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

Washington State Department of CHILDREN, YOUTH & FAMILIES

Original Date: December 23, 2024
Approved for Distribution by Secretary Ross Hunter

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Introduction

We acknowledge that the aspirations in this plan reflect a set of commitments and organizational process to which we will hold ourselves accountable. We acknowledge the Department of Children, Youth, and Families (DCYF) role in past and current harm to the children, families, and communities of Black, Indigenous, and People of Color and Tribal Nations.

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

DCYF embraces Family First Prevention Services Act (Family First or FFPSA) implementation as an opportunity to expand the choices and support we provide to children, youth and families. Through Family First, DCYF will create a culture of community participation in child safety and family well-being, thereby reducing the stigma of seeking help. Increasing family-centered and trauma-informed approaches to safety, permanency, and well-being are at the core of DCYF's mission to support Washington families. The Department will use Family First resources to further engage communities in growing these critical efforts.

Vision for Prevention

DCYF's vision is to ensure that "Washington state's children and youth grow up safe and healthy thriving physically, emotionally and academically, nurtured by family and community."

Guiding principles:

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

Legislative Impacts

DCYF's founding legislation HB 1661, enacted in 2017, is clear about prevention as one priority reason the new agency was created: Sec 1 (1): "The legislature believes that, to improve service delivery and outcomes, existing services must be restructured into a comprehensive agency dedicated to the safety, development, and well-being of children that emphasizes prevention,

early childhood development, and early intervention, and supporting parents to be their children's first and most important teachers." Sec. 101 (1)(b): "The department, in partnership with state and local agencies, Tribes, and communities, shall protect children and youth from harm and promote healthy development with effective, high-quality prevention, intervention, and early educational services delivered in an equitable manner." Recognizing the high priority for enhancing and integrating prevention services in the new agency, DCYF established a set of principles in 2018 to guide the agency-wide approach to prevention.

As an agency founded on a commitment to expanding prevention opportunities, DCYF expects to substantially expand prevention and early intervention opportunities all along its continuum of services. FFPSA Prevention is one important tool in our toolbox to accomplish this and the agency's planning takes into account how the FFPSA-funded services for approved eligibility groups will complement other agency prevention efforts.

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

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

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

Prevention Framework

We are charged as an agency with preventing harm to children and youth. DCYF seeks to enact prevention strategies that strengthen family and community relationships by providing the necessary supports and services that mitigate the intersecting factors such as socioeconomic status, disability, mental health, substance use, and intrafamilial violence that too often leads to significant surveillance, regulation, and family separation in communities. Threaded throughout this document are investments in services and practices designed to enable children and families to remain safe and together, with minimal intrusive, coercive and punitive responses from DCYF and the court systems, historically experienced by children and families. DCYF maps prevention in 3 categories in alignment with The Prevention Continuum to Strengthen Families produced by the Capacity Building Center for States.

Primary Prevention

Prevention at the primary level addresses general population needs and child well-being through a social determinants of health approach. Examples of DCYF services at this level include high quality early learning, community-wide parenting classes for families not involved in the child welfare or juvenile justice systems, and other efforts to build protective factors within families and communities.

Secondary Prevention

Prevention at the secondary level involves targeted direct services that develop and amplify protective factors among individuals or families with one or more risk factors that make them more vulnerable to child maltreatment. Examples of DCYF services at this level include parent education programs, home visiting programs or respite care that are targeted to populations at higher risk for maltreatment, as well as evidence-based mental health, substance use disorder, and parenting services offered to families involved with DCYF's child welfare system prior to any finding of maltreatment or out-of-home placement.

Tertiary Prevention

Prevention at the tertiary level involves providing services to support families and mitigate ongoing harm in which child maltreatment has already occurred or has been indicated. Examples of DCYF services at this level include evidence based mental health, substance use disorder, and parenting services offered to parents attempting to reunify with children in out-of-home care.

Prevention activities must focus on trauma mitigation, reduction of negative consequences, and prevention of recurrence. If child maltreatment is not prevented, recurrence could result in removal of children and youth, and their placement in foster care.

DCYF currently implements strong prevention practices that serve as the foundation of our Family First approach by:

- Partnering to ensure communities have what they need to support children, youth, and families.
- Providing community-based services that support families and promote healthy development in children and youth.
- Providing effective case management for those children, youth, and families who enter our systems of care.
- Ensuring that we make effective services available for those who enter our systems of care.

Equity and Disproportionality

Families of Color, particularly Black/African American and American Indian/Alaska Native (AI/AN) are over-represented in Washington's child welfare system. Data supports that these families also have disparate outcomes compared to the general population in Washington along the child welfare continuum, such as children are more likely to be removed from their homes and have longer stays in foster care.

The Racism as a Root Cause (RRC) approach provides a new framework that outlines four key components to guide agencies in addressing racism and inequities; precise impact, systems change, long-term sustainability, and reparations. This approach highlights that interventions focused on individual factors are more likely to further advance disparities. Racism as a Root Cause approaches must be explicit in their population focus and their intended impact, given the intentional and pervasive lack of access to resources and disenfranchisement. This emphasis is not to negate the impact of racism on many marginalized populations. It seeks to recognize and precisely address the significant negative impact that racial inequities in health and social services have on Black and Indigenous children and families and members of Tribal Nations. Family policing and carceral policies are directly connected to the transatlantic slave trade and the forced assimilation of Indigenous populations. Our response to these longstanding inequities must be wholistic and intentional.

This 5-Year Prevention Plan addresses systemic racism by continuously working to uplift culturally responsive Evidence Based Practices (EBPs) and making cultural adaptations to existing EBPs. Through community collaboration, several culturally responsive EBPs have been identified. DCYF will evaluate the current provider network for these services and implement further processes to build capacity for inclusion in our service array, and in a future plan amendment. By utilizing EBPs such as motivational interviewing for DCYF staff and community partners we are working towards equity and client-led approaches to change management. Through the community-based pathway, DCYF intends to work collaboratively to transfer resources, services, and power back to communities who are seeking their self-determination and who fundamentally and deeply understand the nuanced needs of their most vulnerable members, without state intervention that often leads to family separation through punitive measures.

DCYF has set several outcome goals for children, youth, and families. Overarching all of these is the goal to eliminate DCYF disparities so that race and family income are no longer predictors of well-being. DCYF has developed a racial equity and social justice framework that offers a shared approach to building systems that support each and every child, young person, and family to thrive.

DCYF works to embody our Guiding Principles:

- Racially Equitable: Advancing deep equity means recognizing and healing the wounds and injustices of oppression, and transforming people, institutions, and systems. We interrupt policies and practices that maintain structural racial inequities, racial discrimination, and bias.
- Intersectional: We lead equity efforts with an explicit focus on racism, while also addressing the many ways groups experience oppression and marginalization in our systems.
- Collaborative and Inclusive: We form and sustain authentic partnerships; listen with humility and respect; and meaningfully respond to those most impacted and closest to the pain. We recognize differences in power and identity and do "with" instead of "for".
- Self-Aware and Relationship-based: We move forward individually and collectively by centering our inner work and supporting one another's well-being. We intentionally invest in relationships, especially across differences.
- Strengths-Focused and Cultivating Leadership: We nurture leaderful efforts by valuing every individual and community's strengths and assets. We intentionally build leadership at all levels that reflect the racial and cultural diversity of our state.
- Proactive and Strategic/Targeted Universal Approaches: We focus upstream on root causes; power differentials; and sustainable, high-impact solutions. Race neutral or color-blind policies have failed to address the needs of marginalized communities and have exacerbated racial disparities and disproportionality.
- Responsive and Adaptive: We ensure that our programs and service delivery are culturally affirming and responsive. Services are contoured to the needs of children, youth, and young adults in the context of their family and community.
- Transparent and Accountable: We build trust and common understanding by being transparent and accountable in our actions and processes.

DCYF is committed to transforming the way we operate to promote racial equity, diversity, inclusion, and justice, so all Washington's children and youth grow up safe, healthy, and thriving. Established on July 1, 2020, the Office of Racial Equity and Social Justice (ORESJ) takes an intersectional approach, leading with race, to provide the vision, expertise, and accountability mechanisms necessary to make progress on DCYF's commitment to advance racial equity and to reduce the impact of racial and ethnic disproportionality and disparities.

Washington is home to 29 federally recognized Tribal Nations and multiple other Tribes petitioning to be recognized. Additionally, the state is home to substantial Alaska Native populations. DCYF recognizes that significant work must continue to address the impacts of systemic and generational trauma as a direct result of historical and intentional marginalization of Indigenous populations through Government policy and direct action. DCYF is committed to working with Tribal Governments to address these impacts and create healing opportunities. To cultivate and maintain meaningful relationships with Tribal Nations, DCYF established an Office of Tribal Relations.

The Office of Tribal Relations (OTR) has two primary roles:

- Support the delivery of DCYF services that are of high quality and culturally sensitive.
- Ensure Tribes can access DCYF services in a timely manner.

OTR coordinates, monitors, and assesses DCYF's relationships with Tribal Governments, Recognized American Indian Organizations (RAIOs), and Tribal Serving Organizations working to enhance and improve government to government relationships. OTR's goal is to assist the collective needs of Tribal Governments and RAIOs to assure quality and comprehensive program service delivery in the areas of child welfare and early learning.

In addition, DCYF is implementing a Language Access Plan. This plan applies across all divisions and functions of DCYF so that all people, no matter what they speak as a preferred language, receive equitable access to all DCYF programs and services. DCYF is committed to ensuring the prevention services in this plan are accessible to families and that contracted providers understand the language access requirements.

Culture as Prevention

Culture plays a crucial role in preventing child welfare involvement by promoting culturally competent practices, values and a holistic approach. Children and family develop a sense of belonging and community when engaging in traditional practices, and cultural wisdom is honored and integrated into family life, where family bonds are strengthened and an environment is created where children can thrive, grounded in a strong sense of cultural identity. Given that American Indian/Alaska Native and Black/Africain American families in Washington are disproportionately represented in the state's child welfare system, engagement with Tribal Nations and BIPOC community partners in prevention is an essential element in the success of our Prevention Plan.

Building and nurturing strong cultural connections within the diverse Washington communities helps strengthen healthy families and prevent the occurrence of negative outcomes. Cultural practices and traditional values are protective factors that can also improve child welfare outcomes, maintain family and community connections, and prevent additional harm. A growing body of research supports what Tribal communities have long known and practiced –

that building a sense of belonging and helping youth grow a connection to place and cultural identity helps them grow into healthy adults. Cultural connectedness is closely linked to positive health and social outcomes for Native youth. These factors build resilience and act as a buffer against the effects of trauma.

In 2019, in preparation for the submission of the state's first Prevention Plan, DCYF engaged in consultation with the federally recognized tribes who serve as sovereign nations. DCYF staff engaged in extensive discussion with the Washington Tribal Policy Advisory Committee throughout that planning year. In addition, the DCYF Office of Tribal Relations conducted a survey of Washington tribes in 2019 to inquire about prevention practices embraced in tribal communities, that tribal communities find effective and that they would like DCYF to consider, including in its state Prevention Plan. Those discussions and the survey resulted in four prevention practices (Family Spirit, Positive Indian Parenting, Healing of the Canoe and Healing Circles) that the tribes requested DCYF consider, and they additionally requested that the agency work with an AI/AN researcher to conduct the evidentiary reviews. That review was completed in 2020, and resulted in the public-facing report, Evidence-Based Tribal Child Welfare Prevention Programs in Washington State.

Subsequently, Washington tribes advised the agency that they would prefer to build their own capacity to evaluate tribal prevention practices, rather than relying on DCYF to complete the required evaluation of tribal prevention practices included in the state Prevention Plan. In 2024 and 2025, DCYF is partnering with the Indigenous Wellness Research Institute at University of Washington School of Social Work to provide such evaluation training and support to tribal evaluators. DCYF is currently working with Federally Recognized Tribes, Recognized American Indian Organizations (RAIOs), and other Native Serving Organizations to provide culturally responsive prevention services such as Positive Indian Parenting, Family Spirit, Healing of the Canoe, and Family Circle to build capacity for further evaluation. These services and others are identified within the Tribal Best Practices Appendix for the provision of services under Tribal Title IV-E Agreements per the Child Welfare Policy Manual 8.6 Title IV-E Prevention Services Program.

DCYF is collaborating with community-based organizations, service providers, and individuals with lived experience to better understand culturally competent prevention services that address the unique needs of Black/African American children and families. This initiative aims to identify and expand effective services statewide by partnering with providers who are closely connected to the Black/African American communities to provide culturally responsive services. In 2021, diagnostic work was conducted, and in 2023, DCYF issued a Request for Information (RFI) to gather further input from the Black/African American communities. As a result, two key service elements – service navigation and flexible basic needs support- were identified as essential for culturally responsive service providers serving Black families. Feedback from the RFI and diagnostic work highlighted that Black/African American families see these service elements as critical to meeting basic needs, navigating the child welfare system, and ultimately

increasing the likelihood of family preservation and reunification. DCYF was highlighted in a case study by the Harvard Kennedy School Government Performance Lab, Investing in Culturally Responsive Services: Lessons from Washington State, that highlighted the learning and implementation to improve and test new culturally specific services in Washington state.

Building a Community-Based Pathway

DCYF intends to create and deliver some Family First prevention services via a community-based pathway. A community-cased pathway provides high-need families adjacent to the child welfare system with prevention services, approved within this plan, in their own communities that improve safety, health, and well-being. Services via a community-based pathway are less coercive, offer prevention services funded by Title IV-E, and enable families to connect with neighborhood resources and supports without requiring system involvement as a precondition of eligibility. To increase accessibility, build trust, and ensure cultural relevance within communities, DCYF will leverage partnerships with local community organizations, Family Resource Centers (FRC), and the expanding Plan of Safe Care (POSC) pathway to prevention services.

In a July 2023 policy analysis report, Chapin Hall explored Washington state's current policy landscape, identified promising practices from other jurisdictions, compared alternative methods of pursuing a community-based pathway, and made recommendations to DCYF in alignment with key decision-making criteria, including cost, implementation timeline, and alignment with other system-change initiatives. DCYF is using this Chapin Hall report, as well as ongoing partnership with Chapin Hall, as it begins moving towards this service delivery type. DCYF community–based pathways will emphasize a voluntary framework for accessing services, reducing perceived coercion, and building trust, and will include flexible and inclusive eligibility standards to make prevention services accessible to a broader range of high-need families.

To maximize impact, DCYF will coordinate community-based pathways with other statewide initiatives in healthcare, education, behavioral health and housing creating a comprehensive support network. The community-based pathway presents a great opportunity for Washington state to positively meet the needs of high-need children, youth, and families outside of the traditional child welfare service delivery and case management context. Further, DCYF will implement data collection and evaluation mechanisms to evaluate outcomes and refine services over time. The community-based pathways' cost-effectiveness and feasibility will be regularly reviewed to ensure it stays within the DCYF budget and timeline, as recommended by the Chapin Hall report. Further details around the community-based pathways are included in additional sections throughout the 5-Year Prevention Plan.

Section 1. Service Description and Oversight

Throughout Washington, communities and the child welfare system have been utilizing prevention services to prevent and mitigate child maltreatment. Washington state child-serving agencies, including the legacy agencies that formed DCYF in 2018, have long implemented evidence-based practices as a part of their service arrays. In 2012, Washington state enacted House Bill (HB) 2536, requiring that state agencies serving children move toward greater use of Evidence-Based Practices in their service portfolios. Because of HB 2536, Washington state has a rich tradition of EBPs, including evidentiary review and program evaluation, on which to expand voluntary prevention services. Since 2012 the Washington State Institute for Public Policy (WSIPP) has published updated evidentiary reviews and inventories of practices used by child-serving agencies, both in direct services and in contracts.

RCW 74.14A.025 informs mental health and disability service provision by articulating focus on family-oriented, culturally relevant, and coordinated services that meet the diverse needs of individuals and families with dignity and respect. This includes providing services that honor cultural beliefs, ensure equal access, and encourage self-sufficiency. Services are locally planned, reflecting community strengths and needs, and involve collaboration between public and private partners. The state supports community-based prevention, outcome-based measures to assess progress, and customer service that empowers staff to deliver high-quality, respectful services.

Implementing many of the EBPs included in the 5-year Prevention Plan is not new, yet many rural and smaller communities still struggle to garner the resources to deploy EBPs at scale. Many EBPs are currently delivered through braided funding from a variety of sources, such Medicaid, grants, and state and federal funding. This section describes Washington's strategies for the initial and subsequent selection of EBPs to further the implementation of the Title IV-E Prevention Program established through FFPSA.

The selection criteria for an EBP to be included within this 5-Year Prevention Plan was based on current infrastructure within Washington and current or prior implementation. As Washington continues to grow the prevention service array, DCYF will implement a future process for reviewing additional EBPs to be added to the 5-Year Prevention Plan through amendments. DCYF will utilize several criteria to select further EBPs for Washington's population, the target population to include in the prevention state service array, including:

- the extent to which the EBP meets priority needs among approved service eligibility groups,
- the extent to which the EBP was currently being implemented by DCYF or within communities throughout Washington,
- DCYF capacity for the federally required implementation, evaluation, and QA/CQI supports of the EBP,
- the qualifications of those who would be delivering the EBP,
- the eligibility requirements of the EBP,

- whether the EBP was effective at serving Tribal Nations and BIPOC children and families, and
- the amount of support provided by the purveyor of the EBP and community partners.

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

Choosing EBPs by Assessing Needs and Service Gaps

Prevention services can be leveraged when other funds, such as those described below, have been applied but do not cover all activities within an EBP or when a recipient does not qualify for services through other funding sources. The Title IV-E prevention services funding is the "payer of last resort" as required by FFPSA. Other payers for services may include Medicaid, individual insurance plans or similar safety-net funding sources.

A comprehensive service array is an essential part of every system of care. The array must include adequate and available services that:

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

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

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

Cultural Adaptions of EBPs

Guidance from the Administration for Children and Families, Information Memorandum 21-04, allows states to make eligible adaptations of approved programs reviewed in the Title IV-E Prevention Services Clearinghouse. Under this guidance, agreed upon changes to programs that support the culturally responsive delivery of services to diverse populations may be included to serve their populations.

DCYF is working to implement available cultural adaptations to services that meet the cultural needs of diverse groups, particularly those disproportionately represented in the child welfare

system. In addition, through new policies issued by the Children's Bureau, DCYF is preparing to expand tribal specific and culturally adapted programs now eligible for Title IV-E reimbursement. Culturally responsive prevention services for Tribal Nations are included in Appendix B to be available and accessible for Tribal Governments with Title IV-E agreement with DCYF.

Concrete Goods as Prevention

Loss of income, material hardship, and housing instability are among the most reliable predictors of child welfare systems involvement. In Washington state, RCW 26.44.020 outlines that poverty and experiencing homelessness does not constitute negligent treatment or maltreatment in and of itself. Washington state has made a commitment to address intergenerational poverty and promote self-sufficiency through the establishment of the Poverty Reduction Taskforce under HB 1482 2018 Legislative Session

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

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

Continuous Quality Improvement

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

Implementing a provider monitoring data dashboard to surveil quality, fidelity, and outcomes.

Performance-Based Contracting (PBC) is the tool used to strengthen and improve the quality of contracted services and provide support to programs and providers. DCYF has created an

agency-wide PBC standard that guides programs to become more data-driven and to focus on the outcomes for the children and families they serve. To do this, DCYF's OIAA is developing PBC data dashboards for each contracted service array and each contracted service provider. To meet the standard, all contracts for client services must include measurements of provider services, quality, and outcomes:

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

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

- DCYF's Combined In-Home Services PBC data dashboard allows service providers to use PBC as a tool for continuous improvement for their own monitoring, and to help providers understand and eliminate disproportionality and disparities. The dashboard combines service referral, payment, CANS-F assessment, and outcome data to provide insights into the number of services provided, the demographics of people who receive them, the completion of required CANS-F assessments, and overall child outcomes. The dashboard also provides high level trends of numbers and types of services provided from 2019 through 2023 and establishes a target for service providers to complete CANS-F assessments. Service providers are supported by DCYF staff to review key metrics, disproportionalities and disparities, meet the CANS-F assessment completion target of 70% and to engage in quality assurance work by designing improvement plans when a metric does not meet the target. All service providers receive initial and ongoing training to utilize the interactive dashboard and have access to technical assistance.

- DCYF's Home Visiting PBC data dashboard will similarly allow service providers to use PBC as a tool for continuing improvement. The home visiting data dashboard will combine service referral, service delivery, assessment, and outcome data to provide insights into the number of services provided, client demographics, service dosage, completion of required assessments, and overall child and family outcomes.

Maintaining consultant contracts to support EBP fidelity.

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

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

Establishing an agencywide Quality Assurance & Continuous Quality Improvement Framework.

This framework was developed by DCYF in July 2023, defines quality assurance as activities to ensure quality requirements are fulfilled and continuous quality improvement as activities to improve practice and performance. The framework also recognizes that a primary function of QA/CQI is to address systems that continue to support structural racism and to identify and scale up processes and programs that produce improved outcomes for Black, Indigenous, and People of Color (BIPOC) communities.

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

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

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

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

Future Plans to Add Additional Services

While Washington state expects to continue to expand prevention services as well as the services offered under FFPSA for approved eligibility groups, it is important to note that the services funded through FFPSA are just a portion of DCYF's overall prevention portfolio. As an agency founded on a commitment to expand prevention opportunities, DCYF expects to expand prevention and early intervention opportunities all along its continuum of services. FFPSA is one important tool in our toolbox to accomplish this and the agency's planning takes into account how the FFPSA-funded services will complement other agency prevention efforts. As not all requested services could be included in this 5-Year Prevention Plan, DCYF may support additional prevention services and programs in future amendments.

DCYF has received community feedback supporting the inclusion of Familias Unidas, Effective Black Parenting, and Strong African American Families as culturally specific services. Ensuring

sustainability and building capacity for community providers, DCYF staff and technology systems, are top priorities. DCYF will continue to assess additional services for potential inclusion in future amendments to the 5-Year Prevention Plan. DCYF is also exploring ways to offer intentional support to Tribal Nations, BIPOC, and LGBTQIA2S+ families through pilot programs. DCYF recognizes that selecting and funding EBPs that are culturally responsive and tailored to subpopulations overrepresented in the child welfare system is a crucial step in addressing disproportionality, as this often reflects a mismatch between their cultural needs and the current approach to service delivery.

Additional prioritization is being focused around EBPs that can include direct services to caregivers with substance use disorder, and, if approved, an evidence-based service for economic and concrete supports.

Section 2. Evaluation Strategy and Waiver Request

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

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

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

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

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

DCYF strives to maintain a high degree of model fidelity for well-supported evidence-based practices. Quality assurance and continuous quality improvement plans for Motivational Interviewing, Functional Family Therapy, Homebuilders, Multi-Systemic Therapy, Nurse Family Partnership, Parents as Teachers, Parent-Child Interaction Therapy can be found in Appendix A.

Section 3. Monitoring Child Safety in Child Welfare

During the period that prevention services are being offered to Family First Prevention eligible children and their caregivers, DCYF will provide each child an assessment of safety and risk utilizing multiple tools at regular intervals throughout the life of a case. Providing for child safety is core to DCYF's mission. Decisions on child safety are based on comprehensive information, logical reasoning and analysis, and global, rather than incident-based, assessment. A focus on safety and risk is maintained from the initial assessment through case closure using the agency-approved Safety Framework to gather, assess, analyze, and plan for present and impending danger threats and assess for risk of future abuse or neglect. Every caseworker assesses the safety of the child for present or impending danger at all contacts. If present danger exists, immediate protective action is taken. If a child is experiencing impending danger and identified as unsafe, DCYF caseworkers engage families in safety planning to prevent out-of-home placement. Out-of-home placement is only justified when there is an active safety threat that cannot be controlled or managed with an in-home safety plan.

For all families, including those participating in the Title IV-E agency prevention pathway, DCYF conducts on-going assessments of safety and risk throughout the duration of a case. DCYF utilizes a standardized framework, referred to as the Safety Framework, to reduce bias and increase critical thinking. The Safety Framework includes various assessment-based tools, such as the Safety Assessment or Structured Decision-Making Assessment, that inform and guide caseworkers through the decision-making process.

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

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

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

Tool-based safety and risk assessment occurs periodically throughout the life of a case and is supplemented by other ongoing assessment activities, including monthly Health and Safety Visits with children and caregivers and Shared Planning Meetings, which occur at critical decision points throughout the life of a case and utilize a shared decision-making model.

Face-to-face health and safety visits with children and caregivers, who have an open prevention case, provide opportunities for ongoing assessments of the health, safety, risk and well-being of those children. Regular visits increase opportunities to monitor child safety, progress with services and prevention goals. Children that are part of prevention cases will receive private, individual face-to-face health and safety visits every calendar month. For children aged five or younger and residing in the home, two in-home health and safety visits must occur every calendar month. Important elements of health and safety visits included but are not limited to ongoing assessment of safety and immediate response to present danger. Caseworkers conduct visits with verbal children in private and in a location where the child or youth feels comfortable. For children or youth who experience developmental disability impacting their verbal communication, caseworkers refer to the DCYF Administrative Policy 6.03, Access to Services for Individuals with Disabilities. If the child or youth speaks a language other than English, caseworkers make use of the resources described in the DCYF Administrative Policy 6.02, Access to Services for Clients and Caregivers who are Limited English Proficient (LEP).

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

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

A Family Team Decision Making meeting brings families and communities together with the people involved in their lives to make decisions about the placement of the child. Family Team Decision Making meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding prevention of out-of-home placement. These meetings provide additional opportunities to

assess and plan around safety and risk, that are inclusive of the family's support system and the family's own expertise in what will work for their family, thus making success more likely.

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

Practice Innovation

DCYF is exploring the utilization of the North Carolina Family Assessment Scale-General + Reunification (NCFAS-G+R) for caseworkers managing prevention cases. The NCFAS-G+R is an assessment tool designed to examine family functioning in the domains of Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, Social/Community Life, Self-Sufficiency, Family Health, Caregiver/Child Ambivalence, and Readiness for Reunification. The NCFAS-G+R has 70 subscales in 10 domains. Each of the NCFAS-G+R scales provide an organizing framework for caseworkers to conduct a comprehensive family assessment, intended to inform the development of a prevention plan and subsequently document changes in family functioning that represent outcomes of the services provided.

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

Section 4. Consultation and Coordination

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

Tribal Engagement

It should be noted that Federally Recognized Tribes are sovereign governments recognized as self-governing communities under federal and common law. Tribes are recognized as sovereign nations, Tribal Nations have the authority, among other things, to govern their own people and their land, and define their own Tribal membership criteria. To honor this sovereignty, DCYF utilizes government to government Tribal Consultation and follows the Washington Governor's Office of Indian Affairs Centennial Accord and the New Millennium Agreement.

Throughout the development of the Prevention Plan, DCYF regularly engaged Tribal Nations by hosting government to government Tribal Consultations and utilizing the DCYF Child Welfare Tribal Policy Advisory Committee to solicit input on the development of the Title IV-E Prevention Program. The Tribal Policy Advisory Committee convened in the summer of 2024 followed by two Tribal roundtables, an ICW Subcommittee meeting and a Tribal Listening Session. In these forums, DCYF presented on the importance of inclusion of Tribal voice and requested feedback on the development of eligibility standards so that items listed within this plan meet the needs of Tribal communities. Further, DCYF attained feedback from Tribal Nations on Tribal specific prevention services, eligibility, inclusion of the Washington state Indian Child Welfare Act, and Title IV-E agreement opportunities to include within this 5-Year Prevention Plan.

Since the approval of the 2020-2024 5-Year Prevention Plan, DCYF worked with a Native researcher at the University of Washington Indigenous Wellness Research Center who produced an evidentiary review on four prevention practices prioritized by Tribal Nations in our initial 2020 engagement, including Positive Indian Parenting, Family Spirit, Healing of the Canoe (Canoe Journey), and Family Circle (Talking Circle or Healing Circle). This evidentiary review concluded that only one of the four program models evaluated in the report, Family Spirit, had enough evidence available to be rated under the Title IV-E Prevention Clearinghouse. Family Spirit is currently rated as Promising and is included in this plan submission for implementation by DCYF. This 5-Year Prevention Plan additionally expands services to include Tribal Prevention Services that can be accessed by Tribal Nations with Title IV-E agreements through updated policies issued by the Children's Bureau. These unique services are listed within Appendix B.

DCYF will continue to partner with local Tribal Nations when implementing the 5-Year Prevention Plan to outline how services to American Indian/Alaska Native families will be provided, and to ensure that the plan meets the unique needs of American Indian/Alaska Native children and families and ensures access to culturally responsive services. DCYF will continue to collaborate and amend the prevention plan when additional Tribal Prevention Services are requested to be added.

Community Engagement Office

DCYF's Community Engagement team provides oversight and support in working with external community partners and advisory bodies to ensure consistent and effective communication

between constituents and the agency. Community engagement is the process of involving community partners in the planning and implementation of policies, programs, and services. It is also a continuum of community involvement used to plan and execute, based on the timeline, goals and desired level of partner influence on decision making.

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

Shared Leadership with Lived Experts & Partners

DCYF's strategic focus on racial socioeconomic equity calls for transforming the welfare system to improve children's outcomes without placing additional burden on affected communities. DCYF worked with the University of Washington Evans Consulting Team to determine how co-design can be applied in the child welfare system, to centralize lived experience and align agency processes with DCYF's strategic priorities. A co-design guide was developed with implementation protocols for making co-design the norm for DCYF. The guide highlights a framework, definition to set standards, and co-design tools to improve the system's ability to function in a supportive manner for the families and households interacting with the child welfare system and ultimately be designed in collaboration with these families. DCYF is adopting shared leadership and participatory design for the creation and implementation of future prevention efforts and utilized previous engagement with lived experts to influence the development of this 5-Year Prevention Plan.

Community Collaboration

During the drafting of this 5-Year Prevention Plan, DCYF hosted a series of community engagement sessions in all six child welfare regions throughout Washington to help guide the development of this plan.

Through these discussions, it became clear that the terminology used plays a crucial role in how families view themselves and their situations. In response, DCYF is shifting language regarding eligibility for the Title IV-E prevention services in this plan to be more affirming and supportive. One important change is the adoption of the term "prevention identifiers" to describe characteristics that may link individuals or families to factors known to increase the risk of child abuse or neglect rather than "candidate". This new terminology aims to focus on prevention rather than stigma, recognizing that these identifiers can be a starting point for support rather than a label of deficiency.

Additional discussions centered around the current gaps and barriers in Washington regarding prevention services. These themes underscore critical areas of focus, including the urgent need for funding and resource allocation, improved access to services, and community collaboration. Addressing mental health and substance abuse services, enhancing cultural competence, and ensuring that families receive the support they need are essential for community well-being.

Efforts toward prevention, training, and overcoming systemic barriers will also be vital in fostering a more effective service delivery framework.

Title IV-B Coordination

The Washington Title IV-E Prevention Program will ensure that the Title IV-E Prevention Program aligns with the Title IV-B goals and objectives identified in the Child and Family Services Plan to improve outcomes for children and families in supporting safety, permanency, and well-being. This will be accomplished by creating an ongoing coordination process representative of the full range of child and family services provided by the agency. As well as other service delivery systems providing social, health, education, and economic services (including mental health, substance abuse, developmental disabilities, and housing) to improve access and deliver a range of services to children and their families. The Title IV-E Prevention program will work with internal and external partners in identifying the prevention service needs of youth and families across the state to establish a comprehensive, coordinated and effective service delivery system.

Cross Agency Coordination

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

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

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

DCYF has established an Americans with Disabilities Act Accessibility Program to ensure that individuals with disabilities, including parents, guardians, and children, have full access to DCYF programs and services without discrimination. DCYF and Developmental Disabilities Administration (DDA) work collaboratively and across agency while utilizing staff under the

Integrated Health Services team to provide education, assistance, and liaise across organizations and systems to ensure children, youth, and caregivers with Mental Health and Disability support and service needs are met. Additionally, DDA works directly with DCYF involved families providing services to supports individuals with developmental disabilities living in family homes, as well as children and youth with complex behavioral needs stay in their homes, using a wraparound care model.

Infant and Early Childhood Programs

DCYF's 2022 Family First Needs Assessment identified that three-quarters of all children in foster care placement are under age 11, and one-third are infants. Both DCYF's assessment data and the Washington Health Care Authority's (HCA) data show that many welfare-involved young children under age 5 are healthy overall; while they are likely to develop significant health or behavioral health challenges as they get older. DCYF currently provides Nurse Family Partnership, Parents as Teachers, SafeCare, Promoting First Relationships, Parent-Child Interaction Therapy and Incredible Years. These services capture these important years of development, promote healthy childhood outcomes, promote healthy caregiver mental health, and identify and address the needs of young children which can help link families to needed services, and ultimately to prevent children from being placed in out-of-home foster care.

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

Providers & Partners Delivering Prevention Services

DCYF recognizes the diverse community-based approaches implemented to address needs across Washington state. DCYF intends to design policy and procedures in partnership with others to determine the provision of prevention services for families accessing prevention services in the community. This will include:

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

- Recognizing, honoring, and strengthening community-based providers in trauma-informed practice, family engagement, assessment, and planning in prevention cases

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

Plan of Safe Care (POSC) is a family-centered prevention plan designed to promote the safety and well-being of pregnant persons using substances as well as infants with prenatal substance exposure and their birthing parents. Plan of Safe Care policies and practices are required by DCYF by federal statute, (Public Law 114-198), which DCYF has implemented in collaboration with the state Department of Health, Health Care Authority, and the Washington State Hospital Association. When infants with prenatal substance exposure do not meet criteria for mandated reporting and there is no concern from child safety, birthing hospitals, clinicians, and care providers can voluntarily connect gestational parents/caregivers of substance-exposed newborns and infants to voluntary services and supports through an online referral to Help Me Grow. Help Me Grow connects families with a warm handoff to statewide level benefits, infant developmental screening, recovery resources, evidence-based home visiting programs and other needs. Any intake received on a pregnant person using substances with no other children or safety concerns is screened out. In select counties across the state these families are referred to Help Me Grow for voluntary service navigation and care coordination. POSC as part of the community-based pathway is designed to take a highly collaborative, proactive, and preventative approach to accessing wrap-around services and long-term supports to keep families together, increase protective factors, and improve stability and family well-being.

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

DCYF has requested funding for the 2025 legislative session to support implementation of an FRC-based community pathway in five high-need communities around the state. DCYF is designing, sequencing, and managing implementation of community-based pathways and ensuring that community-based providers are adequately prepared to provide Family First prevention services. DCYF has currently been partnering with nine FRCs in communities across Washington to build capacity to meet family and community needs. While each center is unique and rooted in its community, FRCs have a lot in common in how they approach their work and support families and their communities. Additionally, DCYF will partner and

coordinate with other state agencies for the administration of programs to foster a continuum of care for families.

Family Reconciliation Services (FRS) are voluntary services serving youth and adolescents in conflict with their families in the absence of abuse/neglect. The program targets adolescents between the ages of 12 through 17 with services to resolve crisis situations and prevent unnecessary out-of-home placement. While currently a child welfare program, a community-based pathway is being co-designed. The co-designers of this pathway intended that Family Reconciliation Services:

- Be matched appropriately to client needs
- Are culturally and developmentally responsive
- Create awareness to increase the number of youths who self-refer to the program
- Lessen deeper system intervention

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

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

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

Family Practice Model

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

The framework represents a methodical and reliable way to resource, prepare and support child welfare staff to adapt to practice changes and promote a best practice standard for case work. The FPM establishes a system to operationalize agency values through case practice in a way that promotes consistency of how workers engage, assess, and coordinate services

with/for families. The mission of FPM is to prepare and support field operations staff by clarifying value-driven practice standards and commitment to enhancing the professional environment for staff. The FPM includes a cohesive effort to launch guidance on policy, practice guidance, Family Practice Profiles, workforce development, and quality assurance.

Developed through co-design with the DCYF child welfare workforce, the FPM guides staff in practice that is trauma-informed, motivational, strength-based, and demonstrates cultural humility. This co-design process is part of the agency commitment to the workforce that their voice guides the development of practice profiles. Through co-design sessions, workers operationalized DCYF values in case management practice, organized by how workers engage, assess, and plan with families. The best practice case management standards developed in partnership with child welfare workers ensures alignment with practical application of the standards and provides workers with a sense of ownership in decisions and tools that structure their practice. By implementing a values-based FPM, staff are affirmed and supported so they can serve families through engagement, so families feel seen, heard, and understood.

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

Trauma-Informed and Healing-Centered Practice

Trauma yields vast human, institutional, and financial costs. People with severe early adversities often experience state systems, including child welfare, justice, and public and behavioral health systems. The impacts of colonization and systemic racism have left children of color affected by early adversities. In Washington, nearly one-in-three individuals experience at least three potentially traumatic adverse childhood experiences (ACEs).

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

The Washington state Legislature's 2021 passage of the Fair Start for Kids Act (FSKA) in Senate Bill 5237 provides an opportunity to build on the efforts of trauma-informed and healing-centered champions across DCYF areas of operation. In response to this, DCYF is in the process of completing the following:

- Constructing a shared framework and language to enhance safety and equity in the child, youth, and family learning and support systems; boost workforce stability, retention, and wellness; and improve child, youth, and family outcomes.
- Making trauma-informed and healing-centered training available to all agency staff and contractors.
- Creating trauma-informed and healing-centered communities of practice to support DCYF staff.
- Establishing trauma-informed and healing-centered professional standards that may be applied across systems. The Universal Healing-Centered and Trauma-Informed Professional Competencies are used to identify an individual's skills or professional learning development needs. This will ensure that trauma-informed and healing-centered principles, concepts, and practices are embedded in day-to-day activities.
- Conducting a trauma-informed policy review.
- Administering an organizational trauma-readiness self-assessment to monitor DCYF's progress toward becoming a trauma-informed and healing-centered agency.

Workforce Professional Development

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

The Alliance provides training created to optimize the knowledge, values, and skills for child welfare workers and leaders. Through training and supports the Alliance equips the child welfare workforce to provide anti-racist, culturally responsive, and trauma-informed services. Foundational level learning is designed to prepare the new worker with the knowledge and skills to understand their roles and begin to engage in casework. Continued learning opportunities are designed to continue the scaffolding approach and provide a deeper dive into specific topics and additional program specific instruction. Both foundational and continued learning courses include training on developing appropriate case plans and conducting ongoing risk and safety assessments. The Alliance also provides supervisor and leadership development to support the organizational transformations that lead to better outcomes for families and coaching for skills development to all levels of the organization.

While the Alliance provides foundational training and professional development for child welfare workers, DCYF recognizes the opportunity to provide additional training, and workforce supports for key areas of practice as it relates to Family First. As DCYF has been implementing aspects of the 2020-2024 Prevention Plan, the Family First QA/CQI team is completing FFPSA

baseline office assessments to engage child welfare field offices in their readiness to meet practice-related requirements for Title IV-E prevention fund claiming, and to provide leadership and decision-makers with office-level data regarding the availability/utilization of contracted and community-based therapeutic services.

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

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

Topic	Foundational/Skills	Tracks
Overview of FFPSA and Washington's 5-year prevention plan. *Also available in on-demand format for the public.*	Foundational	Single Track
Developing a prevention mindset and the prevention framework at DCYF. This topic will provide information on how Washington's FFPSA Prevention Plan fits within the larger DCYF prevention portfolio and why FFPSA matters. Addressing disproportionality and providing trauma-informed care are essential to DCYF's prevention efforts and will be covered more in-depth within this training topic.	Foundational	Single Track
Technical procedures necessary for the administration of Family First include determining eligibility by assessing what children and families need; connecting to the families served; developing child-specific prevention plans collaboratively with families; matching services to the families' identified needs; accessing and delivering trauma-informed and evidence-based services; completing ongoing risk assessments; and evaluating the continuing appropriateness of the services.	Skills	Dual Track
EBPs included in Washington's Family First Prevention Plan. The information provided will include the age range of child; location of service; standard length of service; access to concrete funds within service; what family situation and need would this service be appropriate or inappropriate for; and method of service delivery.	Foundational	Single Track
Overview of Washington's community pathway through Family First. Referral pathways for youth and families will be included in the content curriculum, as well as an emphasis on why upstream prevention without child welfare involvement or least intrusive involvement is crucial.	Foundational	Dual Track
Supporting staff through change. The primary audience for this module will be supervisors and others in leadership positions within DCYF. Strategies that DCYF already uses, such as Learner Centered Coaching and the ADKAR model, will be incorporated. *This training will not be required for community prevention partners but will be made available to them on demand as a resource.*	Skills	Single Track (DCYF staff)

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

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

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

leadership. These efforts ensure that the workforce is skilled and competent to provide high quality services and case management to families.

DCYF offers trainings to support workforce development around disability awareness and etiquette as well as disability rights. DCYF also makes available educational materials to DCYF staff related to effectively engaging with parents with a cognitive disability while emphasizing each case or individual needs to be individually assessed, with services tailored to meet their individual needs. Additional resources are available to caseworkers related to tailoring psychological evaluation referrals to assess the client's potential disability and evaluate how behaviors related to this disability affect the parent's ability to parent. The guidance emphasizes the referral should use clear, objective language, focusing on observable behaviors that pose a risk of harm and encourages caseworkers to consider the current risks the client's behavior poses to the child. The guidance is clear that the evaluation reports may not fully predict the parent's response to all potential risks or how their ability to parent may change over time. Staff within the Integrated Health Systems team also conduct 1:1 case consultation with staff, supervisors, and Assistant Attorney General's around how to meet the individual needs of our parents with disabilities.

Contracted Service Provider Training and Support

DCYF has a contract in place to train DCYF service providers on the CANS-F assessment and treatment planning. This training aims to promote clinical practices that foster family engagement in collaborative treatment planning, enhance therapists' culturally responsive services, and support the creation of individualized prevention plans.

Service providers have access to guides that help providers understand their roles and responsibilities within the service framework by offering clear guidelines and procedures for the provision of prevention services. It aims to ensure consistent and effective service delivery, enhance communication between providers and community partners, and improve family engagement in support processes. Guides can outline referral processes, service expectations, reporting requirements, and billing protocols, which are designed to enhance the quality of care for families.

Providers are also supported by the Service Array Team to lead in identifying, developing, implementing, and managing services and providers that match the needs of Washington families. This team supports the contractor community in their ability to work within contract requirements and supports staff in maintaining relationships with DCYF contractors. Additionally, this team conducts statewide provider meetings to support engagement, consistency of practice, and recommendations for contract changes to improve performance and alignment with practice and supports.

Section 7. Prevention Caseloads

Prevention caseloads require working in partnership with families, extensive case planning, and on-going case management throughout the life of the prevention case. DCYF caseworkers who carry prevention cases currently identified as all Family Voluntary Services (FVS) and Family Assessment Response (FAR) will have a prevention caseload standard of 1:15 cases (max 1:18). As we implement additional candidacy groups, caseload standards may be reassessed and adjusted as needed. For example, some caseworkers may be holding a mix of prevention and non-prevention cases; therefore, their prevention caseload size would be much smaller.

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

Section 8. Assurance on Prevention Program Reporting

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

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

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

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

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

- The child has been abused or neglected, and the child's health, safety, and welfare is seriously endangered as a result
- There is no parent capable of meeting the child's needs such that the child is in circumstances that constitute a serious danger to the child's development
- The child is otherwise at imminent risk of physical harm

Washington has determined that if a child or caregiver falls within one of the programs specified below, they can be considered for eligibility for Title IV-E prevention services. While the groups described below are at increased risk of out-of-home placement, a case-by-case, individualized assessment will be required to determine whether an individual child within that category meets the criteria.

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

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

Family First Community-Based Pathway Eligibility

Through community collaboration, DCYF is dedicated to ensuring that a broader spectrum of families can access vital support services designed to prevent the need for out-of-home placement or before child welfare involvement becomes necessary. Identifying child specific eligibility for prevention services funded through the community-based pathway is accessed outside of being involved with the Title IV-E agency. Recognizing the diverse challenges that families face, DCYF will implement prevention identifiers as part of its eligibility criteria. Determination of eligibility will ultimately be based on a comprehensive assessment approved by DCYF, and not the prevention identifier alone. These identifiers will serve as a proactive

measure, helping to identify families at risk before crises escalate through the Family First community-based pathway:

Parent or Caregiver Identifiers

History of Abuse
Behavioral Health Issues
Substance using pregnant person
Parental Stress
Lack of Parenting skills
Disabilities
Eligible for income-based social service

Child Specific Identifiers

Disabilities
Juvenile Justice Involvement
Behavioral Health Issues
Challenging Behaviors
Gender Identity and Sexual Orientation
Premature Birth or Medical Problems
Substance Exposed Newborns
Truancy
Trauma

Family Identifiers

Domestic Violence
Unstable Family Structure
Social Isolation
Prior family child welfare involvement, child removal or referral

Environmental Identifiers

Poverty and Economic Instability
Community Violence
Lack of Access to Services
Priority community with highest rates of screened-in intakes
Priority community with highest numbers of AI/AN and Black child placements

Cultural and Societal Identifiers

As identified by a Tribal Nation
Historical and multigenerational trauma
LGBTQIA2S+

While the characteristics of children in the categories above may contribute to their increased risk of an out-of-home placement, the existence of these characteristics do not, in and of themselves mean that they are likely to enter an out-of-home placement.

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

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

- Current or recent (within 12 months) family involvement with the child welfare agency
- Change in family relationships characterized by frequent conflict or violence
- Recent increase in substance use that impacts daily functioning and ability to care for the child or youth
- Recent incident in which a parent or guardian made a plausible threat to cause serious physical harm to a child or youth
- Incarceration of the caregiver
- Child or youth participated in criminal activity
- Other recent or current circumstances that may cause family instability or a threat to the child/youth's safety or well-being

Pregnant and Parenting in Foster Care

In an effort to improve outcomes for older youth, pregnant and parenting foster youth are eligible for receiving Title IV-E funded prevention services included in the state's 5-year prevention plan. There is no requirement in the Act that children of expectant or parenting foster youth be determined to be at imminent risk of foster care to participate in services. Youth can voluntarily engage in the design of their case plans to include supportive services that meet their individualized needs and the needs of their child(ren). Within DCYF's existing framework for practice, appropriate and relevant Title IV-E funded services provided to pregnant and parenting foster youth under the state's 5-year prevention plan will be added to the youth's existing case plan and the youth will be eligible to receive services for a 12-month period. Continuous 12-month periods of services can be provided as long as the youth is assessed to have a continued need for the services.

Active Efforts and Washington Indian Child Welfare Act

Washington is committed to meeting the unique needs of AI/AN children and families by ensuring that services are provided in a manner consistent with the Washington Indian Child Welfare Act (RCW 13.38) and the Indian Child Welfare Act of 1978 (25 U.S.C. Sec. 1901 et seq.) AI/AN children may be provided prevention services either by a Tribal Title IV-E Prevention

Program or by the DCYF Title IV-E Prevention Program. In the DCYF Title IV-E prevention service pathway, prevention services to an AI/AN child under the program is closely intertwined with the requirement to provide Active Efforts under WICWA and ICWA to maintain an Indian child with their family.

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

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

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

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

ii. What cultural considerations to consider when providing active efforts.

Title IV-E Agency Pathway

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

Tribes operating under a Title IV-E agreement with the state pursuant to 472(a)(2)(B)(ii) of the Act may opt to directly provide Title IV-E prevention services that are both culturally responsive and rooted in tradition. Within this plan, prevention services that are culturally responsive have been included following consultation with the Tribes to expand access to services that are both currently provided or in various stages of development. In Washington state, the Lummi, Quinault, and Makah Tribes all have existing Title IV-E agreements with DCYF. The state has entered consultation with all Tribes to determine how the IV-E prevention program will be incorporated into their existing Title IV-E agreements and Tribes without Title IV-E agreements that may wish to initiate an agreement in the future. Future state plan amendments will include more details about those agreements.

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

Family First Community-Based Pathways

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

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

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

Referral, Intake, and Assessment

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

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

Eligibility Determination

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

Prevention Planning, Coordination of Delivery of Services

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

Oversight of Community Pathways, Safety Monitoring and Risk Assessments

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

Elements of this oversight may include:

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

As outlined above, DCYF is responsible for supervising and ensuring that its contractors appropriately perform all contracted Title IV-E administrative activities in accordance with federal and state requirements and will receive and review periodic reports to support their oversight of their contracted service providers. Service providers will be required to track data for each child deemed eligible for Title IV-E prevention services and share this information with DCYF. Information within the reports may include safety and risk monitoring, adherence to model fidelity standards, length, and completion of services etc. Reporting will ensure safety is being monitored as well as information on services outcomes and adherence to model fidelity.

DCYF, as a part of continuous monitoring, will address any concerns with the service provider over observed systemic issues in care coordination. If DCYF identifies a problem through their review of periodic reports or other performance monitoring activities, they will follow up with their contracted entities to address it immediately.

Conclusion

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

DCYF is prioritizing the enhancement and integration of prevention services for the children, youth and families in Washington. FFPSA is an integral part of a much larger effort to transform the way we serve Washington children and families that began with the creation of DCYF as a new agency in 2018. We are committed to a broader vision that strengthens families by preventing child maltreatment, unnecessary removal of children from their families, incarceration among youth and a range of other destabilizing factors, such as homelessness and economic and food insecurity. We strive to establish and implement prevention approaches that avoid causing further harm, while empowering children, youth, families and their communities to identify and provide the resource needs for safety, connection, healing, and the prevention of future harm. To effect true change and improve service delivery and outcomes through high-quality prevention efforts, we must think differently about our services and how to best support our families before crisis occurs. Through collaborative partnerships with internal and external agencies, Tribal Nations, and the children, youth, and families we serve, DCYF will take a wholistic approach to preventing the conditions that enable child maltreatment and family separation. DCYF will also continue to explore other funding sources to support the agency's broad prevention goals.

Appendix A: Evidence Based Services

Nurse Family Partnership

Rated: Well-Supported

Service Type: In-home Parent-skill based

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

Program Selection and Outcomes

Nurse Family Partnership (NFP) is currently part of DCYF's Home Visiting Services. Home visiting programs are voluntary, family-focused services offered to expectant parents and families with new babies and young children to support their physical, social and emotional health. DCYF has selected Nurse Family Partnership based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

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

Service Description and Training

Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother.

Implementation

Providers commit to contracts that contain elements related to achieving and maintaining model fidelity for the agency's home visiting services, including enrollment, retention, dosage, and home visit content. There are also specifications around the staffing plan for the program as well as enrollment levels, priority populations, and service area. All of these elements, along with data, technical assistance, and continuous quality improvement, are focused on providing quality services to families and children.

Providers must meet or exceed DCYF, Washington state, and applicable Federal agency regulations. This includes participation in meetings, continuous quality improvement, technical assistance, and data collection. Each year programs receive a site visit from the assigned DCYF Program Specialist who may or may not bring a team from DCYF to visit the agency.

Target Population

NFP is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. Home Visiting in Washington prioritizes families with certain risk factors including homelessness, and families with multiple young children between birth to age 5 not connected to early learning resources.

Fidelity Monitoring

Providers are required to deliver Nurse Family Partnership (NFP) and Parents as Teachers (PAT) according to the program model requirements and Start Early Washington provides technical assistance support and implementation in alignment with model fidelity. DCYF asks providers to submit evidence they are in fidelity with their program model, with a letter of fidelity status either from the national model office or from Start Early Washington's technical assistance provider if no national office exists. For NFP and PAT, the Home Visiting Services team collaborates with the Start Early Washington Model Leads and national model offices through a formal partnership to assure communication related to provider's model implementation. The establishment, reporting, and monitoring of these fidelity indicators will be done in alignment with DCYF PBC requirements.

Continuous Quality Improvement

Washington continues to grow and implement a robust continuous quality improvement (CQI) strategy led by DCYF in collaboration with Start Early Washington Implementation Hub WA Department of Health (who implements the HVSA Data and Evaluation work) by offering quality improvement coaching and technical assistance to providers. Each program is guided to implement local CQI projects and reports on their learnings and impact through the quarterly progress reports. Start Early Implementation Hub support strengthening of CQI capacity at the State and provider level and in-depth peer learning opportunities.

CQI promotes the regular and meaningful use of data, tools, and rapid-cycle improvement processes to inform practice and decision-making. CQI is an integrated element of all Hub processes and Start Early's Manager of Quality Improvement and Innovation provides targeted expertise to support discrete process improvement projects with each provider's home visiting program and within the home visiting system. Hub staff provide customized, individual coaching to CQI teams with providers to coach them through a specific CQI project and Plan-Do-Study-Act (PDSA) cycles. The Hub also regularly synthesizes and disseminates home visiting specific CQI-tools and resources as well as lessons learned that emerge with the providers.

The CQI approach used by Washington state includes both reflection and data elements, while ultimately drawing on the expertise and knowledge of provider home visiting staff and families. Through thoughtfully implemented CQI projects, providers are supported to optimize program outcomes, identify and test innovative approaches, disseminate best practices, and enhance program efficiency and effectiveness.

Request for Evaluation Waiver

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

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

Workforce Support and Training

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

Necessary supports include:

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

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

- Staff hiring, onboarding & retention
- Best practices in family engagement

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

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

Prevention Caseloads

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

Waiver Request & Compelling Evidence of Effectiveness

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

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

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

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

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

Parents As Teachers

Rated: Well-Supported

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

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

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

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

Program Selection and Outcomes

Parents as Teachers (PAT) is currently part of DCYF's Home Visiting Services. Home visiting programs are voluntary, family-focused services offered to expectant parents and families with new babies and young children to support their physical, social and emotional health. DCYF has selected Nurse Family Partnership based in part on contracts DCYF already has in place for prevention, as well as community partner feedback and federal guidance.

PAT outcomes include improved child development and school readiness, improved family economic self-sufficiency, improved parent-child interactions and reduction in child maltreatment.

Service Description and Training

PAT is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces.

Families can receive services prenatally until their child starts kindergarten. Parent educators meet with families for about an hour at a time. The frequency of meetings can range from biweekly to monthly, based on need.

Parent educators must have a high school degree or GED with two or more years of experience working with children and parents. In order to receive their PAT certification, all parent educators must attend a three-day foundational training. They must also attend a two-day model implementation training that covers strategies used to implement PAT. The PAT National Center also offers technical assistance and certification renewal sessions.

Implementation

Providers commit to contracts that contain elements related to achieving and maintaining model fidelity for the agency's home visiting services, including enrollment, retention, dosage, and home visit content. There are also specifications around the staffing plan for the program as well as enrollment levels, priority populations, and service area. All of these elements, along with data, technical assistance, and continuous quality improvement, are focused on providing quality services to families and children.

Providers must meet or exceed DCYF, Washington state, and applicable Federal agency regulations. This includes participation in meetings, continuous quality improvement, technical assistance, and data collection. Each year programs receive a site visit from the assigned DCYF Program Specialist who may or may not bring a team from DCYF to visit the agency.

Target Population

PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions.

Fidelity Monitoring & Continuous Quality Improvement

Providers are required to deliver Parents as Teachers according to the program model requirements and Start Early Washington provides Technical Assistance support and implementation in alignment with model fidelity. DCYF asks providers to submit evidence they are in fidelity with their program model, with a letter of fidelity status either from the national model office or from Start Early Washington's Technical Assistance Provider if no national office exists. For NFP and PAT, the Home Visiting Services Account collaborates with the Start Early Washington Model Leads and national model offices through a formal partnership to assure communication related to provider's model implementation. The establishment, reporting, and monitoring of these fidelity indicators will be done in alignment with DCYF's PBC requirements.

Washington continues to grow and implement a robust continuous quality improvement (CQI) strategy led by DCYF in collaboration with Start Early Washington Implementation Hub and WA Department of Health (who implements the HVSA Data and Evaluation work) by offering quality improvement coaching and technical assistance to providers. Each program is guided to

implement local CQI projects and reports on their learnings and impact through the quarterly progress reports. Start Early Implementation Hub support strengthening of CQI capacity at the state and provider level and in-depth peer learning opportunities.

CQI promotes the regular and meaningful use of data, tools, and rapid-cycle improvement processes to inform practice and decision-making. CQI is an integrated element of all Hub processes and Start Early's Manager of Quality Improvement and Innovation provides targeted expertise to support discrete process improvement projects with each provider's home visiting program and within the home visiting system. Hub staff provide customized, individual coaching to CQI teams with providers to coach them through a specific CQI project and Plan-Do-Study-Act (PDSA) cycles. The Hub also regularly synthesizes and disseminates home visiting specific CQI-tools and resources as well as lessons learned that emerge with the providers.

The CQI approach used by the state of Washington includes both reflection and data elements, while ultimately drawing on the expertise and invaluable knowledge of provider home visiting staff and families. Through thoughtfully implemented CQI projects, providers are supported to optimize program outcomes, identify and test innovative approaches, disseminate best practices, and enhance program efficiency and effectiveness. CQI is intended to prompt deep reflection of current practice and outcomes, while recognizing the value of learning and development.

Workforce Support and Training

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

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

Necessary supports include:

- Technical Assistance: regular, personalized support to help programs implement best practices through a mutual goal-setting process and supports that are customized to the program's specific priorities, including consultation, resource connection, reflective supports or observation and coaching.
- Peer Learning: collaborative environments for home visiting professionals to participate in open-ended discussions centered around brainstorming, reflection and communities of support.

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

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

- Staff hiring, onboarding & retention
- Best practices in family engagement
- Family recruitment & enrollment
- Data collection to inform decision making
- Building referral relationships & early childhood system connections
- Supportive organizational policies & procedures
- Technical & adaptive skills in staff supervision, reflective practice & team culture
- Programs implementing Nurse-Family Partnership, Parents as Teachers, and ParentChild+ also receive specific supports on implementing their program with fidelity to model requirements.

Prevention Caseloads

Caseload limit full time staff no more than 48 visits/month in first year and no more than 60 visits/month thereafter.

Waiver Request & Compelling Evidence of Effectiveness

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

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

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

PAT has also been rated as promising by the CEBC with a medium child welfare relevance for the topic areas of home visiting programs for child well-being and prevention of child abuse and

neglect programs. According to studies evaluated by the CEBC, PAT significantly reduced child welfare involvement for participating families, including reduced rates of CPS reports, substantiations, out-of-home placements, and abuse-related injury.

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

Homebuilders

Rated: Well-Supported

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

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

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

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

Program Selection and Outcomes

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

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

Service Description and Training

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

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

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

Homebuilders services are concentrated during a period of 4 to 6 weeks with the goal of preventing out-of-home placements and achieving reunifications. Homebuilders therapists typically have small caseloads of 2 families at a time. Families typically receive 40 or more hours of direct face-to-face services. The family's therapist is available to family members 24 hours per day, 7 days per week. Treatment services primarily take place in the client's home.

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

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

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

Implementation

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

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

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

Homebuilders is a 4 to 6-week intensive intervention with about 10 hours per week spent with the family in the home.

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

Workforce Support and Training

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

Prevention Caseloads

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

Waiver Request & Compelling Evidence of Effectiveness

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

The Prevention Services Clearinghouse has rated Homebuilders as a well-supported practice, a designation granted only to evidence-based practices with at least two studies with non-

overlapping samples implemented in settings as intended by program developers; study designs with moderate or high ratings; and demonstrably favorable and long-lasting effects on outcomes.

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

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

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

Functional Family Therapy

Rated: Well-Supported

Service Type: Mental Health Programs & Services

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

Program Selection and Outcomes

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

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

Service Description and Training

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

needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context.

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

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

Implementation

For families with an open DCYF child welfare case, FFT is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered FFT for placement prevention if the family needs support in helping troubled youth and their families to overcome delinquency, substance abuse and violence, or if the family needs support across multiple systems (juvenile justice or schools). Youth may exhibit external behaviors, internal symptoms, and/or substance abuse: Conduct disorder, oppositional defiant disorder, drug use/abuse, anxiety/depression with behavior disorder symptoms expressions, violence, school problems, truancy, etc.

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

Prevention Caseloads

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

Waiver Request & Compelling Evidence of Effectiveness

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

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

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

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

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

Multisystemic Therapy

Rated: Well-Supported

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

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

Program Selection and Outcomes

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

MST outcomes include eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s), empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents and empower youth to cope with family, peers, school, and neighborhood problems.

Service Description and Training

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

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

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

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

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

Implementation

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

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

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

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

Target Population

Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system.

Fidelity Monitoring & Continuous Quality Improvement

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

Prevention Caseloads

MST therapists provide services for 4-6 families at a time.

Waiver Request & Compelling Evidence of Effectiveness

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

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

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

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

A pilot program implemented in Washington state found similar results among statewide youth as other national-level studies. Among 101 youth involved in the MST pilot program, 12-month rates of conviction decreased from 68% before service initiation to 35% after enrollment. Additionally, MST enrollment was associated with higher rates of mental health service and crisis service utilization.

Parent-Child Interaction Therapy

Rated: Well-Supported

Service Type: Mental Health Programs and Services

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

Program Selection and Outcomes

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

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

Service Description and Training

PCIT is a dyadic behavioral intervention for children and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. 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 consists of two phases:

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

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

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

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

Implementation

For families with an open DCYF child welfare case, PCIT is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

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

Young children with emotional and behavioral disorders

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

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

Target Population

Caregivers with children ages 2-7 years old.

Continuous Quality Improvement & Fidelity Monitoring

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

Prevention Caseloads

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

Waiver Request & Compelling Evidence of Effectiveness

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

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

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

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

Motivational Interviewing

Rated: Well-Supported

Service Type: Substance Abuse Programs and Services

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

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

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

Program Selection and Outcomes

DCYF has selected Motivational Interviewing (MI) as a prominent service and case management tool in the field of child welfare beyond substance abuse. MI is a human-centered and cross-cultural service that provides a shared language between service providers and caseworkers with families. Research and evaluation to date have highlighted MI as an effective service delivery strategy with both adult and youth populations, making it an ideal fit for those eligible for DCYF's prevention services.

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

Service Description and Training

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

DCYF child welfare workers will use MI with clients to reduce resistance when discussing behavioral change. Currently, caseworkers receive introductory and advanced training in Motivational Interviewing from a MINT certified training vendor. After completion of these

trainings, staff are supported with coaching and coding utilizing the MICA to ensure the skills and qualifications of the caseworker meet the necessary fidelity standards to client-centered, competent, and proficient MI.

Contracted Service Providers: MI will also be used by contracted providers who provide services for DCYF clients or through community pathways. Contracted service providers are receiving specialized training and support through a partnership with a MINT certified training vendor. As part of this initiative, the trainers, who are also among the original developers of the MICA tool, deliver 20 hours of comprehensive training. This program includes coding and coaching to help the providers effectively implement MI in their practice.

Implementation

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

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

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

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

Workforce Support and Training

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

Trainers are MINT certified and provide consultation.

Prevention Caseloads

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

Waiver Request & Compelling Evidence of Effectiveness

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

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

After rigorous review, the Clearinghouse identified 75 studies eligible for review, 13 of which achieved a high rating, and an additional 8 achieved a moderate rating. Outcomes of interest for MI were related to child and adult well-being.

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

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

Promoting First Relationships

Rated: Supported

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

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

Program Selection and Outcomes

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

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

Service Description and Training

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

Providers deliver weekly sessions to caregivers and their children. Providers use five strategies during sessions to enhance caregivers' confidence and support children's social-emotional development: (1) joining, in which the provider makes observational statements and asks open-ended non-judgmental questions to form emotional connections with caregivers; (2) reflective observation, in which the provider observes the relationships between caregivers and children and teaches caregivers how to observe children and respond to their needs, sometimes using videotaping to help caregivers reflect; (3) verbal feedback, in which the provider offers positive comments about observed interactions to enhance caregivers' confidence and competence; (4) supporting reflective capacity, in which the provider discusses the importance of feelings and needs, helps caregivers understand how children's behavior is linked to social and emotional needs, and teaches caregivers to read children's nonverbal cues and to empathize with and provide comfort to children in distress; and (5) sharing information, in which providers offer caregivers resources about children's social and emotional development.

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

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

Level 2 Certified Provider Training is a 15-week virtual mentoring professional development program for providers who have already completed the PFR Level 1 Training. For the first 5 weeks, providers watch intervention session videos to hone infant mental health observation and reflection skills. Providers discuss the videos with a master trainer and their peers. For the next 10 weeks, providers deliver the intervention with a caregiver/child dyad and receive individual mentoring. To become certified, providers must record and submit a full PFR session video that demonstrates fidelity to the model.

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

Implementation

For families with an open DCYF child welfare case, Promoting First Relationships is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

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

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

Steps to become a Certified PFR Provider:

1. Attend the PFR Level 1 Workshop; conducted over 4 half days via zoom or 2 full days in person.
2. Successfully complete PFR Level 2 training including phase one and phase two (or equivalent provided by a Certified PFR Agency Train-the-Trainer):
    a. Phase One: View 11-set Video Training series while being mentored online by a PFR Master Trainer weekly for 5 weeks, or until all videos have been viewed and discussed.
    b. Phase Two: Implement a 10-week PFR outline with a training family while being mentored weekly online by a PFR Master Trainer to discuss all core PFR concepts, view caregiver-child interaction videos, review videos of yourself doing PFR to prepare for weekly visits.
3. Meet PFR fidelity requirements on a self-recording of a whole PFR session, measured using the Fidelity Feedback form (see attached measure). Fidelity video must be submitted to PFR program within 2 months of finishing training in order to be eligible for scoring. If Provider does not meet fidelity requirements, further mentoring as listed below can be taken, upon approval of DCYF.

Ongoing Fidelity Requirements:

1. Attend monthly PFR reflective consultation group. Regular attendance is mandatory (Cannot miss more than two meetings per year, unless provider seeks a waiver from the

PFR program due to special circumstance). Reflective Consultation (RC) group activities can include:

   a. Watching and discussing caregiver-child interaction videos
   b. Viewing/reflecting on videos of provider working with dyad while giving video feedback to parent, or doing other curriculum piece
   c. Discussing core PFR principles and applying to dyads on caseload and
   d. Discussing one's own feelings about the work and/or dyad

2. The RC groups will be online, video-based meetings and therefore need to be conducted in a location that supports video conference participation.
3. Newly certified providers need to submit a fidelity video 6 months after their initial certification to renew PFR certification. Once this 6-month fidelity video meets certification requirements, then yearly fidelity checks are required in order to remain a certified PFR provider. The fidelity video must be a self-recording of a whole PFR session,
   which will be reviewed and measured using the Fidelity Feedback form.

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

1. Meet online or in-person with PFR Master Trainer, DCYF PFR Lead, or PFR Agency Train-the Trainer, as appropriate, to discuss fidelity challenges and to receive further mentoring to meet fidelity. The remediation/further mentoring period may take one to two sessions for minor shifts to occur or may take up to 10 sessions to address bigger discrepancies in fidelity. DCYF will approve the number of visits.
2. Remediation/further mentoring sessions will include viewing caregiver-child interaction videos to enhance observational skills; provider recording self and watching and discussing areas of strength and growth areas that require a shift in consultation strategy, understanding of PFR concepts, or way of being in order to achieve fidelity; being assigned additional reading and discussing these core concepts during sessions; and/or discussing personal feelings/motivations that are getting in the way of implementing PFR as intended.
3. Upon completion of the specified number of remediation visits, Provider will submit a Whole Session Fidelity video that includes Video feedback. This submittal will be coded for fidelity, and if the provider meets the fidelity requirements, the Provider will be certified to continue to deliver PFR services to families on their caseload. If Provider does not meet fidelity following remediation/further mentoring, Provider is not considered certified to implement PFR. At this point, Agency can decide whether or not to pay for additional remediation at its' own expense, in order to help Provider achieve fidelity

Prevention Caseloads

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

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were PFR services referred to and initiated in a timely manner?
2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in PFR (service referral, initiation, dosage, and completion)?
3. Were families who received PFR less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received PFR less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

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

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

- Prior CPS intakes
- Current and prior case openings

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

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

Sampling and Analysis

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

Limitations

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

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

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

Dissemination

Upon completion of this program evaluation, a final report will be written and published by OIAA and made available to the public, providers, and other relevant program partners.

Findings from this evaluation will be used to inform internal continuous quality improvement and DCYF will work with program administrators for contracted services to ensure continued monitoring or performance measures through Performance-Based Contracting.

SafeCare

Rated: Supported

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

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

Program Selection and Outcomes

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

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

Service Description and Training

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

Each module is designed to be delivered in 6 sessions (18 total), but some families may need fewer or more sessions to reach skill mastery. Each session typically lasts 50 to 90 minutes and is delivered in the family's home or at another location of the parent's choice.

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

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

Implementation

For families with an open DCYF child welfare case, SafeCare is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

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

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

SafeCare Certified Coach

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

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

Ongoing coach fidelity requirements

For New Providers, not yet certified:

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

For Certified Providers

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

All Providers: Ensure ongoing SafeCare model fidelity by:

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

SafeCare Provider Fidelity

Steps to becoming and SafeCare Certified Provider (provider)

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

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

Ongoing Provider Certification Requirements:

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

Prevention Caseloads

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

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were SafeCare services referred to and initiated in a timely manner?
2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in SafeCare (service referral, initiation, dosage, and completion)?
3. Were families who received SafeCare less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received SafeCare less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

- Service engagement: number of children eligible, referred, engaged, and dosage completed for each service.

- Placement prevention and adoption support: percent of child clients without a screened-in CPS intake or entry/re-entry into out-of-home care.
- Reunification: percent of child clients who exit out-of-home care to reunification, guardianship, or Trial Return Home.

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

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

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

Sampling and Analysis

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

Limitations

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

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

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

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

Dissemination

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

Family Spirit

Rating: Promising

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

Manual: The Family Spirit® Implementation Guide is implemented in conjunction with the Lesson Plans:
Family Spirit Program: Implementation guide. (2019). Johns Hopkins Center for American Indian Health.
Family Spirit Program: Lesson plans. (2019). Johns Hopkins Center for American Indian Health.

Program Selection and Outcomes:

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

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

Service Description and Training

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

Community health paraprofessional home visitors deliver program lessons to participating mothers through six modules: (1) Prenatal care, (2) infant care, (3) your growing child, (4) toddler care, (5) my family and me, and (6) healthy living. The program encourages other family members to participate in the lessons alongside mothers. Home visitors also provide case management and help families access services, as needed. Family Spirit is designed to serve mothers for as long as possible, from 28 weeks gestation until 3 years postpartum. Home visitors teach 63 lessons during 52 home visits. Each visit is 45-90 minutes long. Visit frequency tapers over time. Specifically, mothers receive weekly visits from 28 weeks gestation to 3 months postpartum, biweekly visits between 3 months and 6 months postpartum, monthly visits between 7 months and 22 months postpartum, and bimonthly visits between 23 and 36 months postpartum.

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

Implementation

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

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

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

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

Target Population

Family Spirit is designed to serve young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy. Other family members can participate in the program lessons alongside mothers.

Fidelity Monitoring & Continuous Quality Improvement

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

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

1. Focus CQI activities on one of the following topics:
    a. Family Engagement and Retention
    b. Staff engagement and retention (Team Support and Well-Being)
    c. Caregiver Mental Health
    d. Other topic areas approved by DCYF

2. Establish an internal CQI staff team to oversee, support, and implement CQI activities to assess program processes and outcomes; the CQI Team members are expected to participate in regular CQI team meetings, CQI webinars, and CQI project activities.

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

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

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

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

Prevention Caseloads

Providers can carry up to 12 families on their caseload.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were Family Spirit services referred to and initiated in a timely manner?
2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in Family Spirit (service referral, initiation, dosage, and completion)?
3. Were families who received Family Spirit less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received Family Spirit less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

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

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

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

- Structured Decision Making (SDM) risk assessments
- Family assessments
- Removal records
- Child, family, and household information

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

Sampling and Analysis

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

Limitations

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

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

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

Dissemination

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

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

Incredible Years

Rated: Promising

Service Type: Mental Health Programs and Services

Manual: Webster-Stratton, C. (2011). *Incredible Years parents, teachers and children's training series: Program content, methods, research, and dissemination*, 1980 – 2011. Incredible Years, Inc.
Incredible Years, Inc. (2019). *Toddler basic curriculum set*.
Incredible Years, Inc. (2019). *School age basic curriculum set*.

Program Selection and Outcomes

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

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

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

Service Description and Training

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

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

The Incredible Years - School Age Basic program ("IY-School Age") can be offered as a group-based prevention or treatment program designed for parents of children (6 to 12 years). The program typically targets higher risk populations and parents of children diagnosed with problems such as oppositional defiant disorder and attention deficit hyperactivity disorder (ADHD). IY-School Age aims to strengthen parent-child interactions and attachment and reduce

harsh discipline. It also aims to foster parents' abilities to promote children's social, emotional, and academic development and reduce behavior problems. IY-School Age focuses on 3 developmentally appropriate topics during the sessions: (1) promoting positive behavior, (2) reducing inappropriate behaviors, and (3) supporting children's education.

During each group session, parents watch 8 to 10 situational video vignettes. They engage in discussions facilitated by the group leaders and problem solve about best parenting practices. Parents are encouraged to complete activities at home to apply the skills they learned with the group.

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

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

1. Attend an accredited Incredible Years Workshop approved by the model developer and DCYF.
2. Successfully complete Incredible Years Group Leader or Home Coach Certification:
    a. Complete two full parenting groups (18 sessions for preschool, 13-14 for toddlers, and 8-10 sessions for baby)
    b. Video tape one session during the first parenting group or home coach session and send to Incredible Years.
    c. Video tape another session when ready and send to Incredible Years. Group leaders will need to send in at least one video from every 18-week Incredible Years series (or 14 for toddler and 10 for baby) until they are notified that their video has passed towards their certification. Most group leaders pass a certification review within 2-3 videos.
    d. Attend at least one Incredible Years accredited consultation per year, if made available through DCYF
    e. Upon passing a video review, apply for certification with Incredible Years

Implementation

For families with an open DCYF child welfare case, Incredible Years is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and

caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

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

Target Population

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

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

Fidelity Monitoring & Continuous Quality Improvement

DCYF implements the Incredible Years Quality Assurance Plan

Ongoing Fidelity Requirements:

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

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

Prevention Caseloads

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

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were IY services referred to and initiated in a timely manner?
2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in IY (service referral, initiation, dosage, and completion)?
3. Were families who received IY less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received IY less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

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

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

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

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

Sampling and Analysis

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

Limitations

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

Certain programs may require multiple years of service data to construct a sufficient sample size to readily evaluate program effectiveness. In these cases, the changes in service referral

criteria or capacity over time may affect the pool of an appropriate comparison population. Moreover, a significant portion of DCYF cases receive more than one EBP throughout the life of the case, making it difficult to ascertain the impact of an individual EBP.

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

Dissemination

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

Child Parent Psychotherapy

Rated: Promising

Service Type: Mental Health Programs and Services

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

Program Selection and Outcomes

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

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

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

Service Description and Training

Treatment focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration-related stressors) and respects the family and cultural values. Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect. Together, these approaches for Child-Parent Psychotherapy serve to support families to reach the following primary goals:

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

All CPP providers must have experience as mental health professionals and participate in the required training. CPP offers three types of training models: (1) CPP Learning Collaborative (LC), (2) CPP Agency Mentorship Program (CAMP), and (3) Endorsed CPP internship. In CPP LC, teams of trainees attend an initial 3-day didactic training, participate in two competency building workshops (6 and 12 months after the initial training), provide CPP, and receive feedback through supervision and consult calls over an 18-month period. After an agency has completed the CPP LC, they may apply for CAMP, in which they identify a team of CPP trainers within their agency to train new CPP providers (with oversight from CPP mentors). Several organizations offer endorsed CPP internship programs, which are structured as 1- to 2-year training programs for students in a mental health field who have completed their graduate coursework.

Implementation

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

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

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

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

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

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

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

Prevention Caseloads: Therapists serve 8-12 families at a time.

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were CPP services referred to and initiated in a timely manner?
2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in CPP (service referral, initiation, dosage, and completion)?
3. Were families who received CPP less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received CPP less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

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

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

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

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

Sampling and Analysis

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

Limitations

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

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

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

Dissemination

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

Triple P

Rated: Promising

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

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

Program Selection and Outcomes

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

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

Service Description and Training

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

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

Sessions are parent-driven, with some child involvement. There are multiple parent assessments, guided participation and role plays. The model uses DVD clips, homework, behavior monitoring tools, and a parent handbook. The 5 Core Principles are:

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

All Triple P-Standard practitioners must complete a 3-day training program. This training covers topics including applying positive parenting strategies, identifying risk and protective factors in families, assessing child and family functioning, and making referrals. Practitioners must also

participate in a 1-day pre-accreditation workshop where they practice specific competencies associated with delivery of the model and receive individualized feedback. Then, 6 to 8 weeks later, practitioners complete a half-day accreditation workshop in which they pass a written exam and demonstrate proficiency in key competency areas. Successful practitioners come from all sectors. Minimum training requirements include a desire to learn and experience working with children and families.

Implementation

For families with an open DCYF child welfare case, Triple P is implemented through the Combined In-Home Services contract group. Combined In-Home Services helps children and caregivers involved in the child welfare system by delivering EBPs, family preservation, and crisis intervention services with timely service initiation, a completed CANS-F Family Plan for Change, and EBP model fidelity to prevent placements, support adoptions, achieve placement stability and/or reunification in support of DCYF's resilience goals. DCYF manages these process measures and proximal outcomes utilizing a performance improvement plan. DCYF measures the distal outcomes of this contract group based on the percentage of child clients without a screened-in CPS intake or removal from home 6- and 12-months following service conclusion.

Family risk factors are evaluated and may be offered Triple P for placement prevention if child behavioral issues are the primary area of concern and a primary safety issue for the family is directly related to the behavioral issues of the child. Triple P also supports if caregivers need help with their conflicting parenting decisions or to develop age-appropriate and effective discipline strategies.

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

Target Population

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

Fidelity Monitoring & Continuous Quality Improvement

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

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

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

Prevention Caseloads

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

Evaluation Plan

Research Questions

This program evaluation will answer the following research questions:

1. Were Triple P services referred to and initiated in a timely manner?

2. How did family characteristics and risk factors differ for families based on the capacity with which they engaged in Triple P (service referral, initiation, dosage, and completion)?
3. Were families who received Triple P less likely to have a screened-in CPS intake compared to similar families who did not receive the program?
4. Were families who received Triple P less likely to have a child enter or reenter out-of-home care compared to similar families who did not receive the program?

Outcomes of Interest

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

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

Outcomes will be measured during a 6-month follow-up period from date of service initiation, and at 6- and 12-months following service conclusion.

Data Collection Methods

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

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

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

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

Sampling and Analysis

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

Limitations

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

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

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

Dissemination

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

Appendix B: Tribal Practices & Cultural Adaptations

In 2020, DCYF worked with tribal nations throughout Washington state to identify high priority prevention practices that were accepted and effective in local tribal communities, that Tribes would like to see DCYF include in its revised FFPSA Prevention Plan. DCYF's Office of Tribal Relations held numerous consultative meetings with Tribes and surveyed Tribal Human Service divisions in Washington to learn about effective support programs for community members. This work yielded four notable programs: Positive Indian Parenting, Family Spirit, Healing of the Canoe, and Family Circle. Subsequently, DCYF contracted with the University of Washington's Indigenous Wellness Research Institute to conduct an evidentiary review of these four practices, in anticipation of adding some to future state prevention plans.

To address the disproportionate number of American Indian/Alaska Native children and youth experiencing out-of-home placement, DCYF published two Requests for Applications (RFA) to pilot Culturally Responsive Services for Native Families across Washington state. While the RFA provided examples of possible services the pilot could fund, we explicitly asked respondents to apply for practices they believed would be responsive to community need, be acceptable to community members, and work in their communities, even if not included in the DCYF examples. Through these solicitations DCYF partnered with Tribal Nations, Recognized American Indian Organizations and Native Serving Organizations to provide a diverse array of culturally specific services to native families. These piloted service lines include Positive Indian Parenting, indigenous home visiting services, Healing of the Canoe, language revitalization classes, Tribal Intensive In-home services, Family Spirit, Positive Parenting Program and Positive Indian Parenting Hybrid Services, the Native Youth Olympics, and tribal youth mentorship through the Credible Messengers Program. These culturally specific service lines incorporate culturally embedded teachings such as traditional child-rearing practices and address the historic impact of boarding schools, intergenerational trauma, grief, and forced assimilation of parenting practices.

These programs and others are listed below as Tribal Practices. Tribal Practices are culturally responsive services and practices suggested by Tribal Nation partners in Washington that support the well-being of Indigenous communities. According to the Administration for Children and Families Child Welfare Policy Manual, Tribes implementing Family First prevention services under a Title IV-E Agreement with DCYF may determine the practice criteria for services that are adapted to the culture and context of the tribal communities served under the agreement.

The practice criteria used to select the services below include:

- Alignment with Tribal Values: Services and/or practices must reflect and respect the tribe's cultural values and traditions, ensuring that they resonate with the community's identity.

- Measurable Outcomes: Services and/or practices must have clear, measurable outcomes that align with the Tribe's goals for family preservation and well-being.
- Healing-Centered: Services and/or practices should be designed with an understanding of trauma and its effects, promoting healing and resilience among families.
- Longevity of Practice: Preference is given to services and/or practices with a proven history of successful implementation within the Tribe, demonstrating their effectiveness and adaptability over time.

The services were selected based on two additional criteria: current implementation of these practices by various Tribes, Recognized American Indian Organizations, and Tribal/Native Serving Organizations in Washington, and the existing contracts that DCYF has in place for prevention initiatives.

To assess the effectiveness of these services, participants are asked to provide feedback before and after interventions using eight items from the Awareness of Connectedness Scale. This approach ensures that the impact of the services is not only evaluated but also celebrated within the context of the community's values.

Positive Indian Parenting

Manual: Cross, T. L. (2022). *Positive Indian Parenting. Honoring our children by honoring our traditions: A model Indian parent training manual (4th ed.).* National Indian Child Welfare Association.

National Indian Child Welfare Association. (2020). Positive Indian Parenting program fidelity checklist.

Positive Indian Parenting (PIP) draws on the strengths of traditional Indigenous child-rearing practices. It weaves together storytelling, the use of cradleboards or other traditional methods of wrapping babies, lessons from nature, behavior management techniques, and the power of praise. Recognizing the historical impacts of boarding schools, intergenerational trauma, grief, and forced assimilation, PIP empowers Native families to reclaim their heritage and embrace their rights as positive parents. The program conveys a strengths-based message: the wisdom of ancestors is a birthright for American Indian and Alaska Native (AI/AN) parents. The program is designed for parents or caregivers of any child.

PIP consists of eight sessions:

- Traditional Parenting
- Lessons of the Storyteller
- Lessons of the Cradleboard
- Harmony in Child Rearing

- Traditional Behavior Management
- Lessons of Mother Nature
- Praise in Traditional Parenting
- Choices in Parenting

Sessions can be delivered individually to parents or in groups of 4-20. Introductory home visits with participating parents occur prior to starting the program, fostering a supportive environment where families can share and learn from one another.

Currently, PIP is being implemented by organizations such as the Lummi Nation, Volunteers of America Western Washington (VOAWW), and the American Indian Community Center. PIP may be delivered separately to target audiences with specific needs, such as: fathers, mothers, teen parents, grandparents, and parents with substance abuse issues. Expected outcomes include:

- Reduction in the number of AI/AN children who are placed into out-of-home care
- Improved family strengths and resiliency
- Reduction in the number of screened-in intakes among native families
- Increased service engagement by AI/AN families participating in prevention services.

Providers of PIP complete a three-day training (17 hours) offered virtually or in-person and have the support and encouragement of NICWA staff while they learn, during program development and program implementation.

Fidelity monitoring is implemented by Tribes or the contracted provider utilizing the Positive Indian Parenting program fidelity checklist.

Pilimakua Family Connections Program

The Pilimakua Family Connections Program is designed for Urban Indigenous Communities, providing essential support in families' homes. This program focuses on the physical, social-emotional, cognitive, and cultural health of Native American families with expectant babies, new infants, and young children. By addressing the challenges of racism and colonization, it aims to empower families and strengthen the bonds between parents and their children.

At the heart of the program are home visits, where families receive regular support from home visitors. These visits, which can occur weekly, biweekly, or monthly, offer a chance to discuss parenting topics, engage in activities, and create a safe space for sharing experiences and challenges. The program also features structured parent groups, bringing Indigenous parents and caregivers together to connect and learn from one another. These gatherings foster a sense of community and provide valuable support. Additionally, community connection events allow families to participate in cultural activities that promote child development while celebrating Indigenous heritage. Home visitors also assist families in accessing various resources, including basic necessities, cultural support, and mental health services.

Clients are served from the prenatal period through the child's third year of life (28 weeks pregnant to three years old) and identify as American Indian/Alaska Native/Native Hawaiian/Pacific Islander.

Providers of Pilimakua Family Connections Program are trained in Family Spirit and use an Indigenous Centered Holistic Curriculum. Program vision and goals are:

1. Relationships: Connected to Vision Goals: Relationships Rooted in Indigenous Joy & Healing, Interdependence
2. Resource & Community Connection: Connected to Vision Goals: Abundance & Generosity, Community Connections, Interdependence
3. Reciprocal Knowledge Sharing: Connected to Vision Goals: Reciprocal Knowledge Sharing, Interdependence, Indigenous-Centered Holistic Curriculum

Home visitors work with up to five families at a time.

Healing of the Canoe

The Healing of the Canoe curriculum is a life skills and substance abuse prevention curriculum for use with tribal youth. It was designed to be adapted by tribal communities using their unique tribal traditions, practices, beliefs, values and stories to teach youth the skills they need to navigate life's journey, and to promote a sense of belonging to their tribal community. The curriculum consists of 14 sessions and uses the Pacific Northwest Tribal Canoe Journey as a metaphor for life. Community adaptation committees made up of community members, youth, and Elders worked for a number of months to incorporate each Tribe's specific values, teachings, stories, and practices into the curriculum. Cultural activities and speakers from the community are woven into each session.

The following are the fourteen sessions of Healing of the Canoe, provided to 8-10 families per group:

1. Four Seasons and Canoe Journey Metaphor
2. Who I am: Beginning at the Center
3. How Am I perceived?
4. Community Help and Support
5. Moods and Coping with Emotions
6. Staying Safe: Suicide Prevention
7. How Can I help? Suicide Intervention
8. Who Will I Become? Goal Setting
9. Overcoming Obstacles: Solving Problems
10. Listening
11. Effective Communication: Expressing Thoughts and Feelings
12. Safe Journey without Alcohol and Drugs
13. Strengthening our Community

14. Honoring Ceremony

Healing of the Canoe may be adapted by the Healing of the Canoe facilitator to meet the needs of a participant's individual culture, values, beliefs and traditions. Participants will receive weekly in-person or virtual check-ins lasting 30-60 minutes in duration between weekend retreats. This program is currently being provided by the Healing of the Canoe model developer SaltFire Training Center to youth and their families for substance use prevention but can be adapted for various target populations.

The program recommends at least two facilitators (similar to teachers), one female and one male, as well as a Youth Peer Educator. They need to be people who are trusted by the community and the youth. Training includes a 4-day hosted conference, one-on-one technical assistance, and support for adaptations. The Healing of the Canoe Curriculum Training Manual provides an evaluation guide for Tribes to determine their own outcomes and evaluation methods.

Credible Messengers

Credible Messengers (CM) are implemented as part of the Multisystemic Therapy-Family Integrated Transitions Program (FIT), which serves youth ages 12-17 and/or parents under court supervision. The CM-FIT Program is rooted in both modern therapeutic practices and tribal values, specifically utilizing "credible messengers" who are meaningfully connected to the Tribal community. These mentors, who have lived experience in the justice system, understand the unique needs of the youth and families they serve and reflect the same cultural background. FIT integrates elements from three programs—Multisystemic Therapy (MST), Dialectical Behavior Therapy, and Motivational Enhancement Therapy —with MST providing the foundation. The program tailors treatment goals to each youth's individual risk and protective factors within their natural environment, including family, school, and community settings.

CM-FIT works to build effective, culturally responsive relationships between caregivers and key systems, such as schools, community supports, and parole services. Mentors provide coaching to caregivers, helping them develop skills for advocacy and establishing productive partnerships. The program's interventions also include strategies that promote emotional, cognitive, and behavioral regulation, rooted in both therapeutic techniques and Indigenous practices of healing and community engagement.

There is a connection between the historical wounds to Native people and community violence. There cannot be justice without healing. Quinault Indian Nation is committed to healing the historical wounds to their people to promote community peace. The program, implemented over 6 months, begins with 2-3 sessions per week and reduces to once a week as families stabilize. Mentors are available 24/7 for crisis support. CM-FIT is led by Credible Messenger Mentors from the Quinault Indian Nation, who are trained in conflict resolution, domestic violence awareness, and the CM-FIT model. These mentors are closely supervised by the University of Washington's School of Social Work.

Outcomes of the intervention include reducing out-of-home placements, lowering delinquency rates, improving youth mental health, strengthening family supports, enhancing educational opportunities, and increasing pro-social behaviors among youth. Fidelity is monitored through the FIT Fidelity Questionnaire, administered at three key points during the program, and each mentor works with up to 7 participants at a time.

Triple P Positive Indian Parenting Hybrid

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

Cross, T. L. (2022). Positive Indian Parenting. Honoring our children by honoring our traditions: A model Indian parent training manual (4th ed.). National Indian Child Welfare Association.

This adaption specifically serves Indigenous elders raising teenagers and youth, integrating the principles of Triple P (Positive Parenting Program) with the traditional approach of Positive Indian Parenting (PIP). By combining these methods, parents, caregivers, and youth actively develop healthier relationships through enhanced communication and effective limit-setting.

Recognizing the importance of cultural beliefs for many tribal members, the program builds upon these values within the Positive Indian Parenting curriculum. The hands-on strategies of Triple P promote clear communication and foster a deeper understanding of behaviors. This adaptation aims to blend Triple P concepts with the traditional practices of PIP, facilitating a shift among parents, caregivers, and youth that cultivates more positive and respectful relationships.

The program target population is for elders raising youth ages 12-18. Encounters are 1.5-2-hour sessions, 1-3 times per week, biweekly, or monthly, over a 12–24-week time frame depending on the corresponding service delivery steps below:

Step 1: Engagement Activities

a. Review referral information and contact family within three (3) business days of receiving complete service referral
b. Meet face-to-face 1-3 times weekly to establish trust and relationship with the family, and when applicable, engage in crisis stabilization
c. Complete Child and Adolescent Needs and Strengths-Family (CANS-F) Assessment within twenty-one (21) calendar days of initial in-person meeting to develop family goals, and evaluate family strengths and needs; Send CANS-F Assessment to the DCYF Social Service Specialist/ beda?chelh within seven (7) calendar days of completion

Step 2: Family Stabilization

a. (For DCYF/ beda?chelh involved families, collaborate with DCYF/ beda?chelh on initial assessment and related action steps
b. Meet face-to-face a minimum of one (1) time weekly with family

c. Utilize PIP/Triple P modules as a service tool for implementation of action steps to address the family's needs, reduce stressors, increase family wellness, and assist in completion of goals

Step 3: Conduct follow-up encounters that include:

a. A transition plan for the family, which shall include the provider's recommendations to the family for additional services so that the youth and family may maintain changes and improve family functioning
b. Review cultural and community connections with the family
c. Collect the family's perspective of changed
d. Complete end of intervention CANS-F Assessment and send completed assessment to DCYF/ beda?chelh within seven (7) calendar days of completion

Clinicians work with up to seven families at a time.

High Fidelity Wraparound

Manual: 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 handbook for administrators and managers*. National Wraparound Initiative.

Wraparound is a family-centered approach that supports families with complex emotional and behavioral needs through individualized, strengths-based care. It involves a collaborative team of family members and professionals who create personalized plans that integrate tribal resources in the context of cultural values. The goal is to empower families, promote resilience, and achieve measurable positive outcomes for the child within their community through 10 principles:

1. Family Voice & Choice
2. Team Based
3. Natural Supports
4. Collaboration
5. Home and Community Based
6. Culturally Responsive
7. Individualized
8. Strength Based
9. Outcome Based
10. Unconditional

The provider begins with a voluntary intake to gather general information and discuss the client's goals for the program. After screening for eligibility, the client will assemble a support

team of caring individuals, such as family, friends, or social service providers, who will help identify strengths and work toward achieving the client's goals. The team will regularly check in on progress and reevaluate goals, and once the client is satisfied with their outcomes, a final meeting will be held to discuss the completion of the Wraparound Program.

Training is recommended for providers implementing Wraparound. The National Wraparound Implementation Center provides training, written protocols, assessment tools, and implementation support to states, sites, and organizations implementing Wraparound. Following training, providers may go through an apprenticeship phase where they observe a peer or supervisor implementing Wraparound, practice implementing Wraparound while being observed, and receive coaching feedback and skill assessment. Education requirements are determined by the Tribe implementing Wraparound and the specific role. High fidelity wraparound is currently being implemented by the Puyallup Tribe of Indians.

Transition to Independence Model

Manual: Clark, H. B., & Huntsman, C. (2017*). TIP Model manual - Part one & Part two*. Stars Behavioral Health Group.

The Transition to Independence Process (TIP) Model was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to: a) engage them in their own futures planning process; b) provide them with accessible, developmentally appropriate, non-stigmatizing, culturally competent, trauma-informed, and appealing services and supports; and c) involve the young people, their families (of origin or foster), and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals. Youth and young adults are guided in setting and achieving their own short-term and long-term goals across relevant Transition Domains, such as: employment/career, educational opportunities, living situation, personal effectiveness/well-being, and community-life functioning. The TIP Model is operationalized through seven Guidelines and their associated Core Practices that drive the work with young people to improve their outcomes and provide a transition system that is responsive to them and also to their families.

The goals of the program include:

- Increasing engagement and progress in high school, post-secondary education, and/or technical/vocational training
- Increasing exploration, placement, and progress in employment and careers
- Improving stability in living situation in safe, home-like settings

- Learning relevant life skills for functioning in home, school, work, and community settings, including problem solving & decision making
- Improving emotional coping and self-management skills
- Decreasing interference from mental health and/or substance use problems with their functioning in their school, work, community, and/or relationships
- Improving interpersonal skills and expanding relevant social supports
- Decreasing crisis placements, restrictive residential facilities, homelessness, and involvement with the criminal system and incarceration
- Increasing competence and confidence in continuing to advance their life and future

The TIP Model training and implementation services are provided on-site usually with three site visits per year over a 2-year period (typically 3-days for each site visit), with periodic, interactive teleconference consultation services. However, the training/implementation plans are tailored to match the needs of the agency/collaborative for TIP Model sustainability.

The Yakama Nation adapted the TIP Model to better align youth with their cultural values. Key changes included adding the Yakama's 9 virtues to the curriculum, replacing mediation with a tribally adapted motivational interviewing model, and using storytelling as a method of teaching. The program also focused on cross-agency training to build community buy-in and emphasized hands-on learning activities that promoted interdependence, rather than independence. Staff were intentionally hired for their cultural knowledge and understanding of the community. These cultural adaptations were made while maintaining the integrity of the original TIP Model, ensuring that its core guidelines, practices, and life skills domains remained intact. This approach helped create a program that was culturally relevant, sustainable, and more likely to engage and benefit the Yakama youth it aimed to serve.

Fatherhood is Sacred & Motherhood is Sacred

Manual: Pooley, A. M. (2022). *Fatherhood Is Sacred® and Motherhood Is Sacred® manual.* Native American Fatherhood & Families Association.

Fatherhood is Sacred and Motherhood is Sacred (FIS and MIS) offers participants the opportunity to gain a deeper understanding of the importance of responsible fatherhood or motherhood as reflected in Native American values and beliefs. Through a series of workshops and training sessions, participants learn about effective communication, child development, and the emotional aspects of being a father/mother. These sessions provide valuable insights and practical strategies that fathers and mothers can apply in their daily lives. The program also fosters a sense of community by encouraging fathers/mothers to connect with one another, share their experiences, and build supportive networks. This camaraderie helps reduce feelings of isolation and enhances their parenting practices.

The 12-week program assists fathers, mothers and families to fully realize their potential using a culturally rich model. The program is implemented with mothers and fathers over 12 weeks. Training consists of a 3-day intensive to receive certification.

To become a facilitator, individuals must obtain certification from the Native American Fatherhood & Families Association (NAFFA) and must participate in a 3-day NAFFA FIS/MIS training. Training covers four sessions of the program each day. Facilitators should be Native American or have a good understanding of Native American culture. NAFFA highly recommends that the Fatherhood facilitator is male, and the Motherhood facilitator is female.

Cultural Resilience and Support Programs and Practices

Cultural Resilience and Support Programs and Practices play a crucial role in child welfare prevention by creating environments that prioritize community involvement, cultural identity, and holistic well-being. By addressing the unique needs of Indigenous children and families, these programs and practices contribute to healthier, safer communities so families thrive.

Training for facilitators of these services emphasizes the rich symbolism that underpin the practices and ceremonies with a focus on healing and connection. To maintain fidelity to these cultural practices, a system for monitoring how well facilitators adhere to established guidelines includes following specific steps in the rituals, using appropriate language, and respecting the timing of ceremonies. Facilitators are encouraged to seek feedback from participants, creating an open dialogue that allows clients to express whether they felt heard and understood during their experience. The services below are specifically tailored to meet the needs of the tribal members and individuals who identify as American Indian or Alaska Native, ensuring that the services provided resonate deeply with the cultural identity of those served.

Ceremonies and Rituals

Prevention programs that incorporate ceremony and ritual in order to create a connection to culture. Activities include, but are not limited to, participating in sweat-lodge ceremonies, language and song ceremonies, smudging, learning sacred dances, attending powwows and other community activities and storytelling.

Native Youth Olympics (NYO)

An in-person athletic program where native youth will have the opportunity to learn traditional athletic games, practice skills such as sportsmanship and develop healthy natural and social supports.

- Encounters shall occur once weekly in King County at a location determined by the Indian Nation, for 90 minutes in duration, over a span of twelve (12) weeks
- A group of ten (10) qualifying youth will make up “Team Washington” and will travel to Juneau, Alaska to participate in the 2025 Traditional Games Competition on April 4-6, 2025

- Qualifying youth will be selected based on their participation in practices, age eligibility (ages 11-18 years old), ability to hit minimum event heights, and their performance in the qualifying event held at the end of the 12 weeks.
- The Indian Nation and DCYF shall approve two (2) chaperones who will accompany the youth in their travel to Alaska. Chaperones will be selected from the team's coaches.
    - NYO Coaches will be required to pass background checks and attend NYO Coach Training.
- All youth and chaperone travel arrangements shall be arranged and paid for by the Indian Nation no later than 30 days in advance to the 2025 Traditional Games Competition
- DCYF approval or a new court order is needed any time an activity is in conflict with any court order or supervision/safety plan. The Indian Nation shall collaborate with the assigned DCYF Social Service Specialist to attain all necessary approval documentation for all Washington State Dependent children prior to traveling for the 2025 Traditional Games Competition in Juneau, Alaska.
- Any youth who do not qualify for "Team Washington" travel to Juneau, Alaska, will have the opportunity to attend two additional optional practices to finish out the program.

Indigenous Birthkeepers

Indigenous birthkeepers including midwife assistants, doulas, lactation support specialists, and childbirth educators, provide culturally responsive support during and after childbirth, ensuring families feel comfortable and supported in their traditions and beliefs. They embrace a holistic approach, addressing emotional, spiritual, and physical well-being while fostering community connections and access to resources. A key aspect of their care includes incorporating culturally grounded rituals and remedies, such as traditional ceremonies, herbal medicines, and healing practices that resonate with the family's heritage.

Family Circle

The Talking Circle is a significant ceremony conducted in formal and informal settings. The participants sit in a circle and pass a talking stick or an eagle feather from one to the other, always to the left. The holder of the (sacred) object is the one allowed to speak. All other participants must give their full attention to the speaker and not interrupt.

The Traditionalist opens the Circle with prayer and proceeds to talk to the people without interruption. All participants are expected to listen respectfully until the speaker is finished. All who sit within the Circle will have the opportunity to express themselves if they choose to or they may simply listen. All speakers around the Circle will be given the same respect and allowed to speak from their hearts without interruption. Family Circle is sometimes known as Talking Circle or Healing Circle. This name change does not always indicate an adaptation to a model but rather could be a mere title change made to focus on the utilization purpose of the model.

The use of a Family Circle in service delivery promotes and restores positive youth and adult mental health and well-being, sense of family and community, and holding to one's cultural traditions and values which serve as a protective factor. Family Circle can be used to deliver components of parent skills-based programs, mental health programs or substance use disorder programs.

Cultural Adaptations of Evidence-Based Services

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

Motivational Interviewing

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

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

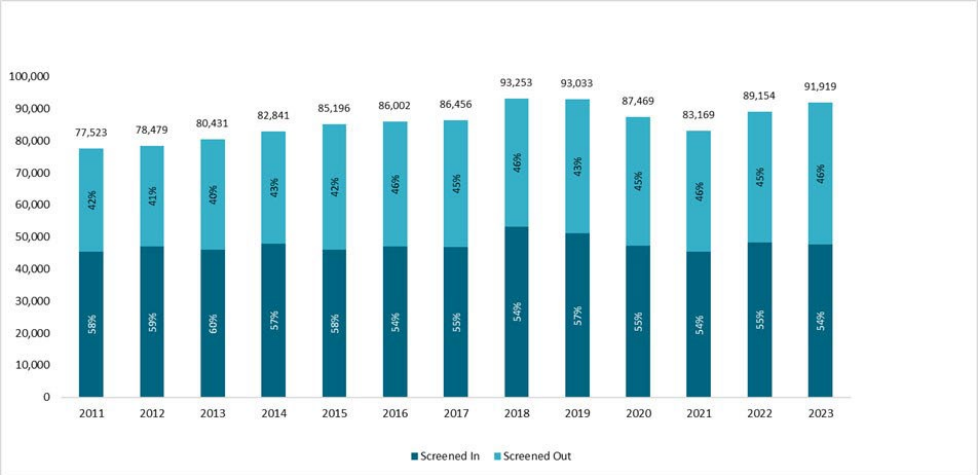
Venner, K. L., Feldstein, S. W., & Tafoya, M. (2006*). Native American motivational interviewing: Weaving Native American and Western practices: A manual for counselors in Native American communities.*

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

Appendix C: Child Welfare Data

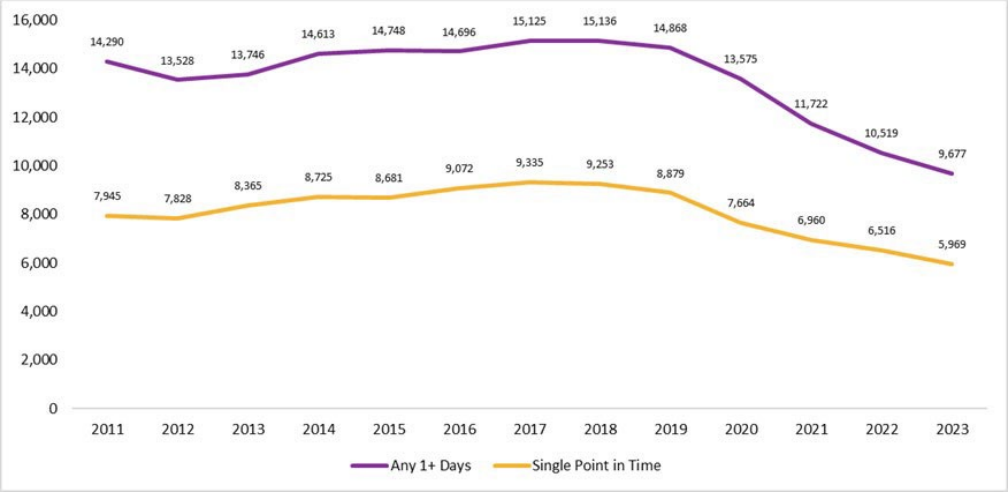
DCYF is committed to a data-informed approach when evaluating agency performance, the measurement of which is tasked to the Office of Innovation, Accountability, and Alignment (OIAA). The following data visualizations represent indicators of numerous agency strategic priorities most relevant to child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

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



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

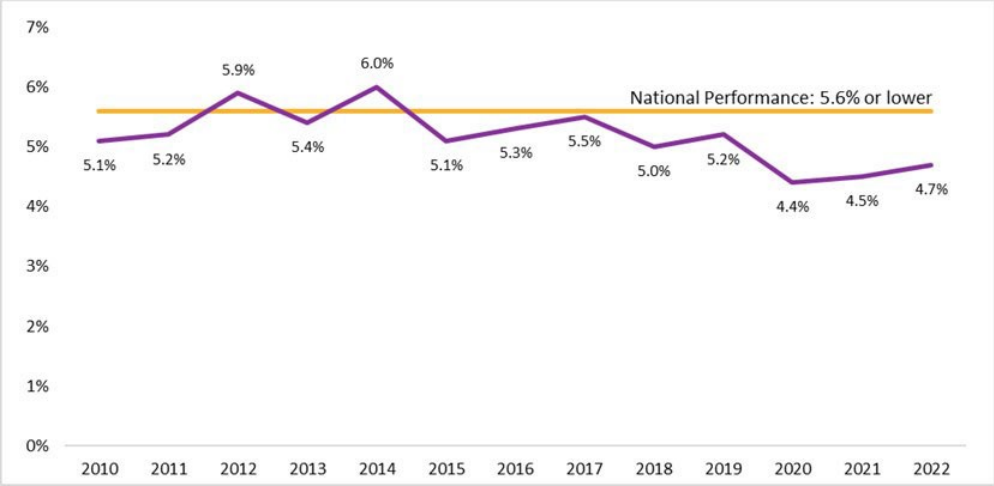
Chart 2: Children and Youth under 18 in Out-of-Home Care, SFY 2011-2023



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

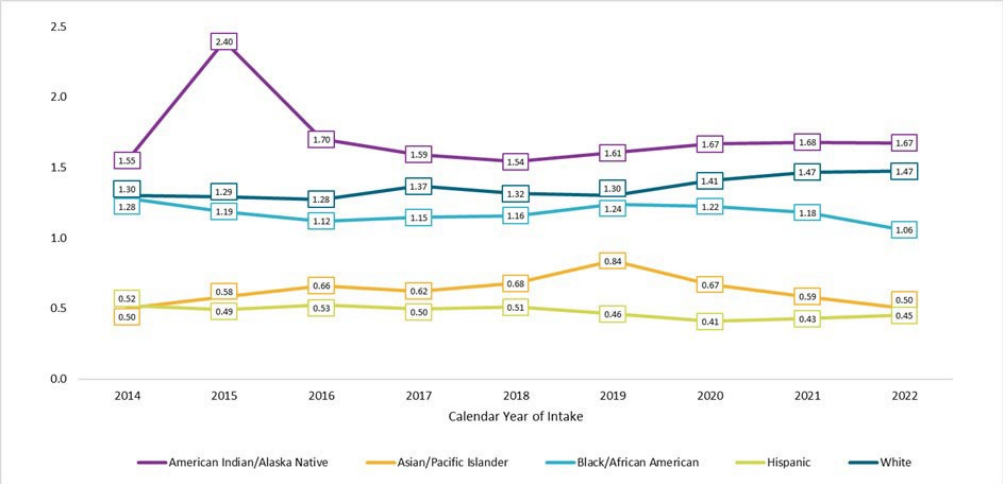
The number of children in out-of-home care has been declining since 2017. On the last day of the state fiscal year 2023, there were 5,969 children and youth in out-of-home care. At that time, 55.9 percent of all children and youth under 18 in out-of-home care were placed with kin or relatives.

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



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

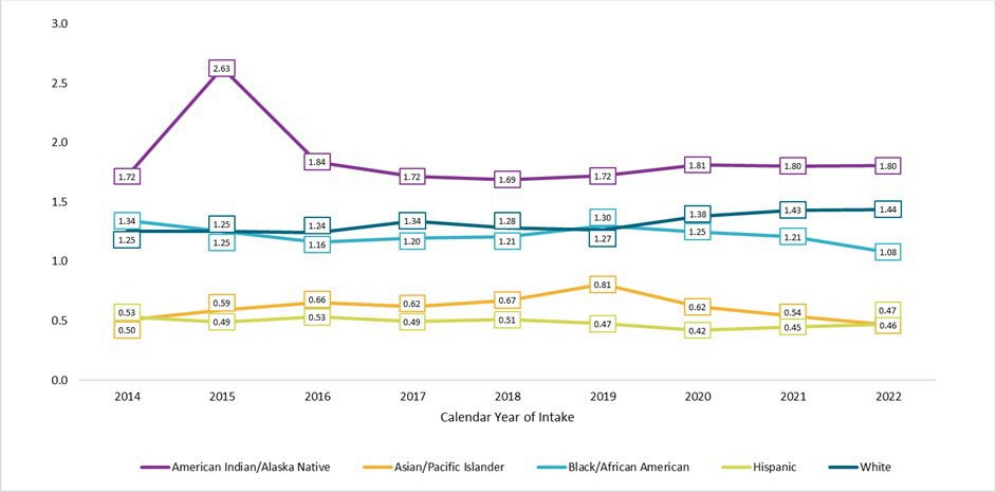
Chart 4: Racial/Ethnic Disproportionality Ratios for All Child Welfare Intakes, CY 2014-2022



Note: Proportion of intakes (screened out or screened in) for each racial/ethnic group in calendar year entry cohort, divided by proportion of each racial/ethnic group in Washington population of children under 18 living in households making 200% of the Federal Poverty Limit or less. A ratio of 1 means that the racial/ethnic group with a child welfare intake is

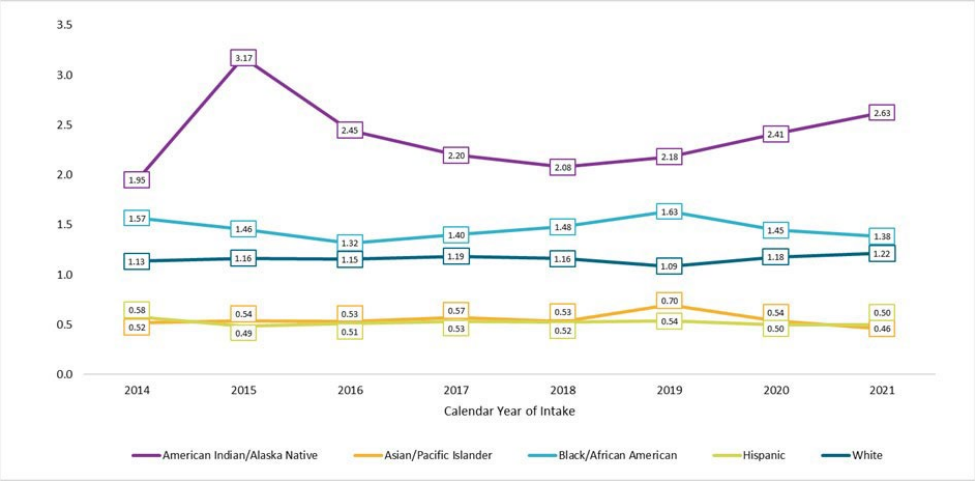
representative of its corresponding general population group; ratios higher than 1 indicate overrepresentation in intakes.

Chart 5: Racial/Ethnic Disproportionality Ratios for Screened-In Child Welfare Intakes, CY 2014-2022



Note: Proportion of screened-in intakes for each racial/ethnic group in calendar year entry cohort, divided by proportion of each racial/ethnic group in Washington population of children under 18 living in households making 200% of the Federal Poverty Limit or less. A ratio of 1 means that the racial/ethnic group with a screened-in intake is representative of its corresponding general population group; ratios higher than 1 indicate overrepresentation in screened-in cases.

Chart 6: Racial/Ethnic Disproportionality Ratios for Child Welfare Removals, CY 2014-2021

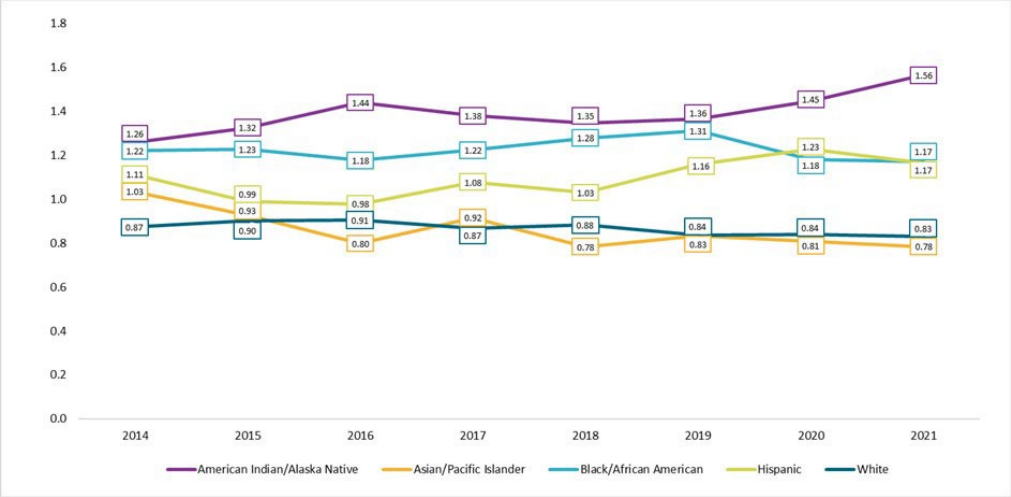


Note: Proportion of each racial/ethnic group in calendar year entry cohort who are removed and placed within 12 months of intake, divided by proportion of each racial/ethnic group in

Washington population of children under 18 living in households making 200% of the Federal Poverty Limit or less. A ratio of 1 means that the racial/ethnic group with child welfare removals is representative of its corresponding general population group; ratios higher than 1 indicate overrepresentation in removals.

Charts 4-6 illustrate the racial disproportionalities at each decision point in child welfare. American Indian/Alaska Native, White, and Black/African American children are overrepresented in child welfare at all points, from intake to removal. Overall, these trends have not changed in the last 10 years, however the magnitude of disparity at which AI/AN children are removed from the home has increased since 2018. Much of these disproportionalities in placement are attributable to disproportionalities at intake.

Chart 7: Racial/Ethnic Disparity Ratios for Out-of-Home Care Placements within 12 Months of Intake, CY 2014-2021



Note: Proportion of placements for each racial/ethnic group in calendar year entry cohort, divided by proportion of intakes for each racial/ethnic group in calendar year. A ratio of 1 means that there was no change between decision points of intake to out-of-home placement; ratios higher than 1 indicate that the group proportion has increased. An increase means that other racial/ethnic groups have exited the system to a greater extent by this point and is a sign of disparity.

In the five most recent years of data, American Indian/Alaska Native, Black/African American, and Hispanic children have been placed in out-of-home care in higher proportions than White or Asian/Pacific Islander children. This disparity has increased for American Indian/Alaska Native children since 2018.

Appendix D: Kinship Navigator-Washington Case Management Model

Non-Reimbursable Services

First Level: Information and referral services for short-term needs that can be addressed without follow-up. (Part of the Kinship Navigator Program, not WCMM.)

Second Level: Case coordination for minimal needs, such as connecting caregivers with basic resources like food or clothing. (Part of the Kinship Navigator Program, not WCMM.)

Reimbursable Washington Case Management Model (WCMM)

Third Level: Case management for more complex needs, which involves long-term support, coordination across multiple services. A case management cycle is made up of an intake with completion of the kinship caregiver needs assessment and goal setting, followed by time specific follow-ups. Once a case management cycle is opened with a baseline assessment, all time and nonfederal money is recorded for reimbursement. (This is the only service level that falls under WCMM.)

Clarification of the WCMM

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

Service Coordination and Eligibility for Reimbursement

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

Target Population and Service Area

The WCMM is currently available in 12 counties with plans to expand statewide and may include tribal kinship navigator programs in Washington state, supporting both formal and informal kinship caregivers—relatives and others raising children when parents are unable to do so. The program provides services to both rural and urban communities. Currently, there are an estimated 50,000 children living with relative caregivers in Washington according to the Annie E. Casey Kids Count Data Center.

Plans to implement:

The WCMM program connects caregivers with trained Kinship Navigators who provide tailored services based on the caregiver's self-identified needs. Using WCMM guidelines, the Kinship Navigators help families apply for state and federal benefits and provide information and referrals for services to meet identified specific needs. Overall, the WCMM program aims to help kinship care families achieve greater stability and self-sufficiency and keep children out of the foster care system. It also supports families involved in the child welfare system, promoting placement stability and increased permanency.

Service coordination with other states or local agencies:

DSHS contracts with local Area Agencies on Aging and Tribes to provide WCMM services and coordinate with other state or local programs. The services provided by the AAA's, their subcontractors, Tribes and WCMM include all three service levels including: information and assistance and referral services, case coordination, and case management. Only those kinship families participating in an open case management cycle of the WCMM program are eligible for IV-E reimbursement. Kinship Navigators are knowledgeable about local resources that may include food banks and pantries, clothing resources, utility resources, respite services, and community events.

The goal is to help kinship care families move towards greater stability and self-sufficiency to keep their children out of the foster care system. The program can serve kinship care families involved in the child welfare system with a goal of moving toward placement stability and increased permanency. To promote stability, kinship navigators through in person meetings, phone calls, and e-mail provide kinship care families with assistance in applying for state and federal benefits including programs such as TANF, Non-Needy TANF, SNAP, and WIC, as well as providing information and referrals for services to address their specific needs. These services promote knowledge and awareness of available resources for health, financial, legal, and other support services, such as local support groups, kinship closets, legal clinics, and free family recreational passes.

In addition to providing information and referral services, kinship navigators also help to reduce barriers faced by kinship care families through problem solving and collaboration with public, private, local, and state service providers.

Consultation with Kinship Caregivers and Community Organizations

The development and operation of the program are informed by ongoing consultation with kinship caregivers, youth raised by kinship caregivers, and community partners. The Kinship Care Oversight Committee (KCOC), created by legislative mandate, plays a critical role in this process. KCOC includes caregivers, youth, representatives from government agencies, and community-based organizations. The committee provides feedback on program policies, practices, and services, ensuring they align with the needs of families. KCOC also serves as a

forum for sharing information about policy changes and local initiatives and promotes collaboration between state agencies and community groups to improve service coordination.

This consultation process ensures that the program remains responsive to the evolving needs of kinship caregivers and the children they support, fostering a strong partnership between state programs, local communities, and the families they serve.

Appendix E: Attachments

Attachment I: Prevention Program Reporting Assurances

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

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

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