out of home care placements, increased family and child well-being, and decreased foster care expenditures (Miles, 2011). Wraparound fidelity monitoring also emphasizes collaborative stakeholder involvement and the gathering of qualitative satisfaction measures (Miles, 2011). Both of which are congruent with Kentucky's CQI approach including quarterly stakeholder meetings for data dissemination and planning for needs identified, and focus groups to garner family perceptions of their needs being met and their satisfaction with services.

Specific to Intercept, Youth Villages has a well-established ongoing process to ensure that Intercept® is delivered with fidelity to the program model. Continuous quality improvement (CQI) is incorporated throughout the Intercept model, with specific fidelity measures tied to high-quality service delivery leading to sustainable, positive long-term outcomes for children and families. The Intercept CQI framework is based on three primary processes that inform program improvement efforts.

- **Program Model Reviews:** The program model review (PMR) is Youth Villages' primary process for monitoring the implementation of the Intercept model. Annually in each location, the PMR gathers data through documentation review, customer surveys, staff surveys, interviews, and aggregate data pulled from the electronic health record. This review generates scores that indicate areas of strength and opportunities for improvement to help ensure that the program meets the expected outcomes. Following the identification of areas that need to be addressed, clinical and operational leadership work with the evaluation team to create a plan for additional monitoring and/or evaluation activities that will support implementation improvement.
- **Performance Management:** In addition to the Intercept model's clinical consultation and group supervision processes, Youth Villages regularly reviews key performance indicators such as caseloads, staff retention, and rates of serious incidents to monitor the program's performance. The regular review of these measures gives leadership a regular, consistent look at whether the program is operating "within the guardrails."
- **Ongoing Outcome Evaluation:** Youth Villages developed an internal evaluation process to collect data at admission, discharge, and 12-months post-discharge to provide the agency with information used for program monitoring and improvement. All youth who receive at least 60 days of service are followed at all post-discharge points, regardless of status at discharge. Data are collected on placement, custody, school status, negative involvement with the justice system, and out-of-home placements.

Youth Villages' fidelity monitoring process is maintained through the organization's annual Program Model Reviews (PMRs) for each location that delivers the Intercept model. For each Intercept PMR review period, a sample of youth is selected at random for review. Youth Villages will continue to utilize existing data collection methods, including an extensive documentation review (involving review of clinical records, consultation notes, staff development plans, and other assessments), customer surveys, staff surveys, interviews, and aggregate data pulled from the electronic health record system. The PMR is conducted by the organization's Clinical Services department and produces scores on a 0-3 scale, with 0 indicating area of strength in the program model implementation and 3 indicating opportunities for improvement that need immediate attention. The scored results of the PMR are displayed through an interactive data visualization instrument that allows program leadership to focus on areas to target interventions (for example, the ability to filter results by office location or to see what specific data was compiled to produce a specific score). Once the review is completed and the dashboard is prepared, leadership from the Clinical Services department meets with the program's operational leadership to review the findings, including discussing action plans to address opportunities for improvement identified in the review. Specific to state level fidelity monitoring for Intercept, Youth Villages Clinical Services Department will also share PMR findings with Kentucky, which are congruent with case reviews completed by the state of Kentucky, including assessing for training/education, appropriateness of the intervention, and service activities. This will aid in collaboration for action planning and include dissemination at quarterly Family First CQI Stakeholder meetings. Intercept will also be incorporated into Reach Dashboard assessment of family access to needed services.

In addition to the annual PMR process, Youth Villages' ongoing performance management process provides program operational leadership with key performance indicators on a regular basis in between PMRs, to ensure that the program is operating within the parameters of the model. This continuous monitoring allows program operational leadership to adjust program operations as needed.

As part of its Data Science department, Youth Villages employs a call team that gathers outcome data. Call team members conduct a survey shortly after discharge to assess satisfaction with services; this survey allows the call team to gather additional contact information that is helpful for the follow-up surveys. At six- and twelve-months post-discharge, surveys examine outcomes in the areas of housing stability, education, employment (for older youth), criminal justice involvement, and out-of-home placements. Additionally, Youth Villages' Evaluation & Research Advisory Committee, which includes some of the most widely respected scholars in the research field, reviews the ongoing outcome evaluation process and provides

guidance on best practices in the field to ensure that the organization maximizes the efficiency and effectiveness of data collection efforts.

Features of Youth Villages' outcome evaluation process include the following:

- All youth who receive at least 60 days of service are followed at all post-discharge points, regardless of their status at discharge.
  - To determine the outcomes of interest following services, this involves assessing only youth who received at least a minimum dose of services, defined as 60 days of enrollment in Intercept.
  - The percent of youth who receive less than 60 days of service is always reported along with the outcome data; this figure is monitored for each program/location through the performance management process so that program leadership can adjust the referral and/or engagement and alignment processes as needed.
- Data focus on behavioral and functional indicators that are important to the organization's vision of helping children and families live successfully. Youth Villages collects data on placement, custody, school status, negative involvement with the justice system, and out-of-home placements; for older youth, questions are also asked about employment, pregnancy, and parenting.
- Surveys are completed with youth and families who have discharged from Youth Villages' services altogether. If a youth re-enters Youth Villages services, the survey cycle is reset, beginning again with their new discharge date; the percentage of youth who have re-entered services is reported along with the outcomes.
- Post-discharge data collection occurs mostly through phone surveys, although mail and electronic surveys are also utilized to reach families.
  - Call team members use texting to reach families who may have limited minutes of talk on their phones or who have text-only cell phones.
  - Extensive internet searches are conducted to find hard-to-locate families for follow-up surveys.

### ***Evaluation Strategy for Promising and Supported Programs***

Pursuant to Section 471(e)(5)(B)(iii)(V), the Family First Prevention Services Act of 2018 requires states to conduct a well-designed and rigorous evaluation of allowable programs or services. Specifically states are required to outline:

*“(V) how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary.”*

### ***Kentucky's Family First Well-Designed and Rigorous Evaluation Efforts***

Kentucky's evaluation strategy for Family First implementation will apply an evaluation model that includes process, outcome, and impact measures. Given their evidence ratings from the Title IV-E Clearinghouse (or to be determined rating), this evaluation plan will apply to: (1) START, (2) TF-CBT, and Wraparound. While DCBS has developed an over-arching evaluation strategy for Family First implementation as a whole within the State, the agency will be working with Cabinet for Health and Family Services evaluators and an internal CQI team to ensure that there is a discrete evaluation or CQI strategy for each EBP proposed within this Title IV-E Prevention Plan.

This section will present the roles and responsibilities of the evaluation team, the unique features of each evaluation strategy, some particularities around data collection and sampling, and perceived limitations and they will be addressed.

### ***Evaluation Roles and Responsibilities***

An evaluation/CQI team of CHFS Family First research/evaluation staff, program leadership, front line staff, community stakeholders, and client stakeholders is being developed. As mentioned earlier, the evaluation team will be led by Matthew Walton, PhD, MSSW and Dana Quesinberry, JD, DrPH. They are each staff members of the Division of Analytics in the Office of Health Data and Analytics (OHDA) at the Cabinet for Health and Family Services – where they work alongside a team of analysts.

In addition to the leadership of Dr. Walton and Dr. Quesinberry, the Family First evaluation will be supported by the technical professionals of the Office of Health Data and Analytics (OHDA). OHDA operates within a close partnership with the Kentucky Department of Medicaid Services, and serves as one of CHFS' primary resources for data analytics, data privacy and confidentiality concerns, and statistical analysis. It is staffed by biostatisticians, data architects, and analysts with expertise in health and social services data. The research support provided by OHDA will enable the evaluation team to have access to multiple technical experts to aid their efforts.

Dr. Walton and Dr. Quesinberry will also coordinate with the lead evaluator of the former Title IV-E Waiver Demonstration programs; Dr. Martin Hall, PhD, MSSW at the University of Louisville – Kent School of Social Work. Dr. Hall is the lead evaluator for the START program in Kentucky. Dr. Hall is a tenured professor of social work, and has several years of experience as a program evaluator. He has built the research infrastructure to sustain the ongoing program evaluation of START. Therefore, rather than serving as primary evaluation team for START, OHDA plans to serve as a coordinator and source of support for Dr. Hall and the START evaluation during its implementation under Family First.

More specifically, the evaluation strategy outlined in this plan is largely an extension of the methodologies employed by the START evaluation – meaning that DCBS has the full confidence that the continuation of the START evaluation will adhere to the historical satisfactory degree of rigor and strength of design. Additionally, Dr. Walton and Dr. Hall have been in consultation during the development of this evaluation to coordinate their efforts, methodological approaches, and knowledge of the available data in the TWIST system. For further information about the historical approach to the design elements of the START evaluation, please see Huebner et al. (2012), Huebner, Posze, Willauer & Hall (2015), and Hall et al. (2015).

While DCBS is proposing that a formal, well-designed, rigorous evaluation will apply to some EBPs and CQI strategies will apply to others, this evaluation/CQI team will work in partnership to ensure a shared conceptual framework, promote collaboration and information sharing, and create a sound foundation for DCBS’ broader Family First implementation. Again, in light of Kentucky’s waiver request for well supported interventions, DCBS still intends to use data and a critical appraisal of evidence to inform decision making about child safety and program outcomes.

### ***A Note on Evaluation Strategies***

Because Kentucky has a comprehensive, state-wide data collection tool (i.e., the TWIST system) and a data-sharing agreement between OHDA and DCBS, each of the four individual well-designed and rigorous evaluations of prevention services will share a set of underlying methodological similarities. Specifically, secondary child welfare administrative data will be stored and accessed in the same way for each evaluation, and utilizes the same structure (i.e., variable names, conceptual/theoretical definitions, assessment tools). Furthermore, there are foreseeable instances where DCBS clients will receive two or more prevention services during the same case plan (START + TF-CBT being particularly common in Kentucky). Drawing from a common source of data will allow the evaluation team to estimate whether synergistic treatment effects are realized by these clients who receive multiple interventions for the same case. This being the case, this section will provide an outline of each program’s individual evaluation strategy, and then proceed to describe how the evaluation team understands those common underlying elements that will inform the evaluation as a whole.

### ***Evaluation Outline – High Fidelity Wraparound***

As described earlier, High-Fidelity Wraparound is a care coordination strategy for children with multiple complex needs. It will be provided by a network of community mental health centers, clinics, and other centers in Kentucky that treat the behavioral and psychological needs of children and families. The thesis behind offering High-Fidelity Wraparound as a means of preventing OOH is that providing more integrated and coordinated services will decrease the likelihood of the “falling through the cracks” phenomenon. In other words, where children are

removed from the home or placed in a more restrictive environment because of the exacerbation of an underlying problem that arose because of a missed appointment, a lack of effective communication between providers, or a failure of a care coordination plan, (e.g., transportation problem, health insurance problem, etc.). This capacity of High-Fidelity Wraparound has been illustrated by Cosgrove, Lee, & Unick (2020), who demonstrated that a statewide implementation of the model in Maryland significantly reduced the utilization of residential care amongst children and youth. Table 7 provides an outline of the approach that will be taken to perform the evaluation of High-Fidelity Wraparound as part of Kentucky’s implementation of Family First.

### ***Inclusion Criteria & Sampling***

High-Fidelity Wraparound will be offered to children who are candidates for foster care and their parents or caregivers when the family is involved with multiple systems of care. This inclusion criteria will often be satisfied because children and youth have severe emotional or behavioral health problems that require the services of disparate care providers – such as special education teachers, juvenile justice systems, psychological treatment providers, and other child-serving agencies. Contrary to some of the other evidence-based practices, High-Fidelity Wraparound has a very broad application with a high degree of flexibility for which families satisfy these inclusion criteria. This flexibility applies to the diagnoses children have, the age range they fall within, and the types of services that are coordinated via the High-Fidelity Wraparound intervention.

The intervention, (i.e., “experimental”) group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child’s Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child’s Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice



Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

### *Data Collection*

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive High-Fidelity Wraparound. DCBS case workers and other providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and which placement types are utilized, (e.g., kinship care, fictive kin, QRTP, etc.).

### *Outcome Measures*

This evaluation will make treatment effect estimates for whether High-Fidelity Wraparound: (1) reduces the likelihood of a subsequent, substantiated maltreatment report, (2) reduces the likelihood of a child being removed from the home, and (3) whether High-Fidelity Wraparound decreases the average length of time children spend in OOHC. Please see Table 7 for the proposed analytic approaches for these outcomes.

### *Limitation: Training the Child Welfare Workforce in Motivational Interviewing will Alter the Meaning of 'Treatment as Usual' in Kentucky*

A call for training child welfare workforces in MI has been issued in the literature by Barth, Lee, & Hodorowicz (2017). In their article, the authors note that, broadly speaking, child welfare professionals are interested in (and open to) receiving training in practices that help them engage with their clients in more fruitful ways. Notably, Barth, Lee, & Hodorowicz (2017)



provide a particularly useful example of a successful MI-training initiative to prepare child welfare professionals with this skill set.

While there is clinical evidence that Kentucky's decision to provide universal MI training to its DCBS workforce is likely to promote favorable family outcomes (see Shah et al., 2019; Hall, Sears, & Walton, 2020), it will admittedly complicate the program evaluation. However, for several reasons, the evaluation team does not believe these complications will be prohibitive of making valid and practically useful study conclusions.

First, there is a dearth of research on the effects of MI on the principal outcome measures of Kentucky's Family First program evaluation efforts – namely: (1) out of home care placements, and; (2) recurrence of maltreatment. In a systematic review of MI in child welfare services, Hall, Sears, & Walton (2020) acknowledged this reality, saying:

“In spite of MI's conceptual appropriateness for families involved in CW, this review identified few studies evaluating the impact of MI-trained CW workers on placement in OOHC and no studies evaluating their impact on recurrent child maltreatment. Additionally, studies of more proximal outcomes, such as engagement in treatment, show mixed results. Notably, variation in study results may reflect important differences in study populations, MI training protocols, or other factors.” (p. 273)

In other words, while it is likely that some beneficial outcomes will be realized from this broad scale MI training initiative within DCBS, the evaluation team cannot identify any empirical literature that would lead them to believe they can know exactly how they will be manifested. In the absence of such evidence, the principles of the null hypothesis in this style of research would dictate that the evaluation begin with the assumption that MI – as it will be applied in this case – will have no significant effect on the primary program evaluation outcomes. While this may present a challenge to the interpretation of results, the evaluation team believe it falls within the range of acceptable study limitations.

Second, because MI training as proposed here applies to all DCBS workers, the evaluation team believes this could effectively result in what Barth and colleagues (2017) referred to as “raising the floor on clinical practice” (p. 217). In effect, the evaluation team envisions this to mean that, whatever benefits are realized from this training initiative, they will evenly apply to comparison groups as well as treatment/experimental groups. Conceptually, this will mean that, as increasingly more of the DCBS workforce is trained in MI, the “Treatment As Usual” comparison groups in evaluation analyses will be understood to contain the effects of the use of MI in child welfare casework.

The team of Kentucky’s evaluators for the implementation of Family First have met to discuss these effects that broad training of the DCBS workforce in MI and how they might impact future evaluation analyses. Broadly speaking, the evaluators understand that introducing this new capacity in the workforce may create confounding effects on evaluation analyses of individual evidence-based practices in ways that will be difficult to predict. To address these confounding effects, studies produced by the evaluation will attempt to adjust for them, and will at least include the presence of the MI training initiative as a documented limitation on isolating the unique effects of a given intervention (e.g., TF-CBT) for families and children.

<b>Table 7</b> <i>Evaluation Strategy – High-Fidelity Wraparound</i>	
Orienting Question	Is effectively addressing a child’s care coordination needs associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> <li>○ Children and adolescents that have multiple complex care needs and are at risk for out of home care placement. Examples include: <ul style="list-style-type: none"> <li>- Diagnosed with anxiety and/or mood disorder, externalizing disorders, (e.g., Depression, Oppositional Defiant Disorder)</li> <li>- Young people with severe learning challenges</li> <li>- Young people involved with the juvenile justice system</li> </ul> </li> <li>○ The parents &amp; caregivers of children and adolescents with complex care needs.</li> </ul>
Data Collection & Management	<ul style="list-style-type: none"> <li>○ The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes: <ul style="list-style-type: none"> <li>- Data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators)</li> <li>- Case milestone dates (investigation, case opening, removal dates, etc.)</li> <li>- Flag variable for which children have been identified as FFPSA candidates</li> <li>- Flag variables to identify children that have been placed in foster care</li> <li>- Results of assessments and screenings</li> </ul> </li> </ul>
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> <li>○ The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> <li>- Primary source of secondary administrative child welfare data</li> <li>- Used for investigatory phase, assessing family risk and protective factors</li> </ul> </li> <li>○ The Structured Decision Making Tool (SDM)*</li> <li>○ The North Carolina Family Assessment Scale</li> </ul>
Sampling	<ul style="list-style-type: none"> <li>○ Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> <li>- i.e., clients who are: a) determined to be families w/ a FFPSA</li> </ul> </li> </ul>

	<p>child candidate; b) screened for clinical appropriateness to receive services; c) receive at least 1 occurrence of High-Fidelity Wraparound</p> <ul style="list-style-type: none"> <li>○ Comparison group – propensity score matched sample <ul style="list-style-type: none"> <li>- i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables</li> </ul> </li> </ul>
Outcomes of interest	<ul style="list-style-type: none"> <li>○ Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services</li> <li>○ Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening</li> </ul>
	<ul style="list-style-type: none"> <li>○ Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety</li> </ul>
	<ul style="list-style-type: none"> <li>○ Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home</li> </ul>
Analysis Plan	<ul style="list-style-type: none"> <li>○ For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> <li>- Categorical variables – Chi-square tests (<math>\chi^2</math>)</li> <li>- Continuous variables – t-tests</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> <li>- Chi square tests of significance (<math>\chi^2</math>)</li> <li>- Logistic regression</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For time-oriented outcome variables: <ul style="list-style-type: none"> <li>- Event-history analysis (i.e., Kaplan-Meier estimation)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> <li>- Generalized linear modeling techniques</li> <li>- (Will consider natural log data transformations if appropriate and indicated)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> <li>- Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions</li> </ul> </li> </ul>
Limitations	<ul style="list-style-type: none"> <li>○ PSM cannot control for unobserved co-variates</li> <li>○ The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> <li>- Parental motivation/capacity for change</li> <li>- Therapist/counselor experience, skill level, and therapeutic rapport</li> </ul> </li> <li>○ Measures of parent and child well-being</li> <li>○ Variance in case features not related to intervention <ul style="list-style-type: none"> <li>- Judicial decision-making</li> <li>- Availability of extra services &amp; supports (e.g., housing/utilities support, child support payments, school-based services)</li> </ul> </li> </ul>
*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and	

implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.

### ***Evaluation Outline – Trauma-Focused Cognitive Behavioral Therapy***

As described earlier, Trauma-Focused Cognitive Behavioral Therapy is a psychiatric intervention intended to address disorders specifically related to psychological/emotional trauma. TF-CBT is one of the most widely offered of the EBP’s listed on this plan. It will be provided by a network of community mental health centers, clinics, and other centers that treat the psychological needs of children and families. The thesis behind offering TF-CBT as a means of preventing out of home care Table 8 provides an outline of the approach that will be taken to perform the evaluation of TF-CBT as part of Kentucky’s implementation of Family First.

### ***Inclusion Criteria & Sampling***

TF-CBT will be offered to children and their parents or caregivers who exhibit signs and symptoms of psychological distress that is consistent with trauma. The treatment manual dictates that the intervention is intended to benefit children aged 3 years to 18 years of age – and is most commonly provided for anxiety and mood disorders. The intervention (i.e., “experimental”) group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child’s Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child’s Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child’s Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	“Substantiated” or “Services Needed”	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk

<b>Parental Mental Illness</b>	<b>Whether mental illness is an identified risk factor</b>	<b>Parental mental illness significantly effects the outcomes of child welfare work</b>
<b>Domestic Violence</b>	<b>Whether domestic violence in the home is an identified risk factor</b>	<b>Domestic violence is an important risk factor for certain child welfare outcomes</b>
<b>Poverty</b>	<b>Whether an investigation has identified the presence of material deprivation as a risk factor</b>	<b>Poverty and material hardship are significantly related to the risk for child maltreatment reports</b>
<b>Parental Criminal History</b>	<b>Whether an investigation identified criminal history as a risk factor</b>	<b>A parent's criminal history may be suggestive of risks to child safety or permanency</b>
<b>Risk Due to Substance Use</b>	<b>Whether parental substance use was identified as a risk for future maltreatment</b>	<b>Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being</b>

### *Data Collection*

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive TF-CBT. DCBS case workers and psychiatric treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and which placement types are utilized (e.g., kinship care, fictive kin, Q RTP, etc.).

### *Outcome Measures*

This evaluation will make treatment effect estimates for whether TF-CBT: (1) reduces the likelihood of a subsequent, substantiated maltreatment report, (2) reduces the likelihood of a child being removed from the home, and (3) whether TF-CBT decreases the average length of time children spend in out of home care. Please see Table 8 for the proposed analytic approaches for these outcomes.

### *Limitation: Training the Child Welfare Workforce in Motivational Interviewing will Alter the Meaning of 'Treatment as Usual' in Kentucky*

A call for training child welfare workforces in MI has been issued in the literature by Barth, Lee, & Hodorowicz (2017). In their article, the authors note that, broadly speaking, child welfare professionals are interested in (and open to) receiving training in practices that help them engage with their clients in more fruitful ways. Notably, Barth, Lee, & Hodorowicz (2017) provide a particularly useful example of a successful MI-training initiative to prepare child welfare professionals with this skill set.

While there is clinical evidence that Kentucky's decision to provide universal MI training to its DCBS workforce is likely to promote favorable family outcomes (see Shah et al., 2019; Hall, Sears, & Walton, 2020), it will admittedly complicate the program evaluation. However, for

several reasons, the evaluation team does not believe these complications will be prohibitive of making valid and practically useful study conclusions.

First, there is a dearth of research on the effects of MI on the principal outcome measures of Kentucky's Family First program evaluation efforts – namely: (1) out of home care placements, and; (2) recurrence of maltreatment. In a systematic review of MI in child welfare services, Hall, Sears, & Walton (2020) acknowledged this reality, saying:

“In spite of MI’s conceptual appropriateness for families involved in CW, this review identified few studies evaluating the impact of MI-trained CW workers on placement in OOHC and no studies evaluating their impact on recurrent child maltreatment. Additionally, studies of more proximal outcomes, such as engagement in treatment, show mixed results. Notably, variation in study results may reflect important differences in study populations, MI training protocols, or other factors.” (p. 273)

In other words, while it is likely that some beneficial outcomes will be realized from this broad scale MI training initiative within DCBS, the evaluation team cannot identify any empirical literature that would lead them to believe they can know exactly *how they will be manifested*. In the absence of such evidence, the principles of the null hypothesis in this style of research would dictate that the evaluation begin with the assumption that MI – as it will be applied in this case – will have no significant effect on the primary program evaluation outcomes. While this may present a challenge to the interpretation of results, the evaluation team believe it falls within the range of acceptable study limitations.

Second, because MI training as proposed here applies to all DCBS workers, the evaluation team believes this could effectively result in what Barth and colleagues (2017) referred to as “raising the floor on clinical practice” (p. 217). In effect, the evaluation team envisions this to mean that, whatever benefits are realized from this training initiative, they will evenly apply to comparison groups as well as treatment/experimental groups. Conceptually, this will mean that, as increasingly more of the DCBS workforce is trained in MI, the “Treatment As Usual” comparison groups in evaluation analyses will be understood to contain the effects of the use of MI in child welfare casework.

The team of Kentucky’s evaluators for the implementation of Family First have met to discuss these effects that broad training of the DCBS workforce in MI and how they might impact future evaluation analyses. Broadly speaking, the evaluators understand that introducing this new capacity in the workforce may create confounding effects on evaluation analyses of individual evidence based practices in ways that will be difficult to predict. To address these confounding

effects, studies produced by the evaluation will attempt to adjust for them, and will at least include the presence of the MI training initiative as a documented limitation on isolating the unique effects of a given intervention (e.g., TF-CBT) for families and children.

<b>Table 8</b> <i>Evaluation Strategy – Trauma-Focused Cognitive Behavioral Therapy</i>	
Orienting Question	Is effectively addressing psychological trauma (and its associated anxiety and depression) associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> <li>○ Children and adolescents that have been exposed to traumatic experiences (i.e., child candidates for foster care) <ul style="list-style-type: none"> <li>- Diagnosed with anxiety and/or mood disorder (e.g., Depression)</li> <li>- Often children exhibiting signs &amp; symptoms of PTSD</li> <li>- Not for very young, pre-verbal children (typically ages 3 – 18 years old) or children with severe communication disorders</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ The parents &amp; caregivers of traumatized children and adolescents</li> </ul>
Data Collection & Management	<ul style="list-style-type: none"> <li>○ The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes: <ul style="list-style-type: none"> <li>- Data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators)</li> <li>- Case milestone dates (investigation, case opening, removal dates, etc.)</li> <li>- Flag variable for which children have been identified as FFPSA candidates</li> <li>- Flag variables to identify children that have been placed in foster care</li> <li>- Results of assessments and screenings</li> </ul> </li> </ul>
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> <li>○ The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> <li>- Primary source of secondary administrative child welfare data</li> <li>- Used for investigatory phase, assessing family risk and protective factors</li> </ul> </li> <li>○ The Structured Decision Making Tool (SDM)*</li> <li>○ The North Carolina Family Assessment Scale</li> </ul>
Sampling	<ul style="list-style-type: none"> <li>○ Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> <li>- i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services; c) receive at least 6 sessions of TF-CBT</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ Comparison group – propensity score matched sample <ul style="list-style-type: none"> <li>- i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables</li> </ul> </li> </ul>
Outcomes of interest	<ul style="list-style-type: none"> <li>○ Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services</li> </ul>
	<ul style="list-style-type: none"> <li>○ Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening</li> </ul>

	<ul style="list-style-type: none"> <li>○ Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety</li> </ul>
	<ul style="list-style-type: none"> <li>○ Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home</li> </ul>
Analysis Plan	<ul style="list-style-type: none"> <li>○ For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> <li>- Categorical variables – Chi-square tests (<math>\chi^2</math>)</li> <li>- Continuous variables – t-tests</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> <li>- Chi square tests of significance (<math>\chi^2</math>)</li> <li>- Logistic regression</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For time-oriented outcome variables: <ul style="list-style-type: none"> <li>- Event-history analysis (i.e., Kaplan-Meier estimation)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> <li>- Generalized linear modeling techniques</li> <li>- (Will consider natural log data transformations if appropriate and indicated)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>○ For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> <li>- Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions</li> </ul> </li> </ul>
Limitations	<ul style="list-style-type: none"> <li>○ PSM cannot control for unobserved co-variates</li> <li>○ The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> <li>- Parental motivation/capacity for change</li> <li>- Therapist/counselor experience, skill level, and therapeutic rapport</li> </ul> </li> <li>○ Measures of parent and child well-being</li> <li>○ Variance in case features not related to intervention <ul style="list-style-type: none"> <li>- Judicial decision-making</li> <li>- Availability of extra services &amp; supports (e.g., housing/utilities support, child support payments, school-based services)</li> </ul> </li> </ul>
<p>*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.</p>	

## ***Evaluation Outline – Sobriety Treatment and Recovery Teams***

### ***A Proposed Sub-study of the START Program***

A rigorous evaluation was undertaken as part of the IV-E Waiver (2014-2019) awarded to Kentucky's Department of Community Based Services. This evaluation consisted of 526 children in families randomized to START or usual child welfare services in Jefferson County, Kentucky. Additionally, the IV-E Waiver evaluation included 336 children in families receiving START or usual services who were part of a propensity score matched (PSM) outcome evaluation in Boyd, Fayette, and Kenton Counties (the PSM process was similar to the one outlined for START elsewhere in this document). The evaluation assessed subsequent maltreatment and out of home placement within 12-months of the event that initiated START or usual child welfare services. Due to the duration of START (14 months on average) and the



time constraints of the Waiver, outcomes beyond that could not be assessed as part of this specific evaluation effort.

However, this creates an interesting opportunity for longer-term follow-up study with this sample. Such a study would stand to make an important contribution as it would provide estimates of START's effects 6 and 12-months after case closure. If START were found to demonstrate favorable effects in this follow-up period, it could potentially elevate START's status from a promising to well-supported practice. Given that this study sample resulted from randomization and a rigorous propensity score matching process, it presents an opportunity to build on the existing evidence base of START. This would be valuable for Kentucky's DCBS and other jurisdictions that either offer START currently or plan to in the future.

Specifically, in the third year of this plan, TWIST data will be used to evaluate recurrent maltreatment and out of home placements 6 and 12-months after case closure for children included in the IV-E Waiver sample. Waiting until the third year of the plan to execute this substudy will ensure that all IV-E Waiver families have at least 12 months of case closure.

As described earlier, Sobriety Treatment and Recovery Teams is a child welfare intervention oriented around partnerships between special CPS units and addiction treatment providers. This intervention is designed to intervene in families with very young children where a parent or caregiver struggles with substance use. It is currently administered in seven counties around Kentucky. Its primary approach to reducing the risk of out of home care placement is based on the thesis that helping a parent establish long-term addiction recovery will serve as a sufficient protective factor against future maltreatment. Table 9 provides an outline of the approach that will be taken to perform the evaluation of START as part of Kentucky's implementation of Family First.

#### *Inclusion Criteria & Sampling*

START will be offered to families of children aged birth – 5 years old. START is designed to build rapport with, and then support parents and caregivers who exhibit high-risk substance use and consent to participating with intensive psychosocial services in order to maintain custody of their child. The START treatment manual dictates that the intervention is intended to be administered over an approximately one-year period of time (adherence to ASFA permanency timelines is especially emphasized). The intervention (i.e., “experimental”) group will be sampled through purposive sampling; in other words all eligible clients who are deemed appropriate to participate after the referral and assessment processes will be followed for the evaluation study. In terms of the comparison groups, 1:1 nearest-neighbor PSM matching will

be used; without replacement and with a caliper size of .20 of the standard deviation of the propensity score. The matching variables will be as follows:

Variable	Description	Justification for Inclusion
DCBS Service Region	Service region where the index CPS case originated	Sampling from the same geographic and administrative state region helps reduce selection bias in non-experimental studies
Child's Age	Families will be matched based on the features of the youngest named child on the CPS report	It is known that younger children are at highest risk of the most extreme consequences of maltreatment
Child's Race	Will be coded as White, Black, or Other Race	There is an extensive body of literature that details how racial disproportionality is manifested in child welfare practice
Child's Biological Sex	Will be coded as Male or Female	Boys and girls differ in their degree of risk for certain types of maltreatment (e.g., girls are more often sexually abused)
Investigation Finding	"Substantiated" or "Services Needed"	The case designations required to be named a FFPSA foster care candidate
Index Year of Contact with CPS	The year a case was opened	Time is a meaningful covariate in statistical analyses (e.g., fixed vs random-effects linear models)
Past Substantiated CPS Case	Whether a family has been served by CPS in the past	Past substantiated reports of child maltreatment are predictors of future risk
Parental Mental Illness	Whether mental illness is an identified risk factor	Parental mental illness significantly effects the outcomes of child welfare work
Domestic Violence	Whether domestic violence in the home is an identified risk factor	Domestic violence is an important risk factor for certain child welfare outcomes
Poverty	Whether an investigation has identified the presence of material deprivation as a risk factor	Poverty and material hardship are significantly related to the risk for child maltreatment reports
Parental Criminal History	Whether an investigation identified criminal history as a risk factor	A parent's criminal history may be suggestive of risks to child safety or permanency
Risk Due to Substance Use	Whether parental substance use was identified as a risk for future maltreatment	Parental substance use is recognized by FFPSA as a meaningful predictor of risk to children's safety and well-being

### *Data Collection*

The DCBS TWIST system will be used to collect data on child welfare outcomes for families that receive START. DCBS case workers and psychiatric treatment providers will enter data continuously throughout the case as clients participate in the intervention; key outcome measures will be whether children are subjected to subsequent maltreatment, are removed from the home, and which placement types are utilized, (e.g., kinship care, fictive kin, QRTP, etc.).

### *Outcome Measures*

This evaluation will make treatment effect estimates for whether START: (1) reduces the likelihood of a subsequent, substantiated maltreatment report, (2) reduces the likelihood of a

child being removed from the home, and (3) whether START decreases the average length of time children spend in out of home care. Please see Table 9 for the proposed analytic approaches for these outcomes.

*Limitation: Training the Child Welfare Workforce in Motivational Interviewing will Alter the Meaning of ‘Treatment as Usual’ in Kentucky*

A call for training child welfare workforces in MI has been issued in the literature by Barth, Lee, & Hodorowicz (2017). In their article, the authors note that, broadly speaking, child welfare professionals are interested in (and open to) receiving training in practices that help them engage with their clients in more fruitful ways. Notably, Barth, Lee, & Hodorowicz (2017) provide a particularly useful example of a successful MI-training initiative to prepare child welfare professionals with this skill set.

While there is clinical evidence that Kentucky’s decision to provide universal MI training to its DCBS workforce is likely to promote favorable family outcomes (see Shah et al., 2019; Hall, Sears, & Walton, 2020), it will admittedly complicate the program evaluation. However, for several reasons, the evaluation team does not believe these complications will be prohibitive of making valid and practically useful study conclusions.

First, there is a dearth of research on the effects of MI on the principal outcome measures of Kentucky’s Family First program evaluation efforts – namely: (1) out of home care placements, and; (2) recurrence of maltreatment. In a systematic review of MI in child welfare services, Hall, Sears, & Walton (2020) acknowledged this reality, saying:

“In spite of MI’s conceptual appropriateness for families involved in CW, this review identified few studies evaluating the impact of MI-trained CW workers on placement in OOHC and no studies evaluating their impact on recurrent child maltreatment. Additionally, studies of more proximal outcomes, such as engagement in treatment, show mixed results. Notably, variation in study results may reflect important differences in study populations, MI training protocols, or other factors.” (p. 273)

In other words, while it is likely that some beneficial outcomes will be realized from this broad scale MI training initiative within DCBS, the evaluation team cannot identify any empirical literature that would lead them to believe they can know exactly *how they will be manifested*. In the absence of such evidence, the principles of the null hypothesis in this style of research would dictate that the evaluation begin with the assumption that MI – as it will be applied in this case – will have no significant effect on the primary program evaluation outcomes. While

this may present a challenge to the interpretation of results, the evaluation team believe it falls within the range of acceptable study limitations.

Second, because MI training as proposed here applies to all DCBS workers, the evaluation team believes this could effectively result in what Barth and colleagues (2017) referred to as “raising the floor on clinical practice” (p. 217). In effect, the evaluation team envisions this to mean that, whatever benefits are realized from this training initiative, they will evenly apply to comparison groups as well as treatment/experimental groups. Conceptually, this will mean that, as increasingly more of the DCBS workforce is trained in MI, the “Treatment As Usual” comparison groups in evaluation analyses will be understood to contain the effects of the use of MI in child welfare casework.

The team of Kentucky’s evaluators for the implementation of Family First have met to discuss these effects that broad training of the DCBS workforce in MI and how they might impact future evaluation analyses. Broadly speaking, the evaluators understand that introducing this new capacity in the workforce may create confounding effects on evaluation analyses of individual evidence based practices in ways that will be difficult to predict. To address these confounding effects, studies produced by the evaluation will attempt to adjust for them, and will at least include the presence of the MI training initiative as a documented limitation on isolating the unique effects of a given intervention (e.g., TF-CBT) for families and children.

<b>Table 9</b> <i>Evaluation Strategy – Sobriety Treatment and Recovery Teams</i>	
Orienting Question	Is effectively addressing parental substance use disorders associated with favorable child welfare outcomes?
Target Population	<ul style="list-style-type: none"> <li>○ Families with a young child and a parent/caregiver that has been determined to engage in high-risk substance use; and:               <ul style="list-style-type: none"> <li>- Substantiated or services needed CPS case determination</li> <li>- Child determined to be a candidate for foster care</li> <li>- Family home determined to be safe enough for child to remain at home during the course of the intervention</li> </ul> </li> </ul>
Data Collection & Management	<ul style="list-style-type: none"> <li>○ The DCBS TWIST child welfare case management software system; and affiliated data systems with the Cabinet for Health and Family Services. Example data stored in the TWIST system includes:               <ul style="list-style-type: none"> <li>- Administrative data will be collected by DCBS workers as they go about their casework with families (which will then be made available to evaluators)</li> <li>- Case milestone dates (investigation, case opening, removal dates, etc.)</li> <li>- Flag variable for which children have been identified as FFPSA candidates</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>- Flag variables to identify children that have been placed in foster care</li> <li>- Results of assessments and screenings</li> </ul>
Measurement Instruments, Assessment Tools, etc.	<ul style="list-style-type: none"> <li>o The DCBS Assessment and Documentation Tool (ADT) <ul style="list-style-type: none"> <li>- Primary source of secondary administrative child welfare data</li> <li>- Used for investigatory phase, assessing family risk and protective factors</li> </ul> </li> <li>o The Structured Decision Making Tool (SDM)*</li> <li>o The North Carolina Family Assessment Scale</li> </ul>
Sampling	<ul style="list-style-type: none"> <li>o Treatment group – Purposive, non-probability sampling: <ul style="list-style-type: none"> <li>- i.e., clients who are: a) determined to be families w/ a FFPSA child candidate; b) screened for clinical appropriateness to receive services</li> </ul> </li> <li>o Comparison group – propensity score matched sample <ul style="list-style-type: none"> <li>- i.e., clients who reside within the same DCBS service region, and match along a set of demographic and risk-factor based variables</li> </ul> </li> </ul>
Outcomes of interest	<ul style="list-style-type: none"> <li>o Recurrence of any type of substantiated child maltreatment within 1 year after discharge from services</li> <li>o Removal of a child candidate from the home within: a) 6 months of case opening; b) 1 year of case opening; c) 2 years of case opening</li> </ul>
	<ul style="list-style-type: none"> <li>o Improvements in NCFAS measures of: a) overall child well-being; b) overall family health; c) overall family safety</li> </ul>
	<ul style="list-style-type: none"> <li>o Differences in days spent in out of home care between treated vs. untreated children that have been removed from the home</li> </ul>
Analysis Plan	<ul style="list-style-type: none"> <li>o Propensity score matching to construct comparison group</li> </ul>
	<ul style="list-style-type: none"> <li>o For assessing between-group equivalence at baseline: <ul style="list-style-type: none"> <li>- Categorical variables – Chi-square tests (<math>\chi^2</math>)</li> <li>- Continuous variables – t-tests</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>o For non-parametric, categorical outcome variables: <ul style="list-style-type: none"> <li>- Chi square tests of significance (<math>\chi^2</math>)</li> <li>- Logistic regression</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>o For time-oriented outcome variables: <ul style="list-style-type: none"> <li>- Event-history analysis (i.e., Kaplan-Meier estimation)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>o For non-parametric, continuous outcome variables: <ul style="list-style-type: none"> <li>- Generalized linear modeling techniques</li> <li>- (Will consider natural log data transformations if appropriate and indicated)</li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>o For non-parametric, count-based outcome variables: <ul style="list-style-type: none"> <li>- Poisson regression modeling w/ corrections for zero-inflated and/or over-dispersed distributions</li> </ul> </li> </ul>
Limitations	<ul style="list-style-type: none"> <li>o PSM cannot control for unobserved co-variates</li> <li>o The TWIST system cannot provide information on several relevant features of cases, such as: <ul style="list-style-type: none"> <li>- Parental motivation/capacity for change</li> <li>- Therapist/counselor experience, skill level, and therapeutic rapport</li> <li>- Measures of parent and child well-being</li> </ul> </li> </ul>
*The SDM is not currently in use in the field by DCBS staff. It is in process of being acquired and	

implemented, but data produced by the tool will be an asset to future evaluation efforts and analyses.

### ***Common Evaluation Elements - Data Collection, Storage, and Security***

Data will be collected and stored in both the state CCWIS system (known as “TWIST”; The Worker Information System), as well as an in-home provider database. Every single family who makes contact with Kentucky’s CPS agency has information generated and stored in the TWIST system; even if their allegation is not investigated or substantiated. The TWIST system is the case management software platform used by DCBS child protection workers. In other words, the primary source of data for the evaluation of Family First evidence based programs will be secondary administrative data and case records that have been documented by workers in the field. This data system has been used for program evaluations of child welfare interventions in Kentucky for over ten years; most recently by Title IV-E Waiver Demonstration evaluation teams. Please refer to Hall and colleagues (2015); Hall, Wilfong, Huebner, Posze, and Willauer (2016); and Huebner, Willauer, and Posze (2012) for examples of this use of TWIST data in published articles.

The TWIST system allows for DCBS to collect and store data at the level of an individual child, the named adult on their CPS case, and the family unit. This data is collected and entered into the centralized system each time a DCBS case worker makes contact with a client family, meaning the evaluation team will have access to a rich set of variables on each family. Moreover, each individual is assigned a system-generated identification number, a family case number, and a unique incident number. This allows analysts to observe outcomes across time and space when a child enters services more than one time or moves to another Kentucky county. TWIST data is ideal for use in the Family First evaluation for three reasons: (1) because the TWIST system is already in use as DCBS’ case management software platform, it is the least burdensome means for staff to report client data. (2) TWIST is a rich source of data, with very large sample sizes. (3) TWIST data allows the evaluation team to describe results as they occur in the field, under all of the real-world circumstances that families and DCBS workers face as they carry out their casework. DCBS and OHDA have negotiated and signed a memorandum of understanding that allows for the sharing of child welfare data from the data systems operated by DCBS to the evaluation team at OHDA. With this memorandum comes an established protocol for keeping the data secure, including encryption measures for storage and access and training for all staff that will work with it. Please see appendix S.

### ***Information Housed in the TWIST System and Example Variables***

The TWIST system in Kentucky is a very comprehensive case management and data storage platform to assist caseworkers in the field as they work with clients. While it is beyond the scope of this plan to outline the full capacity of the TWIST system, this section will describe

some of the specific variables that are of particular relevance to the evaluation effort. There are several notable features of the system that make it particularly useful for tracking outcomes and creating suitable comparison groups within the child welfare-involved population in Kentucky.

First, the TWIST system collects data on each CPS case that is received by a Kentucky child abuse hotline. Each family then receives a case ID number that remains constant during each additional contact with the state child welfare system. In other words, whether a family contacts CPS one time or one hundred times, an evaluator will always be able to identify that family from a single database by their unique TWIST case ID. Moreover, the TWIST system also assigns individual ID numbers to each person named on a case. Therefore, each child and each adult involved with the act of maltreatment has an ID that can be tracked by evaluators. This TWIST ID follows clients as they receive services from contracted providers of health and social services; allowing analysts to coordinate data systems. This is a particularly useful feature given the reality that families often enter, exit, then reenter DCBS services.

Second, the TWIST system collects rich data about DCBS case milestones. For example, the date that a call is received with a child maltreatment allegation, the date that a case is opened, and the date that prevention services are discontinued are all stored in the TWIST system in a manner that is accessible to the evaluation team. The TWIST system also stores the results of investigations and assessments, which allow evaluators to match along baseline risk factors and stratify or cohort families based on important demographics. This level of precision allows analysts to understand several important features of an individual case and make inferences about outcomes of interest.

Third, the TWIST system collects data that can be used to investigate child welfare outcomes. Among these are: (1) whether recurrent maltreatment occurs, (2) whether a child is removed from the home, (3) the type of placement utilized by DCBS for each child (and how many placements occur within the removal), (4) whether a children that has been removed is ultimately reunified with their family of origin.

Table 10 outlines some of the most relevant information stored in the TWIST system. Several members of the evaluation team have experience using ADT data to create comparison groups and test measures of baseline equivalence when estimating treatment effects of child welfare interventions. Principally, the DCBS investigations teams collect ADT data that describes granular levels of detail about child-level and adult-level risk and protective factors. There is a significant degree of overlap in terms of the detail that is collected by the ADT and the variables of interest that Family First targets (e.g., parental mental illness and substance use as risk

factors for child placement in out of home care). Importantly, the ADT collects information related to social determinants of health and wellness, such as child nutrition, housing stability, and educational matters. The evaluation team views this data as an important source to inform future recommendations for ways to address the needs of DCBS families.

**Table 10**

*Sample Variables Contained in the DCBS Assessment & Documentation Tool*

***Child Physical and Mental Health***

**Risk Factors**

- Hearing or vision impaired ☐
- History of seizures ☐
- Medical diagnosis requiring life sustaining care ☐
- Medical issues (asthma, broken arm, allergies, etc.) ☐
- Mental health diagnosis requiring ongoing medications ☐
- Physical disability ☐
- Requires psychotropic medication to function ☐
- No risk factors ☐

**Protective Factors**

- No physical/mental health issues ☐
- Received care for identified mental health issues ☐
- Receives care for identified medical issues ☐
- Up to date on immunizations ☐

***Risk of General Harm***

- Caretaker has a prior Termination of Parental Rights order on another child ☐
- Caretaker self-reports inability to cope [with parental duties] ☐
- Caretaker self-reports they may harm child ☐
- Child allowed to use drugs and/or alcohol ☐
- Child born exposed to drugs and/or alcohol ☐
- Child or family member threaten with a weapon ☐
- DV related incidents are more severe/frequent ☐
- Parent's cannot meet own needs ☐
- Per court order, caretaker does not have custody of child ☐
- Sibling of a child fatality/near fatality victim ☐
- Violation of Emergency Protective Order/Domestic Violence Order puts child in danger ☐
- No issues ☐

***CPS/APS/Criminal History***

**Risk Factors**

- Adult is registered sex offender ☐
- Parental rights on a child involuntarily terminated ☐
- Prior convictions involving drugs/alcohol ☐
- Variety of types of criminal convictions ☐
- Prior felony convictions involving weapon/violence ☐
- Prior reports of domestic violence ☐
- Prior revocation of parole/probation ☐
- Prior substantiated reports ☐
- Prior substantiation death/near death of another child ☐
- Action or lack of action contributed to death/serious harm of a child ☐
- Multiple prior reports not accepted for investigation ☐
- Prior unsubstantiated reports ☐
- No risk factors ☐

**Protective Factors**

- Acknowledges responsibility for prior charges ☐
- Acknowledges responsibility for child welfare allegations ☐
- No criminal charges ☐
- No felony convictions ☐
- No prior CPS/APS history ☐
- Non-violent/traffic offenses ☐
- Other rehabilitative services ☐
- Received treatment/rehabilitative services related to prior sexual abuse ☐

***Maltreatment Risk Factors (Degree of Connection to Incident that Precipitated Case)***

- Mental Health | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable ☐



Family Violence | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable ☐  
Substance Abuse | – Directly Contributed – Indirectly Contributed – Was a Risk Factor – Not Applicable ☐

In preparation for the implementation of Family First, DCBS has adapted the TWIST software to allow CPS workers to identify children as Family First foster care candidates. This will allow the evaluation team to easily isolate study samples from the broader child welfare population in TWIST reporting. In the language of propensity score matching, this designation of candidacy for foster care variable (in addition to the other observed covariates) will also allow the evaluation team to estimate propensity scores for non-treated children's predicted propensity to receive treatment. Additionally, The TWIST system collects data on several fields that are important for analysis and reporting outcomes – among these are:

- (1) Recurrence of substantiated maltreatment reports;
- (2) Removal and placement into out of home care;
- (3) Time spent in out of home care (in days);
- (4) Type of placement (kinship care, residential treatment, etc.);
- (5) Which services families were referred to.

The in-home provider database was built by Eastern Kentucky University (EKU), and will be maintained by ECU throughout the implementation of Family First in Kentucky. It was built specifically for use by DCBS' specialized services for particularly at-risk families, and is therefore well suited for the purposes of the Family First evaluation. Because the providers that use this system are engaging in special services, this database also stores information on families collected through the administration of the North Carolina Family Assessment Scale (NCFAS; Reed-Ashcraft, Kirk, & Fraser (2001). Additionally, the in-home provider database has been in operation for several years, and has generated rich data for use by the Title IV-E Waiver projects in Kentucky in the past (i.e., START; K-STEP). There are several examples of published studies in peer-reviewed journals that used TWIST data for their analyses (see Huebner et al. 2012; Hall, Wilfong, Huebner, Posze, & Willauer, 2016; Hall et al., 2015). As these studies illustrate, the TWIST system contains sufficient administrative data to create valid comparison groups for analysis (i.e., untreated families that received usual CPS services). In many ways, the Family First evaluation team intends to replicate and enhance the approach used by the existing evaluation efforts of Title IV-E Waiver Demonstration programs.

Data will also be collected utilizing a screening tool to ensure data are collected consistently and accurately. Quality Control Analysts within the Information and Quality Improvement Unit of DCBS will assist with regard to any data issues encountered. The sample size reviewed will be large enough to make statistical inferences and reviewed with regard to geographical location and population. Because TWIST stores data on every single contact that DCBS makes

with a family in KY (including hotline calls that are not even investigated), past evaluation efforts have had data on thousands of families. In the case of Family First, sample size will be dictated more by referral volume and provider capacity than by limitations related to data collection. Specific caseload data will be screened to provide context and address agency performance. Quarterly CQI meetings will be held with a variety of providers reviewing administrative reports consisting of key data points, assessing challenges to successful implementation and planning for solutions to eliminate the barriers identified by stakeholders. Data collected during the case review process will also be shared with providers during quarterly meetings. This will allow for providers to inform analysis and to increase collaborative efforts. Furthermore, focus groups with families and providers will be conducted annually.

In addition to client-level data collected by DCBS' case management software applications, DCBS has commissioned the adaptation of its invoicing system to be able to record data on payments to providers for prevention services. This process has involved consultants and CHFS software developers to allow invoices to store information on which family was provided a given service, which EBP was provided, which agency provided it, and how much DCBS paid for it. This data will also be made available to the evaluation team to enable cost analyses.

The evaluation team will also plan for the inclusion of provider and client surveys in the evaluation plan. A dissemination plan for evaluation findings - both interim, periodic, and final – will be developed and will include a report to the Clearinghouse of evidence that supports the inclusion or identification of these interventions as well-supported.

### ***Common Evaluation Elements - Notes on Methodology & Design***

This will be a utilization-focused evaluation, with its chief objective being to be of use to DCBS in assessing the quality of programming that it offers to its clients. As a secondary objective, this evaluation will seek to further develop the knowledge base around what practices are effective at promoting favorable family outcomes in Kentucky. Keeping in mind that the evaluation is beholden to individual providers' programmatic and administrative particularities, the realities of a data management system that is adapting to the needs of Family First, and the practical features of the DCBS standard operating procedure, the evaluation team feels that a tailored approach should be taken as appropriate for each prevention service. This is especially true for conceptualizing appropriate comparison groups. The evaluation team foresees instances where alternative comparison strategies can be used to enhance the propensity score approaches described earlier. Therefore, to estimate the treatment effects on maltreatment recurrence and the prevention of out of home care placement, there will be multiple means available to compare families who receive *promising* or *supported* prevention services. These include:

- **Propensity Score Matching:** Given the reality of the evaluation's data sources, propensity score matching will be the primary methodology to construct suitable comparison groups. A fortunate byproduct of the thorough assessments that are warehoused by the TWIST system is a rich set of baseline measures of family functioning prior to the referral to services which can serve as matching variables for propensity score matching. This method has been successfully executed by Dr. Walton in the past (Walton, 2019), and is also currently being utilized in studies produced by the Title IV-E Waiver evaluation of START.
- **Waitlist Control:** Comparing families that engaged in and successfully completed services to those who were referred to services, but had to be waitlisted and referred back to usual CPS care whilst awaiting a treatment spot. This method of comparison balances an attempt to account for some degree of selection bias with not requiring the level of burden or perceived risk to children that randomization imposes on the DCBS workforce and administration. This information is already collected as a component of daily child welfare practice. This method was successfully employed in a statewide evaluation study of family drug treatment courts in North Carolina (Gifford, Eldred, Vernerey, & Sloan, 2014). Admittedly, this approach cannot fully contend with possible validity threats in as robust a manner as RCT's can. Waitlisted clients may differ in some systematic way from their peers. However, the mere fact that the evaluation will only ever make comparisons between candidates who (1) receive prevention services and other candidates who also reside in the same service region, (2) share the same referring risk factors, and (3) enter CPS involvement around the same point in time will substantially reduce the risk of erroneous estimations of treatment effects. The evaluation team will have several data fields available to them to enable secondary checking and to ensure satisfactory baseline equivalence before performing further analyses or drawing conclusions.
- **Randomized Controlled Trial:** For special instances where a certain set of circumstances are in place (e.g., buy-in from DCBS staff, IRB interest and approval, etc.), the evaluation team will implement a randomized controlled trial of a *promising or supported* evidence based practice to test its effects on child welfare outcomes. The CHFS IRB has historically approved a random assignment procedure as a subcomponent of the START evaluation – this will serve as a model for the Family First evaluations of individual programs.

Every evaluation must contend with the validity threats of selection bias and the influences of unobserved covariates. Therefore, in every instance where this evaluation will make comparisons between treated and untreated clients, it will constrain those comparisons within geographic regions. Because there are meaningful regional differences in the economic,

political, and sociocultural circumstances across the Commonwealth of Kentucky, this evaluation will only ever compare people within the DCBS service region where their case originated.

### ***Common Evaluation Elements - Research Questions***

The following is a list of additional research questions that will be used to guide the analysis of each prevention service in its respective evaluation plan (i.e., TF-CBT & START). Sampling, data collection, and outcome measures will be tailored to the particularities of each intervention.

#### Process evaluation questions:

1. Out of all the children and families served by DCBS in Kentucky, how many children are identified as Family First foster care candidates?
  - a. What are the frequencies of each presenting family problem/risk factor (mental health diagnoses, addiction, in-home skill building)?
  - b. What are the frequencies of each service provided to candidates and their caregivers?
2. What are the demographics of the identified Family First foster care candidates?
  - a. Age
  - b. Race
  - c. Sex
  - d. County of residence
  - e. Socioeconomic status
3. How long (on average) does it take for referred families to receive their first service?
  - a. How long (on average) does it take for referred families to receive their first five sessions? (This is a measure of fidelity and client engagement used by the START program; see Huebner et al., 2015).
4. Are there any identifiable trends in the total number of petitions to remove children from the home after the implementation of Family First in Kentucky?
  - a. E.g., Is there a generally detectable rate of decline?
5. Are there any identifiable trends in the total number of children placed in foster care in Kentucky as a result of Family First implementation?

#### The evaluation will aim to collect data for the following confounding variables:

1. Social support
2. Household income; Percent Federal Poverty Level
3. DCBS staff turnover
4. Ecological risk factors

#### Impact evaluation questions

1. Has the implementation of Family First Prevention Services kept at-risk children from being removed from their homes at six months, one year, and two years post-discharge?

2. What is the contribution of each EBP to the reduction of removals of at-risk children?
  - a. Is there a dose-response effect for these services?
  - b. Are there better outcomes when services are provided to both caregivers and children than when provided only to the children or only to the caregivers?
  - c. Is there a synergistic effect when two or more services are provided? What are the more effective combinations?
3. Do families with Medicaid have significantly different outcomes after the provision of services than families privately insured or uninsured? (Florence, Brown, Fang, & Thompson, 2013; Fang, Brown, Florence, & Mercy, 2012; Johnson-Reid, Drake, Kohl, 2009)
4. Are there treatment effects in terms of differences in utilization of therapeutic foster care?

#### Program-specific impact evaluation questions

1. What percentage of the families who participate complete the program?
2. What are the costs, and who bears them, for providing this service? Is the program cost effective? (Johnson-Motoyama, Brook, Yan, & McDonald, 2013)
  - a. By family served
  - b. By reduction of removals of at-risk children
  - c. By number of days spent in out of home care

Additional outcomes that may be examined include:

- Increase in provider capacity to provide evidence-based programs.
- Fewer children placed in out of home care statewide.

#### ***Common Evaluation Elements – Institutional Review Board Approval***

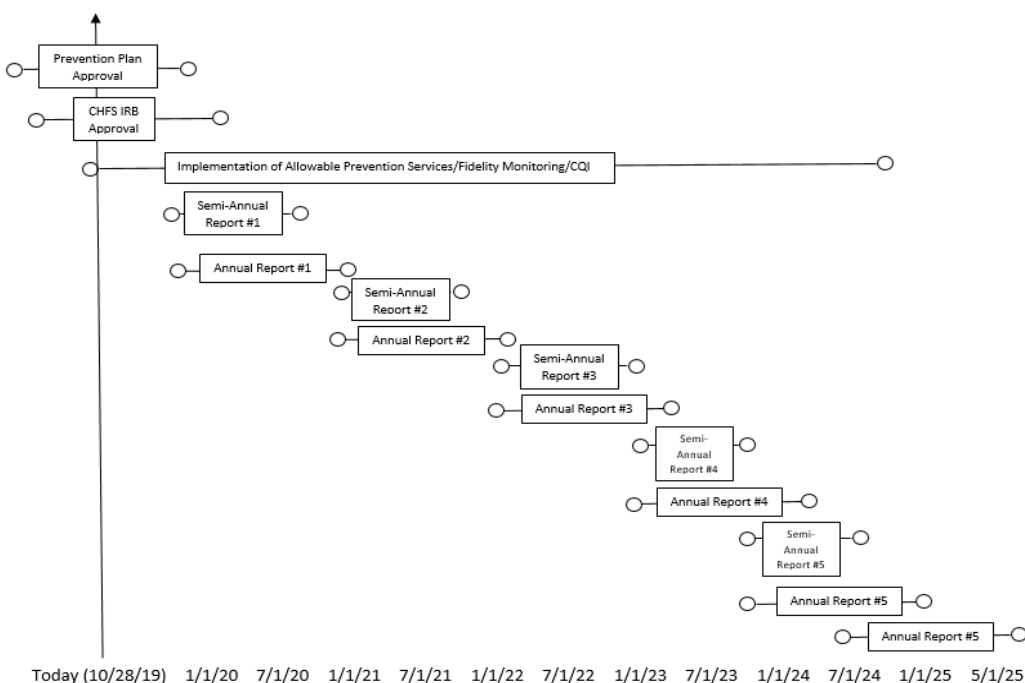
The evaluation plan includes engaging the CHFS Institutional Review Board (IRB) for a review and approval of the study methods. Kentucky has a fully functioning and independent IRB headquartered in the CHFS that is charged with evaluating research projects that involve state government services. This IRB is well-versed in issues concerning data security and confidentiality, and has been the historical source of IRB reviews of child welfare evaluations in Kentucky (especially the Title IV-E Waiver Demonstration projects). CHFS has a prescribed process of obtaining IRB approval that begins with sending the proposal to the office of the Ombudsman, where the IRB is headquartered. Because Family First involves the provision of services to especially vulnerable populations (children in foster care, adults with mental illness, etc.) and the use of sensitive data (psychiatric diagnoses, orders of termination of parental rights), the evaluation team imagines the proposal will require a full review, and will not be

exempted. The evaluation team expects this process to take no longer than one month from initial submission to approval. Since this proposed evaluation does not involve direct risk of physical harm or discomfort to children or their adult caregivers, the primary risks outlined in this IRB proposal will involve the use of protected data. The CHFS IRB has reviewed the evaluation team’s proposal, and exempted it from further review (i.e., has allowed the research to proceed). Please see Appendix T for IRB documentation related to this evaluation plan.

### ***Evaluation Timeline***

The evaluation will proceed along semi-annual, internal reporting milestones. Summary annual reports will be provided to DCBS leadership in December of each year to outline outcomes, discuss implementation, and offer data-driven recommendations. The Gantt chart provided in this section describes the projected timeline of major evaluation activities, which will progress from primarily descriptive analyses in the first year to outcome and impact-oriented analyses as more data is collected from the TWIST system.

*Figure 1 – Gantt Chart of Evaluation Timeline*



### ***Common Evaluation Elements – Reporting, Disseminating, and Using Findings***

The results and the insights that are drawn from them by the evaluation team and DCBS officials will be disseminated through a variety of mediums. The primary means of cataloging and reporting findings will be the preparation of semi-annual reports in the same style as those required by the Title IV-E Waiver Demonstration Projects. These will become the authoritative accounts of Family First activities and outcomes for Kentucky.

The evaluation team also intends to report the findings of its well-designed, rigorous evaluations through the broader academic child welfare community. This includes presentations at professional conferences, manuscript submissions to refereed academic journals, and other forums such as government policy briefs and community engagement events. Kentucky acknowledges that Family First provides states with a unique and special opportunity to further test the treatment effects of existing behavioral health interventions on child welfare outcomes. DCBS intends to seize this opportunity by being an active partner with the research and academic community to further develop the evidence base of the child welfare field.

Furthermore, the evaluation team intends to maintain an active partnership with DCBS officials to allow their findings to inform programmatic and organizational improvements. One of the ways in which this will be done will be to monitor if any gaps in services exist. The identification of such gaps will be relayed to the relevant DCBS committees to potentially result in the recommendation of new EBP's to satisfy unmet needs in the population. For example, housing instability is a recognized risk factor for child maltreatment (Gubits et al., 2018). Should this surface as an underlying feature in a sufficient number of CPS cases, the evaluation team will alert DCBS to allow them to consider how to best address the needs of Family First candidates.

### ***Common Evaluation Elements – Limitations***

The evaluation of each of these EBP's will have limitations in terms of the conclusions they will be able to draw about how families respond to services. Chief amongst these limitations will be its primary reliance on secondary administrative data. While the TWIST system is extraordinarily useful for evaluation research, it ultimately cannot match the degree of insight and precision that primary data collection can provide. What this data source can contribute in terms of its large scale comes at the cost of the exactitude that validated measurement scales offer. For example, the evaluation methods outlined herein will very capably capture the estimated treatment effects of Family First EBP's on concrete, procedural variables – such as out of home care placement – but it will be limited about what it can conclude about the more abstract indicators of child and family wellbeing. Similarly, while the TWIST system captures many of the important confounding variables that influence child welfare outcomes, there are many that it will be unable to incorporate into its analyses. The inability to capture the effects of unobserved (i.e. endogenous) covariates is the chief limitation of between-group comparison strategies that rely on propensity score matching.

Furthermore, it must be noted that DCBS-involved families typically navigate multiple systems at once. For example, the judges in Kentucky that preside over cases involving child

maltreatment often differ substantially from one county to another in terms of their judicial philosophy and decision making – especially around choices involving removing children from their homes. This reality could be a source of between-group differences that are not attributable to whether a client received a given intervention. However, because Family First foster care candidates will have their cases heard in courtrooms all across Kentucky (alongside comparison group families), the evaluation team does not believe this will be a source of systematic bias in the analyses.

In a related vein, analyses that do not utilize random assignment are limited in terms of making causal inferences, and attributing any observed between-group differences to the intervention under study. This evaluation methodology is admittedly limited in this same way. However, this plan builds in several strategies to address this methodology. The most important of these is to restrict matching procedures to participants whose CPS cases originated within the same geographic DCBS service region. This measure not only addresses limitations that could arise from heteroscedasticity, but also enhances the evaluation by making comparisons to families who will receive usual CPS services in the same geographic area – where CPS practices are theoretically the most similar.

In their investigation of the performance of quasi-experimental vs. experimental methods in program evaluation of welfare to work programs, Bloom, Michalopoulos, Hill, & Lei (2002) wrote:

*“So what do we conclude from these tests? With respect to the first question addressed, ‘which nonexperimental methods work best?’ **we conclude that local comparison groups** [as compared to interstate comparisons] **are the most effective and simple differences of means or OLS regressions perform as well as more complex alternatives.** Because these findings are consistent across many replications based on large samples from combinations of six different states, we believe that they probably generalize to many other mandatory welfare and work programs. It is less clear, however, how they generalize to voluntary programs where the sources, nature, and magnitude of selection bias might be different.”*

A second strategy for addressing this limitation is by using a risk factor-based matching strategy for between-group comparisons. These variables rely on data collected from trained child welfare workers who are making assessments based on direct contact with clients in their homes and communities and interviews with collateral sources. For example, the ADT assessments that DCBS workers complete include recording information related to whether: a) substance use; b) mental illness; c) domestic violence or d) proxy indicators of poverty are risk factors for child maltreatment. In other words, this evaluation plans to not make each of these



features of CPS cases have been empirically demonstrated to correlate with child welfare outcomes (especially out of home care placement). This reflects a level of precision not found in other child welfare studies that have utilized propensity score matching (e.g., Florence et al. 2013).

**Table 11:** Promising and Supported programs to be implemented and submitted to evaluation

Program	CEBC Rating	Title IV-E Prevention Services Clearinghouse Rating	Program Description
High-Fidelity Wraparound	Promising	Promising	Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems, who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties.
Sobriety Treatment & Recovery Team (START)	Promising	Supported	START is a child welfare intervention designed to partner with parents whose involvement with CPS is related to drug or alcohol use. Specific features of the intervention include the presence of a peer mentor, capped caseloads, and rapid access to treatment.
Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)	Well-supported	Promising	TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

## Section 6: Child Welfare Workforce Training and Support

### *Ensuring a well-trained provider agency workforce*

As indicated earlier in the Prevention Plan, all EBPs are administered within a trauma-informed framework. To accomplish this objective, all clinicians within Kentucky’s provider agencies and broader service array receive trauma training. In addition, DCBS recognizes that ongoing trauma training is necessary to sustain and grow knowledge and skills around trauma-

responsive practice. As such, DCBS is exploring mechanisms to ensure that the provider workforce has access to ongoing training opportunities together with the public agency workforce. Creating joint learning opportunities will ensure that both public and private workers and clinicians have the opportunity for a shared knowledge base and peer-learning opportunities. Provider contracts require that providers be trained/certified in intensive evidence-based in home service models as well as research-based nationally recognized curricula, assessments or other appropriate tools with demonstrated effectiveness in reducing or avoiding the need for out of home placement. Documentation of EBP model training and certification is maintained by the agency to be reviewed annually by contract monitors for fiscal and programmatic compliance.

As mentioned above, Kentucky will initially expand practices that are currently available. As such, there are existing mechanisms in place to ensure child welfare and provider staff receive relevant training and coaching in these practices. Existing relationships with trainers and purveyors will be examined and updated as necessary to accommodate additional training needs and establish learning collaboratives as needed. Additionally, DCBS will seek opportunities to collaborate with the Department for Behavioral Health, Developmental & Intellectual Disabilities (DBHDID) and other agencies within the Cabinet for Health and Family Services to integrate existing or create new contracts with training entities that are providing training to multiple agencies within the Cabinet (i.e., Motivational Interviewing, Parent Child Interaction Therapy). Likewise, DBHDID will extend invitations to non-Community Mental Health Center (CMHC) providers to join new and ongoing learning collaboratives in evidence-based practices.

As DCBS expands contracts to new providers and/or for new interventions, the contracts will require that clinicians are appropriately trained and certified in the models they administer. Compliance with these requirements will be addressed through contract monitoring activities and other technical assistance and support provided by DCBS.

### ***Ensuring a well-trained child welfare agency workforce***

Every Protection and Permanency Employee receives the Training Academy for new employees. The Academy is a credit-for-learning initiative, which is a collaborative partnership between the public universities and DCBS. The Training Academy provides college graduate credit from accredited graduate social work programs for job related learning for new employees in the Academy. The Training Academy has four courses: Course 1: Introduction to Child Welfare; Course 2: Collaboration Assessment and Documentation, Course 3: Case Management and Course 4: Child Sexual Abuse. New employees of DCBS will receive training on the service array

and child specific prevention plans through the Case Management course, in the DCBS Academy Training.

Staff are trained to conduct initial risk assessment during the investigative phase of cases, through Course 2 of the academy, Collaboration Assessment and Documentation. In this course staff achieve competency in risk and safety identification, assessment as a continuum, analyzing safety threats, protective factor mitigation, and in completion of the investigative Assessment and Documentation Tool (ADT). Staff are trained to conduct periodic risk assessments during the ongoing phase of cases, through Course 3, Case Management. In this course staff achieve competency in assessing progress made on objectives in managing high risk patterns, both individually and as a family. Staff are also trained to assess familial ability to handle stressors, child behavior management, and caregiver protective capacities.

In preparing for Family First, the Training Academy will be enhanced and modified to include training on trauma-informed, evidence-based services. Current DCBS Staff will receive training through web-based and face-to-face trainings designed to educate staff on the evidence-based services along with the referral process to each service to ensure families have access to these services. Regional Family First liaisons will be trained on Family First provisions and their practice implications and requirements to help support front line staff. Front line staff are in the process of completing the seven module Web-based Training on Family First as follows:

Module 1: Family First Overview

Module 2: Prevention Services Array Overview

Module 3: Evidence Based Practices and Prevention Services Referral

Module 4: In-Home Case Planning Process (Prevention Strategy Development)

Module 5: Out of Home Care Process

Module 6: Leveling and Placement

Module 7: Supervisory Module

Front line staff receive both prevention services and QRTP relevant processes in the Web-Based Training to assist their understanding of Family First implications, expected changes to preventive case work practice, including content related to candidacy definition, risk assessment and related decision-making, child-specific prevention plan development, and identification, linkage, and monitoring receipt of evidence-based interventions. Frontline staff are trained on EBPs available for prevention services in Module 3. They are also trained within this module to identify EBPs for families, including what interventions are relevant to familial

risk factors, based on the target population and outcomes of each intervention. Workers are provided an EBP selection document, which is specific to their region, to assist in their recommendation of relevant EBPs. Please see Appendix O for SOP Chapter 6. In Module 4 staff are trained in completion of the familial prevention strategy. Here staff achieve understanding of how the candidacy date documented in the referral for services is populated to the case plan for the child specific prevention strategy, along with the identified intervention. Staff are also trained within module 4 to incorporate the EBP intervention into case plan objectives, specific to the high risk behavior the intervention is addressing. Please see Appendix O SOP 3.4 for development of the prevention strategy. In addition to ensuring a qualified DCBS workforce, private in-home providers also have access the Family First Web-based Training.

To reinforce the Academy Training Material and the implementation of Family First Legislation, supervisor engagement strategies have been incorporated into the Training Academy. This allows new workers opportunities to practice skills learned in the classroom, enables new employees and their supervisors to gain a better understanding of the new employees' abilities, and provide supervisors with a clear focus for continued coaching activities. During the Assessment Phase, new employees' strengths and areas in need of further development are identified, Coaching Action Plans for development of those areas in need of improvement are created, the regional training coordinator facilitates a face-to face meeting with the new worker and supervisor to discuss the Coaching Action Plan, and information gathered through the Assessment Phase is shared with designated regional staff and the DCBS Training Branch. Coaching Action Plans will be modified to reflect language around Family First and the EBP Models. This will be one way for supervisors to coach and mentor new staff around Family First Legislation.

A supervisory module, module 7, was also added to the Family First Web-based training, where the impact of Family First prevention services on frontline supervision is identified. Frontline Supervisors are trained to discuss potential candidates and preventative services during all cases consultations and all phases of assessment. They are trained of their responsibilities to review and approve the Prevention Services Referral in the state CCWIS system, along with ensuring appropriate risk determination and appropriate EBP selection.

The training branch also conducts the Advanced Supervisory Series, which is comprised of three credit-for-learning courses. The courses focus on the knowledge, skills, and opportunities for application of critical supervisory skills. The training branch will make adjustments and modify training content to include Family First requirements along with material on how supervisors support their staff around the Family First implementation and oversight of ongoing casework.

Kentucky will also pursue training frontline workers and supervisors in MI under Family First to enhance family engagement, completion of EBP intervention, and completion of the child-specific prevention plan. Equipping frontline staff with MI training will allow utilization of the intervention with families, assisting in increasing the uptake of prevention services in Kentucky. With 27,522 candidates for foster care in Kentucky, it is vital familial ambivalence is resolved and client-centered partnership is cultivated prior to prevention service referral, to maximize the success of families served. Preparing families with internal motivation for change, will allow continuity in goal achievement between initial child welfare involvement, the uptake of services, and ultimate success of additional EBP intervention and child-specific prevention plan completion.

Kentucky updated in home case SOP sections and added an entire Chapter to SOP to assist in guiding the state's workforce in candidate eligibility, intervention selection, development of the child specific prevention plan, the ending of Family First candidacy eligibility and redetermination. Resources available to workers, supervisors, and regional staff include the Prevention Services Referral Form, an EBP Selection Document for each region of the state, and a Prevention Services Description and Eligibility Criteria document. Additional SOP was also developed to differentiate low risk in home services, from those appropriate for candidates of foster care. This, along with a separate low risk in home services referral form, were created to support Kentucky's workforce in implementation. Please see Appendix O for SOP Chapter 6 Prevention Services.

## **Section 7: Prevention Caseloads**

Please see Appendix K, Program Descriptions, for contracted in-home service provider caseload size.

When discussing prevention caseloads, it is important to distinguish between the caseloads maintained by the DCBS in-home workforce, and the caseloads maintained by the private providers administering the EBPs. Public agency caseworkers and private providers work in partnership to serve the family, keep children safe, and achieve case plan goals.

DCBS partners contractually with private providers to work with families through in-home prevention services. Additionally, DCBS is working on an internal hiring effort to meet caseload standards of 18:1. Decreasing caseloads is a primary Child Welfare Transformation goal, and there are a number of strategies underway to promote achievement of this goal. Regardless of current caseload size, DCBS case managers maintain at least monthly contact with families to

assess safety and risk. In addition, the prevention service providers maintain more frequent and intensive contact with families.

Private contracted prevention services providers are able to regulate their caseloads at a more manageable level based on needs of the families they serve through the contract. Those caseloads vary based on composition of family risk level as well as worker experience. In-home services where children have been identified as being at imminent risk for removal require provider staff hold no more than four cases at a time due to the service intensity necessary. In-home services for moderate risk cases extend provider staff caseloads to no more than six cases at a time. Kentucky's Title-IV E Waiver and substance abuse in-home services range from nine cases at a time for KSTEP and 15 cases at a time for START.

In-home service provider caseloads are determined, managed, and overseen by contracted provider leadership for all programs, excluding START. START caseworkers are determined, managed, and overseen by DCBS supervisors, regional staff, START leadership, and Kentucky's Personnel Cabinet.

## **Section 8: Assurance on Prevention Program Reporting**

Appendix L contains DCBS' assurance (CB-PI-18-09 Attachment I) that it will comply with all prevention program reporting requirements put forward by the Children's Bureau. At a minimum, DCBS will provide the following information for each child that receives Title IV-E prevention services:

- The specific services provided to the child and/or family
- The total expenditures for each of the services provided to the child and/or family
- The duration of the services provided
- If the child was identified in a prevention plan as a "child who is a potential candidate for foster care:"
  - the child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a "child who is a potential candidate for foster care" in a prevention plan
  - whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period
- Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity).

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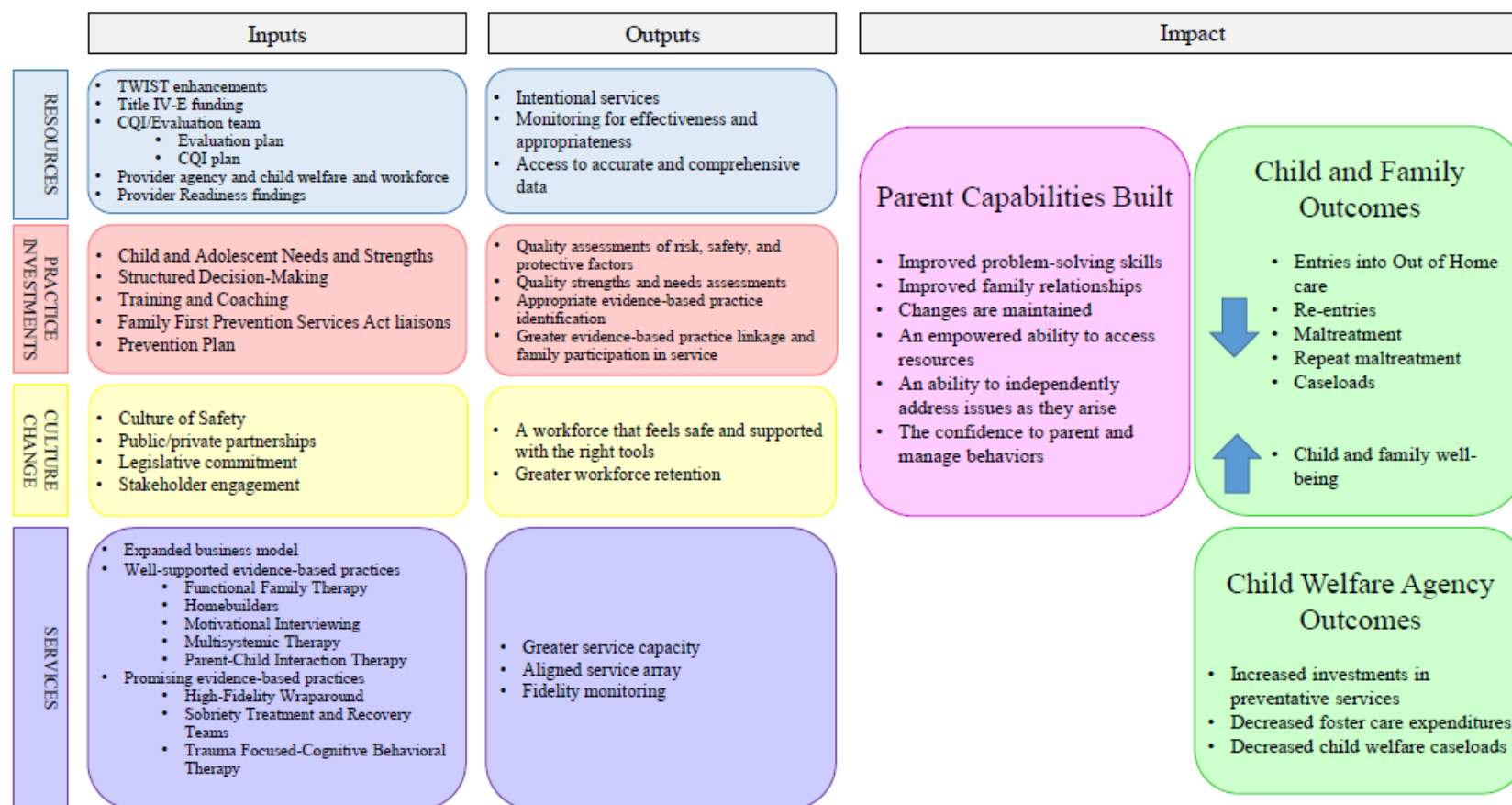
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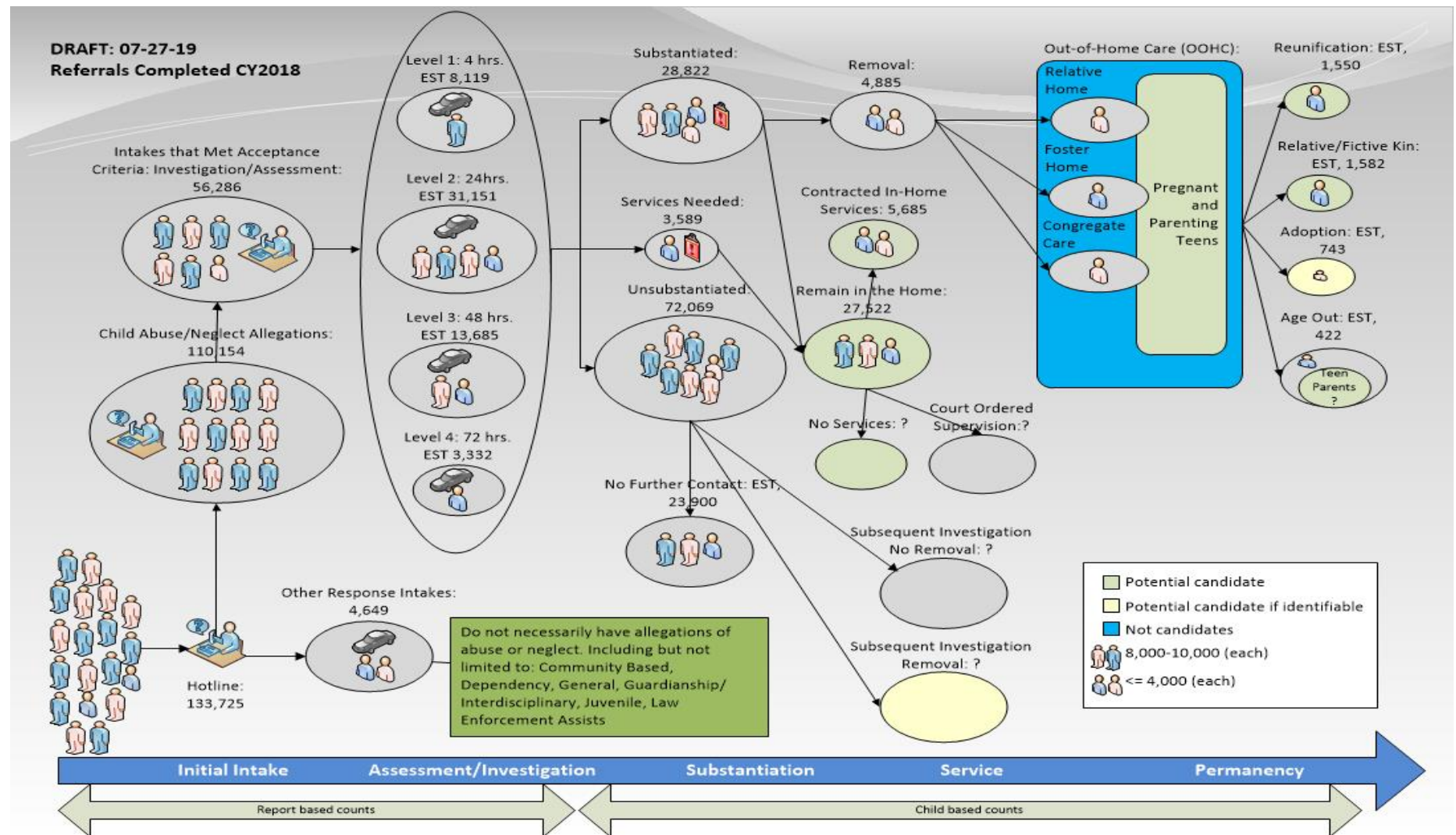
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## Appendix A: DCBS' Overarching Theory of Change for its Title IV-E Prevention Plan

### Kentucky – Prevention Plan Theory of Change

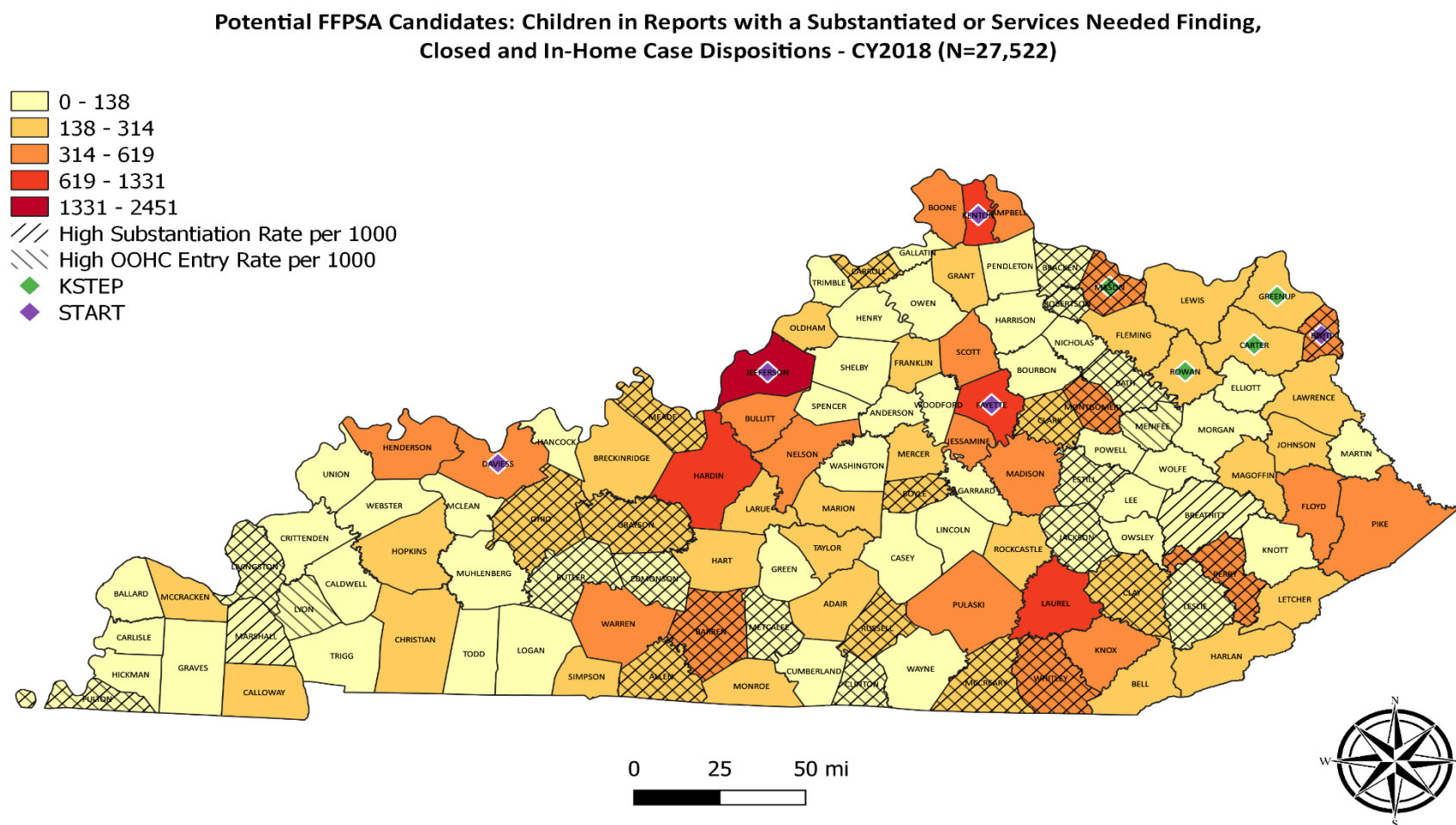


## Appendix B: Referrals Completed in CY2018





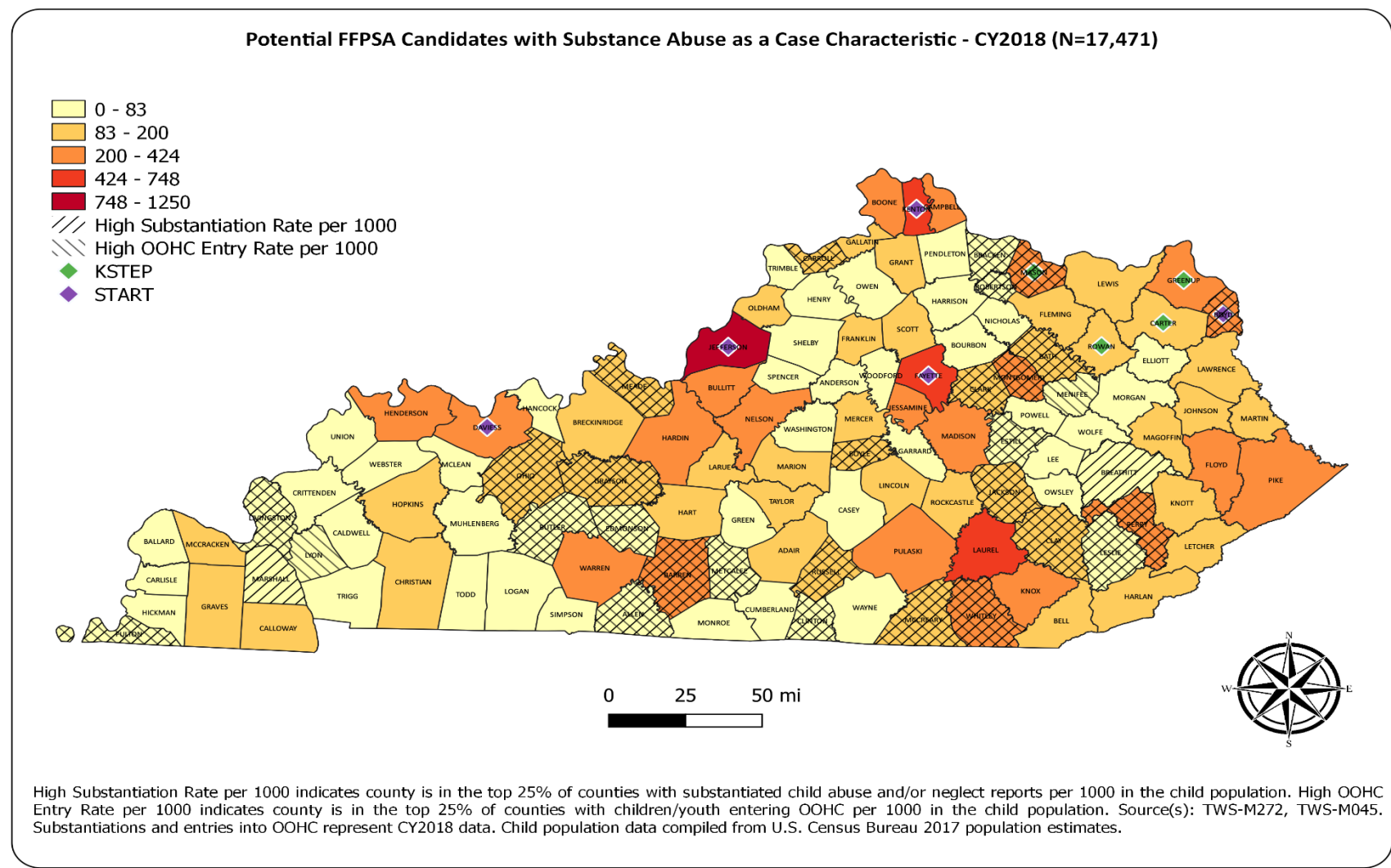
## Appendix C: Potential Family First Candidates State Map



High Substantiation Rate per 1000 indicates county is in the top 25% of counties with substantiated child abuse and/or neglect reports per 1000 in the child population. High OOHC Entry Rate per 1000 indicates county is in the top 25% of counties with children/youth entering OOHC per 1000 in the child population. Source(s): TWS-M272, TWS-M045. Substantiations and entries into OOHC represent CY2018 data. Child population data compiled from U.S. Census Bureau 2017 population estimates.

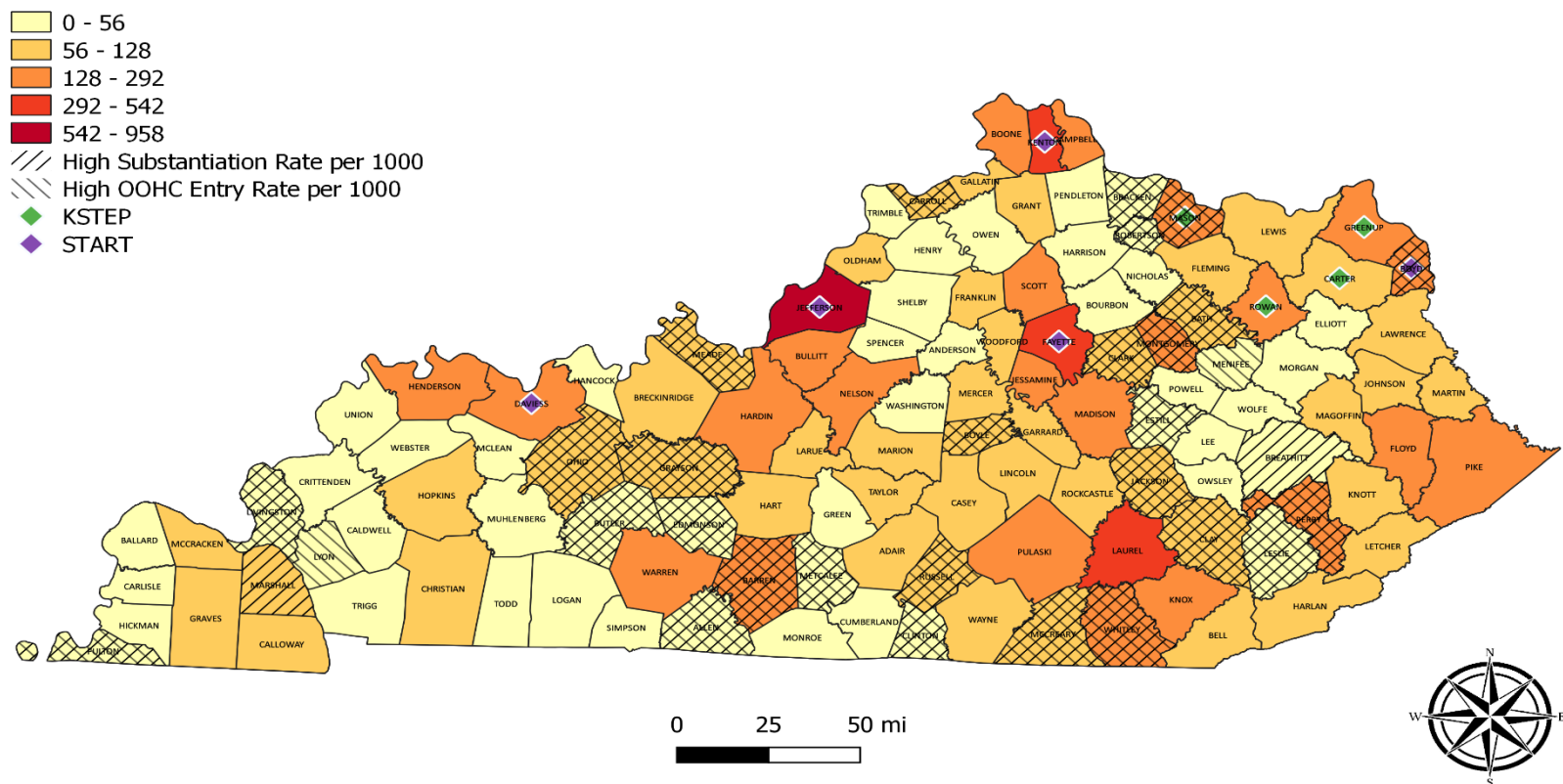


Appendix D: Potential Family First Candidates with Substance Abuse as a Characteristic State Map



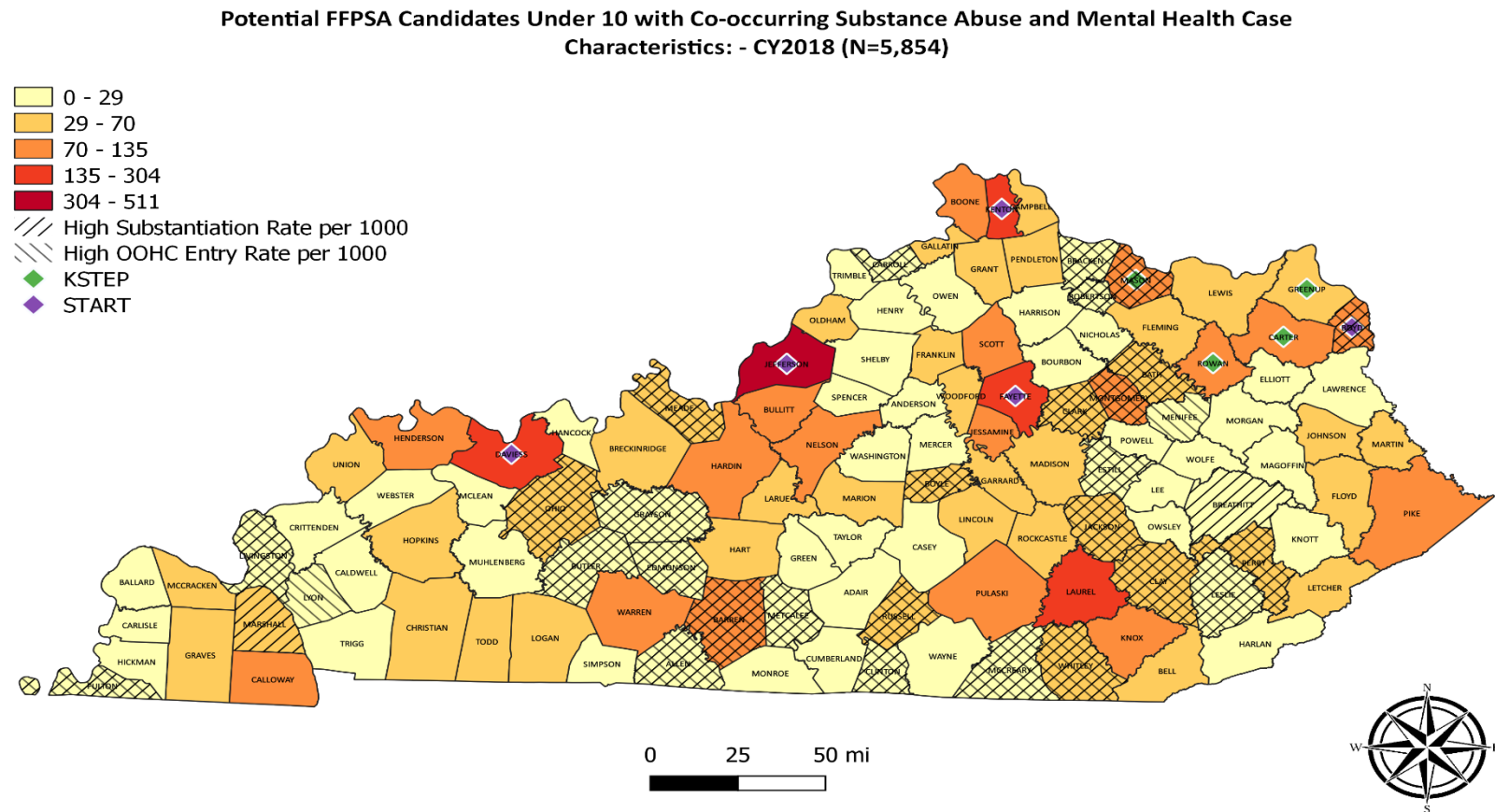
## Appendix E: Potential Family First Candidates Under 10 with Substance Abuse as a Characteristic State Map

Potential FFPSA Candidates Under 10 with Substance Abuse as a Case Characteristic: - CY2018  
(N=12,164)



High Substantiation Rate per 1000 indicates county is in the top 25% of counties with substantiated child abuse and/or neglect reports per 1000 in the child population. High OOH Entry Rate per 1000 indicates county is in the top 25% of counties with children/youth entering OOH per 1000 in the child population. Source(s): TWS-M272, TWS-M045. Substantiations and entries into OOH represent CY2018 data. Child population data compiled from U.S. Census Bureau 2017 population estimates.

## Appendix F: Potential Family First Candidates Under 10 with Substance Abuse and Mental Health as a Characteristic State Map



High Substantiation Rate per 1000 indicates county is in the top 25% of counties with substantiated child abuse and/or neglect reports per 1000 in the child population. High OOHHC Entry Rate per 1000 indicates county is in the top 25% of counties with children/youth entering OOHHC per 1000 in the child population. Source(s): TWS-M272, TWS-M045. Substantiations and entries into OOHHC represent CY2018 data. Child population data compiled from U.S. Census Bureau 2017 population estimates.

## Appendix G: Overview of Proposed Evidence-Based Interventions

Following is an overview of each of the proposed evidence-based interventions, including the evidence rating by the CEBC and Title IV-E Prevention Services Clearinghouse, brief description of the program, target population, and intended outcomes.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
Mental health treatment						
	<b>Functional Family Therapy</b>	<b>Well-Supported</b>	<b>Well-Supported</b>	For children/adolescents ages: 11 – 18. FFT is a family intervention program for dysfunctional youth with disruptive, externalizing problems. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based	<ul style="list-style-type: none"> <li>• Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use)</li> <li>• Improve prosocial behaviors (i.e., school attendance)</li> <li>• Improve family and individual skills</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				model. The FFT clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.		
	High-Fidelity Wraparound	Promising	Promising	Wraparound is a team-based planning process intended to provide individualized and coordinated family-driven care. Wraparound is designed to meet the complex needs of children who are involved with several child and family-serving systems, who are at risk of placement in institutional settings, and who experience emotional, behavioral, or mental health difficulties. The Wraparound process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The	<ul style="list-style-type: none"> <li>• Maintain children with highest levels of mental health and related needs successfully and safely in their homes and communities</li> <li>• Improve functioning across life domains</li> <li>• Decrease out-of-home placements</li> </ul>	Rigorous evaluation strategy

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				team continues its work until members reach a consensus that a formal Wraparound process is no longer needed.		
	Motivational Interviewing	Well-supported	Well-supported	Caregivers of children referred to the child welfare system, has been used with adolescents. MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.	<ul style="list-style-type: none"> <li>• Enhance internal motivation to change</li> <li>• Reinforce this motivation</li> <li>• Develop a plan to achieve change</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.
	Multi-systemic Therapy	Well-Supported	Well-Supported	Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system (some other restrictions exist, see the Essential Components section for more details). Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home	<ul style="list-style-type: none"> <li>• Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s)</li> <li>• Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents</li> <li>• Empower youth to cope with family, peer, school,</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.	and neighborhood problems	
	Parent-Child Interaction Therapy	Well-Supported	Well-Supported	Children ages 2 - 7 years old with behavior and parent-child relationship problems; may be conducted with parents, foster parents, or other caretakers. Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to	Child-Directed Interaction component: <ul style="list-style-type: none"> <li>• Build close relationships between parents and their children using positive attention strategies</li> <li>• Help children feel safe and calm by fostering warmth and security between parents and their children</li> <li>• Increase children's organizational and play skills</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				<p>decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. PCIT is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions.</p>	<ul style="list-style-type: none"> <li>• Decrease children's frustration and anger</li> <li>• Educate parent about ways to teach child without frustration for parent and child</li> <li>• Enhance children's self-esteem</li> <li>• Improve children's social skills such as sharing and cooperation</li> <li>• Teach parents how to communicate with young children who have limited attention spans</li> </ul> <p>Parent-Directed Interaction component:</p> <ul style="list-style-type: none"> <li>• Teach parent specific discipline techniques that help children to listen to instructions and follow directions</li> <li>• Decrease problematic child behaviors by teaching parents to be consistent and predictable</li> <li>• Help parents develop</li> </ul>	



Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
					confidence in managing their children's behaviors at home and in public	
	Trauma Focused-Cognitive Behavioral Therapy	Promising	Well-Supported	Children, 3-18 years of age, with a known trauma history who are experiencing significant posttraumatic stress disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment. TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.	<ul style="list-style-type: none"> <li>• Improving child PTSD, depressive and anxiety symptoms</li> <li>• Improving child externalizing behavior problems (including sexual behavior problems if related to trauma)</li> <li>• Improving parenting skills and parental support of the child, and reducing parental distress</li> <li>• Enhancing parent-child communication, attachment, and ability to maintain safety</li> <li>• Improving child's adaptive functioning</li> <li>• Reducing shame and embarrassment related to the traumatic experiences</li> </ul>	Rigorous evaluation strategy
Substance abuse treatment and prevention	Motivational Interviewing	Well-supported	Well-supported	Caregivers of children referred to the child welfare system, has been used with adolescents. MI is a client-centered, directive method designed to enhance client	<ul style="list-style-type: none"> <li>• Enhance internal motivation to change</li> <li>• Reinforce this motivation</li> <li>• Develop a plan to</li> </ul>	Evaluation waiver will be requested and CQI strategy to

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.	achieve change	be implemented for EBP.
	Multi-systemic Therapy	Well-Supported	Well-Supported	Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system (some other restrictions exist, see the Essential Components section for more details). Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the	<ul style="list-style-type: none"> <li>• Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s)</li> <li>• Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents</li> <li>• Empower youth to cope with family, peer, school, and neighborhood problems</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.		
	<b>Sobriety Treatment and Recovery Team (START)</b>	<b>Supported</b>	<b>Promising</b>	Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the	<ul style="list-style-type: none"> <li>• Ensure child safety</li> <li>• Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible</li> <li>• Achieve child permanency within the Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents or, if that is not possible, with a relative</li> <li>• Achieve parental sobriety in time to meet ASFA permanency timeframes</li> <li>• Improve parental capacity to care for children and to engage in essential life tasks</li> </ul>	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services Clearinghouse is well supported)

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.	<ul style="list-style-type: none"> <li>• Reduce repeat maltreatment and re-entry into out-of-home care</li> <li>• Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues</li> <li>• Improve collaboration and the system of service delivery between child welfare and mental health treatment providers</li> </ul>	
In-home, skill-based parenting programs	Homebuilders®	Well-Supported	Supported	Homebuilders® is a home- and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting,	<ul style="list-style-type: none"> <li>• Reduce child abuse and neglect</li> <li>• Reduce family conflict</li> <li>• Reduce child behavior problems</li> <li>• Teach families the skills they need to prevent placement or successfully reunify with their children</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports, or other community groups. Child neglect referrals often require case activities related to improving the physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.		
	<b>Intercept®</b>	<b>Well-Supported</b>	<b>Well-Supported</b>	Intercept® provides intensive in-home services to children and youth at risk of entry or re-entry into out-of-home placements or who are currently in out-of-home placements, (e.g., foster care, residential facilities, or group homes). Family intervention specialists use an integrated, trauma-informed approach to offer individualized services intended to meet the needs of children and their families of origin. Specialists address needs identified in children's schools, peer groups, neighborhoods, and communities. Specialists	<ul style="list-style-type: none"> <li>•Reduce foster care utilization by providing prevention services to children and their families of origin.</li> <li>•Reduce time spent in foster care by providing reunification services to children and their families of origin.</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				also support the family in school or legal meetings and are on-call to provide crisis support 24/7. Intercept® uses an online resource called GuideTree® to facilitate treatment. GuideTree® includes a comprehensive resource library, access to licensed program experts, and supports for developing and reviewing treatment plans.		
	<b>Motivational Interviewing</b>	<b>Well-supported</b>	<b>Well-supported</b>	<b>Caregivers of children referred to the child welfare system, has been used with adolescents. MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI can be used by itself, as well as in combination with other treatments. It has been utilized in pretreatment work to engage and motivate clients for other treatment modalities.</b>	<ul style="list-style-type: none"> <li>• Enhance internal motivation to change</li> <li>• Reinforce this motivation</li> <li>• Develop a plan to achieve change</li> </ul>	Evaluation waiver will be requested and CQI strategy to be implemented for EBP.
	<b>Sobriety Treatment and Recovery Team (START)</b>	<b>Supported</b>	<b>Promising</b>	Families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START is an intensive child welfare program for families with co-occurring substance use and child maltreatment delivered in an integrated manner with local	<ul style="list-style-type: none"> <li>• Ensure child safety</li> <li>• Reduce entry into out-of-home care, keeping children in the home with the parent when safe and possible</li> <li>• Achieve child permanency within the</li> </ul>	Rigorous evaluation strategy (required unless TBD rating by Title IV-E Prevention Services

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
				addiction treatment services. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.	Adoptions and Safe Families Act (ASFA) timeframes, preferably with one or both parents or, if that is not possible, with a relative <ul style="list-style-type: none"> <li>• Achieve parental sobriety in time to meet ASFA permanency timeframes</li> <li>• Improve parental capacity to care for children and to engage in essential life tasks</li> <li>• Reduce repeat maltreatment and re-entry into out-of-home care</li> <li>• Expand behavioral health system quality of care and service capacity as needed to effectively serve families with parental substance use and child maltreatment issues</li> <li>• Improve collaboration and the system of service</li> </ul>	Clearinghouse is well supported)

Prevention Program categories	DCBS Proposed Evidence-Based Programs	Title IV-E Prevention services Clearing-House Rating	CEBC Rating	Brief Description and Target population	Intended outcomes	evaluation strategy
					delivery between child welfare and mental health treatment providers	



## Appendix H: DCBS' Signed Assurance for Trauma-Informed Services

DCBS' signed assurance that all services provided under this Title IV-E Prevention Plan will be administered within a trauma informed organizational structure and treatment framework.

Title IV-E Prevention and Family Services and Programs Plan  
State of Kentucky

ATTACHMENT III

### State Assurance of Trauma-Informed Service-Delivery

**Instructions:** This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child 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.

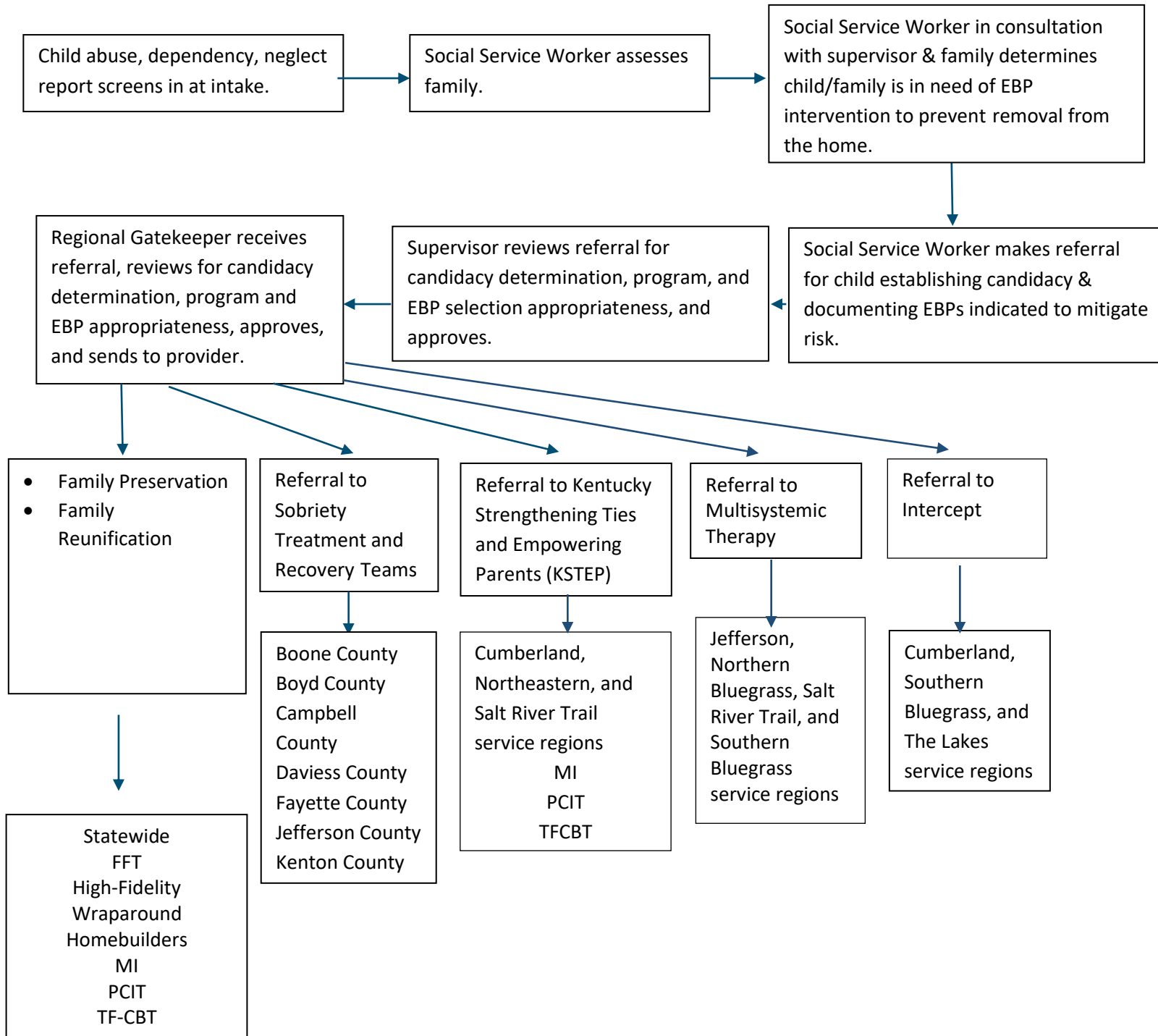
The Department for Community Based Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

**Signature:** This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

8/23/2019  
(Date)

 Commissioner  
(Signature and Title)

## Appendix I: Evidence-based Practice Selection Process Mapping



**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

8/23/2019  
(Date)

 Commissioner  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Motivational Interviewing (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

11/13/2019  
(Date)

 Commissioner  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)



**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Mutisystemic Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

8/23/2019  
(Date)

 Commissioner  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Parent Child Interaction Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

8/23/2019  
(Date)

Eric S. Lee Commissioner  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Homebuilders (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

10/31/2019  
(Date)

\_\_\_\_\_  
(CB Approval Date)

 Commissioner  
(Signature and Title)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)



**State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**

**Instructions:** This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

**The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.**

The Department for Community Based Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Intercept (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

**Signature:** This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

3/29/2022

(Date)

(CB Approval Date)

DocuSigned by:

Marta Miranda-Straub

DCBS Commissioner

(Signature and Title)

(Signature, Associate Commissioner, Children's Bureau)



## Appendix K: Program Descriptions for contracted in-home service provider

Prevention Services Description and Eligibility Criteria	Duration and Service Intensity
<b>Intensive Family Prevention Services (IFPS)</b>  Eligibility Criteria: Imminent risk of removal of child from home	Duration: Average 4-6 weeks Service Intensity: Intensive in-home services provided for 6-10 direct hours per week Caseload: 2 – 4 families at a time Age limit: 0-17 years old Accessed Statewide
<b>Family Reunification Services</b>  Eligibility Criteria: A plan to return child home from out-of-home care	Duration: Average 3-6 months <ul style="list-style-type: none"> <li>• Extensions permitted up to 15 months</li> <li>• Extensions determined by a risk assessment completed every three months</li> </ul> Service Intensity: Average minimum 3-8 direct hours per week Caseload: Not to exceed 6 cases at a time Age limit: 0-17 years old Accessed Statewide
<b>Families &amp; Children Together Safely (FACTS)</b>  Eligibility Criteria: Moderate risk of removal of a child from the home	Duration: Average 3-6 months <ul style="list-style-type: none"> <li>• Extensions permitted up to 15 months</li> <li>• Extensions determined by a risk assessment completed every three months</li> </ul> Service Intensity: Average minimum 3-8 direct hours per week Caseload: Not to exceed 6 cases at a time Age limit: 0-17 years old Accessed Statewide
<b>Diversion</b>  Eligibility Criteria: Imminent risk of removal of an older child from the home, with a larger clinical focus	Duration: Average 3-6 months <ul style="list-style-type: none"> <li>• Extensions permitted up to 15 months</li> <li>• Extensions determined by a risk assessment completed every two months</li> </ul> Service Intensity: Average minimum 3-8 direct hours per week Intensity is determined based on needs of family Caseload: Not to exceed 6 cases at a time Age limit: 5-17 years old

Prevention Services Description and Eligibility Criteria	Duration and Service Intensity
	Accessed Statewide
<p><b>KSTEP (Kentucky Strengthening Ties and Empowering Parents)</b></p> <p>Eligibility Criteria: Child(ren) at moderate to imminent risk of removal from the home, with parental substance abuse as a primary feature affecting child safety</p>	<p>Duration: Up to 8 months, with extensions permitted beyond this, as assessed by family progress/phase completion.</p> <p>Service Intensity:</p> <ul style="list-style-type: none"> <li>• 5-10 hours per week, 2 contacts a week (1 must include children) for 2-5 months</li> <li>• 2-10 hours per month, 1 contact a week (must include children) for 1-3 months</li> <li>• 1-8 hours per month, 1 contact a month (must include children) for 1-2 months</li> </ul> <p>Caseload: Not to exceed 9 cases at a time</p> <p>Age limit: Under 10 years</p> <p>Counties Served: Bath, Carter, Fleming, Greenup, Mason, Lewis, Montgomery, and Rowan</p>
<p><b>START (Sobriety Treatment and Recovery Team)</b></p> <p>Eligibility Criteria: New referral (not an active case), substantiated finding or FINSA, one child 0-5 in the home, primary risk factor of parental substance abuse, Medicaid/TANF eligible or work towards insurance</p>	<p>Duration: On average 14 months, with no maximum duration</p> <p>Caseload: Not to exceed 15 cases at a time</p> <p>Age limit: Under 6 years</p> <p>Counties Served: Boone, Boyd, Campbell, Daviess, Fayette, Jefferson, and Kenton</p>

## Appendix L: DCBS' Reporting Assurance (CB-PI-18-09 Attachment I)

Title IV-E Prevention and Family Services and Programs Plan  
State of Kentucky

ATTACHMENT I

### State Title IV-E Prevention Program Reporting Assurance

**Instructions:** This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, Department for Community Based Services, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such 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.

**Signature:** This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

8/23/2019  
(Date)

 Commissioner  
(Signature and Title)

\_\_\_\_\_  
(CB Approval Date)

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)

## **Appendix M: Systematic Review team Qualifications**

### **Dr. Chris Newhard**

The review team is led by Dr. Chris Newhard. Dr. Newhard serves as the lead data analyst for evaluations of child welfare, juvenile justice, and community-based prevention programs that are conducted by Public Consulting Group's (PCG) Services practice. He uses case management data files to measure the impact of programs, as well as assessment tools that are used to identify a client's service needs upon enrollment into a program and track progress over time. Dr. Newhard worked closely with the Systematic Review Team to verify the studies selected for the review met the Title IV-E Prevention Clearinghouse's strict standards, reviewed the content of the data reported in Tables 2 through 11, and verified or measured the statistical significance and size of the effects for both the favorable and unfavorable outcomes. Dr. Newhard earned his doctoral degree in biophysics from Rensselaer Polytechnic Institute.

### **Karen Hallenbeck**

Karen Hallenbeck, the Program Manager for PCG's Human Services' Evaluation team, provides oversight and guidance, helping to ensure projects and staff have sufficient resources to carry out our work. She oversaw the process, outcome and cost evaluations which PCG completed for three states' Waiver programs, specifically Arkansas, Maine and West Virginia, helping to develop the methodologies and data collection instruments, identify sufficient resources were available to complete the work, and review the semi-annual, interim and final evaluation reports prior to their submission. Ms. Hallenbeck has been providing oversight and guidance to our evaluation team for over 20 years. She earned her bachelor's degree in Finance, with a minor in Accounting, from Siena College in Loudonville, New York.

### **Tina Williams**

Tina Williams, who has master's degrees in education and public administration, has been an integral member of the Systematic Review Team. She conducted much of the research to identify studies completed of programs Kentucky seeks the Prevention Clearinghouse to review and rate. Ms. Williams reviewed the studies and completed the tables, as prescribed in ACYF-CB-PI-18-09. Since joining PCG earlier this year, Ms. Williams has participated in a number of program evaluations and organizational assessments, most often conducting interviews and focus groups with key stakeholders including clients, to assess program or process fidelity and identify gaps in service needs.

### **Kyle Feuer**

Kyle Feuer, a Research Analyst who has been involved in PCG's evaluation work for over seven years, also assisted with the review of the studies. He helped to identify which studies were relevant to include, e.g., did they employ a randomized control trial or quasi-experimental approach, if the treatment and comparison groups were statistically equivalent, and what positive and negative outcomes were achieved. Mr. Feuer, who is also responsible for analyzing data for multiple evaluations conducted by PCG, worked closely with Dr. Newhard and Ms. Williams to record the relevant documentation. Mr. Feuer earned his bachelor's in Business, Management and Economics from the State University of New York Empire State College.

## Appendix N: Conflict of Interest Statements



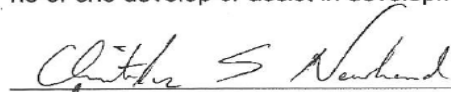
Solutions that Matter

### Conflict of Interest Statement

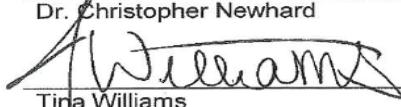
In mid-2019, the Kentucky Cabinet for Health and Family Services contracted with Public Consulting Group, Inc. (PCG) to perform an independent review of studies conducted of evidence-based programs. The reviews are being done to determine how the Title IV-E Prevention Services Clearinghouse is likely to rate the evidence-based programs that Kentucky plans to implement as part of its Title IV-E Prevention Services Plan.

The reviews were conducted by members of PCG's Evaluation Team. While the Evaluation Team has experience conducting rigorous evaluations of evidence-based programs, none of the studies included in the review were authored or developed by members of PCG, nor did any of the staff from PCG participate in developing the programs or services reviewed.

By signature below, each member of the Evaluation Team who participated in the review of the evidence-based programs attests that he or she did not participate in any of the studies nor did he or she develop or assist in development of the evidence-based programs reviewed.

  
Dr. Christopher Newhard

Date: 2019-12-13

  
Tina Williams

Date: 12/13/19

  
Kyle Feuer

Date: 12/13/19

  
Karen Hallenbeck

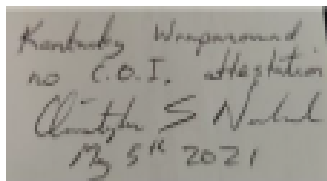
Date: 12.13.19

### Conflict of Interest Statement

In mid-2019, the Kentucky Cabinet for Health and Family Services contracted with Public Consulting Group, Inc. (PCG) to perform an independent review of studies conducted of evidence-based programs. The reviews are being done to determine how the Title IV-E Prevention Services Clearinghouse is likely to rate the evidence-based programs that Kentucky plans to implement as part of its Title IV-E Prevention Services Plan.

The reviews, including that of the Wraparound program, were conducted by members of PCG's Evaluation Team. While the Evaluation Team has experience conducting rigorous evaluations of evidence-based programs, none of the Wraparound studies included in the review were authored or developed by members of PCG, nor did any of the staff from PCG participate in developing the Wraparound program.

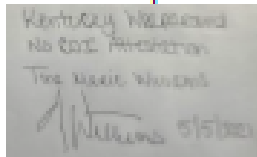
By signature below, each member of the Evaluation Team who participated in the review of the Wraparound program attests that he or she did not participate in any of the Wraparound studies nor did he or she develop or assist in development of the Wraparound program.



Kentucky Wraparound  
no C.O.I. attestation  
Christopher S. Newhard  
May 5<sup>th</sup> 2021

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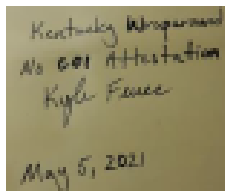
**Dr. Christopher Newhard**



Kentucky Wraparound  
No COI Attestation  
Tina Williams  
5/5/2021

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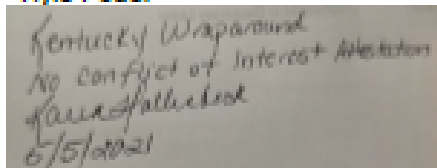
**Tina Williams**



Kentucky Wraparound  
No COI Attestation  
Kyle Feuer  
May 5, 2021

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**Kyle Feuer**



Kentucky Wraparound  
No Conflict of Interest + Attestation  
Karen Hallenbeck  
5/5/2021

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**Karen Hallenbeck**

## Appendix O: Standards of Practice (SOP)

### Standards of Practice 1.5 Supervision and Consultation

1.5 Supervision and Consultation  
Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual  
Chapter:  
Chapter 1-Fundamentals of Practice  
Effective:  
9/27/2019  
Section:  
1.5 Supervision and Consultation  
Version:  
11

When a section of SOP has been revised users will see the following: Added **{This is added material}**, Deleted ~~{This is deleted material}~~. The bold and strikethroughs will appear on the site for fifteen (15) days after a modification and will then be removed.

#### Forms

[Provide Supervisory Consultation Quarterly Review.doc](#)  
[In-Home Services Case Consultation Template.docx](#)  
[Investigative Consultations and Staffings Template.docx](#)  
[Ongoing OOHC Case Consultation Template.docx](#)  
[DPP-20 Utilization Review Consult Form.doc](#)

#### Legal Authority/Introduction

##### LEGAL AUTHORITY:

N/A

##### Introduction:

Supervision is an integral part of ensuring that appropriate and timely services are being assessed, offered and provided to the vulnerable families and children served by DCBS. It is important that the FSOS supports staff in critical thinking and decision making. The purpose of case consultation is to use the knowledge and expertise of the supervisor and designated regional staff to guide the casework being completed by staff, and ensure that staff are completing tasks/objectives as delineated in the assessment, case plan and as instructed by the supervisor. In addition to the standards established below, regional consultations can be requested by staff at any time.

Regional case consultation protocol has been established for investigations and out of home care cases. Protocol for in home cases and high risk protocol consultations are currently in development. In order to eliminate additional meetings for staff the OOHC case consultations incorporate the following:

- Swift adoption issues;
- Utilization review consults;
- MSW consults;
- Adoption and Safe Families Act (ASFA) reviews;
- Decisions about sibling separation/return/reunification;
- Case closure reviews;
- Planned permanency living arrangement (PPLA) reviews; and
- Regional consult committee review.

This means that by completing the OOHC case consultations, as outlined in the procedures below, staff will no longer have to conduct the meetings listed above.

### **Procedure**

#### **The FSOS:**

1. Meets monthly with each worker to discuss and strategize case specific issues for each CPS and APS cases;
2. Ensures that staff complete all identified tasks or actions as discussed and documented on the corresponding case consultation form;
3. Documents the following information on the consultation form when a task or action is unable to be completed by the next consult:
  - A. Why the task or action was not completed;
  - B. Barriers to completing the task or action;
  - C. Strategies to assist the family and SSW in completing the task; and
  - D. Anticipated date of completion of the task or action;
4. Assesses completion of the identified tasks or actions at the next consultation meeting.

#### **Utilization Review Consultation**

1. Upon determination that the child cannot safely remain in the home, consults with the regional office utilizing the DPP-20 Utilization Review Consult form.
2. Sends the DPP-20 form to a master's level practitioner the following business day for review and approval. Regional office maintains a copy of the signed DPP-20 form.

#### **Regional Investigative Case Consultation**

1. Within 72 hours from the time the referral was accepted by centralized intake, the FSOS staffs with their regional office, investigations alleging physical abuse involving a child four (4) and younger unless the case:
  - A. Involves a fatality/near fatality;
  - B. Has been designated as a specialized investigation; or
  - C. The case is receiving ongoing regional office or central office consultations.
2. Designated regional office staff cover the following content during the consultation:



- A. Who are the household members (describe each member's age, disability, etc.);
  - B. What are the allegations;
  - C. What lead up to the event (48 hour timeline);
  - D. What are the strengths and protective capacities of the family;
  - E. What is the family history with CPS/APS (investigations and ongoing);
  - F. What is the high risk pattern of behavior of the perpetrator;
  - G. What is the protective capacity of the primary caregivers;
  - H. Are you concerned about the children's safety and why;
  - I. Consider the vulnerability of the child based on age and development; (add this to the template)
  - J. Who has been interviewed so far;
  - K. What documentation has been gathered; and
  - L. What needs to be done next (interviews, referrals for service, etc.).
3. Designated regional office staff and the FSOS will conduct a follow up staffing no later than fourteen (14) working days after initial staffing, unless it is clearly determined that the allegations will be unsubstantiated.
  4. The FSOS will notify the designated regional office staff of any changes in the investigation since the fourteen (14) day investigative consultation.
  5. The FSOS will ensure all action steps are completed prior to the approval of the assessment.
  6. Investigative consultations will be documented in the assessment and will include the following details:
    - A. Date each consultation was held;
    - B. Type of consultation held (Regional Investigative Case Consultation);
    - C. Parties involved in the consultation; and
    - D. Rationale for omitting the fourteen (14) day follow-up consultation (if applicable)

#### **In Home Services Case Consultations**

1. The FSOS meets with the SSW monthly to review all in home services cases.
2. The FSOS and regional office staff meet with the SSW to staff in home cases that have been open for fifteen (15) consecutive months and every six (6) months thereafter:
3. During the consultation the FSOS and regional office staff cover the following content:
  - A. Who are the household members;
  - B. What are the strengths of the family;
  - C. What are the dates of the most recent face to face contact with the mother, father and children, investigative assessment, ongoing assessment, case plan and FTM;
  - D. What risks were identified with the family that resulted in a case being opened;
  - E. What are the services in place to reduce risk or further maltreatment;
  - F. **What prevention services are being offered to the family;**
  - G. **What date did services start;**
  - H. **What is the date the child(ren) were identified as candidates for foster care;**
  - I. **What are the evidence based practices (EBPs) being utilized with the family to mitigate high risk behaviors;**
  - J. What high risk patterns were identified;
  - K. What services are in place for each adult to address high risk patterns of behavior;

- L. What progress has been made by the mother, father or other caregiver to reduce high risk patterns of behavior and safety concerns identified on the case plan;
  - M. Is the court case active and what court orders are in place;
  - N. What are the final tasks that need to be completed on the case plan for the case to be closed;
  - O. What does the family see as barriers to case closure and how do they believe these barriers can be overcome;
  - P. What does the SSW see as barriers to case closure and how do they believe these barriers may be overcome;
  - Q. What is the projected date of closure; and
  - R. What community resources does the family need to be linked to prior to case closure (formal and informal).
- 4. Ongoing in home consultations will be documented in service recording and will include the following details:
    - A. Date the consultation was held;
    - B. Type of consultation held (in home services case consultation); and
    - C. Parties involved in the consultation.
  - 5. The completed case consultation template will be maintained by the regional office designee (either electronically or in hard copy format).

#### **Out of Home Care Regional Case Consultation**

- 1. The FSOS and designated regional office staff meet to consult on the progress of an out of home care ongoing case:
  - A. After a child has been in out of home care for three (3) months and documents information on the Three (3) Month Initial OOHC Case Consultation Template;
  - B. Prior to the child being in care for twelve (12) months; and
  - C. Every twelve (12) months thereafter, according to the child's entry date into OOHC, until the child achieves permanency;
- 2. The results of the periodic case consultations are documented on the Ongoing OOHC Case Consultation Template.
- 3. Ongoing OOHC consultations will be documented in service recording and will include the following details:
  - A. Date the consultation was held;
  - B. Type of consultation held (Out of Home Care Regional Case Consultation); and
  - C. Parties involved in the consultation.
- 4. The completed case consultation template will be maintained by the regional office designee (either electronically or in hard copy format).
- 5. For agency cases, the consultation is documented utilizing the Agency Case Consultation Template.

## **Standards of Practice 2.11 Investigation Protocol**

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual

Chapter:

Chapter 2-Child Protective Services (CPS) Intake and Investigation

Effective:

6/28/2019

Section:

2.11 Investigation Protocol

Version:

17

When a section of SOP has been revised users will see the following: Added {This is added material}, Deleted {~~This is deleted material~~}. The bold and strikethroughs will appear on the site for fifteen (15) days after a modification and will then be removed.

### **Forms and Resources**

[ADAM WALSH STATE CONTACTS FOR CHLD ABUSE REGISTRIES](#)

[DPP-106I Methamphetamine Exposure Medical Evaluation and Follow-Up Form.doc](#)

[DPP-152C Child Protective Service \(CPS\) No Finding Notification Letter.docx](#)

[DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding.doc](#)

[DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding \(Spanish\).doc](#)

[Collective Letter Between DCBS and the Department of Education.PDF](#)

[Communicating with the School System When Working with Families.docx](#)

[Determination of Findings Matrix.docx](#)

[Mental Health-Illness Indicators Tip Sheet.doc](#)

[Meth Lab Protocol for APS Workers-Intake and Assessment of Vulnerable Adults in or Exposed to Meth Labs.doc](#)

[Meth Lab Protocol for CPS Workers-Intake and Assessment of Children in or Exposed to Meth Labs.doc](#)

[Meth Lab Protocol- Medical Evaluation for Children and Adults.doc](#)

[Interviewing Children at School Tip Sheet.docx](#)

[Pain Faces for Children Tip Sheet.doc](#)

[Physical Abuse Determination Tip Sheet.doc](#)

[Shaken Baby Syndrome-Inflicted Head Trauma Fact Sheet.doc](#)

[Substance Use and Abuse Tip Sheet.doc](#)

[Title IV-E Candidates-Claiming for In Home Cases.docx](#)

- [Traumatic Skin Lesions-Bruises-Burns-Bites Fact Sheet.doc](#)
- [When Your Child is Removed from Your Care.docx](#)
- [When Your Child is Removed from Your Care-Spanish.docx](#)

- Ky Coalition Against Domestic Violence
- CPS REPORTS WITH RISKS ASSOCIATED WITH DOMESTIC VIOLENCE TIP SHEET.doc

## **Legal Authority/Introduction**

### **LEGAL AUTHORITY:**

- 42 USC Section 5106a Grants to States for child abuse or neglect prevention and treatment programs
- KRS 600.020 Definitions for KRS Chapters 600 to 645
- KRS 620.030 Duty to report dependency, neglect, abuse or human trafficking-Husband-wife and professional-client/patient privileges not grounds for refusal to report-Exceptions-Penalties
- KRS 620.040 Duties of prosecutor, police and cabinet-Prohibition as to school personnel-Multidisciplinary teams
- KRS 620.050 Immunity for good faith actions or reports-Investigations-Confidentiality of reports-Exceptions-Parent's access to records-Sharing of information by children's advocacy centers-Confidentiality of interview with child-Exceptions
- 922 KAR 1:330 Child protective services
- 2017 KY Acts Chapter 188

## **Procedure**

### **Sequence of Interviews**

In the following sequence whenever possible, the SSW:

1. Conducts unannounced face to face interviews with all household members including:
  1. The alleged victim;
  2. All other children in the home;
  3. The non-offending parent/caretaker; and
  4. All adults living in the home;
2. Conducts face to face interviews, or phone interviews at a minimum if face to face is not practical, with collaterals, including:
  1. School personnel, within two (2) working days, when school is in session and the child is of school age; and
  2. Other collaterals who can assist in the determination of the incident and provide information to assist with a safety and risk assessment, as necessary;12
3. Conducts a face to face interview with the alleged perpetrator/caretaker:
  1. If the alleged perpetrator of abuse, neglect or dependency is a child age twelve (12) to eighteen (18), and the child/youth was in a caretaking role, the alleged perpetrator is not interviewed without notification to the parent/custodian of the alleged perpetrator. The parent/custodian can require that they or an attorney be present for the alleged perpetrator's interview; and
  2. Provides the alleged perpetrator during their interview (pursuant to 42 U.S.C. 5106a) with:
    1. Notice of the basic allegations, void of any specifics that may compromise the investigation;

2. Notice that they will be provided notification of the findings upon completion of the investigation; and
3. A copy of the DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding explaining the alleged perpetrators rights to appeal a substantiated finding and who they can contact to file a complaint.

### **Content of Interviews and Information to be Collected**

The SSW:

1. Collects evidence and information for specific documentation in TWIST including:
  1. The identity of every household member, and their relationships to one another;
  2. The date, time, and location of each interview;
  3. A summary of each interview to include the subject's version of the sequence of events, their account of any observable impact on the child, and details relevant to an integrated safety assessment;
  4. Environmental information, particularly as it relates to the allegations;
  5. References to photographs taken or other information collected from collateral sources, including medical records as necessary;
  6. Clinical consultations with other professionals as warranted by the case circumstances, i.e. mental health professionals, medical personnel, etc.;
2. Discusses with the parent/caretaker or children, as appropriate, past agency and/or criminal history;
3. Determines if the family/household member has resided out of the state within the previous seven (7) years;
4. Utilizes the Adam Walsh State Contacts for Child Abuse Registries as a resource to contact other states to request records, if the family/household member has resided out of state in the last seven (7) years and:
  1. Discusses the prior history with the family and considers the significance when determining their level of intervention for the current report and findings; and
  2. Contacts the Child Protection Branch at [DCBSChildProtection@ky.gov](mailto:DCBSChildProtection@ky.gov) or 502-564-2136 if experiencing difficulty obtaining information from the other state.
5. Assesses, during each interview, for risk related to domestic violence, substance use/abuse misuse, mental health issues, cognitive delays, or learning disabilities;
6. Evaluates interview content to determine whether or not accounts of the incident are consistent, and whether or not those accounts conflict with any objective information (i.e. TWIST history, AOC history, medical records, law enforcement records, etc.)
7. Visits the child's residence or residences as often as necessary to ensure the child's safety in that setting. 3

### **Safety and Risk Assessment throughout the Course of the Investigation**

The SSW:

1. Continuously evaluates for risk throughout interviews and contacts with the family to determine if there are safety issues that require intervention;

2. Consults, as necessary, with the FSOS to strategize for any immediate safety issues, barriers to the investigative process, and additional information collection that are necessary to the investigation/assessment;
3. Utilizes the Determination of Findings Matrix to assess whether the child is at serious or imminent risk of removal (472)(i)(2) of the Social Security Act);
4. When the determination is made that a child is at immediate risk at any point during contact with the family:
  1. Negotiates a prevention plan with the family clearly documenting the preventive services and interventions agreed upon with the family;
  2. Utilizes Family Preservation (FPP) and other in home services to prevent removal whenever possible and documents why less restrictive alternatives were not utilized in the assessment;
  3. Considers filing a petition (removal or non-removal) in court (Refer to SOP 11 CPS Court); and
  4. Assesses other services that may be of assistance to the family to prevent removal, which may include:
    1. Preventive assistance;
    2. A food bank referral;
    3. Child care assistance;
    4. Or other supportive services as outlined 922 KAR 1:400;
5. Upon determination that the child cannot safely remain in the home:
  1. Consults with regional office, to include at least one masters level practitioner and utilizing the DPP 20 Utilization Review Consult Form.
  2. Provides the custodial parent with a copy of the When Your Child is Removed from Your Care-Guide for Parents Brochure; and
  3. Follows placement considerations (Refer to SOP 4.9);
6. Integrates a safety assessment into the investigative narrative that considers:
  1. The age of the child(ren);
  2. Harm or threats of harm, and severity;
  3. Vulnerability and protective capacities of the child(ren);
  4. Capacity of the parent/caretaker to protect the child(ren);
  5. The caregiver's high risk behaviors;
  6. Family interactions and support systems;
  7. Features of the family or individuals that add stressors to the family;
  8. The perpetrator's access to the child(ren);
  9. The household composition;
  10. The physical household environment; and
  11. The attitude and level of cooperation exhibited by household members;
7. Determines:
  1. The circumstances leading up to the incident.
  2. The individuals present during the incident.
  3. The sequence of events as the incident transpired.
  4. The observable impact on the child.

5. The likelihood of future maltreatment to the child based upon the risk factors identified during the assessment.
8. Consults with FSOS immediately to discontinue the prevention plan when there are no remaining safety threats that require the provisions of the prevention plan, and:
  1. Conducts an immediate phone call with the parent/caregiver; and
  2. Sends a letter to parent/caregiver discontinuing the prevention plan if all safety threats and risks are eliminated.
9. Completes a face to face interview with the parent/caregiver within forty eight (48) hours if the prevention plan needs to be renegotiated based on safety threats or risks to the child(ren). 4

#### **Contingencies and Clarifications**

1. In addition to notifying the school when a report is accepted (see Procedure 2A), the SSW should also notify the school within two (2) working days of the conclusion of the agency's work with the family, if school is in session.
2. If an investigation is not completed within thirty (30) working days, the SSW has monthly contact with the family until the investigation is complete and the agency's work with the family is done, or until an ongoing case is opened.
3. If the cabinet receives custody of a child, the SSW:
  - A. Notifies the school principal, assistant principal or guidance counselor verbally and via e-mail on the day a court order is entered and again on any day a change is made regarding who is authorized to contact or remove the child from school, or on the following school day if the court order or change occurs after the end of the current school day; and
  - B. Provides written notification via e-mail within ten (10) calendar days following a change of custody or change in contact or removal authority
4. Beginning on June 28, 2019, if information is discovered resulting in the basis of the report no longer meeting the acceptance criteria, the SSW can request to discontinue the investigation with a "no finding" determination within 10 business days of receipt of report. A no finding determination cannot:
  - A. Be utilized for reports received prior to June 28, 2019;
  - B. Be utilized with reports designated as specialized investigations, including fatality or near fatality reports, as defined in SOP 2.15; 5 or
  - C. Be utilized if multiple interviews have been conducted.
5. A no finding determination can only be used in familial investigations, and when there are no other risk factors identified in the report, found during interviews with the child(ren) and/or caregivers, or during worker observations of the family and environment. 6
  - A. The SSW:
    - i. Consults with the FSOS and SRA or designee;
    - ii. Does not conduct any additional interviews if FSOS and SRA or designee are in agreement that the report meets for a no finding determination;
    - iii. Submits a determination of no finding and includes a statement in the Assessment Conclusion narrative box within 10 business days of receipt of report; 7 and

- iv. Sends the DPP-152C notification letter to alleged perpetrator and parent or caregiver within 10 business days after final approval from SRA or designee.
- B. The SRA or designee:
  - i. Approves the no finding determination in TWIST within 10 business days of receipt of report; and
  - ii. Notifies the Child Protection Branch at [DCBSChildProtection@ky.gov](mailto:DCBSChildProtection@ky.gov) of receipt of report for tracking purposes.

## **Practice Guidance**

### **General Practice Guidance**

- The SSW has access to all records and documentation to complete an investigation regarding the child alleged to have been abused or neglected and the alleged perpetrator.
- Throughout the investigation, the investigator and FSOS are responsible for assessing for imminent risk by considering the following:
  - Children with (or indications there may be) serious injuries from physical abuse, particularly those in critical areas of the body (Refer to Inflicted Head Trauma Fact Sheet and Traumatic Skin Lesions Fact Sheet);
  - Children ages five (5) years and younger;
  - Children suffering from acute untreated medical condition(s) that demand urgent attention whose parent/caretaker is refusing to obtain treatment or cannot be located;
  - Self-referral from a parent/caretaker who states they are currently unable to cope or feel they may harm their child(ren);
  - A child who expresses fear of their current circumstances;
  - Sexual abuse allegations in which the perpetrator is suspected to have immediate access to the alleged victim or other children in the home;
  - Physical abuse or neglect appears imminent;
  - A child presently receiving bizarre forms of punishment, for example being locked in a closet or tied to a chair or bed;
  - A child at risk of immediate harm from a parent/caretaker who is behaving in a bizarre manner;
  - Abandoned (parent/caretaker has no intent to return) children who are currently without supervision of a responsible adult;
  - Children who are currently without supervision by a responsible person who are at risk of harm based on their age, environment, or other factors. The investigation determines the child's level of maturity, development and ability to function safely alone and whether the family has an established plan of action in case of emergency;
  - Situations involving weapons; or
  - Other situations related to the caregiver's high risk behaviors that constitute immediate risk to the child in the judgment of the FSOS and SSW.
- The worker's contact with the parent or caretaker should occur in the home promptly, or as soon as possible, after interviewing the child(ren) unless there are documented safety issues.



- The worker does not identify the reporting source to anyone, unless ordered to report such by a court of competent jurisdiction. If included as a collateral interview, the reporting source should only be identified in the case record/TWIST as a collateral source, rather than the referral source in to maintain confidentiality.
- Additional information should not be shared with the reporting source, unless the reporting source is a person in a continuing and ongoing professional relationship with the child or family (such as a physician, therapist, family resource center staff, health department staff or teacher) and meets the standard under KRS 620.050 as having a legitimate interest in the case. The worker or FSOS consults with the regional attorney, as needed, when there are concerns regarding the sharing of information. Workers and supervisors should note that drug treatment information and psychotherapy notes are protected under federal law and cannot be reproduced without a specific release from the client.
- When information is to be shared, the worker:
  - Informs the reporting source with legitimate interest that the information is being shared based upon the conditions of KRS 620.050 and information may not be further shared with others;
  - Shares information that may be relevant with the person with legitimate interest that is specific to the child, summarizing services the parent/caretaker may be receiving to address abuse or neglect issues including:
    - Concerns related to safety issues for the child; Domestic violence, substance use disorder, mental health history or learning disabilities of the parent/caretaker; or The finding of an investigation.
- If necessary, the worker or FSOS may seek assistance from the regional attorney and/or law enforcement if a family or individual fails to cooperate with an investigation.
- If the parent has already made an appropriate adoptive plan for the child, the SSW may work the investigation simultaneously with the adoptive plan continuing, and SSW may not need to seek emergency custody of the child with the appropriate adoptive plan in place. Contact the Adoption Services Branch at 502-564-2147 with questions or regarding the validity of the adoptive plan.

### **Practice Guidance Specific to Methamphetamine Labs**

- Initiation of a meth lab allegation investigation should take place within four (4) hours.
- The investigator does not enter a meth lab location. If worker or investigator encounters a meth lab during a case contact, the worker/investigator leaves immediately and contacts law enforcement for assistance.
- The worker or investigator cooperates with law enforcement regarding meth lab protocol. Law enforcement and a site safety officer may direct documentation of the scene and decontamination procedures. In the absence of coordination by law enforcement the worker may contact EMS as necessary to evaluate children found in a meth lab and decontamination procedures. When emergency medical services are not required, the worker ensures that all children that have been exposed to methamphetamine, or the chemicals used to produce methamphetamine, are taken to an emergency room or

appropriate medical facility for a complete medical assessment and appropriate decontamination. If decontamination procedures are not available at the scene, the worker:

- Leaves all of the child's personal belongings (including shoes, blankets, toys, etc.) at the home, due to possible contamination by dangerous toxins;
- Uses gloves, if possible, to clean the child's face, hands, and hair with water;
- Places a protective covering (paper suit), if available, over the child's clothing for protection;
- The SSW may use a blanket, if available, to cover the car seat prior to placing the child in a car for transporting.
- The worker utilizes the DPP-106I Methamphetamine Exposure Medical Evaluation and Follow-Up Form to document the physical health and care of an exposed child. Refer to the Meth Lab Protocol for CPS Workers-Intake and Assessment of Children in or Exposed to Meth Labs and Meth Lab Protocol-Medical Evaluation for Children and Adults.
- Methamphetamine testing should be completed if possible, within two (2) hours, but no longer than twelve (12) hours, of removal since the drug may not be detectable after that time. The worker requests from the medical facility the following diagnostic testing:
  - Urine drug screening, including methamphetamine testing at a detection level;
  - Diagnostic lab work to include the following:
    - CBC with differential;
    - Chemistry panel including BUN/creatinine and liver functions;
  - Additional tests should include the following:
    - Vital signs;
    - X-ray;
    - EKG; and
    - Pulmonary function testing, if clinically indicated; and
  - A thorough lung examination, including respiratory rate and oxygen saturation on room air;

#### **Practice Guidance Specific to Sexual Abuse Investigations**

- Prior to finalizing the investigation, the SSW is encouraged to staff the investigation with the local multi-disciplinary team.
- Additional multi-disciplinary team members may be involved in the investigation per local protocol.

#### **Practice Guidance Specific to Physical Abuse Investigations**

- Determines, the level of pain felt by the child or how the child was impaired due to the reported incident (Refer to the Physical Abuse Determination Tip Sheet and Pain Faces for Children Tip Sheet);
- Requests that the parent or guardian has the child examined by a medical provider if the SSW is concerned about the extent of the child's current or possible injuries upon interviewing the child;

- When there is physical evidence of abuse, a medical assessment should be conducted as early as possible in the investigation. The Medical Support Section can also consult with the worker to strategize as to what type of medical information is needed and if appropriate, assist with a referral to Division of Forensic Medicine.

### **Practice Guidance Specific to Neglect Allegations**

- Valid evidence collection sources include medical witness, such as a physician, physician's assistant, or a nurse as to:
  - Whether the caretaker is providing necessary medical care;
  - Any action or inaction of the caretaker that has placed the child's health or welfare at risk; and
  - Likely consequences of further action or inaction (e.g. missed appointments, shots, failure to medicate) on the child's health.
- The worker refers allegations of withholding medically indicated treatment of disabled infants with life threatening conditions in hospitals or health care facilities to the central office Medical Support Section.
- For educational neglect, valid documentation may include a record of unexcused absences and documentation of prior attempts to intervene in an effort to stop unexcused absences.
- For physical neglect, valid documentation may include:
  - Photographs, which show health or safety hazards, of the home;
  - Collateral accounts as to the condition of the home, appearance or condition of the child(ren), food supply, or supervision;
  - The presence or extent of domestic violence that is occurring in the family; and
  - Documentation of parents repeatedly leaving child alone or failing to provide essential care.

### **Practice Guidance Specific to Risks Associated with Domestic Violence**

- SSW conducts an in-depth assessment of the:
  - Danger posed to the child,
  - Safety of the child due to the high risk behaviors of the perpetrator; and
  - Physical, emotional, and developmental impact on the child.
- SSW assesses the protective capacity of the non-offending parent to ensure the child's safety.
- SSW provides victims of domestic violence with educational materials through the Kentucky Coalition Against Domestic Violence.
- Refer to the CPS Reports with Risks Associated with DV Tip Sheet for detailed guidance.
- Refer to SOP 1.8 for non-offending parent/caregiver safety planning.

## RESOURCES

### Footnotes

1. Appropriate collaterals may include persons in the community such as school personnel, police officers, relatives, child's physician, family's service/treatment providers, etc. SSW interviews collaterals on behalf of any non-verbal/intellectually impaired child.
2. Per 2017 Ky. Acts chapter 188, schools and childcare facilities shall provide the cabinet access to interview children without parental consent during an investigation.
3. Workers may not visit, if through consultation with the FSOS, a residence is unsafe.
4. The phone call, face to face renegotiation (if applicable), and written notification (if applicable) are documented in the ADT, and the written notification (if applicable) is filed in the case file.
5. Examples of scenarios in which a no finding determination may be appropriate include but are not limited to:
  - A. An allegation that a child has inflicted bruises; however, upon medical examination, the bruises are observed and documented as Mongolian spots, and there are no other risk factors.
  - B. Parent of a young child was reported to have a positive drug test for heroin; however, reporting source calls back to state the reporting source erroneously provided the wrong individual's name, and there are no other risk factors.
6. Examples of additional risk factors include but are not limited to, the family's high risk patterns of behavior; history or current indicators of substance misuse, family violence, mental health issues; agency history; AOC results; worker observations of injuries, unsafe environment and/or indicators of maltreatment; etc.
7. Similar to the unable to locate determination, the ADT does not populate with a no finding determination. SSW includes a statement in the Assessment Conclusion narrative box documenting that the report no longer meets the acceptance criteria, there are no other risk factors or indicators of maltreatment identified or observed to continue the investigation, and the no finding determination was agreed upon and approved by the SRA or designee within 10 business days of receipt of report.

## Standards of Practice 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding

Cabinet for Health and Family Services

Department for Community Based Services

Division of Protection and Permanency

Standards of Practice Online Manual

Chapter:

Chapter 2-Child Protective Services (CPS) Intake and Investigation

Effective:

6/28/2019

Section:

2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding

Version:

9

When a section of SOP has been revised users will see the following: Added {This is added material}, Deleted {~~This is deleted material~~}. The bold and strikethroughs will appear on the site for fifteen (15) days after a modification and will then be removed.

### Forms and Resources

- [DCBS-1B Application for Services.doc](#)
- [DPP-20 Utilization Review Consult Form.doc](#)
- [DPP-152C Child Protective Service \(CPS\) No Finding Notification Letter.docx](#)
- [DPP-154 Protection and Permanency Service Appeal.doc](#)
- [DPP-154 Protection and Permanency Service Appeal \(Spanish\).doc](#)
- [DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding.doc](#)
- [DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Finding \(Spanish\).doc](#)

### ADT Templates:

- [ADT CPS Assessment for Abuse or Neglect.docx](#)
- [ADT Dependency Assessment.docx](#)
- [Amend Results Tip Sheet.pdf](#)
- [Case Naming Protocol Tip Sheet.doc](#)
- [Case Planning Meeting Brochure.docx](#)
- [Child Development Milestones.doc](#)
- [CPS Investigative Distribution Chart.doc](#)
- [Determination of Findings Matrix.docx](#)
- [EPO-DVO Admin User Guide.doc](#)
- [EPO-DVO User Guide.doc](#)
- [iTWIST Navigation Map for Searching and Reading.docx](#)
- [Mental Health-Illness Indicators Tip Sheet.doc](#)
- [Shaken Baby Syndrome-Inflicted Head Trauma Fact Sheet.doc](#)

- [Substance Use and Abuse Tip Sheet.doc](#)
- [Traumatic Skin Lesions-Bruises-Burns-Bites Fact Sheet.doc](#)
- [TWIST Account Request for EPO-DVO.DOC](#)

#### **Links to External Websites:**

- First Steps Regional Contact

#### **Legal Authority/Introduction**

##### **LEGAL AUTHORITY:**

- [42 USC Section 5106a Grants to States and public or private agencies and organizations](#)
- [922 KAR 1:330 Child protective services](#)

The Assessment and Documentation Tool (ADT) is a stand-alone document. It is utilized to conduct a thorough assessment of all reports received, regardless of the assessment path. To conduct a thorough assessment, the SSW must take into consideration information received from all alleged victims, alleged perpetrators, non-offending caretakers, collaterals, and records received. All information is to be documented in the assessment.

#### **Practice Guidance**

- Abused or neglected child as defined in KRS 600.020 is a child whose health or welfare is harmed or threatened with harm when his or her parent, guardian, person in a position of authority or special trust, as defined in KRS 532.045 or other person exercising custodial control or supervision of the child:
  - Inflicts or allows to be inflicted upon the child physical or emotional injury as defined in this section by other than accidental means;
  - Creates or allows to be created a risk of physical or emotional injury as defined in this section to the child by other than accidental means;
  - Engages in a pattern of conduct that renders the parent incapable of caring for the immediate and ongoing needs of the child including, but not limited to, parental incapacity due to alcohol and other drug abuse as defined in KRS 222.005;
  - Continuously or repeatedly fails or refuses to provide essential parental care and protection for the child, considering the age of the child;
  - Commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon the child;
  - Creates or allows to be created a risk that an act of sexual abuse, sexual exploitation, or prostitution will be committed upon the child;
  - Abandons or exploits the child;
  - Does not provide the child with adequate care, supervision, food, clothing, shelter, and education or medical care necessary for the child's well-being. A parent or other person exercising custodial control or supervision of the child legitimately practicing the person's religious beliefs shall not be considered a

negligent parent solely because of failure to provide specified medical treatment for a child for that reason alone. This exception shall not preclude a court from ordering necessary medical services for a child; or

- A person twenty-one (21) years of age or older commits or allows to be committed an act of sexual abuse, sexual exploitation, or prostitution upon a child less than sixteen (16) years of age.

#### **Unable to locate:**

- The investigator does not make a determination of “Unable to Locate” until efforts have been made, presented to the supervisor, and approved. The investigator does not make a determination of “Unable to Locate” if either the victim or caretaker have been located and interviewed.

#### **No Finding:**

Beginning on June 28, 2019, if information was discovered resulting in the basis of the report no longer meeting the acceptance criteria, the SSW can request to discontinue the investigation with a “no finding” determination within 10 business days of receipt of report. A no finding determination cannot:

1. Be utilized for reports received prior to June 28, 2019;
2. With reports designated as specialized investigations, including fatality or near fatality reports, as defined in SOP 2.15; 6 or
3. If multiple interviews have been conducted.

A no finding determination can only be used in familial investigations, and when there are no other risk factors identified in the report, found during interviews with the child(ren) and/or caregivers, or during worker observations of the family and environment. 7

The SRA or designee must approve the no finding determination within 10 business days of receipt of report.

#### **Unsubstantiation**

The SSW:

- Completes the assessment and documents why the assessment is unsubstantiated or in the Risk Assessment Conclusion section;
- Closes the assessment without an aftercare plan if there are no further issues;
- Completes an aftercare plan and closes the referral if there are issues that need to be clarified to assist in preventing future abuse or neglect.



## Family in need of services

The SSW:

- Assesses the situation using all available information and:
  - If the overall assessment indicates moderate risk in the Maltreatment Conclusion section, the SSW considers substantiating the case;
  - If the issue or concern identified falls below the level that would indicate that a protection case needs to be opened, the parent is refusing services, or the results of the Maltreatment Factors section are in the low risk category, the assessment may be closed and an aftercare plan developed with the family that links them to community resources to prevent the reoccurrence of the reported incident;
- Consults with the FSOS when a family is found in need of services, but refuses ongoing preventive services.

## Procedure

The SSW:

1. Completes the assessment in TWIST using the appropriate ADT template;
2. Documents the following information in the Chronology Related Data section of the assessment:
  1. All interview and evidence content;
  2. Dates, times, locations, full names and relationships of everyone interviewed; and
  3. Information gathered/steps taken to assess and protect a child during the assessment;
3. Ensures that all identifying information including full names, social security numbers, and dates of birth are accurate and associated with the correct individuals in the case (Refer to the Case Naming Tip Sheet when updating information in TWIST);
4. Identifies and documents safety and risk issues for all children in the home;
5. Makes a determination of finding on each child on all reports based upon assessment of credible information and supportive documentation gained in the investigation and the assessment process;
6. Uses the following guidelines for credible information when determining the finding of an investigation:
  1. Personal observations of the home, child(ren), neighborhood and family interaction;
  2. Interviews with caretakers, alleged victims, alleged perpetrators and collateral sources including witnesses, teachers, neighbors or other sources of information regarding family functioning;
  3. Written statements from caretakers, alleged victims, alleged perpetrators and collateral sources;
  4. Pictures of injuries and/or hazardous living conditions; and
  5. Expert opinions or statements from medical or other professionals who are able to make statements diagnosing a specific condition; or

6. An adjudication of same by the court;
7. Ensures that the social work finding is consistent with statute and regulation;
8. Consults with the FSOS as appropriate when determining the investigative finding;
9. Completes the assessment within thirty (30) working days;
10. Provides the caretaker and alleged perpetrator written notice of the outcome of the investigation, and each receive a DPP-154 Protection and Permanency Service Appeal form. The alleged perpetrator receives a DPP-155 Request for Appeal of Child Abuse or Neglect Investigative Findings form.
11. If an ongoing case is opened, the SSW provides a copy of the Case Planning Meeting Brochure to custodial parent(s) in person or when sending the notification letter(s).

### **Making a finding**

1. After obtaining all information needed to complete the assessment (using the ADT Worksheet), the investigator determines whether the referral is:
  1. Substantiated;
  2. Unsubstantiated;
  3. Family in need of services.
2. Prior to substantiation or finding a family in need of services, the investigator affirms that:
  1. Injury or risk of injury was inflicted, or that the basic needs of the child are not met;
  2. The injury, risk or omission of care was inflicted non-accidentally; “intentional” is defined in statute (KRS 600.020);
  3. A caretaker was responsible; “caretaker” is defined in statute (KRS 600.020); and
  4. Injury or risk of injury met a threshold recognized by statute, “injury” is defined in statute (KRS 600.020).

### **Definitions:**

- Caretaker: Parent, guardian or other person exercising custodial control or supervision of the child
- Non-accidental: Conduct where the actor’s conscious objective is to cause that result or engage in that conduct
- Injury: Substantial physical pain or impairment of physical condition
- Serious Physical Injury: Physical injury which creates a substantial risk of death or which causes serious and prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily member or organ
- Needs of the Child: Necessary food, clothing, health, shelter, and education necessary for the child’s well-being
- Emotional Injury: Injury to the mental or psychological capacity or emotional stability of a child as evidenced by a substantial and observable impairment in the child's ability to function within a normal range of performance and behavior with regard to his age, development, culture, and environment as testified to by a qualified mental health professional

- Preponderance of evidence: The documented evidence is to be sufficient to allow a reasonable person to conclude that the child victim was abused or neglected, and that it is more likely than not that the alleged perpetrator committed the act of commission or omission as governed by KRS 600.020(1).
- Found and substantiated: Physical abuse, sexual abuse, neglect, or dependency that was not originally reported by the referral source, but was found and substantiated during the investigation/assessment.
- Unsubstantiated: Sufficient evidence, indicators, or justification does not exist for the substantiation of abuse, neglect, or dependency.

### **Following a substantiation**

The SSW:

1. Considers completing, based on identified risks and the caregivers' high risk behaviors:
  1. An aftercare plan if the case will be closed; or
  2. A prevention plan if the case will be opened (Refer to SOP 3.3 Tools for Case Planning);
2. Takes age into consideration as follows:
  1. If an investigation of abuse or neglect is substantiated on a child under three (3) years of age, pursuant to 42 U.S.C. 5106a(b)(2)(xxi), the SSW makes a referral for early intervention services to the regional service provider for early intervention services using established regional protocol/procedures, and documents the referral in the Chronology Related Data section of the assessment (Refer to Child Development Milestones and First Steps Regional Contact Information);
  2. If the alleged perpetrator of abuse, neglect or dependency is a child age twelve (12) to eighteen (18), and the child/youth was in a caretaking role:
    1. That child/youth is identified as the alleged perpetrator if the investigation/assessment is determined to be substantiated;
    2. Does not release the name of the alleged perpetrator except by court order pursuant to KRS 620.050.
3. When it is determined that a case will be opened, the SSW ensures that the DCBS-1B Application for Services is completed by all appropriate family members.

### **Court involvement**

The SSW:

1. Determines whether the local judge wants the SSW to tender any Administrative Office of the Court (AOC) form partially or fully completed with the relevant information pertaining to that child for the judge's signature;
2. Contacts, within forty-eight (48) hours after an adjudicatory finding, the Office of Legal Services (OLS) regional attorney for consultation if the court makes a finding that conflicts with the Cabinet's finding if the FSOS believes that there is enough evidence to support the original investigative finding;

3. Decides, after consultation with the FSOS and OLS, whether to proceed with contesting the court's adjudicatory finding on appeal. 1

The FSOS:

1. Changes the department's finding to match the courts, following any hearing where the court hears evidence on the petition and makes a finding on the allegations presented in the petition;
2. Only changes the finding of the assessment and:
  1. Documents in TWIST, on the "Amend Results" tab, (refer to Amend Results Tip Sheet, for step by step instruction on this process) the reason the finding is being changed;
  2. Files a hard copy of the court order;
3. Refers the individual to the CAPTA fair hearing process if a petition is informally adjusted, dismissed, or an agreement made without proof being heard;
4. Following a CAPTA, files a copy of the final CAPTA order in the case record. 2 3
5. Sends a notification of findings letter to the caretaker and alleged perpetrator if the finding was overturned via CAPTA process.

#### **Contingencies and Clarifications**

Request for an extension

1. If the investigative worker is unable to complete the assessment within thirty (30) working days (forty-five (45) calendar days from receipt of the investigation), the SSW utilizes the following guidelines in determining the need to request an extension:
  1. The first extension request is approved by the FSOS and may be requested for the following reasons:
    1. Another agency is expected to make available information that is necessary to a finding during an extension period; 4
    2. A specialized investigation requires a large number of individual interviews or consultations with central office; or
    3. Law enforcement is conducting a criminal investigation and has not completed their work on the case. 5
  2. If a second extension becomes necessary it must be approved by the SRAA supervising the FSOS.
  3. Extension requests are submitted in TWIST to the FSOS or designee by the SSW or by e-mail if TWIST is not available.
  4. All approved extensions are documented in TWIST in the Risk Assessment Conclusion section of the assessment.
2. During the extension time period, the SSW makes monthly contacts with the family until:
  1. The investigation is closed and the agency's work with the family is complete; or
  2. A case is opened with the family and monthly contacts begin in the ongoing function.

## Footnotes

1. If the decision is to proceed, the OLS regional attorney has ten (10) days to file a motion to alter, amend or vacate the order; or thirty (30) days to file an appeal.
2. If the final order from a CAPTA fair hearing process overturns the Cabinet's substantiated finding that a child has been dependent, neglected or abused, the Commissioner's office staff changes the finding and notes the reason for the change in the Risk Assessment Conclusion section.
3. Although the finding is changed, no changes are made to the case record or the assessment.
4. A finding should not be delayed to wait for a court determination.
5. CPS findings are not contingent upon law enforcement's findings. In cases where law enforcement asks CPS staff to delay making their finding so as not to compromise a law enforcement investigation, CPS staff should seek guidance from regional office.
6. Examples of additional risk factors include but are not limited to:
  - A. The family's high risk patterns of behavior;
  - B. History or current indicators of substance misuse;
  - C. Family violence;
  - D. Mental health issues;
  - E. Agency history;
  - F. AOC results;
  - G. Worker observations of injuries;
  - H. Unsafe environment; and/or
  - I. Indicators of maltreatment; etc.
7. Similar to the unable to locate ~~f~~determination, the ADT does not populate with a no finding determination. SSW includes a statement in the Assessment Conclusion narrative box documenting:
  - A. That the report no longer meets the acceptance criteria;
  - B. There are no other risk factors or indicators of maltreatment identified or observed to continue the investigation; and
  - C. The no finding determination was agreed upon and approved by the SRA or designee within ten (10) business days of receipt of report.

## Standards of Practice 3.1 Engaging the Family and Opening the Case

Cabinet for Health and Family Services

Department for Community Based Services

Division of Protection and Permanency

Standards of Practice Online Manual

Chapter:

Chapter 3-In Home Child Protective Services (CPS) Case

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3.1 Engaging the Family and Opening the Case

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### Forms and Resources

- [CHFS-300 Notice of Privacy Practices.doc](#)
- [CHFS-300 Notice of Privacy Practices \(Spanish\).doc](#)
- [CFC-305 Authorization for Disclosure of Protected Health Information \(PHI\).doc](#)
- [CFC-305 Authorization for Disclosure of Protected health Information \(PHI\) \(Spanish\).doc](#)
- [CFC-305A Authorization for Disclosure of Psychotherapy Information.doc](#)
- [CFC-305A Authorization for Disclosure of Psychotherapy Information \(Spanish\).doc](#)
- [DCBS-1 Informed Consent and Release of Information and Records.xls](#)
- [DCBS-1 Informed Consent and Release of Information and Records \(Spanish\).doc](#)
- [DCBS-1A Informed Consent and Release of Information and Records Supplement.doc](#)
- [DCBS-1A Informed Consent and Release of Information and Records Supplement \(Spanish\).doc](#)
- [DCBS-1B Application for Services.doc](#)
- [DPP-154 Protection and Permanency Service Appeal.doc](#)
- [DPP-154 Protection and Permanency Service Appeal \(Spanish\).doc](#)
- [DPP-1281 Family Case Plan.doc](#)
- [Prevention Plan \(Incorporated\).doc](#)
- [Prevention Plan \(Spanish\).pdf](#)
- [CPS CQA Anchors.doc](#)
- [Genogram-Family Tree Tip Sheet.doc](#)
- [Relative Placement Decision Making Matrix.doc](#)
- [Relative Placement Tip Sheet.doc](#)

## Legal Authority/Introduction

### LEGAL AUTHORITY:

- 922 KAR 1:430 Child protective services in-home case planning and service delivery

An in home CPS case is opened when the assessed level of risk determined by the assessment process, the parental/guardian capacity to protect and the level of informal and formal supports indicate that a child may be safely maintained in their home . **A referral for prevention services can be made by the SSW on all open in home CPS cases with a substantiated or a services needed finding (see SOP Chapter 6) for information about DCBS prevention services and referrals.**

The services that a SSW may perform are social work functions such as:

- Family and individual counseling;
- Advocacy;
- Case coordination; and
- Referral to other agencies or community resources.

**The Family First Prevention Services Act (FFPSA) emphasizes key provisions around prevention and family preservation services. FFPSA stresses that children thrive best and deserve to be in family like settings whenever they can do so safely. The use of foster care should be an intervention of last resort. FFPSA has made partial federal title IV-E funds specific to prevention services available to states for the first time.**

### Procedure

The SSW assigned to the family:

1. Reviews the results of the investigation/assessment; ~~and the prevention plan;~~
2. Makes the initial home visit within five (5) working days of the case assignment in order to discuss:
  1. The continuing family assessment;
  2. Identifying SSW and family roles and expectations;
  3. Initiating the formation of a family team, including identified fathers as outlined in SOP 4.15 Family Attachment and Involvement; and
  4. Identifying service providers.
3. **Along with the family, identifies needed services and the prevention strategy that will be identified on the case plan and possible evidenced based practices (EBPs) that will be needed to mitigate the risk to the child(ren).**
4. Ensures that the family receives the DPP-154 Service Appeal Request, either by mail or by hand delivery, and documents that the family has received it;
5. Asks the appropriate family members to sign the:



1. DCBS-1 Informed Consent and Release of Information and Records (if appropriate for HIV/AIDS, alcohol or other drug treatment);
2. DCBS-1A Informed Consent and Release of Information and Records Supplement to obtain permission from the client in order to consult with other professionals; and
3. DCBS-1B Application for Services;
6. Follows guidelines related to HIPAA compliance;
7. Ensures that the family case plan is developed within fifteen (15) calendar days of case assignment by the FSOS.

## **Footnotes**

1. The purpose of the first visit is to engage the family in establishing a therapeutic relationship based on trust.

## Standards of Practice 3.2 Timeframes and Ongoing Service Requirements for All In Home Services Cases

Cabinet for Health and Family Services

Department for Community Based Services

Division of Protection and Permanency

Standards of Practice Online Manual

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### Forms

- [DPP-1281 Family Case Plan.doc](#)
- [Visitation Between Caseworker and Parents Tip Sheet.doc](#)

### Legal Authority/Introduction

#### LEGAL AUTHORITY:

- [KRS 620.180 Administrative regulations](#)
- [922 KAR 1:430 Child protective services in-home case planning and service delivery](#)

The FSOS and SSW utilize the following timeframes for all in home services cases.

### Procedure

1. The FSOS assigns the case being opened to the SSW for ongoing services within three (3) working days of the date the assessment results are approved.
2. The SSW makes a home visit with the family within five (5) working days of case assignment to begin negotiating the:
  1. **Prevention strategy for the family;**
  2. **Evidence based practices (EBPs) to be utilized in prevention services;**
  3. Case plan goals to be agreed upon with all family members;
  4. Case plan objectives and tasks; and

5. Participants who will be invited to participate in case planning, including identified fathers as outlined in SOP 4.14 Family Attachment and Involvement and the service providers.
3. The SSW negotiates the initial case plan with the family within fifteen (15) calendar days of the case assignment by the FSOS.
4. The SSW enters the information in the DPP-1281 Family Case Plan (TWIST) verbatim when the blank signature page of the case plan is signed, based on the negotiated objectives and tasks.
5. The SSW reviews with the family any changes to the negotiated objectives and tasks-and obtains a new signature page.
6. The SSW enters the completed/developed date in the "effective from date" on the case plan. This is the date that the family signed the signature page. 2
7. The SSW enters/submits the case plan information within ten (10) working days from the date it was developed with the family.
8. The SSW considers all team member opinions, as well as family circumstances to negotiate at least one task for each objective with a begin and potential end date.
9. The SSW renegotiates the DPP-1281 case plan with the family every six (6) months until the case is closed. 3
10. The FSOS approves the case plan within ten (10) working days from the date it was developed with the family and submitted by the SSW.
11. The SSW mails or delivers the TWIST copy of the case plan to the family within three (3) calendar days of the FSOS approval.
12. The SSW follows procedures outlined in SOP 3.11 Onsite Provision of Services when assistance is requested from one county or region to another county or region to provide needed ongoing services.
13. The SSW visits every calendar month, making face to face contact with the family and all children ~~child~~ in the home to:
  1. **Assess progress on accomplishing Family Case Plan goals, objectives and tasks, and assess the need for continuing prevention services and EBPs;**
  2. Observe the interaction among parent, child and siblings; and
  3. Determine the suitability of these interactions and protective capacity of the parent, including identified fathers as outlined in SOP 4.14 Family Attachment and Involvement.
14. **The SSW documents all contacts with or on behalf of the family; service recordings reflect the progress toward prevention strategies, goals, objectives and tasks;**
15. The SSW completes a case plan evaluation/assessment at least every six (6) months, and also:
  1. Within thirty (30) days prior to the family case plan periodic review;
  2. When any significant change occurs in a family, such as:
    - i. **A need to change prevention strategies, services and/or EBPs;**
    - ii. A trial home visit begins;
    - iii. Change in the composition of the family;
    - iv. Loss of job;
    - v. Change in family income;

- vi. Loss of basic needs being met; or
  - vii. Prior to considering case closure.
16. The SSW updates the case plan within six (6) months from the case planning conference date of the previous case plan, and every six (6) months thereafter;
  17. The SSW follows the guidelines for case consultation as outlined in SOP 1.5 Supervision and Consultation.
  18. The SSW follows up with court involvement as necessary, as outlined in SOP 11.14 When to File a Petition.

## **Footnotes**

1. The blank signature page of the case plan may be signed at the time of negotiating the objectives and tasks as outlined in SOP 23.2 Prevention Plans.
2. The case plan is considered completed/developed on the date it was negotiated. This will be the same date the family signs the signature page of the case plan.
3. Prevention plans are no longer required to complete a case plan. The case plan objectives and tasks can be entered directly into TWIST while negotiating the strategies, objectives, and tasks with the family.

## Standards of Practice 3.4 Initial In Home Case Planning Conference

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual

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3.4 Initial In Home Case Planning Conference

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### Forms and Resources

- [DPP-1281 Family Case Plan.doc](#)
- [APS-CPS Concurrent Reports Tip Sheet.doc](#)
- [CPS CQA Anchors.doc](#)
- [Prevention Plan \(Incorporated\).doc](#)
- [Promoting Family Team Meetings \(FTM\) Tip Sheet.doc](#)
- [Quick Reference Grid for P and P Case Planning.doc](#)
- [Some Practice Considerations for Child Protection Cases Involving.docx](#)

### External web link:

- Community Supports for Fathers and Families

### Legal Authority/Introduction

#### LEGAL AUTHORITY:

- [KRS 194A.010 Cabinet for Health and Family Services-Functions](#)
- [KRS 620.180 Administrative regulations](#)
- [922 KAR 1:140 Foster care and adoption permanency services](#)
- [922 KAR 1:430 Child protective services in-home case planning and service delivery](#)

- CAPTA 106(b)(2)(B)

The case planning process, is based on strengths, safety and risk issues identified by the social service worker (SSW) during an investigation, assessment or ongoing casework. The Department for Community Based Services (DCBS) encourages families served to participate fully in the process and to retain as much personal responsibility for case planning as possible.

**The Family First Prevention Services Act (FFPSA) allows states to claim partial federal title IV-E reimbursement for in home prevention services. There are elements of the case that require documentation on the family case plan in order for the prevention services to be eligible for claiming. Information from the prevention services referral will populate into the family case plan when the screens are completed in TWIST. Prevention services include Intensive Family Preservation Services (IFPS), Families and Children Together Safely (FACTS), Diversion, Family Reunification Services (RFS), Kentucky Strengthening Ties and Empowering Parents (KSTEP), and Sobriety Treatment and Recovery Teams (START) (see)(SOP Chapter 6 for prevention services details and referrals).**

## **Procedure**

The SSW:

1. Involves, to the fullest extent possible, the participation of the family, other significant persons in the child's life not living in the family unit, ( i.e. legal and/or biological parents (including identified fathers, family, friends etc.) and relatives;
2. **Invites prevention service providers to the case planning conference;**
3. Includes the child or children, when age appropriate, in case planning efforts;
4. Reviews the case planning process with the family and members of the family's team, once a case has been opened for ongoing services (this includes a discussion of the need for community partner involvement in case planning);
5. Provides information, during the initial case planning meeting contact to develop a case plan, when appropriate, about the following:
  1. Basis for DCBS involvement regarding risk and safety issues;
  2. Rights and responsibilities of the parent and child;
  3. Child protective services; and
  4. Service options that address the:
    1. Prevention of future maltreatment, presenting problem or need;
    2. Individual behavior changes needed;
    3. Risk factors that threaten the safety of all family members;
6. **Identifies if the case plan is a FFPSA plan. This is for cases where a prevention services referral has been made. This information will populate from the prevention services referral screens in TWIST if a referral for prevention services has been completed in the TWIST screens;**
7. **Identifies, when the case plan is identified as a FFPSA plan, the child(ren) that is identified as a candidate for foster care and the start date of their**

- candidacy. This information will populate from the prevention services referral screens in TWIST;**
- 8. Identifies the evidence based practice (EBP) that will be used to mitigate the high risk behaviors or circumstances causing the child to be a candidate for foster care. This information populates from the prevention services referral screens in TWIST;**
  - 9. Identifies a child specific prevention strategy for each candidate and incorporates the EBPs into the case plan objective;**
  10. Incorporates the following tasks, which is based on a family's strengths to develop primary objectives that are related to the prevention of further child maltreatment in the home and associated tasks to include:
    1. Identifying strengths of the family;
    2. Identifying high risk behaviors;
    3. Identifying high risk patterns and developing a return to use plan that includes;
      1. Identifying early warning signals;
      2. Planning to prevent high-risk situations;
    4. Ensuring that substance affected infant cases incorporate plan features that provide services to address the health needs of the infant and the substance abuse treatment needs of the caregiver in accordance with SOP 1.15 Working with Families Affected by Substance Use (Sections 106(b)(2)(B)(ii) and (iii) of CAPTA);
      1. Planning to interrupt high-risk situations early, if not prevented; and
      2. Planning for escape from the high-risk situation, if early interruption fails;
    5. Assures that the case plan is:
      1. Specific;
      2. Measurable;
      3. Individualized based on identified safety and risk factors;
      4. Realistic; and
      5. Time limited;
  11. Includes in the case plan all services offered to assist the family to improve the following:
    1. Safety;
    2. Care;
    3. Relationship with their children; and
    4. Parent's ability to fulfill their roles to promote child and family safety, well-being and permanency, whenever possible;
  12. Negotiates the tasks and objectives with the family and community partners and documents them in the case plan;
  13. Ensures that a secondary family level objective is designed, when the child is placed with a relative, to establish tasks and services to keep the child safe in the relative's home. These objectives and tasks should address permanency, attachment and visitation, medical and mental health needs and education. The OOHC portion of



the DPP 1281 Family Case Plan should be completed when the child is in DCBS custody instead of the secondary level objectives;

14. Arranges for services from community partners, through use of the assessment and case plan, which may include, but are not limited to, the following:
  1. Child care;
  2. Family preservation and reunification;
  3. Home health;
  4. Mental health;
  5. Physical health;
  6. Education;
  7. Housing; and
  8. Clothing;
15. Completes the case plan in TWIST;
16. Submits the case plan to the FSOS for approval after the case planning meeting, with or without the parents' signature;
17. Documents in the comment section of the DPP-1281 Family Case Plan (hard copy) why the parents did not sign;
18. Makes efforts to discuss the case planning conference with each parent, and the child when they are unable to attend;
19. Mails or distributes a copy of the following documents to the participants listed below:
  1. The approved DPP-1281 Family Case Plan:
    1. Parent or legal guardian (certified restricted mail if not in attendance);
    2. Identified fathers (certified restricted mail if not in attendance);
    3. Any person or agency providing services to the family (with parental consent);
    4. Any community partners assigned a task on the case plan (with parental consent); and
    5. The child's guardian ad litem, when applicable;
  2. The DPP-154 Protection and Permanency Service Appeal (certified restricted mail) to parent or legal guardian; and
  3. All other relevant documents;
20. Documents in the service recordings:
  1. How the partnership is carried out in case planning and service delivery; and
  2. When the family declines community partner involvement.
21. **Completes candidacy redetermination via the selection on the DPP-1281, when the need for services extends beyond twelve (12) months.**

The FSOS:

1. Provides input into case plan development;
2. Assists the SSW in determining how to protect the safety of the non-offending parent and children, when domestic violence is involved;
3. Ensures that the case plan is developed within required timeframes;

4. Reviews and approves the case plan prior to distribution.

#### Practice Guidance

- In cases where domestic violence has been identified as a risk factor, the SSW collaborates with the family's team to develop a logical and achievable plan for the children and family by prioritizing service needs.
- **Children identified as candidates for foster care will meet one of the following criteria:**
  - **A victim of substantiated maltreatment where existing safety and risk factors can be mitigated by provision of in-home services;**
  - **A child for whom maltreatment has not been substantiated, however, moderate to severe risk factors for maltreatment are present and services are necessary to prevent maltreatment and subsequent entry into foster care; and**
  - **A child who has recently been reunified for whom services to the family will mitigate identified risks, preventing further maltreatment and re-entry into out of home care.**

Elements of the Case Plan
<p>Objectives support the overall goal and are either family related or individual specific.</p> <p>Family Level Objectives (FLO) are those things that the whole family can work on. They center around an everyday life event and are always directly related to the maltreatment that resulted in opening the case.</p> <p>Individual Level Objectives (ILO) focus on the individual patterns of high risk behavior that lead to the maltreatment. It is important to understand why the pattern occurred in order to create the most effective objective.</p> <p>Objectives Objective example:</p> <p>A single parent home with two young children, neglect was substantiated and the case was open. The investigator identified during the assessment that the single parent was overwhelmed and that is why the home was unsafe.</p> <ul style="list-style-type: none"><li>○ The FLO would surround ensuring the house is safe and free from environmental hazards.</li><li>○ The ILO would surround helping the parent figure out why he/she is overwhelmed and make a plan to manage this issue.</li><li>○ If the investigator had identified that the single parent was depressed and that is why the home was unsafe, the ILO could surround</li></ul>

	mental health treatment or counseling.
Strengths	<p>A child's and family's available past and present experiences, assets, interests, resources, resiliency, interests and preferences provide strengths to meet needs. These strengths should be used when building the action steps of the case plan.</p>
Needs	<ul style="list-style-type: none"> <li>○ A need is a requirement that is essential to all human beings such as the need for shelter, food, affiliation or nurturance.</li> <li>○ A need may be a description of the underlying conditions that are often the source of the problems that a family is encountering.</li> </ul> <p>Tasks support the objectives and outline what steps will be taken to reach the objectives.</p> <p>Tasks should be person specific, measurable and time limited. They should answer who, what and when at a minimum.</p>
Tasks	<p>Tasks also:</p> <ul style="list-style-type: none"> <li>○ Identify difficult situations or triggers;</li> <li>○ Identify early warning signs;</li> <li>○ Assist families in avoiding high risk situations;</li> <li>○ Assist families in coping with risk situations not avoiding them.</li> </ul>

#### Footnotes

1. The case plan is based on a partnership with the family and others.
2. As implemented by DCBS.

## Standards of Practice 3.5 Participants and Notification for All In Home Cases

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### Resources

- [Case Planning Meeting Brochure.docx](#)

### Legal Authority/Introduction

#### LEGAL AUTHORITY:

- [KRS 620.180 Administrative regulations](#)
- [922 KAR 1:430 Child protective services in-home case planning and service delivery](#)

For all in home services cases, case planning participants are optional based on the family's request. Families have the right to choose whom to involve in their case planning.

### Procedure

The SSW:

1. Encourages families to involve family members, friends, family members and community partners that have the potential to be beneficial;
2. Involves the following individuals in case planning, including but not limited to:
  1. Family members of appropriate age, including identified fathers as outlined in SOP 4.14 Family Attachment and Involvement, of appropriate age;
  2. Biological mothers and fathers, step parents, and parent paramours;
  3. Custodians/caregivers (i.e. relative/fictive kin placement caregivers);
  4. FSOS and other staff involved;
  5. Court Appointed Special Advocates (CASA) and Guardian Ad Litem, if court is involved;
  6. Parents attorney;
  7. Community partners including service providers and school personnel;

8. **Prevention services providers including:**
  1. **Intensive Family Preservation Services (IFPS);**
  2. **Families and Children Together Safely (FACTS)**
  3. **Diversion**
  4. **Family Reunification Services (FRS)**
  5. **Kentucky Strengthening Ties and Empowering Parents (KSTEP)**
  6. **Sobriety Treatment and Recovery Teams (START)**
9. Children; and
10. Formal and informal supports for the family;
3. Notifies, verbally or in writing, in advance all participants expected to attend the case planning conference of the:
  1. Purpose;
  2. Date;
  3. Time; and
  4. Location of the case planning conference;
4. Provides a copy of the Case Planning Meeting Brochure;
5. Document, in both the DPP 1281 and service recordings, efforts to involve all of the above parties in the case planning process.

#### Practice Guidance

- Although the child's capacity to participate actively in case planning will need to be decided on a case by case basis, as a guideline, most children who are elementary school aged or older may be expected to participate to some extent.
- Involvement of both parents is instrumental in achieving desired outcomes for children. Fathers are required participants even when they are absent from the home. Workers must make every effort to locate and involve fathers or other available paternal relatives.
- The lack of the father's involvement can significantly delay case progress. Often, fathers are unaware of situations that involve their children for various reasons. The fathers or their relatives are encouraged to participate in case planning and be allowed to maintain attachment with the child through visitation when appropriate.
- In situations involving domestic violence, a discussion with the mother will ascertain the level of risk posed if the father is involved in the case planning process.
- Recognize that family members may be new participants in the child welfare and juvenile justice systems. Take the time to explain how these systems work and answer any questions asked by the family.
- Respect the pace at which the family moves. Intervention is traumatic and the family may need time to process what is happening. Don't rush discussion and be sure to convey the importance of each contact.
- Recognize the value of the family members and value their expertise on the family history.
- **Involvement of prevention services providers, when applicable, is not optional and should only be declined in the event of a strong objection by the family. Prevention service providers will be an integral part of the case planning process, development of a child**

**specific prevention strategy and in determining the evidence based practices (EBPs) to be incorporated into the objectives and tasks.**

## **Standards of Practice 3.10 SSW's Ongoing Contact with the Birth Family and Child**

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual  
Chapter:  
Chapter 3-In Home Child Protective Services (CPS) Case  
Effective:  
10/1/2019  
Section:  
3.10 SSW's Ongoing Contact with the Birth Family and Child  
Version:  
7

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### **Forms and Resources**

- [Caseworker Visit Template.doc](#)

### **Legal Authority/Introduction**

#### **LEGAL AUTHORITY:**

[KY Acts Chapter 188](#)

[CAPTA 106\(b\)\(2\)\(B\)](#)

[922 KAR 1:430 Child protective services in-home case planning and service delivery](#)

From the moment of the initial contact with the family, the SSW and the department are obligated under federal and state law to make reasonable efforts to keep families intact whenever possible; and in removal situations, to make reasonable efforts to reunify children with their families. As part of this obligation, the SSW is required to maintain personal contact with families and children. Ongoing contact with the family provides information that contributes to a thorough assessment of whether or not the family has reduced the risks that initially lead to the involvement of DCBS.

Features of an acceptable pattern of visits include:

- Unannounced, if necessary to ensure the child's safety, face to face contact frequently enough to sufficiently evaluate the family's progress;

- Sufficient meaningful discussion of case planning tasks and objectives; and
- Sufficient opportunity to observe the residence(s) of the parent(s) and child(ren), or other family members significant to the case.

Through the life of the case, the burden is on the SSW to locate and maintain contact with family members based on individual needs of each case.

## **Procedure**

### **Ongoing Contact with the Family**

The SSW:

1. Has individual, face to face contact with parents;
2. Has a private, face to face visit with the child(ren) at least once every calendar month in the home;
3. Discusses the following with the family during each contact:
  1. Assesses for safety issues, high risk behaviors, or risk factors;
  2. Evaluates the family's progress toward reducing the immediate safety issues and/or reducing the risks that necessitated case action;
  3. Reviews the family's progress toward accomplishment of their case planning tasks;
  4. Reviews the tasks of other service providers and progress toward accomplishment of these;
  5. Identifies and resolves barriers to completing case objectives;
  6. Prepares for the next ongoing assessment, case planning conference/periodic review and court hearing; and
  7. When appropriate, prepares an aftercare plan
4. Thoroughly documents in TWIST service recordings:
  1. All case planning conferences and family team meetings with the type of plan being negotiated (i.e. initial, six (6) month periodic review, modification, etc.) with documentation of who was invited and the attendees.
  2. Monthly communication with community partners and prevention service providers to document the family's progress (or lack of progress) toward mitigating high risk behaviors;
  3. Monthly observations regarding the family and the home setting;
  4. Monthly progress (or lack of progress) toward each objective and task on the family case plan;
  5. The family's response to services they receive from other providers;
  6. Additional assessment and planning information provided by the family; ~~and~~
  7. That the family has been provided information about the child's:
    - i. Physical and mental health;
    - ii. Education; and
    - iii. Activities.



5. Documents in their ongoing assessments, any barriers to their ability to maintain contact with the family including, but not limited to:

- A. The parent's whereabouts are unknown;
- B. Written determination by the FSOS that family members are or may be violent; or
- C. Family members refuse to participate in ongoing visits.

### **Contingencies and Clarifications**

The SSW is expected to consider and document reasonable efforts for ongoing contact with non-custodial parents during an in home, ongoing case.

The SSW:

1. Respects the decision-making authority of the custodial parent with regards to approaching the non-custodial parent, case planning and information sharing about the case;
2. Assesses the custodian's willingness to work on deficits in the parent/child attachment or cooperative parenting with the non-custodial parent;
3. Obtains a description of the custody/visitation arrangements between the non-custodial parent and the child, prior to case planning;
4. Conducts an assessment of the non-custodian's relationship with the child, and an assessment of how well the custodian and non-custodian cooperate to parent/meet the children's needs;
5. Develops case plan objectives and tasks that support or improve the non-custodial parent's relationship with the child, when the custodial parent is in agreement;
6. Includes case plan objectives and tasks that improves the ability of the custodial and non-custodial parents to work collaboratively for the child's benefit;
7. Documents whether or not the custodial parent sets limits or rejects proposed changes in the non-custodial parent's role, or their involvement in the case;
8. Documents safety issues that affect the SSW's ability to engage the non-custodial parent.

### **Practice Guidance**

#### **Ongoing Contact with the Child**

- The SSW may utilize the Caseworker Visit Template during the face to face contact with the child.

#### **Ongoing Contact with the Family**

- Ideally, the SSW makes face to face contact with parents, in their residences, at a minimum of once per calendar month. However, the appropriate frequency of visit is guided by the case specific circumstances. When the overall pattern of face to face visits is not monthly

(once per calendar month), the SSW enters an explanation for the pattern of contact into the next case plan evaluation/ongoing assessment.

- In addition to face to face contact, the SSW may utilize telephone, mail or email; however, the case specific circumstances should guide the overall pattern of contact within the case.
- The burden is on the SSW to document a pattern of visits with the children and parents that will appropriately demonstrate reasonable efforts to keep children in their own homes, reunify children who have been removed from their homes, or finalize an appropriate permanency plan for children.
- Workers are not required to execute visits to parents if there is a no contact order prohibiting contact, or if a judge has granted a waiver of efforts in the case. Workers will document the issuance of such orders in their ongoing assessment until the no contact order is lifted, or until case closure.
- A worker is prohibited from documenting that a face to face contact occurred, unless an actual face to face visit was completed by department personnel or personnel contracted to make a visit. An entry reflecting a face to face contact when none actually occurred is considered falsification of records, and is an ethical violation (refer to chapter 2.1 Employee Conduct in the Personnel Procedures Handbook).

## Standards of Practice 3.12 Case Plan Evaluation/Ongoing Assessment

Cabinet for Health and Family Services

Department for Community Based Services

Division of Protection and Permanency

Standards of Practice Online Manual

Chapter:

Chapter 3-In Home Child Protective Services (CPS) Case

Effective:

3/30/2018

Section:

3.12 Case Plan Evaluation/Ongoing Assessment

Version:

6

When a section of SOP has been revised users will see the following: Added {This is added material}, Deleted {~~This is deleted material~~}. The bold and strikethroughs will appear on the site for fifteen (15) days after a modification and will then be removed.

Forms

- [Case Plan Evaluation-Ongoing Assessment Template.docx](#)

**Legal Authority/Introduction**

**LEGAL AUTHORITY:**

- [922 KAR 1:430 Child protective services in-home case planning and service delivery](#)

**Procedure**

The SSW:

1. Creates the ongoing case plan evaluation/ongoing assessment:
  1. At least every six (6) months;
  2. Prior to the periodic case planning conference; and
  3. Prior to case closure;
2. Considers the high risk behaviors that brought the family into contact with the agency;
3. Utilizes information gathered during contact with the family; and contact with the service providers;
4. Considers the level of cooperation and efforts made by family members to reduce risk and address high risk behaviors;
5. Assesses whether or not risk has been reduced in the home;
6. Assesses whether or not the family has achieved their case plan objectives;
7. Assesses whether or not the child is at serious or imminent risk of placement in foster care (472(i)(2) of the Social Security Act-Redetermination for IV-E Candidate Claiming);

8. Outlines the services or case actions necessary to achieve the case plan objectives and case closure; and
9. Submits the evaluation/assessment for supervisor approval.

## Standards of Practice 6.1 Family Preservation Program (FPP)

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual

Chapter:

Effective:

10/1/2019

Section:

6.1 Family Preservation Program (FPP)

Version:

1

When a section of SOP has been revised users will see the following: Added {This is added material}, Deleted {~~This is deleted material~~}. The bold and strikethroughs will appear on the site for fifteen (15) days after a modification and will then be removed.

### Forms and Resources

- [Prevention Services Referral Form.docx](#)
- [Prevention Services Description and Eligibility Criteria.pdf](#)

### Legal Authority/Introduction

#### Legal Authority

- [KRS 200.575 Family preservation services programs](#)
- [42 USC 671 State plan for foster care and adoption assistance](#)

#### Introduction

The Family Preservation Program (FPP) is an intensive, evidence based crisis intervention resource that is intended to prevent the unnecessary out of home placement of children.

- The expectations of FPP staff include:
  - Providing intensive services according to the needs of each family, including families with substance misuse, for one (1) to six (6) months;
  - Providing three (3) to ten (10) direct service hours per week, at least half of the services in the family's home, or other natural community setting;
  - Carrying no more than four (4) to six (6) cases at one time;
  - Being available to families twenty-four (24) hours a day, seven (7) days a week;
  - Aiding in the solution of practical problems that contribute to the family stress;

- Making referrals (as needed) to other available community resources; and
- Providing client assistance funds (as appropriate and to the extent that funds are available) to enhance the success of intervention.
- The duties of the FPP management team is to implement FPP by:
  - Identifying the referral and selection committee and reviewing referral procedures and criteria;
  - Interviewing prospective FPP staff members;
  - Discussing regional needs;
  - Developing additional linkage agreements, as appropriate; and
  - Meeting regularly to discuss ongoing issues related to program quality and integration of services.

## Procedure

For Family Preservation, the SSW:

1. Consults with FSOS to identify that a child is a candidate for foster care by determining:
  - A. The child's safety is at risk or will be at risk in the immediate future without intervention; and
  - B. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention. 2
2. Reviews the Prevention Services Description and Eligibility Criteria resource to select one of the following programs:
  - A. Intensive Family Preservation Services (IFPS);
  - B. Family Reunification Services (FRS);<sup>3</sup>
  - C. Diversion; or
  - D. Families and Children Together Safely (FACTS).
3. Reviews the regionally relevant evidenced based practice selection document for evidence based practice (EBP) intervention selection.
4. Upon approval from the FSOS, discusses the potential referral with the family to:
  - A. Inform the family that in-home services are an alternative to out-of-home placement;
  - B. Determine the family's willingness to participate with the referral to in-home services;
  - C. Discuss with the family the appropriate EBPs to be utilized with the family, based on regional and program availability; and
  - D. Informs the family that if FPP is appropriate and available, a referral will be initiated upon the family's agreement and notify the family if the referral is approved.
5. Completes the Prevention Services Referral Form in TWIST, identifying the candidate, the identified risk factors, and EBP interventions to mitigate risk factors.
6. Submits the Prevention Services Referral Form in TWIST for FSOS and gatekeeper approval.
7. Upon receipt of referral approval from the gatekeeper, informs the family that FPP will schedule a visit within twenty-four (24) hours of receipt of the referral;
8. Joins, if possible, the FPP staff for the initial visit within twenty four (24) to seventy two (72) hours, depending on the receipt of referral, level of risk, and if an opening is available;
9. Completes the DPP-1281 Family Case Plan:

- A. Documenting the date of candidacy, candidate, prevention strategy (selected EBP), and the date of the prevention strategy (date of referral approval); and
  - B. Incorporating the EBPs into a case plan objective.
- 10. Consults with FPP staff as often as necessary and updates the EBP intervention via a modified case plan, if FPP staff identify a second or multiple interventions or a change in intervention; selects candidacy end date in TWIST, under preventative services and in the in-home prevention case plan when:
  - A. A candidate has entered foster care; 4
  - B. The family has successfully completed services; or
  - C. The family's services were terminated unsuccessfully.
- 11. Completes candidacy redetermination via the selection on the case plan, when the need for services extends beyond twelve (12) months.
- 12. Conducts (at minimum) one joint home visit with FPP staff and is encouraged to consult with FPP staff through:
  - A. Telephone;
  - B. FPP staff's weekly case conferences;
  - C. Cabinet case planning meetings; or
  - D. Other face to face contacts;
- 13. Reviews the FPP termination summary and provides follow-up services as necessary, once termination of FPP involvement occurs;
- 14. Ensures that the case record includes the following FPP documentation:
  - A. Prevention Services Referral Form;
  - B. FPP family functioning assessment and initial treatment goals;
  - C. FPP termination summary; and
  - D. Contacts with FPP staff.

#### The FSOS:

- 1. Consults with the SSW to identify if the child is a candidate for foster care by determining:
  - A. The child's safety is at risk or will be at risk in the immediate future without intervention; and
  - B. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention.
- 2. Reviews the Prevention Services Referral Form for appropriate program selection and EBP selection;
- 3. Signs the Prevention Services Referral Form; and
- 4. Assigns a risk level to the Prevention Services Referral Form.

#### The SRA:

- 1. Designates a cabinet staff person to be the regional referral and selection staff (gatekeeper); and 5

2. Establishes an FPP management team, consisting of:
  - A. SRA or designee;
  - B. Referral and selection staff;
  - C. The FPP specialist in central office;
  - D. The FPP supervisor (contract agency); and
  - E. The program director (contract agency).

**The Gatekeeper:**

1. Checks TWIST workbasket daily for region specific referrals;
2. Reviews the Prevention Services Referral Form for appropriate program selection and EBP selection;
3. Communicates with providers regarding their availability to accept referred cases;
4. Tracks referrals in TWIST with the below designations:
  - A. Approved;
  - B. Rejected;
  - C. Waitlist start date; or
  - D. Waitlist end date;
    - i. Waitlist end date reasons:
      - a. Accepted;
      - b. Diverted to other services; or
      - c. Closed out without services.

**Footnotes**

1. Pregnant or parenting youth in out of home care do not require a candidacy determination to receive services.
2. Interventions may be accessed by the family and/or caregivers, as long as they are tied to a candidate for foster care.
3. Children cannot be identified as a candidate for foster care for FRS if services start prior to the child's return home. Paper referrals must be made in these instances.
4. Excludes FRS when services start after the child's return home.
5. This individual assumes responsibility for reviewing all referrals to FPP.



## Standards of Practice 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP)

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual

Chapter:

Effective:

10/1/2019

Section:

6.2 Kentucky Stengthening Ties and Empowering Parents (KSTEP)

Version:

1

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### FORMS

- [DCBS-1 Informed Consent and Release of Information and Records.doc](#)
- [DCBS-1A Informed Consent and Release of Information and Records Supplement.doc](#)
- [DPP-1281 Family Case Plan.doc](#)
- [Prevention Services Description and Eligibility Criteria.pdf](#)
- [Prevention Services Referral Form.docx](#)

### Legal Authority/Introduction

#### LEGAL AUTHORITY:

- [42 USC 671 State plan for foster care and adoption assistance](#)

### Procedure

The SSW:

1. In consultation with their supervisor:
  - A. Identifies a KSTEP eligible family:
    - i. Residing in Bath, Carter, Fleming, Greenup, Lewis, Mason, Montgomery, or Rowan counties;
    - ii. With a child(ren) at moderate to imminent risk of removal from the home;
    - iii. With at least one household child under the age ten (10);
    - iv. With parental substance abuse as a primary feature affecting child safety;

- v. Who did not have an ongoing DCBS case at the time the investigation was received; and
  - vi. Whose investigation will result in the case being opened for ongoing services.
- B. Identifies the referred child as a candidate for foster care by determining:
  - i. The child's safety is at risk or will be at risk in the immediate future without intervention; and
  - ii. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention.
- 2. Reviews the EBP Selection Document for EBP intervention selection.
- 3. Upon approval from the FSOS, discusses the potential referral with the family to:
  - A. Inform the family that in-home services are an alternative to out of home placement;
  - B. Determine the family's willingness to participate with the referral to in-home services;
  - C. Discuss with the family the appropriate evidence based practices (EBP) to be utilized with the family, based on regional and program availability; and
  - D. Inform the family that a referral will be made upon the family's agreement and that the KSTEP provider will schedule a visit within twenty four (24) hours of receipt of the referral.
- 4. Obtains signed releases of information from the family, DCBS-1 and DCBS 1A.
- 5. Provides the KSTEP in-home provider agency with information that outlines the reason for referral, basic demographics, contact information, and recommended EBP intervention, via phone or email; 1
- 6. Completes the Prevention Services Referral Form in TWIST, ONLY identifying the candidate, the identified risk factors, and EBP interventions to mitigate risk factors. 2
- 7. Submits the Prevention Services Referral Form in TWIST for FSOS risk rating and signature;
- 8. Joins, if possible, the KSTEP staff for the initial visit within twenty-four (24) hours of receipt of referral, if an opening is available;
- 9. Forwards the following documents to the KSTEP in-home provider agency within three (3) days of referral:
  - A. Information about allegations of substance use and/or family violence to include prior criminal charges and their disposition. This should include any charges that may indicate risk or safety to the family or to the KSTEP in-home provider agency. The SSW will notify the KSTEP in-home provider agency of immediate threats to child safety and any known threats to SSW/KSTEP in-home provider safety.
  - B. Prior substantiated allegations including but not limited to physical abuse to child by parent, domestic or family violence, and neglect where substance use/abuse or family violence was a contributing risk factor.
  - C. Copy of P&P prevention plan, case plan and/or court orders
  - D. A copy of the case summary face sheet, with correct and updated case member demographic and relationship information.
  - E. Release of information forms DCBS-1 & DCBS-1A signed by the family.
- 10. Flags KSTEP cases utilizing the checkbox on the case management screen;
- 11. Attends family team meetings;
  - A. Within six (6) to twelve (12) days of referral;

- B. Monthly; and
  - C. As needed.
12. Completes the DPP-1281 Family Case Plan:
    - A. Documenting the date of candidacy, candidate, prevention strategy (selected EBP), and the date of the prevention strategy (date of referral approval);
    - B. Incorporating the EBPs into a case plan objective; and
    - C. Incorporating the objectives of the KSTEP in-home provider case plan into the DCBS-1281 Family Case Plan. 3
  13. Consults with KSTEP staff as often as necessary and updates the EBP intervention via a modified case plan, if KSTEP staff identify a second or multiple interventions or a change in intervention;
  14. Selects candidacy end date in TWIST, under preventative services and in the case plan when:
    - A. A candidate has entered foster care;4
    - B. The family has successfully completed services; or
    - C. The family's services were terminated unsuccessfully.
  15. Completes candidacy redetermination via the selection on the case plan, when the need for services extends beyond twelve (12) months;
  16. Reviews weekly reports on the family's progress, provided by the KSTEP in-home prevention provider, including an update from substance abuse treatment providers and from the in-home provider.

#### The FSOS:

1. Consults with the SSW to identify if the child is a candidate for KSTEP and a candidate for foster care by determining:
  - A. The child meets KSTEP program acceptance criteria;
  - B. The child's safety is at risk or will be at risk in the immediate future without intervention; and
  - C. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention.
2. Reviews the Prevention Services Referral Form for appropriate EBP selection;
3. Signs the Prevention Services Referral Form; and
4. Assigns a risk level to the Prevention Services Referral Form.

#### The Gatekeeper:

1. Checks TWIST workbasket daily for region specific referrals; and
2. Approves KSTEP referrals and takes no further action.

#### Footnotes

1. KSTEP referrals do not require the entire referral be completed or gatekeeper approval.
2. Best practice is to make the referral from the home in collaboration with the family.

3. Family objectives will be specific to the childcare tasks that are at risk and the individual objectives will be specific to the caretaker patterns of personal behavior that is threatening the ability of the caretakers to ensure the safety and well-being of their children.
4. Families may continue in the KSTEP program when children are placed out of the home, to expedite their return, however, they are no longer eligible for title IV-E claiming.

## **Standards of Practice 6.3 Sobriety Treatment and Recovery Teams (START)**

Cabinet for Health and Family Services  
Department for Community Based Services  
Division of Protection and Permanency  
Standards of Practice Online Manual

Chapter:

Effective:

10/1/2019

Section:

6.3 Sobriety Treatment and Recovery Team (START)

Version:

1

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Forms/Resources

- [DPP-115 Confidential Suspected Abuse-Neglect, Dependency or Exploitation Reporting Form.doc](#)
- [START Eligibility Guidelines.docx](#)
- [START Referral Form.pdf](#)
- [START Timeline.pdf](#)
- [Prevention Services Referral Form.docx](#)

### **Legal Authority/Introduction**

- [42 USC 671 State plan for foster care and adoption assistance](#)

### **Introduction**

Sobriety Treatment and Recovery Teams (START) is a child welfare based intervention for families with young children affected by co-occurring parental substance use and child maltreatment.

### **Goals of START:**

- Child safety and well-being;
- Preventing foster care entry;
- Parental recovery;
- Permanency for children;
- Family stability and self sufficiency; and
- Improved capacity for addressing parental substance use and child maltreatment.

START pairs a specially trained SSW and a family mentor to share a caseload of twelve (12) to fifteen (15) families. Family mentors bring life experience to guide and coach families through both the recovery and child welfare processes. START engages the family early in their child welfare case utilizing a rapid timeline and shared decision making. The program provides quick access to a holistic assessment and treatment services for all parents addressing substance use, mental health and trauma. START provides a service delivery system that involves cross-system collaboration and frequent and intense coordinated service provision. The START manual outlines and guides the START model and the timeline guides the first thirty (30) days of START intervention. START Minimum Work Guidelines guides practice for the START team.

## **Procedure**

For START the SSW:

1. Upon receipt of the DPP-115, reviews the eligibility form to determine if the family meets START criteria;
2. Consults with FSOS to identify if a child is a candidate for foster care by determining:
  - A. The child's safety is at risk or will be at risk in the immediate future without intervention;
  - B. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention.
3. Makes a referral to the START FSOS in the region through e-mail or phone call within ten (10) days of receipt of DPP-115;
4. Follows regional protocol to schedule an initial staffing/safety meeting within three (3) days of acceptance by START;
5. Notifies the family of the initial staffing/safety meeting;
6. Attends the initial staffing/safety meeting with the family and START team to occur within three (3) days of acceptance by START to:
  - A. Develop plan for child safety and services;
  - B. Work with START to schedule an initial comprehensive psychosocial assessment that includes a substance use history and mental health screening to occur within two (2) days; and
  - C. Work with START to follow minimum work guidelines.
7. Completes the case plan and:
  - A. Documents the date of candidacy, candidate, prevention strategy (selected EBP), and the date of the prevention strategy (date of referral approval);
  - B. Incorporates the EBPs into a case plan objective;
  - C. Selects service end date in TWIST, under preventative services and in the case plan when a candidate has entered foster care; and
  - D. Completes candidacy redetermination via the selection on the case plan, when the need for services extends beyond twelve (12) months.
8. Follows START minimum work guidelines through the duration of the case; and
9. Flags START cases utilizing the checkbox on the case management screen in TWIST.

The FSOS:

1. Consults with the SSW to identify if the child is a candidate for foster care by determining:
  - A. The child's safety is at risk or will be at risk in the immediate future without intervention;
  - B. The safety issues can be mitigated with the selection and use of child-specific, evidence based intervention; and
  - C. Shares the case in TWIST with the START FSOS immediately following the staffing/safety meeting.

THE START FSOS:

1. Completes the Prevention Services Referral Form in TWIST, identifying the candidate, the identified risk factors, and the EBP interventions to mitigate risk factors.

THE SRA:

1. Participates in regular START meetings as available; and
2. Participates in START check in calls quarterly.

# Appendix P: Memorandum of Understanding Between DCBS and OHDA

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## **Memorandum of Understanding (MOU)**

### **For Data Sharing**

Issued by

**The Cabinet for Health and Family Services**  
275 East Main Street, 4E-C, Frankfort, KY 40621

Hereafter referred to as "Department"

On Behalf Of

### **Department for Community Based Services**

To exchange

DCBS records

With

Office Health Data and Analytics

Point of Contact  
Leslie Proctor

Office of Administrative and Technology Services  
Division of Procurement and Grant Oversight  
MOU/Grant Branch  
275 East Main Street, 4E-C  
Frankfort, KY 40621  
Telephone: 502-564-7736, ext. 3413  
E-mail: Leslie.Proctor@ky.gov



## Section 1 – Contact Information

	INFORMATION PROVIDER (DCBS)	INFORMATION RECIPIENT (OHDA)
<b>Organization Name</b>	Department for Community Based Services (DCBS)	Office of Health Data and Analytics (OHDA)
<b>Business Contact Name</b>	Eric Clark	Maik Schutze
<b>Title</b>	Commissioner	Chief Analytic Officer
<b>Address</b>	275 East Main St, 3W-A, Frankfort, KY 40601	275 East Main St, 4W-E, Frankfort, KY 40601
<b>Telephone #</b>	502-564-3703 Ext 3797	(502) 564-7940 x3992
<b>Email Address</b>	EricT.Clark@ky.gov	Maik.Schutze@ky.gov
<b>IT Security Contact Name</b>	Dennis Leber	Dennis Leber
<b>Title</b>	CHFS Chief Information Security Officer	CHFS Chief Information Security Officer
<b>Address</b>	12 Mill Creek Park, Frankfort, KY 40601	12 Mill Creek Park, Frankfort, KY 40601
<b>Telephone #</b>	502-564-6478	502-564-6478
<b>Email Address</b>	dennis.leber@ky.gov	dennis.leber@ky.gov
<b>Privacy Contact Name</b>	Kathleen Hines	Kathleen Hines
<b>Title</b>	CHFS Privacy Officer	CHFS Privacy Officer
<b>Address</b>	275 East Main St, 4W-E, Frankfort, KY 40601	275 East Main St, 4W-E, Frankfort, KY 40601
<b>Telephone #</b>	502-564-7905	502-564-7905
<b>Email Address</b>	Kathleen.Hines@ky.gov	Kathleen.Hines@ky.gov

## **Section 2 – Purpose of Agreement**

This Agreement is between the Department for Community Based Services (hereinafter “DCBS”) and the Office for Health Data and Analytics (hereinafter OHDA), to establish the procedures relating to an exchange of information contained in DCBS’s data, related to the services utilized by and the child/family characteristics of the population served by DCBS.

WHEREAS, OHDA and DCBS are sister agencies within the Cabinet for Health and Family Services, and DCBS is requesting assistance from OHDA to perform data analysis related to DCBS’ Family First Effort;

WHEREAS, KRS 620.050, designates that all reports of suspected child abuse, neglect, or dependency and all information obtained by the cabinet or its delegated representative, as a result of such an investigation or assessment shall not be divulged to anyone except in accordance with the provisions set forth in KRS 620.050. KRS 620.050(5)(c) allows records to be disclosed to persons within the cabinet with a legitimate interest or responsibility related to the case;

WHEREAS, DCBS records containing administrative and demographic data for the population served by DCBS directly related to the ability of OHDA to identify and analyze trends and evaluate programs, specifically records contained in DCBS’ Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) data sets;

WHEREAS, OHDA is requesting access to data from above described records to perform analysis on behalf of DCBS and has demonstrated a direct, tangible, and legitimate interest in the information contained in those records;

NOW, THEREFORE, in consideration of the mutual covenants and promises hereinafter set forth, the parties hereto agree as follows:

## **Section 3 – Scope of Services**

### **3.00 – Required Activities**

DCBS and OHDA hereby mutually agree as follows:

- A. Beginning September 1, 2019, DCBS shall provide DCBS records to OHDA on the following basis.
  - 1. NCANDS data reports: DCBS will initially provide NCANDS historical data reports from the data collected for the period of time between October 1, 2015 through September 30, 2018. Thereafter DCBS will provide annual NCANDS data to OHDA on May 1 of each year following the reporting year.
  - 2. AFCARS data: DCBS will initially provide AFCARS historical data reports from the data collected for the period of time between October 1, 2015 through March 31, 2019. Thereafter DCBS will provide AFCARS A and B data reports to OHDA within 30 days of delivery of the reports to the Children’s Bureau.
- B. DCBS shall certify that the records or information contained therein are accurate, except that the parties expressly agree that DCBS is not responsible for the accuracy of information or data provided by third-parties, including but not limited to Social Security Numbers.
- C. The file layout for records exchanged pursuant to this Agreement shall be agreed upon by both parties.
- D. OHDA will provide a copy of this agreement to each individual granted access to data under this Agreement. Each individual shall read and acknowledge understanding of the compliance with the

terms set out herein. OHDA shall keep records of members who will have access to such records and their agreement of these terms.

- E. OHDA shall prohibit re-disclosure of information obtained from such records to anyone outside OHDA or its legitimate agents in any form that would permit identification of individuals who are the subject of DCBS records. OHDA shall prohibit use of information obtained from such records for any purpose other than purposes enumerated herein without prior written approval from DCBS. Where applicable OHDA shall suppress cells with five or fewer cases and the comment shall be inserted "five or fewer cases." If the cell's original size can be determined by subtraction from the total, then totals also should be removed from the table or the exact number of the next smallest cell shall also be withheld.
- F. Both parties, including any subcontractors or agents of the party, agree to comply with all applicable state and federal confidentiality laws and to protect the security, confidentiality and integrity of health information. OHDA acknowledges and agrees that DCBS shall be entitled, without waiving any other rights or remedies, to injunctive or equitable relief to enforce the requirements of this provision of the Agreement.
- G. OHDA shall acknowledge the "Kentucky Cabinet for Health and Family Services, Department for Community Based Services" as data source in any and all publications based on these data with prior written approval from the Cabinet;
- H. OHDA shall secure the data specified in this Agreement when the data is not under the direct and immediate control of an authorized individual performing the functions of this Agreement. OHDA shall notify DCBS within five (5) business days of discovery of any use or disclosure of the data not provided for by this Agreement of which a party is aware.

### **3.01 Restrictions:**

OHDA shall not:

- A. Attempt to link or permit others to attempt to link the DCBS records of persons in this data set with personally identifiable records from any other source without prior written approval from DCBS;
- B. Attempt to use or permit others to use the data sets to learn the identity of any person included in any set;
- C. Release or permit others to release any information based on these data that identifies individuals, either directly or indirectly;
- D. Complete data requests or release aggregate copies of this data for/to anyone outside of OHDA without approval from DCBS;
- E. Contact or permit others to contact providers or persons represented in the data;
- F. Use or permit others to use data concerning individual providers;
- I. Make any statement nor permit others to make statements implying or suggesting that interpretations drawn are those of health care providers that may be identified in the data, either individually or as a group, or those of DCBS;

### 3.02 Security

OHDA shall:

- A. Adhere to all security standards as for data transmission as expressed in CHFS and Commonwealth Office of Technology's IT Policies.
  - 1. CHFS IT Policies <https://chfs.ky.gov/agencies/os/oats/Pages/ITpolicies.aspx>
  - 2. 050.102- Information Systems Incident Response and Reporting.pdf  
<https://chfs.ky.gov/agencies/os/oats/polstand/050102InformationSystemsIncidentResponseandReporting.pdf>
  - 3. 050.103- System's Security Plan.pdf  
<https://chfs.ky.gov/agencies/os/oats/polstand/050103SystemsSecurityPlan.pdf>
  - 4. COT Policies (<http://technology.ky.gov/policy/Pages/policies.aspx>)
  - 5. <http://technology.ky.gov/policy/Pages/CIO-074.aspx>
  - 6. <http://technology.ky.gov/policy/Pages/CIO-090.aspx>
- B. Obtain all necessary waivers from the Cabinet for Health and Family Services' Institutional Review Board. A copy of the Waiver of Authorization will be attached to this Agreement, if applicable.
- C. Keep the data confidential and in accordance with all state and federal laws and privacy policies established by governmental agencies. All OHDA employees and personnel with access to DCBS data under this Agreement shall have a signed CHFS Form 219, "Employee Privacy and Security of Protected Health, Confidential and Sensitive Information Agreement", on file.
- D. Re-disclose data as required by law.
- E. Adhere to all security standards relating to data storage, including the protection and destruction of data required by Kentucky Security policies and standards.
  - 1. The project will implement security controls in compliance with National Institute of Standards and Technology (NIST) special publication 800-53 rev. 4 guidance for moderate baseline controls in accordance with CHFS security standards, and will comply with all relevant state and local security and privacy regulations, as well as federal security and privacy standards adopted by the U.S. Department of Health and Human Services for Exchanges.
  - 2. Security services within the project shall be exposed as standards-compliant, reusable web services whenever feasible, and shall align to the MITA Maturity Model and MITA security and policy standards.
  - 3. The project shall be built using leading practices for secure application development, and shall protect the privacy and disclosure of sensitive, protected health information (PHI) and personally identifiable information (PII) in accordance with HIPAA Security and Privacy Rules.
  - 4. As with all CHFS projects, Recipient must adhere to the Commonwealth Office of Technology (COT) security and enterprise policies and procedures and the Cabinet for Health and Family Services (CHFS) security policies and procedures. Below is a listing of

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additional applicable policies, procedures, and laws for which the project must be prepared to comply:

- a. *Computer Fraud and Abuse Act [PL 99-474, 18 USC 1030]*
  - b. Privacy Act of 1974 as amended [5 USC 552a]
  - c. Protection of Sensitive Agency Information [OMB M-06-16]
  - d. NIST 800-53 [Moderate]
  - e. IRS Publication 1075
  - f. Center for Medicare and Medicaid Services (Health Benefit Exchange)
- F. Provide documentation and certifications as may be needed to satisfy internal agency or APA audits regarding the management and security of the information provided by DCBS upon the request of DCBS.
- G. Prevent any and all unauthorized access to "Identity Information" of Commonwealth citizens, clients, constituents, and employees. "Identity Information" includes, but is not limited to, an individual's first name or initial and last name in combination with any of the following information:
- 1. Social Security Number;
  - 2. Driver's License Number;
  - 3. System Access IDs and associated passwords; and
  - 4. Account Information including account number(s), credit/debit/ProCard number(s), and/or passwords and/or security codes.
- H. Upon learning of any unauthorized breach/access, theft, or release of Commonwealth data containing "Identity Information," Recipients shall immediately notify the contracting agency, the Office of Procurement Services, and the Commonwealth Office of Technology. Recipient is subject to the requirements of KRS 61.931-934.
- I. Provide written notice of violation of the terms of this Agreement within 24 hours of discovery.
- J. OHDA shall cooperate fully in the efforts to mitigate any harm that may result from any violation of these Identity Theft Prevention and Reporting Requirements, and agrees that the Commonwealth may terminate for default this Agreement, and may demand payment(s) from the Recipient in an amount sufficient to pay the costs of notifying Members of unauthorized access or security breaches.

#### **Section 4 - Term Agreement**

This Agreement shall be effective beginning August 1, 2019 thru December 31, 2020, unless terminated pursuant to the termination clause contained. Each party agrees to review this Agreement annually to ensure compliance and the continued need for support under this Memorandum of Understanding.

## **Section 5 - General Provisions**

- A. Nothing in this Agreement shall be construed as authority for either party to make commitments that will bind the other party beyond **Section 3 - Scope of Services** contained herein.
- B. OHDA is prohibited from using or disclosing the data or non-public analysis for marketing purposes.
- C. Recipient agrees that sensitive data shall not be stored on mobile data storage media unless there is a documented agency business necessity approved in writing by the CIO of CHFS, and that all data storage media containing sensitive data are physically and logically secured.
- D. Datasets containing confidential, sensitive, PHI, or PII shall be encrypted when stored or transmitted. All reasonable precautions shall be taken to secure the data from individuals who do not specifically have authorized access. Data shall be kept on a password-protected file server located in a secure environment.
- E. At no time shall confidential, sensitive, PHI, PII, or other data deemed "identifiable to an individual" be used without agreement and written approval from DCBS.

## **Section 6 - Termination**

Either party may terminate this Agreement prior to the expiration of the term in **Section 4 - Term Agreement**, with or without cause, upon 30 days' written notice to the other.

Upon termination of this Agreement, Recipient agrees to delete or destroy all information, records, data, reports, or derived products provided by DCBS unless authorization to maintain the information is provided or required by law.

## **Section 7 - Integration, Modification, and Assignment**

This document represents the entire Agreement between the parties. Any modification of these terms must be in writing and signed by all parties, including the authorized representatives of both DCBS and OHDA. This Agreement shall be interpreted in accordance with the laws of the Commonwealth of Kentucky.



**ORIGINAL AGREEMENT****Approvals**

This Memorandum of Understanding (MOU) is subject to the terms and conditions stated herein. By affixing signatures below, the parties verify that they are authorized to enter into this agreement and that they accept and consent to be bound by the terms and conditions stated herein. In addition, the parties agree that (i) electronic approvals may serve as electronic signatures, and (ii) this agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all counterparts together shall constitute a single agreement.

**DCBS Signature:**

DocuSigned by:



Signature

Signature

Eric Clark

Printed Name

Commissioner

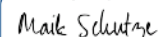
Title

9/10/2019 | 12:26 PM EDT

Date

**OHDA Signature:**

DocuSigned by:



Signature

Maik Schutze

Printed Name

Chief Analytics Officer

Title

9/10/2019 | 4:35 PM EDT

Date

**Security Signature:**

DocuSigned by:



Signature

Dennis Leber

Printed Name

CISO

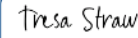
Title

9/10/2019 | 11:20 AM PDT

Date

**CHFS Signature:**

DocuSigned by:



Signature

Tresa Straw

Printed Name

Chief of Staff

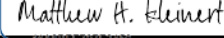
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9/10/2019 | 5:26 PM EDT

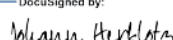
Date

**Approved as to form and legality:**

DocuSigned by:

**Legal**

DocuSigned by:



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M-565

## Appendix Q: CHFS IRB Exempt Determination



MATTHEW G. BEVIN  
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES  
INSTITUTIONAL REVIEW BOARD  
275 EAST MAIN STREET, 2E-O  
FRANKFORT, KENTUCKY 40621  
(502) 564-5497  
FAX (502) 564-9523  
IRB00005487 FWA00003302  
[WWW.CHFS.KY.GOV/OS/OMB/IRB](http://WWW.CHFS.KY.GOV/OS/OMB/IRB)

ADAM M. MEIER  
SECRETARY

November 26, 2019

CHFS-IRB-OHDA-FY20-07

Matthew T. Walton, PhD  
Data Management Specialist  
Office of Health Data and Analytics  
275 E. Main Street 4W-E  
Frankfort, KY 40621

Dana Quesinberry, JD, DrPH  
Research Coordinator  
Office of Health Data and Analytics  
275 E. Main Street 4W-E  
Frankfort, KY 40621

Dear Dr. Walton and Dr. Quesinberry;

The Kentucky Cabinet for Health and Family Services Institutional Review Board (CHFS IRB) has determined that your research project titled "A Program Evaluation of Kentucky's Implementation of the Family First Prevention Services Act" meets the criteria for exemption and no further review is required.

This determination was based on the following Code of Federal Regulations:

45 CFR 46.101(b)(5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants.

If you have any questions about any of the above, please contact me at (502) 564-5497 x3711 or [bob.blackburn@ky.gov](mailto:bob.blackburn@ky.gov).

Respectfully,

Robert L. Blackburn  
CHFS IRB Administrator



## **Appendix R: State Prevention Plan Preprint**

### **B. STATE PLAN FOR TITLE IV-E OF THE SOCIAL SECURITY ACT: PREVENTION SERVICES AND PROGRAMS**

#### **STATE OF Kentucky**

U.S. Department of Health and Human Services Administration for Children and Families  
Children's Bureau November 2018

SECTION 1. Service description and oversight  
SECTION 2. Evaluation strategy and waiver request  
SECTION 3. Monitoring child safety  
SECTION 4. Consultation and coordination  
SECTION 5. Child welfare workforce support  
SECTION 6. Child welfare workforce training  
SECTION 7. Prevention caseloads  
SECTION 8. Assurance on prevention program reporting  
SECTION 9. Child and family eligibility for the title IV-E prevention program

ATTACHMENT I: State title IV-E prevention program reporting assurance  
ATTACHMENT II: State request for waiver of evaluation requirement for a well-supported practice  
ATTACHMENT III: State assurance of trauma-informed service-delivery  
ATTACHMENT IV: State annual maintenance of effort (MOE) report

**As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the** Cabinet for Health and Family Services, Department of Community Based Services

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**(Name of State Agency)**

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

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

Federal Regulatory/ Statutory References <sup>1</sup>	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
<b>Section 1. Services Description and Oversight</b>		
<b>471(e)(1)</b>	<p>A. SERVICES.</p> <p>The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care:</p> <ol style="list-style-type: none"> <li>1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child.</li> <li>2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.</li> </ol>	<p>SOP 3.4 Initial In Home Planning Conference</p> <p>SOP 6.1 Family Preservation Program (FPP)</p> <p>SOP 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP)</p> <p>SOP 6.3 Sobriety Treatment and Recovery Teams (START)</p>
<b>471(e)(5)(B)(i)</b>	<p>B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.</p>	<p>Contractual agreements between DCBS and private providers addressing</p>
<b>471(e)(5)(B)(iii)(I)-(IV)</b> <b>471(e)(4)(B)</b>	<p>C. PRACTICES. With respect to the title IV-E prevention services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of—</p>	<p>SOP 6.1 Family Preservation Program (FPP)</p> <p>SOP 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP)</p>

		SOP 6.3 Sobriety Treatment and Recovery Teams (START)
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<sup>1</sup> Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

<b>Federal Regulatory/ Statutory References<sup>1</sup></b>	<b>Requirement</b>	<b>State Regulatory, Statutory, and Policy References and Citations for Each</b>
	<ol style="list-style-type: none"> <li>1. the services or programs selected by the state, and whether the practices used are promising, supported, or well-supported;</li> <li>2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;</li> <li>3. How the state selected the services or programs;</li> <li>4. the target population for the services or programs;</li> <li>5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and</li> <li>6. how each service or program provided will be evaluated.</li> </ol>	<p>Attachment III</p> <p>SOP 6.1 Family Preservation Program (FPP)</p> <p>SOP 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP)</p> <p>SOP 6.3 Sobriety Treatment and Recovery Teams (START)</p> <p>KRS Chapter 45A</p> <p>MOU agreement between DCBS and the Office of Health Data and Analytics for completion of evaluation of family first implementation in Kentucky and for the TF-CBT intervention.</p> <p>Contractual agreement</p>

		between DCBS and Eastern Kentucky University for completion of the START evaluation.
<b>Section 2. Evaluation strategy and waiver request</b>		
<b>471(e)(5)(B)(iii)(V)</b>	<p>A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and</p>	<p>MOU agreement between DCBS and the Office of Health Data and Analytics for completion of evaluation of family first implementation in Kentucky and for the TF-CBT intervention.</p> <p>Contractual agreement between DCBS and Eastern Kentucky University for completion of the START evaluation.</p>

<b>471(e)(5)(C)(ii)</b>	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Attachment II
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<b>Federal Regulatory/ Statutory References<sup>1</sup></b>	<b>Requirement</b>	<b>State Regulatory, Statutory, and Policy References and Citations for Each</b>
<b>Section 3. Monitoring child safety</b>		
<b>471(e)(5)(B)(ii)</b>	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	SOP 1.5 Supervision and Consultation SOP 2.11 Investigation Protocol SOP 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding SOP 3.2 Timeframes and Ongoing Service Requirements for All In Home Services Cases SOP 3.4 Initial In Home Planning Conference SOP 3.10 SSW's Ongoing Contact with the Birth Family and Child SOP 3.12 Case Plan Evaluation/Ongoing Assessment SOP 6.1 Family Preservation Program (FPP) SOP 6.2 Kentucky

		Strengthening Ties and Empowering Parents (KSTEP) SOP 6.3 Sobriety Treatment and Recovery Teams (START)
<b>Section 4. Consultation and coordination</b>		
<b>471(e)(5)(B)(iv) and (vi)</b>	<p>A. The state must:</p> <ol style="list-style-type: none"> <li>engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and</li> <li>describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.</li> </ol>	Child and Family Services Plan (CFSP)
<b>Section 5. Child welfare workforce support</b>		
<b>471(e)(5)(B)(vii)</b>	<p>The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including—</p> <ol style="list-style-type: none"> <li>ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well-supported practice models selected; and</li> </ol>	<p>SOP 3.1 Engaging the Family and Opening the Case</p> <p>SOP 3.2 Timeframes and Ongoing Service Requirements for All In Home Services Cases</p> <p>SOP 3.4 Initial In Home Planning Conference</p> <p>SOP 3.5 Participants and Notification for All In</p>

		Home Cases SOP 3.10 SSW's Ongoing Contact with the Birth Family and Child SOP 3.12 Case Plan Evaluation/Ongoing Assessment SOP 6.1 Family Preservation Program (FPP) SOP 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP) SOP 6.3 Sobriety Treatment and Recovery Teams (START)
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<b>Federal Regulatory/ Statutory References<sup>1</sup></b>	<b>Requirement</b>	<b>State Regulatory, Statutory, and Policy References and Citations for Each</b>
	B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	SOP 2.11 Investigation Protocol SOP 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding SOP 3.12 Case Plan Evaluation/Ongoing Assessment SOP 6.1 Family Preservation Program (FPP) SOP 6.2 Kentucky Strengthening Ties and



		Empowering Parents (KSTEP) SOP 6.3 Sobriety Treatment and Recovery Teams (START)
<b>Section 6. Child welfare workforce training</b>		
<b>471(e)(5)(B)(viii)</b>	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	SOP 1.5 Supervision and Consultation SOP 2.11 Investigation Protocol SOP 2.12 Completing the Assessment and Documentation Tool (ADT) and Making a Finding SOP 3.1 Engaging the Family and Opening the Case SOP 3.2 Timeframes and Ongoing Service Requirements for All In Home Services Cases SOP 3.4 Initial In Home Planning Conference SOP 3.5 Participants and Notification for All In Home Cases SOP 3.10 SSW's Ongoing Contact with the Birth Family and Child SOP 3.12 Case Plan Evaluation/Ongoing Assessment SOP 6.1 Family Preservation Program (FPP) SOP 6.2 Kentucky

		Strengthening Ties and Empowering Parents (KSTEP) SOP 6.3 Sobriety Treatment and Recovery Teams (START)
<b>Section 7. Prevention caseloads</b>		
<b>471(e)(5)(B)(ix)</b>	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	KAR 200.575
<b>Section 8. Assurance on prevention program reporting</b>		
<b>471(e)(5)(B)(x)</b>	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	Attachment I
<b>Section 9. Child and family eligibility for the title IV-E prevention program</b>		
<b>471(e)(2)</b>	<p>A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is:</p> <ol style="list-style-type: none"> <li>1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).</li> <li>2. A child in foster care who is a pregnant or parenting foster youth.</li> </ol>	<p>SOP 31.2.1 In Home and Prevention Service Title IV-E Claiming</p> <p>SOP 6.1 Family Preservation Program (FPP)</p> <p>SOP 6.2 Kentucky Strengthening Ties and Empowering Parents (KSTEP)</p> <p>SOP 6.3 Sobriety Treatment and Recovery Teams (START)</p>

Title IV-E Plan – State of Kentucky

**PLAN SUBMISSION CERTIFICATION**

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

I, Eric T. Clark hereby certify that I am authorized to submit the title IV-E Plan on behalf of Kentucky.

I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date 10/31/2019

Eric T. Clark

(Signature)

Commissioner

(Title)

APPROVAL DATE:

EFFECTIVE DATE:

\_\_\_\_\_  
(Signature, Associate Commissioner, Children's Bureau)