Arkansas Title IV-E Prevention Program

Five-Year Plan: 2020-2024 R. 05/2022

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I. Forward

a. **Acronyms and Definitions:**

ARBEST: Arkansas Building Effective Services for Trauma is a state funded program at the University of Arkansas Medical Sciences, Psychiatric Research Institute.

CACD: Crimes Against Children Division – A division of the Arkansas State Police that investigates most Priority 1 (generally severe maltreatment) investigations.

CEBC: California Evidence-Based Clearinghouse

CHRIS: Arkansas's current SACWIS system

DCFS: Division of Children and Family Services

D.R.: Differential Response is an alternative response to allegations of child maltreatment. There is no investigation or investigative finding. D.R. is designed to engage families in order to connect them to formal and informal community supports and services. D.R. aims to safely reduce the number of children entering foster care and prevent future occurrence of child maltreatment.

EBP: Evidence-Based Practice

FSW: Family Service Worker – The FSW is the frontline DCFS staff. They can work ps cases, ss cases, fc cases, and investigations; however, DCFS often refers to FSW's who work investigations as investigators. FSW and caseworker are used interchangeably.

FFPSA: Family First Prevention Services Act (also referred to below as "the Act" or Family First)

The Hotline: The Child Abuse and Neglect Hotline receives all allegations of child abuse/neglect and decides if they meet the requirements for an investigation, a DR, or are screened out (screened out referrals are documented, but not sent to anyone). The hotline also determines if the allegations are a Priority 1 or 2 and if they go to DCFS or CACD. The Hotline is run by the State Police.

Priority 1: certain allegations of child abuse/neglect that require a 24-hour response time to see the victim children face to face.

Priority 2: certain allegations of child abuse/neglect that require a 72-hour response time to see the victim children face to face.

PS Case: Protective Services Case – A case opened due to an investigation with a true finding. These are in-home cases with no removal.

SS Case: Supportive Services Case – A case opened through an avenue other than a true finding on an investigation. These cases are "voluntary" on the part of the parents (examples: a parent requests services, a Judge orders DCFS to provide services through a FINS case, an investigation is unsubstantiated, but the family agrees to services, a family involved with DR needs services past the DR time frame.)

True Finding: An investigation has been completed, and it is determined there is a preponderance of evidence to support the allegation of child abuse/neglect.

Unsubstantiated: An investigation has been completed, and it is determined there is not a preponderance of evidence to support the allegation of child abuse/neglect.

b. **Introduction**

In 2016, Arkansas was in crisis. There were alarmingly high numbers of children in care, unmanageable caseloads, and a lack of fundamental supports for families and child welfare staff. The Division set out on an aggressive but strategic plan to tackle a growing crisis in its child welfare and foster care system.

First, Paul Vincent, the Director of the Child Welfare Policy and Practice Group, was asked to complete a review of the Arkansas Department of Human Services (DHS), Division of Children and Family Services (DCFS). His report was released in July 2015 and included ten recommendations to help the Division respond to the crisis and create a stronger child welfare system. Then, DHS pulled together staff from across the agency in addition to child welfare experts and stakeholders to help DCFS address the foster care crisis and how to implement the recommended changes.

In Phase One, outlined in the Division's first annual report *Moving Beyond the Crisis*, DCFS identified the key systemic issues and a plan for triage. By September 2017, the number of children in foster care had stopped rising, caseloads had declined, and families felt more supported. It seemed that the crisis had peaked, but there was still more work to be done.

Phase Two began with the release of a report called *Renewed Hope*. This report focused on three key areas of improvement: (1) Strengthening families so children can remain safely at home and families are more resilient, (2) Improving the foster care system so that it is stable for those who need it, and (3) Building, supporting, and empowering a strong DCFS workforce. *Renewed Hope* was designed to begin laying the groundwork for long-term, positive, and sustainable improvements.

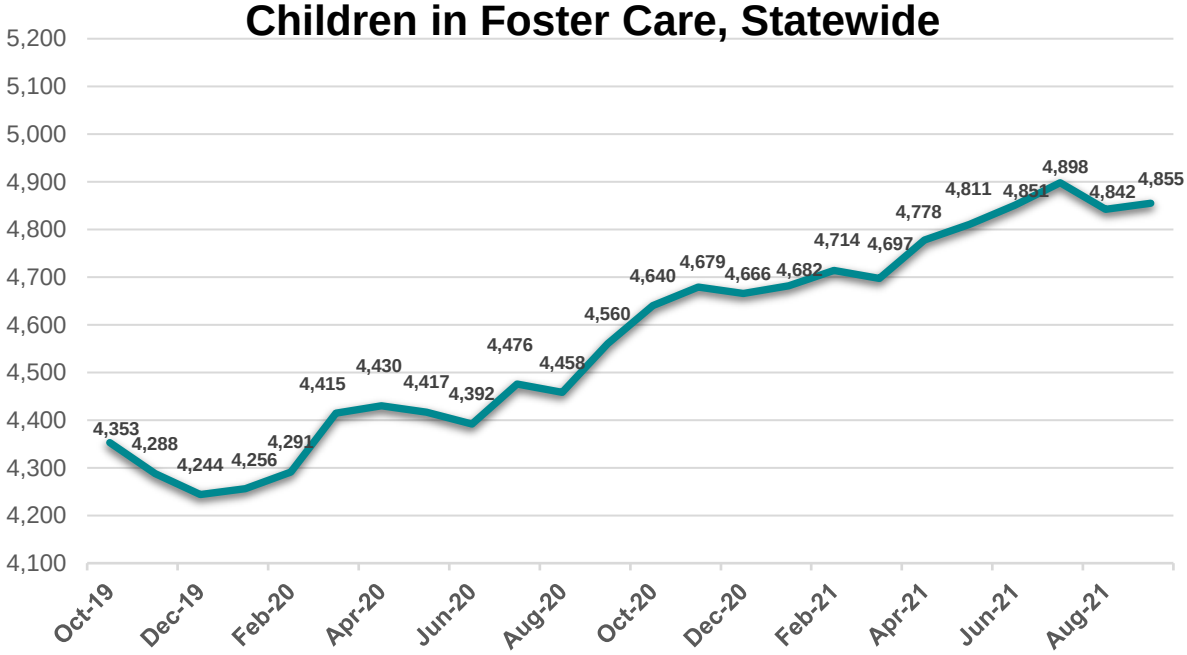
DCFS began Phase Three in 2019 with a continued focus on the three overarching buckets of focus. Though not all goals were achieved, the Division made significant progress. Below are just some on the gains DCFS has made between 2016 and 2019.

- The average caseload for a frontline worker decreased from 28 cases in 2016 to 18.7 in June 2019.
- The number of overdue child maltreatment investigations is down from 721 in 2016 to 112 in June 2019.
- The number of children in foster care in Arkansas dropped from 5,196 in late 2016 to 4,327 today, a 17-percent decline and the lowest since the crisis response began.
- The percentage of children who are placed with relatives increased from 23 percent in 2016 to 30 percent in the fall of 2019.
- The percentage of children placed in family-like settings is up from 78 percent in 2016 to 87 percent in the fall of 2019.
- The ratio of foster home beds to children in care is up from 0.69 in 2016 to 0.81 in the fall of 2019.
- DCFS established a Central Office Prevention and Reunification Unit that was fully staffed by 2018 thanks to more positions and funding approved by Governor Asa Hutchinson and the State Legislature. This unit provides support, training, coaching, and technical assistance to field staff for Differential Response (DR), Investigations, and In-Home cases. The unit also focuses on family reunification once a child is in foster care and places an intense focus on building families up so that their children never need to come into foster care.
- The Division created the Parent Advisory Council in June 2019 to help the Prevention and Reunification Unit:
    - Build partnerships between parents and staff;
    - Promote parent leadership development;
    - Help expand the meaningful roles of parents throughout the system;
    - Ensure strong parent voices are included when developing programs, services, and strategies.

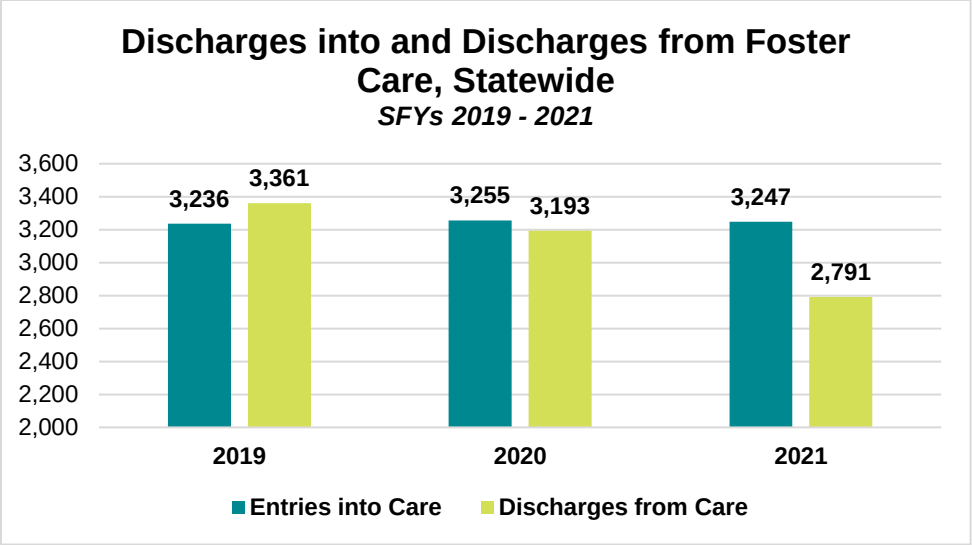
All the work the Division achieved was underpinned by the DCFS value that children do best in families, and every child deserves a safe, stable, and nurturing family every day. Due to the hard work that occurred between 2016-2019, the Division found itself in a strong position to implement the Family First

Prevention Services Act (“Family First” or FFPSA) on October 1, 2019 as it was already in line with its vision and goals.

When the COVID-19 pandemic hit, however, the number of children in foster care began to increase. As of December 1, 2021, there were 4,814 children in foster care. Once again, this increase in the number of children in foster care is not tied to higher-than-average entries into foster care. Rather, the challenges with discharging children from care during the public health emergency -- when staff and clients were frequently quarantined, and services were often delayed or interrupted for a variety of reasons tied to the COVID-19 pandemic – are contributors in this regard. The graph below shows the increase of number of children in foster care over a portion of the pandemic and the graph on the following page compares entries into and exits from foster care over the last three state fiscal years.

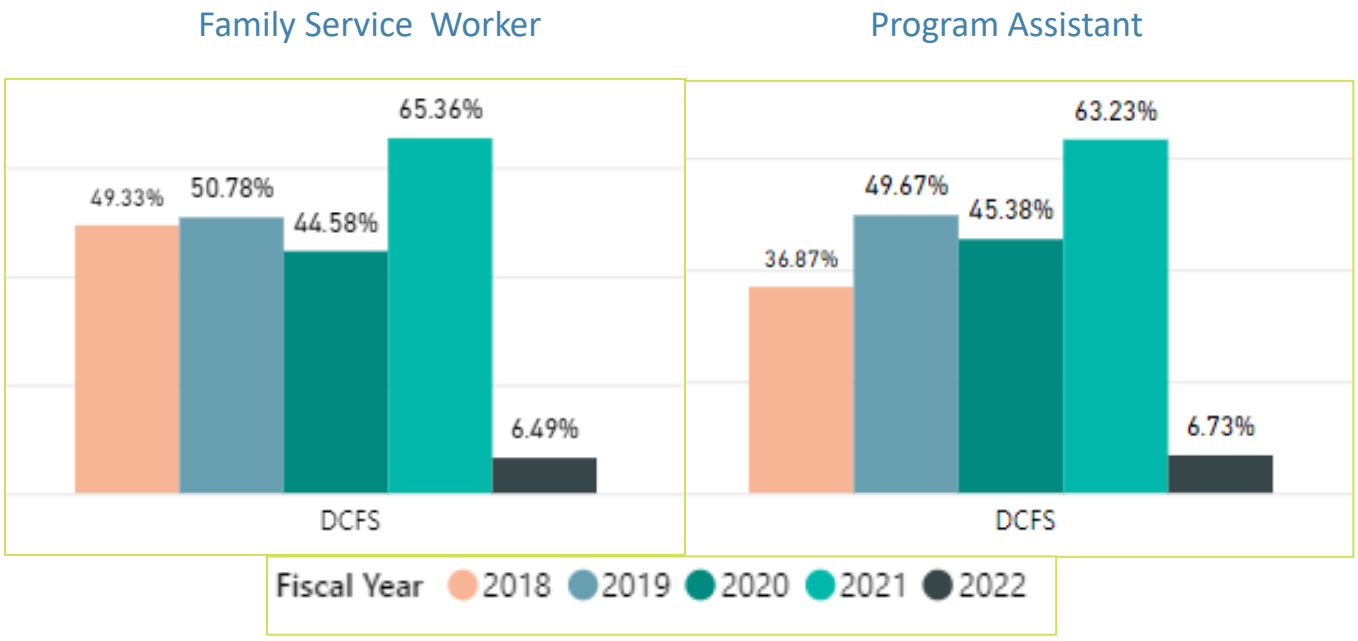


The blue line above represents the number of children in care at the end of each month.



The challenges of the public health emergency and the rising number of children in foster care, among other reasons, have also seemingly led to a higher degree of staff turnover and a corresponding increase in the average statewide FSW caseload. In SFY 2020, the overall turnover rate for all DCFS staff was 39.7% whereas the SFY 2021 turnover rate to date for all DCFS staff rose to 56.52%. This rate includes terminations, demotions, promotions, and transfers.

More tellingly, the SFY 2020 turnover rate specific to Family Service Workers (FSWs, a.k.a. caseworkers) was 44.58%, but rose to 65.36% in SFY 2021 for FSWs. Similarly, the SFY 2020 turnover rate for Program Assistants (support level staff who frequently provide transportation for clients, supervise parent-child visits, conduct drug screens, etc.) was 45.38%, but increased to 63.23% in SFY 2021 as illustrated on the graph below.



Not surprisingly, the increased rate of staff turnover has led to a significant number of vacancies at any given time throughout DCFS as staff go through the hiring process. As of January 25, 2022, there are approximately 190 vacant positions throughout DCFS, which impacts the rate at which children discharge from state custody. The high number of vacancies at any given time over the last year-and-a-half have also been compounded by the number of staff who have not been able to fully complete their job duties while on quarantine due to being positive for COVID or having been exposed to COVID. As of October 15, 2021, 1,325 DCFS staff had been quarantined at some point. More recently, from December 27, 2021-January 24, 2022, approximately 200 DCFS staff, or almost 10% of the workforce, tested positive for COVID. When considering that quarantined staff cannot, for example, conduct home visits, supervise parent-child visitation, or provide transportation that number – more than the total number of DCFS staff at any given time – is staggering.

Despite the COVID-19 pandemic and staffing challenges, DCFS has held strong in many areas. For instance, the percentage of children placed in a family-like setting has remained relatively study at approximately 87%-88% since 2019 to the present. As another example and in spite of recent challenges, the Division has increased the number of children in foster care placed with relatives from 30% in the fall of 2019 to 41% as of January 31, 2022. Finally, DCFS has continued to expand some of the services rolled out in 2016 and increased access and quality of existing services as described below.

Expanding Programs and Services:
In recent years, DCFS started several programs that use a team-based approach to determine the safety and permanency of children who interact with the child welfare system that engage families in ways that were not common in the state's system prior. To ensure these programs would result in stronger families and be better for Arkansas children, DCFS limited the scope or reach of these programs to certain areas or types of cases. Now DCFS is ready to expand those programs with the overall goal of preventing future maltreatment and increasing the family's capacity to care for children safely at home (and thereby preventing the need for foster care intervention). Those programs include: Team Decision Making, SafeCare, and Nurturing the Families of Arkansas.

Creating new programs to ensure parents have access to services:
DCFS continues to see a need for more intensive and one-on-one programs that can provide parents with concrete steps and information that will lead to thriving parents and long-term family stability. DCFS launched two new programs at the end of 2018 and beginning of 2019.

Baby and Me WIC clinic project launched on October 1, 2018. The Director of the Children's Trust Fund, which is part of the Prevention and Reunification Unit, worked with the Arkansas Department of Health to develop this program for pregnant women and new moms who are getting services through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). When the women visit a WIC clinic to receive or renew their benefits, a trained parent support mentor will provide one-on-one sessions that will include a brief health and safety lesson, a check of the baby's developmental milestones, and activities that promote parent-child bonding. The topics covered in the curriculum were selected because they are closely related to the leading causes of infant death and injuries in the state. The seven modules of the program include:

- Safe Sleep Practices
- Dealing with Infant Crying
- Importance of Routines
- Handling Stress and Depression
- Home Safety

- Preparing for Discipline
- Understanding Developmental Milestones

Parents are also connected to community services and supports as needed and receive diapers and wipes for each module of the program they complete.

The pilot started in 6 counties and has now grown to 14 counties. The project is being evaluated through a contract with the Department of Family and Preventative Medicine, Research, and Evaluation Division at UAMS.

Intensive In-home Services is a new program to help prevent placing kids in foster care or get them back home quickly and safely. These new services, which will be offered by DHS contractors, will focus on helping stabilize families for the long-term instead on the immediate crisis of the moment. The goal is to safely reduce the number of children in care by providing in-home services.

Phase One of the effort to improve Arkansas's child welfare system was largely successful at stabilizing the system and preventing a breakdown of the system. Phase Two built upon those efforts and focused on putting initiatives, programs, and practices in place to ensure that the system and the people within and around it are stronger, stable, supported, and empowered to make smarter, more effective decisions. That work built the foundation for this past year of Phase Three and the future of child welfare in Arkansas. This solid footing, grounded in a continued emphasis on safety, permanency, and well-being for the children and families served, will allow the Division to push forward with programs and partnerships that have shown success. It also allows DCFS to try new initiatives that hold real promise for the future. With the continued support of the Governor, the Legislature, and community partners, as well as the amazing dedication and passion of DCFS frontline and support staff, the Division is poised to make a real difference in the lives of the people that it serves every day. While the Division has been making a concerted effort to increase prevention services, Family First creates an exciting opportunity for DCFS to leverage resources and expand access to evidence-based practices that would otherwise not be achievable.

II. Title IV-E Prevention Services Description and Oversight

Pre-Print Section 1

Arkansas has worked hard the past several years to build its prevention services and In-Home program prioritizing evidence-based services that meet the needs of families and help to keep kids safely in their homes. Family First offers an opportunity to continue and expand some of the existing services and expand the array of evidence-based services. Below are the programs Arkansas has identified to best meet the needs of its clients. DCFS has started this transformation with in-home parenting programs but will include Mental Health and Substance Abuse services and programs in the future as the Division expands implementation of Family First. Arkansas worked with the National Council on Crime and Delinquency (NCCD), now called Evident Change to complete the independent systematic review of each service as was necessary to claim transitional payments.

a. **In-Home Parenting**

SafeCare – SafeCare is a home visiting program with more than 30 years of research supporting its effectiveness at reducing child abuse and neglect and strengthening positive parenting skills. The parent-skill based intervention is for parents or caretakers of children ages zero to five. SafeCare is module based and delivered over 18-22 sessions. The three modules address three risk factors that can lead to

child abuse and neglect: 1) The parent-child relationship, 2) home safety, and 3) caring for the health of young children. Each module includes a baseline assessment, intervention (training sessions), and a follow-up assessment to monitor progress over the course of the program. SafeCare is trauma informed and is a clearly defined and replicable program.

DCFS has a partnership with Arkansas Children's Hospital (ACH). ACH is responsible for the provision of SafeCare in central Arkansas and through subcontracts with local providers across the state. They are supported by the National SafeCare Training and Research Center, which monitors fidelity and grants accreditation. Arkansas's SafeCare received initial accreditation in April 2019 and has continued to receive yearly accreditation since that time.

SafeCare is under the umbrella of the Arkansas Home Visiting Network; unlike other home visiting programs in the network, it is exclusively for DCFS clients and is available statewide.[1] Since its inception, Medicaid has paid for SafeCare which continues to be the case. As such, DCFS will not be requesting reimbursement for SafeCare at this time.

Current referral criteria for SafeCare includes a child who is the subject of a Garrett's Law investigation or a protective services case is open due to a true finding of medical neglect, failure to thrive, Munchausen by Proxy, or other neglect categories. If the true finding is for abuse, it requires approval from the In-Home Program Manager. As SafeCare started prior to the passage of Family First, candidacy and/or Family First eligibility was not initially included in the eligibility criteria. It was planned that it would be a requirement starting Oct. 1, 2019; however, as it was not officially approved as a claimable part of Arkansas's Five-Year Prevention Plan it was not required. Instead, workers have been encouraged to begin including SafeCare in their prevention plans when applicable to get accustomed to the prevention plan before it becomes a requirement. If and when it does become a requirement, this should not have a negative impact on referrals as a review of SafeCare clients showed that 96% of referrals met Arkansas's definition of candidacy. When DCFS assumes payment, the PIs will be changed so that SafeCare can also be provided to parenting youth who are in foster care and who do not have a true determination of maltreatment. SafeCare has now been rated by the Title IV-E Prevention Services Clearinghouse and is rated as "supported."

Positive Parenting Program Standard Level 4 (Triple P SL4) – Triple P is an evidence-based, trauma-informed in-home parenting program. While there are several versions of Triple P, Triple P Standard Level 4 is the model Arkansas is using and is clearly defined and replicable.
Triple P has now replaced Nurturing the Families of Arkansas (NFA) as the Division's evidence-based parenting program.

Arkansas had previously included, *Nurturing the Families of Arkansas* (NFA) which was Arkansas's version of the Nurturing Parenting Program, in the Five-Year Prevention Plan. This program was already state-wide and had been part of Arkansas's IV-E Waiver Demonstration Project . NFA had positive outcomes according to the state's IV-E Waiver Evaluation. However, after an independent systematic review, Arkansas was not confident that NPP could meet the level of "promising" as defined by FFPSA, which was later confirmed by the Title IV-E Prevention Services Clearinghouse's determination that NPP did not meet criteria. Arkansas DCFS partnered with, UALR MidSOUTH, its NFA provider, to determine the best course of action to best meet the needs of the children and families in need of a parenting program. Since Triple P was being reviewed by the Title IV-E Prevention Services Clearinghouse and after a review of the research, Triple P was determined to be a viable option.

[1] See Appendix A for a map showing SafeCare Coverage.

The director of the UALR MidSOUTH parenting program was sent to a Triple P training in Dec. 2019. Her feedback was that it would be a good fit for the clients served and solved some of the barriers that clients and DCFS faced with NFA/NPP. Specifically, Triple P Standard Level 4 is held in the home and not meant for group settings, which was especially a barrier in rural counties. Triple P is also shorter, but more behaviorally based which makes it easier for clients to make greater changes in a shorter period of time. Triple P also has one educator, instead of two, per family which helps with retention of staff and also increased the number of families that could be served.

All MidSOUTH parenting educators were trained in Triple P Standard Level 4. DCFS stopped taking referrals for NFA on July 1, 2020 and started taking referrals for Triple P. By Oct. 2020, no families were receiving NFA and Triple P was fully implemented statewide. Because the referral criteria is similar, and MidSOUTH already had the infrastructure in place and a relationship with county offices, the transition to Triple P was relatively smooth. Referral forms were updated and sent out to staff. Because of the COVID-19 pandemic, a series of Zoom meetings were held in July and August 2020 to introduce workers to the new program and discuss the differences between NFA and Triple P.

Triple P SL4 is for families with children ages 0-12 years who exhibit behavior or emotional difficulties. Parents receive one-on-one sessions for ten weeks. These ten sessions do not include the initial assessment, which is normally done on a prior day, but can be done at the first session if necessary. Sessions typically last about an hour. Some families need extra help and may take more than one session to do a lesson, or sessions are canceled due to reasons such as illness. Therefore, some families may stay in the program longer than ten weeks. Triple P SL4, can be provided in a clinical setting, in the home, or in a community setting according to their standards. Arkansas has stated these services will be held in the home if possible but can be held in a community setting or in an office if that is best for the family. Additionally, because of the pandemic, sessions are sometimes held virtually. Triple P SL4 sessions focus on promoting child development, managing misbehavior, and implementing planned activities and routines to encourage independent child play.

While only Triple P SL4 for ages 0-12 was reviewed by the Title IV-E Prevention Services Clearinghouse and rated as “Promising,” SL4 is also available for youth ages 13-18. MidSOUTH educators are trained in both age groups and serve Arkansas children ages 5-18. They can also serve ages 0-4 if either the parent of the 0-4-year-old is a pregnant or parenting teen or an exception approval by the In-Home Program Manager is given. Exceptions are given if the family does not meet SafeCare referral criteria (i.e., there is no true finding), or if Triple P is determined to be a better fit for the family than SafeCare. When Arkansas is approved for and begins claiming on Triple P, only cases where a child meets the FFPSA eligibility requirements and is aged 0-12 will be funded through FFPSA funds until the 13-18-year-old program is reviewed and rated.

Intensive In-Home Services – Arkansas implemented Intensive In-Home Services in February 2019 as a pilot program in 37 counties.[2] Arkansas identified a gap in its service array, for families that needed intensive services for longer than four to six weeks to help them achieve stability and maintain gains. Arkansas wanted a program that was similar to its Intensive Family Services[3], but in addition to crisis intervention, provided longer-term support to help families achieve the necessary skills and social support network to maintain long-term stabilization. Arkansas put out an RFQ with the parameters that needed to be met including length of service and expected outcomes, but requested the providers propose the evidence-based intervention used to deliver the service. Arkansas chose three providers that presented

[2] See Appendix A for a map of IIHS services.

[3] See page 10 regarding Intensive Family Services in Arkansas.

different intervention models. Below are the interventions (additional information on Intensive In-Home Services can also be found in Arkansas's 2020-2024 Child and Family Services Plan Goal 2, Strategy 4). For a family to be eligible for Intensive In-Home Services they must have an open in-home case where at least one child is a candidate for foster care or an open foster care case where intensive services is needed for reunification to be successful. While not the target population, any of the Intensive In-Home Services programs may be appropriate for a youth in foster care who are also parenting, if their needs cannot be met by Triple P or SafeCare.

YVIntercept

YVIntercept is the model developed and used by Youth Villages. It is an integrated approach to in-home parenting skill development that offers a variety of evidence-based practices to meet the individualized needs of a family and young person. Specifically, it employs the following evidence-based practices, as clinically indicated: Adolescent Community Reinforcement Approach (ACRA), Community Advocacy Project (CAP), Collaborative Problem Solving (CPS), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Motivational Interviewing. This program is a trauma informed in-home services program providing family-centered treatment with strength-based interventions. This comprehensive intervention takes a therapeutic approach to parenting skills education, educational interventions, development of positive peer groups, and extensive help for families and children in accessing community resources and long-term, ongoing support.

Family intervention specialists work with both the child and the caregivers to address issues that are impacting the stability of the family, meeting with children and caregivers a minimum of two to three times weekly depending on family need and providing families with access to 24-hour on-call support. Services are tailored to meet each family's needs, ongoing assessments and reviews measure progress throughout the intervention.

The goals of the program are to reduce subsequent maltreatment, prevent foster care placement, and reduce time in state custody by successfully reuniting children with their families in a timelier manner. The length of treatment is determined by the needs of the family and their progress. However, diversion services generally last four to six months, while reunification services generally last six to nine months.

Intercept is currently available in Alabama, Arkansas, Florida, Georgia, Indiana, Massachusetts, New Hampshire, North Carolina, Oklahoma, Ohio, Oregon, and Tennessee. Intercept was recently the subject of a rigorous evaluation by an independent third party that examined whether Intercept (1) reduced the risk of placement into foster care among children who were at risk of placement having never been in out of home care previously, and (2) affected the rate of permanency, time to permanency, and re-entry into care for children referred to the program while in foster care. Arkansas contracted with Evident Change to complete an independent systematic review in order to receive transitional payments for this service. Evident Change determined a rating of "ell-supported" for Intercept.[4] Intercept was initially rated as "supported" by the Title IV-E Prevention Services Clearinghouse but has since been rated as "well-supported" at the conclusion of a re-review. Please see Section V: Evaluation Strategy and Waiver Request for more information regarding Arkansas's requested changes to the evaluation specific to Intercept as a result of this "well-supported" rating by the Title IV-E Prevention Services Clearinghouse.

[4] See Appendix C. Attachment V: Required Documentation of Independent Systematic Review for Transitional Payments.

Youth Villages has implemented Intercept in nine counties in north central and eastern parts of Arkansas (Areas 8 and 9) and will take referrals from neighboring counties, specifically Craighead, based on need and capacity. In addition, Youth Villages began operating the Intercept Program in Pulaski County in July 2021 and is currently interviewing for staff who will run the Intercept Program in Sebastian and Crawford counties. Pulaski County (Area 6) is located in Central Arkansas, and Sebastian and Crawford Counties (in Area 2) are on the western side of the state. Area 6 and Area 2 have the highest population of foster children in the state with numbers rising during the COVID-19 pandemic. It is anticipated that Youth Villages will begin taking referrals in Sebastian and Crawford Counties in late spring 2022 once staff are hired and trained. Continued expansion of Intercept is planned throughout the remainder of 2022 and into calendar year 2023. Specific implementation counties are still to be determined. However, counties that do not currently have Family Centered Treatment (see next section below) and only have Intensive Family Services (IFS) as a DCFS-contracted, in-home service will be prioritized as Intercept expansion continues (see Intensive Family Services section at the bottom of p. 13 for more information regarding IFS in Arkansas).

There is only one version of Intercept and it is clearly defined and replicable: Goldsmith, T. (Ed.). (2007). ***Youth Villages clinical protocols treatment manual***. Youth Villages.

The Youth Villages website includes information regarding training and certification, implementation support and documentation. There is also an online clinical portal that is proprietary and accessible only to staff who are trained in the model. The document that describes this process and the online clinical portal tool can be found directly here: https://www.youthvillages.org/wp-content/uploads/2019/10/Clinical_Process.pdf.

The following are the relevant studies which demonstrates the effectiveness of Intercept:

Study 10899

Huhr, S., & Wulczyn, F. (2020a). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/10/YV-Intercept-Results-1-8-2020-final.pdf

Huhr, S., & Wulczyn, F. (2020b). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2020/09/Permanency-YVIntercept-final-982020.pdf

Study 12839

Huhr, S., & Wulczyn, F. (2021). The impact of Youth Villages' Intercept program on placement prevention: A second look. The Center for State Child Welfare Data.

Family Centered Treatment

Family Centered Treatment (FCT) is a strength-based, trauma-informed, and evidence-based family preservation model that provides services to families directly in their homes. FCT is designed to find simple, practical, and common-sense solutions for families faced with disruption or dissolution of their family.

This program follows a four-stage process of Joining and Assessment, Restructuring, Valuing Changes, and Generalization. The length of treatment is determined by the family's needs and progress, but the average length of treatment is six months. The foundations of FCT are grounded in Eco-Structural Family Therapy and Emotionally Focused Therapy. FCT is clearly defined and replicable. The Family Centered Treatment Foundation has a best practice

implementation process that allows prospective and current licensed FCT providers to identify and plan for sustainable implementation. FCT has been evaluated by the Title IV-E Prevention Services Clearinghouse and was given a rating of “supported” in a re-review of the program(Arkansas had previously contracted with NCCD to complete an independent systematic review in order to receive transitional payments for this service. NCCD had determined a rating of Well-Supported for FCT prior to the Title IV-E Prevention Services Clearinghouse rating for this program being released).[5]

The manuals used for implementation of FCT in Arkansas are:

Painter, W. E., & Smith, M. M. (2004). Wheels of Change—Family Centered Specialists handbook and training manual. Institute for Family Centered Services.

Wood, T. J. (2018). Family Centered Treatment® design and implementation guide (Revised ed.). Family Centered Treatment Foundation Inc.

The following are relevant studies which demonstrate the effectiveness of FCT.

1) Bright, C. L., Betsinger, S., Farrell, J., et all. (2015). *Youth Outcomes Following Family Centered Treatment® in Maryland.* Baltimore, MD: University of Maryland School of Social Work.
2) Bright, C. L., Farrell, J., Winters, A. M., Betsinger, S., & Lee, B. R. (2018). Family Centered Treatment, juvenile justice, and the grand challenge of smart decarceration. *Research on Social Work Practice, 28*(5), 638-645.
3) The Indiana University Evaluation Team & The Department of Child Services. (2018) Indiana Department of Child Services Child Welfare Title IV-E Waiver Demonstration Project Final Report. Indianapolis, IN: Indiana University School of Social Work and Indiana Department of Child Services.
4) Sullivan, J. P. (2006). *Family Centered Treatment: A unique alternative*. Corrections Today, 68(3).

As the initial review of Family Centered Treatment resulted in a “does not meet criteria” finding, St. Francis and Youth Advocate Program both looked into Family Check-Up as an alternative. Family Check-Up® is a strengths-based, trauma-informed, and evidence-based intervention for families with children ages 2-17. The model has three main components – 1) an initial interview that involves rapport building and motivational interviewing to explore parental strengths and challenges related to parenting and family context; 2) an ecological family assessment that includes parent and child questionnaires, a teacher questionnaire if there is a school age child, and a videotaped observation of family interactions; 3) tailored feedback that involves reviewing assessment results and discussing follow-up service options for the family. These follow up services may include clinical or support services in the community or the Everyday Parenting Program that is typically delivered by the provider. Family Check-Up® can be delivered in a variety of settings to maintain fidelity to their model, but Arkansas has stated these services will be held in the home if possible but can be held in a community setting or in an office if that is best for the family. Family Check-Up® is extremely flexible and allows for the intensity and duration of the service to be based on the family’s interest and need. Because of this flexibility Arkansas believes that Family Check-Up® can meet the requirements of its Intensive In-Home Services contract. Family Check-Up® has been reviewed by the Title IV-E Prevention Services

Clearinghouse and received a rating of “well-supported.” Youth Advocate Programs was impressed with Family Check-Up and is considering a switch to that model even though FCT is now approved. At this time, they will continue providing FCT.

St. Francis Ministries has officially implemented FCT in 15 counties in the Northern and Eastern parts of Arkansas (Areas 8, 9, and 10) but also takes referrals from neighboring counties on a case-by-case basis based on need and capacity. These counties include Jefferson, Lonoke and Prairie in Area 5 and Greene in Area 8, for a total of 19 counties served by FCT.

Youth Advocate Programs (YAP) originally implemented a different model to provide Intensive In-Home Services; however, after the results of the Independent Systematic Review, YAP switched their model to FCT. YAP offcially services an additional 13 counties in the northern and southern parts of Arkansas (Areas 5, and 4) but also accepts referrals from neighboring counties in Area 3 including Polk, Howard, Pike, Clark, and Hot Spring. They can also take cases from Calhoun, Bradley, and Lincoln in Area 7. These are on a case-by-case basis based on need and capacity. As such, YAP serves a total of 21 counties.

Arkansas may also expand Family Centered Treatment to more counties by June 2023

Intensive Family Services – Arkansas currently provides Intensive Family Services (IFS) in 20 counties. IFS is a four to six-week intensive in-home service to improve parenting skills, parent-child relationships, and prevent children from coming into foster care. IFS is delivered by six different providers across the state. Current IFS providers are not required to be accredited by or to otherwise utilize an evidence-based model. The current contract for IFS ends June 30, 2022. Arkansas plans to secure a six-month renewal for IFS through December 31, 2022, as Intensive In-Home Services continue to expand throughout the state. Counties in which IFS was the only DCFS contract-based, in-home service will be prioritized as a location for implementation of Intensive In-Home Services as that program expands. The state does not wish to continue offering IFS since the current IFS models are not evidence-based and the state’s Intensive In-Home Services Programs are not only evidence-based, but also producing positive outcomes for children and families. Arkansas previously researched evidence-based models and had selected Homebuilders® as the required evidence-based model that would have been required if IFS continued, but with the expansion of Intensive In-Home Services, this transition to Homebuilders® is no longer necessary.

As the current IFS is not a specified model, Arkansas does not claim reimbursement for it. However, IFS will continue to be an option in the family’s prevention plan through December 31, 2022. As the population IFS serves will remain the same, this could help DCFS plan for cost and refining candidacy and referral criteria.

Table 1 Chosen In-Home Parenting EBP's, with proximal outcomes, and selection reason[6]

EBP Intervention	Target Population	Expected Proximal Outcomes	Expected Distal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed[7]
SafeCare	Children ages 0-5 and their caregivers	• Increase positive parent child interaction; • Improvement in parents' care of child's health; • Enhanced home safety.	• Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population.	Evidenced based practice with successful outcomes for the population DCFS serves that filled a service gap for a vulnerable age group.	Formal Contracted Evaluation	✓
Triple P	Children ages 5-18 and their caregivers and parenting foster youth regardless of the child's age. *The Title IV-E Prevention Services Clearinghouse only rated the program from 0-12-year-olds.	• Increased knowledge, skills, and confidence of parents/caregivers; • Parents' demonstrated use of positive parenting routines; • Improved parent-child relations; • Decreased family stress; • Increase in assertive (non-abusive) behavior management of children.	• Long-term improvements in family functioning; • Reduced parent-child conflict; • Reduced child maltreatment; • Strengthening of families (preventing removals); • Prepares children for successful; experiences with peers and at school.	Evidence- based parenting program with results in preventing child abuse and neglect. In-home delivery method, length of behavior-based curriculum, and staffing requirements have more benefits to children and families and contracted workforce than previous Nurturing the Families of Arkansas (NFA) Parenting Program.	N/A. However Triple P International only authorizes practitioners who are trained and accredited by Triple P Trainers to deliver its program.	✓
Intercept	Children ages 0-18 and their caregivers	• Decrease in length of time spent in residential, psychiatric or other out-of-home placement; • Decrease in emotional and behavioral problems in youth; • Decrease in substance abuse and involvement with juvenile justice system.	• Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population.	Proven track record of helping to reduce the number of children in foster care in Tennessee and has experience providing prevention services in multiple states. Uses evidence-based interventions with a stringent supervision model. Meets a gap in the DCFS service array.	Formal Contracted Evaluation	✓

[6] Table 1 only references those programs that are currently in place

[7] See Appendix C, Attachment III: State Assurance of Trauma-Informed Service Delivery

EBP Intervention	Target Population	Expected Proximal Outcomes	Expected Distal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed[7]
Family Centered Treatment	Children 0-18 and their caregivers	• Reduction in hurtful and harmful behaviors affecting family functioning; • Development of emotional and functioning balance in family so that the family system can cope effectively with individual members' intrinsic challenges; • Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist; • Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability.	• Reduction in future maltreatment reports; • Reduction in foster care entry and/or re-entry; • Reduction in overall foster care population.	St. Francis has had success in providing Family Centered Treatment in two other states. This model addresses the needs of families with a trauma -informed and evidence-based service. St. Francis included in their proposal an understanding of the challenges and impact of community poverty which is important as some of the counties where they provide services are some of the poorest areas in the nation.	Formal Contracted Evaluation	✓

b. **Mental Health**

Arkansas recognizes that evidence-based mental health services are critical to the populations it serves. Furthermore, DCFS wants to continue to improve the quality of mental health services available to clients. Mental health treatment for adults and children involved with child welfare are mainly covered through Medicaid and private insurance. Many DCFS clients already have Medicaid and workers can help eligible clients apply if they do not have coverage or their coverage has lapsed. DCFS does have small contracts for counseling services for those children and caregivers who do not have coverage. These contracts are for counseling agencies and/or private licensed providers.

The Division's current counseling contracts do not specify that therapists must be certified to provide specific therapies. While DCFS will not amend its contracts to require certification in the below therapeutic modalities, as that would be too limiting on providers and clients, the contract PIs will be revised to encourage providers to be trained in these approaches. DCFS is also changing the format of the providers' monthly reports. Providers will now report not only which clients they see and whether or not the payor source is Medicaid, DCFS contract, or other, but also if they are using one of the specified trauma-informed, evidence-based therapies listed in the Division's IV-E Prevention Program Five-Year Plan, and if the client is eligible under Family First. DCFS recognizes that not all of clients will be appropriate for one of these therapies, that not all mental health diagnoses have a corresponding evidence-based therapy as a best practice standard of care, and that some clients may need an evidence-based therapy that is currently not included in the plan. For these reasons, DCFS is not limiting its contracted therapists to these treatment modalities. In addition, providers may choose to add to their monthly report other evidence-based therapies they are providing which may lead to other evidence-based therapies added to Arkansas's IV-E Prevention Program Five-Year Plan.

In the past, DCFS has partnered with Arkansas Building Effective Services for Trauma (ARBEST) to help educate DCFS staff on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and increase the use of this therapy for children in foster care. ARBEST is a state-funded program through the University of Arkansas Medical Sciences, Psychiatric Research Institute which aims to improve outcomes for traumatized children and families through excellence in clinical care, training, advocacy, and evaluation. In addition to the work ARBEST has done in regard to TF-CBT, they also provide training for therapists in the evidence-based, trauma-informed practices of Parent Child Interaction Therapy (PCIT), Cognitive Processing Therapy (CPT) and Parent Child Psychotherapy (CPP). ARBEST keeps an up-to-date register of therapists in Arkansas who are able to provide each of these therapies. Because of the respected work ARBest is already doing in the state and the strong partnership between ARBEST and DCFS, the Division included these therapies in its IV-E Prevention Program Five-Year Plan. DCFS also chose Functional Family Therapy (FFT) to include in the plan. While ARBEST does not provide training for this intervention, FFT is well-supported and specifically addresses the needs of older youth and their families.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) – TF-CBT is a trauma informed evidence-based mental health treatment for children and adolescents who have experienced trauma from events such as sexual or physical abuse. TF-CBT is considered the gold-standard in treatment for child trauma. TF-CBT aims to reduce trauma symptoms while strengthening the parent-child relationship. The Title IV-E Prevention Services Clearinghouse has rated TF-CBT as a promising practice. As such, Arkansas will not be requesting reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Parent Child Interaction Therapy (PCIT) – PCIT is an evidence-based dyadic behavioral intervention for children ages two through seven and their parents or caregivers. The treatment focuses on decreasing externalized disruptive behavior in young children with a history of trauma. This treatment has been

shown to improve parent-child attachment, reducing symptoms of trauma in children, and improvements in children's behavior. PCIT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse. DCFS has contracts across the state with multiple counseling agencies. PCIT is provided by several therapists in these various agencies. All therapists providing PCIT have been certified in PCIT with The *Parent-Child Interaction Therapy Protocol*- **Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol: 2011.* PCIT International, Inc.** This is the manual used in the Title IV-E Prevention Services Clearinghouse review of PCIT. ARBEST provides the training for PCIT which involves an 18-month process including a four-day in-person training, a two day follow up training, and 18 months of consultation calls held weekly and requiring the completion of two full PCIT cases. PCIT also requires agency support for therapists. Contracted therapists providing PCIT must show proof of training and fidelity to the model. The DCFS Assistant Director of Mental Health provides contract oversight and CQI of contracted mental health providers. In addition to monthly reports, quarterly meetings are held to discuss issues and address barriers and the DCFS Assistant Director of Mental Health also completes quarterly Vendor Performance Reports. Arkansas will not be requesting reimbursement for this service at this time.

Cognitive Processing Therapy (CPT) – CPT is a trauma-informed cognitive behavioral treatment for PTSD in adults. It has shown to be effective in reducing PTSD symptoms to a variety of traumatic events such as rape, abuse, and events of war. CPT is endorsed by the U.S. Departments of Veterans Affairs and Defense as a best practice for the treatment of PTSD. In order to increase the number of CPT-trained therapists in Arkansas, ARBEST began providing CPT training in 2019. The Title IV-E Prevention Services Clearinghouse has not yet rated CPT. As such, Arkansas will not be requesting reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Child-Parent Psychotherapy (CPP) - CPP is a trauma-informed, evidence-based treatment for young children (ages zero through five) who have experienced trauma. It has been shown to be effective at reducing emotional and behavioral difficulties associated with trauma, strengthen the parent-child relationship, and enhance safe caregiving practices. The Title IV-E Prevention Services Clearinghouse has not yet rated CPP. As such, Arkansas will not be requesting reimbursement for this service until such a time as it becomes well-supported according to the federal clearinghouse or Arkansas is able to do an independent evaluation.

Functional Family Therapy (FFT) – FFT is a trauma-informed evidence-based therapeutic intervention for at-risk families and juvenile justice involved youth. The FFT model is for families with children ages 10-18 to help develop better family relationships, learn to control anger and problem solve without fighting, improve positive communication skills, build trusting and respectful family relationships, and prevent involvement in the juvenile and legal system. FFT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse. DCFS has contracts across the state with multiple counseling agencies. Currently no therapists are trained in FFT, but several are interested in becoming FFT providers. All therapists providing FFT will be certified in FFT with *Functional Family Therapy for Adolescent Behavioral Problems*-

Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for Adolescent Behavioral Problems.* Washington, D.C.: American Psychological Association. This is the manual used in the Title IV-E Prevention Services Clearinghouse review of FFT. Contracted therapists providing FFT must show proof of training and fidelity to the model which includes three phases: clinical training, supervisor training, and maintenance phase. The maintenance phase includes ongoing training and annual renewal. In addition to the requirements set by FFT, DCFS' Assistant Director of Mental Health would provide contract oversight and CQI of providers through monthly reports

and quarterly meetings to discuss issues and address barriers. Arkansas is not requesting reimbursement for this service at this time.

Table 2 Chosen Mental Health EBP's, with proximal outcomes, and selection reason

EBP Interventions	Target Population	Expected Proximal Outcomes[8]	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed[9]
TF-CBT	Children ages 3-18 and their caregivers	Improved PTSD, depression, and anxiety symptoms; reduced behavior problems; reduce parenting distress; improved adaptive functioning, and improved parenting skills.	TF-CBT is an evidence-based and considered the gold standard in trauma treatment for children. Arkansas has a good support and training system for TF-CBT therapists through ARBEST.	Promising	No	✓
PCIT	Children ages 2-6 and their caregivers	Increased parent-child closeness; decreased anger and frustration; increased self-esteem; increased parental ability to comfort child; improved parenting skills in behavior management and communication.	PCIT is a well-supported evidence-based model that addresses many of the needs of children and families served by DCFS. ARBEST also trains therapists across Arkansas in PCIT.	Well-Supported	No	✓
CPT	Adults	Decrease symptoms of PTSD and depression; help clients feel emotions about the traumatic event and reduce avoidance; develop balanced and realistic beliefs about the event,	CPT is an evidence-based treatment for adults with trauma. Many of the adults the Division serves have unaddressed	Not yet rated	No	✓

[8] Proximal outcomes from program goals profiles on the CEBC: http://www.cebc4cw.org/

[9] See Appendix C, Attachment III: State Assurance of Trauma-Informed Service Delivery

EBP Interventions	Target Population	Expected Proximal Outcomes[8]	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed[9]
		oneself, others and the world; decrease the emotions that result from maladaptive beliefs (guilt/shame/anger).	trauma that is a complicating factor in their lives. ARBEST is currently training therapists in this modality. Arkansas expects CPT to be well-supported when it is rated by the Title IV-E Clearinghouse.			
CPP	Children 0-5 and their caregivers	Support and strengthen the caregiver-child relationship; reduce emotional and behavioral difficulties associated with trauma.	CPP is a trauma informed evidence-based model that addresses many of the needs of children and families served by DCFS. ARBEST also trains therapists across Arkansas in CPP. Arkansas expects CPP to be well-supported when it is rated by the Title IV-E Clearinghouse.	Not yet rated	No	✓
FFT	Children 11-18 and their families	Eliminate behavior problems, delinquency, and substance abuse; improve prosocial behavior for the youth; and improve overall family	FFT is a well-supported evidence-based model that addresses many of the needs of older youth and	Well-Supported	No	✓

EBP Interventions	Target Population	Expected Proximal Outcomes[8]	Reason for Selection	Title IV-E Clearinghouse Rating	Evaluation Waiver Request	Trauma Informed[9]
		functioning and skills.	families served by DCFS.			

At this time, DCFS is not able to provide an evaluation for each therapeutic intervention listed. Therefore, while the work will begin in terms of teaching the Division's front-line staff about these therapies, changing the PIs in the DCFS counseling contracts, and implementing the new provider monthly reports in January 2020; DCFS will not request claimability on all of these services until such time as they are on the Title IV-E Prevention Services Clearinghouse as well-supported or it becomes feasible for DCFS to conduct its own evaluation.

c. **Substance Abuse**

DCFS is not currently requesting any substance abuse programs or treatment be a part of its Title IV-E Prevention Program Five-Year Plan. There are no approved substance abuse treatment models on the Title IV-E Prevention Services Clearinghouse that are currently being used in Arkansas, nor does Arkansas have the resources at this time to do an independent evaluation of substance abuse treatment modalities. However, DCFS is looking at the following programs/services to explore for expansion of FFPSA implementation at a later date.

Methadone Maintenance Therapy – Methadone Maintenance Therapy combines therapy with methadone medication for the treatment of opiate addiction. There are currently five Methadone Maintenance Clinics in Arkansas. The Title IV-E Prevention Services Clearinghouse has rated Methadone Maintenance Therapy as a promising practice. DCFS does not have the resources at this time to do an independent evaluation of clients in this treatment but will be exploring this as a possibility for expansion of FFPSA implementation.

Arkansas Center for Addictions Research, Education, and Services (Arkansas Cares) – Arkansas Cares is a program of Methodist Family Health. It is a 3-month residential treatment program for parenting mothers with children 12 years old and younger. It is a dual diagnosis program that treats substance abuse and mental illness simultaneously. The family centered approach used is based on the Teaching Family Model. Additional services include parent training, vocational and educational training, children's mental health services, early education services, and transitional housing. The program aims to decrease maternal substance abuse and promote healthy families. Arkansas Cares is currently rated as a promising practice on the CEBC. As the Title IV-E Prevention Services Clearinghouse has not rated the program and DCFS does not currently have the ability to do an independent evaluation, DCFS is not requesting transitional payments for this service at this time. However, DCFS will be working with Methodist Family Health to explore how to partner to expand service availability and make this an official part of Family First in Arkansas.

d. **Cross Sectional**

Motivational Interviewing (MI) - Motivational interviewing is a client-centered method used to help increase clients' intrinsic motivation to change. MI can be used by itself or in combination with other treatments. It is often used in pre-treatment work to help engage and motivate clients for other treatment modalities as it helps clients explore and resolve their ambivalence to change. MI is currently being reviewed by the Title IV-E Prevention Services Clearinghouse under substance abuse interventions; however, DCFS is encouraging the Children's Bureau to take a broader look at MI as a beneficial piece in

multiple disciplines. Such an expansion might then warrant all front-line child welfare staff being trained in MI. DCFS is exploring the costs associated with MI training, the logistics of training and coaching staff, and the feasibility of implementing an independent evaluation.

Table 3 Chosen Substance Abuse and Cross-sectional EBP's, with proximal outcomes, and selection reason

EBP Interventions	Target Population	Expected Proximal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed[10]
Methadone Maintenance	Adults with opioid addiction	Reduction in the use of other opioids; mortality; injection drug-related risk behaviors, criminal activity; improvement in physical and mental health, social functioning, quality of life; retention in treatment programs.	Methadone Maintenance Therapy is evidence-based and is available in Arkansas. Methadone Maintenance Clinics could be a vital support to parents with opioid addiction.	To be determined	✓
AR Cares	Mothers with dual diagnosis (children must be 12 and under)	Decrease maternal substance abuse; promote healthy families; reduce foster care placements.	AR Cares is a successful residential program where mothers can keep their children with them. There is a lack of services available in the state.	To be determined	✓
Motivational Interviewing	All clients as a support for other interventions	Higher rates of active participation in services including drug treatment	MI is appropriate for use with youth and adults. It is evidence-based but does not require a Master's	To be determined	✓

[10] See Appendix C, Attachment III: State Assurance of Trauma-Informed Service Delivery

EBP Interventions	Target Population	Expected Proximal Outcomes	Reason for Selection	Evaluation Plan	Trauma Informed[10]
			level education enabling all front-line staff to be able to provide this service. Being trained in MI would give staff another tool and resource to help build their skills and ability to work with clients.		

Table 4 Timeline of Services[11]

In-Home Parenting	*Service*	*DCFS Contract*	*Provider*	*Coverage*	*Payment Source*	*Title IV-E Clearinghouse Rating (Designated (D)/Anticipated (A))*	*Expected FFPSA IV-E Match*
	SafeCare	✓	Arkansas Children's Hospital and subcontractors	Statewide[12]	Medicaid	Well-Supported (A)	TBD
	Triple P (ages 0-12)	✓	MidSouth University Partners	Statewide	SSBG	Promising (D)	TBD
	Intercept (IIHS)	✓	Youth Villages	10 (soon to be 12) Counties	DCFS	Well-Supported (D)	Jan. 1, 2020
	Family Centered Treatment (IIHS)	✓	St. Francis	19 Counties	DCFS	Supported (D)	Oct. 1, 2019
	Family Centered Treatment (IIHS)	✓	Youth Advocate Programs	21 Counties	DCFS	Supported (D)	March 1, 2020
		✓					
		✓					

[11] No services will be claimed until an approved prevention plan, including the transitional payment requirements

[12] See Appendix A for SafeCare rollout schedule

Mental Health[13]	TF-CBT		Multiple Providers	Statewide	Medicaid/ DCFS	Promising (D)	TBD
	Parent Child Interaction Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (D)	TBD
	Cognitive Processing Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (A)	TBD
	Child Parent Psycho-therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (A)	TBD
	Functional Family Therapy		Multiple Providers	Statewide	Medicaid/ DCFS	Well-Supported (D)	TBD
Substance Abuse	Methadone Maintenance Therapy		Multiple Providers	5 Counties	Medicaid/ private pay[14]	Promising (A)	TBD
	Arkansas Cares		Methodist	Pulaski	Medicaid/ DCFS	Promising (A)	TBD
Cross-Sectional	Motivational Interviewing		DCFS	Statewide	DCFS	Well-Supported (D)	TBD

Oversight and CQI

Oversight is provided by DCFS Program Management Staff and DHS contract management staff. DCFS uses monthly reports and a contract provider portal for monthly data analysis along with provider meetings and feedback loops between front line staff and providers. DCFS will implement semi-annual case reviews performed by the Program Management staff to oversee contract performance and ensure quality service delivery to children and families. Contract providers using evidence-based models are required to maintain fidelity of the model.

In addition to DCFS' contracted evaluation, many of these services also have fidelity measures to which they must adhere in order to administer the program. SafeCare is a model that requires oversight and accreditation from the national SafeCare office. Intercept and Family Centered Treatment (FCT) are the current models for Intensive In-Home in Arkansas. Youth Villages created Intercept which has strong fidelity measures to ensure appropriate implementation. Triple P providers receive accreditation through Triple P International.

FCT requires licensure through the Family Centered Treatment Foundation which provides training, coaching, and certification to allow agencies to implement this model. Specifically, in order for an agency to apply to provide the FCT model, to the agency must ensure Family Centered Treatment Certification for all FCT clinicians, FCT-approved supervisor training for all FCT supervisors, sustainability of adherence of fidelity to the FCT model after implementation and certification, and a system to provide data collection to assure fidelity to the model. As the providers of FCT are licensed by the Family Centered Treatment Foundation, there is already stringent monitoring of fidelity to the model. The DCFS In-Home Program Manager is in communication with the Family Centered Treatment Foundation consultant in charge of monitoring fidelity for St. Francis and will continue that for Youth Advocate Program.

DCFS is committed to providing continuous quality improvement and has included FCT and Intercept into the overall activities for the State's CQI process and amended the contract with Public Consulting Group

[13] DCFS has contracts with mental health providers, but not specific contracts for each therapy modality

[14] Current payment structure

(PCG), to include CQI of FCT and Intercept. PCG currently conducts Quality Service Peer Reviews for DCFS using the federal Onsite Review Instrument (OSRI) to continually assess the ability of DCFS to improve its case practice. The CQI team is expanding to assess the extent to which the FCT and Intercept contracted providers are adhering to the model of the evidence-based program and that positive outcomes in the areas of safety, permanency, and well-being are being achieved for families who are served.

For FCT, PCG uses a combination of case record reviews; interviews with parents/caregivers, DCFS staff, and providers; and a survey administered to program participants to inform the CQI reviews. These reviews aim to answer the following questions:

Process Questions for FCT

1) To what degree were the model's tools used to adequately identify changes needed to improve family functioning?
2) To what degree was sufficient structure provided to families to guide them to complete tasks to meet their goals?
3) To what extent were families able to learn to recognize and value their improved behaviors?
4) To what extent do families have the capacity to handle crises independently of DCFS and other external parties?
5) To what extent are families satisfied with the support they received from the provider?

Outcome Questions for FCT

1) To what extent are children of participating families able to remain safely in their own homes?
2) To what extent do children have improved behavioral and emotional functioning?
3) To what extent have parenting practices improved?
4) To what extent has family functioning improved?

For Intercept, PCG uses the same combination of case record reviews; interviews with parents/caregivers, DCFS staff, and providers; and a survey administered to program participants to inform the CQI reviews. These reviews aim to answer the following questions:

Process Questions for Intercept

1) To what degree was the Intercept clinical portal used to adequately identify changes needed to improve family functioning?
2) To what degree was sufficient structure provided to families to guide them to complete tasks to meet their goals?
3) To what extent were families able to learn to recognize and value their improved behaviors?
4) To what extent do families have the capacity to handle crises independently of DCFS and other external parties?
5) To what extent are families satisfied with the support they received from the FCT provider?

Outcome Questions for Intercept

1) To what extent are children of participating families able to remain safely in their own homes?
2) To what extent do children have improved behavioral and emotional functioning?
3) To what extent have parenting practices improved?
4) To what extent has family functioning improved?

As described above, data collection includes case record reviews, interviews, and surveys. The collection strategy for each is described below.

Case record reviews – For FCT, PCG selects a total of 50 cases annually, with 25 cases reviewed semi-annually. For Intercept, PCG selects a total of 50 cases annually, with 25 cases reviewed semi-annually. The semi-annual reviews provide DCFS with the opportunity to make mid-course corrections if needed. The CQI team created a structured case record review instrument, on each program, for reviewers to gather needed information to answer the research questions, minus the one which assesses client satisfaction, as that will be captured elsewhere.

St. Francis Ministries now serves 19 counties and Youth Advocate serves a total of 21 counties in some capacity. Stratified samples are taken, selecting cases in proportion to those who began FCT within the last four to eight months prior to the start of the review month. This provides an opportunity to conduct a review of cases for families that have completed the program, providing the ability to assess all four phases of FCT, as well as an increased opportunity to meet with families in the interview phase of data collection, especially with those who are still active.

Youth Villages has implemented Intercept in 10 counties and is expanding to two more. Stratified samples are taken, selecting cases in proportion to those who began Intercept within the last four to eight months prior to the start of the review month. Once the program has been in Sebastian and Crawford Counties for four months, they will be included in the pool of which cases are selected from. This again provides an opportunity to conduct a review of cases for families that have completed the program, as well as an increased opportunity to meet with families in the interview phase of data collection, especially those are still actively receiving services.

Interviews – As part of the case reviews, the CQI review team conducts and interviews with at least one parent or caregiver from each case, the case manager from the FCT provider or the case manager from Intercept who is or was assigned the case, and the DCFS family service worker. Attempts are made to ask families who are no longer participating in the program to also participate in the interviews. A semi-structured interview protocol encourages discussion with the respective parties and helps to identify the successes and challenges the families, FSW, and FCT or Intercept provider, as applicable, encountered while receiving or providing support. This data collection strategy may help shape recommendations to improve the FCT and Intercept programs and likely other in-home service models as well.

Surveys – A survey is administered to all families as they exit the program, regardless of whether they completed FCT or Intercept successfully or not. The survey consists of a series of yes/no, multiple choice, and Likert scale questions, and at least one open-ended question, in order to quantify the extent to which the FCT providers adhered to the four phases of the model or that the Intercept provider adhered to their protocol, from the perspective of the clients themselves. Results of the survey are used to gauge client satisfaction. The open-ended question(s) allow respondents an opportunity to either explain their answer(s) or provide additional input. Based on the past experience of PCG, the providers are asked to give the survey to families as they exit the program. The survey includes an online address which families can access to respond. Alternatively, families are given an opportunity to return the completed survey in a postage paid return address envelope. These measures promote an increased response rate by allowing families to respond to PCG directly, promoting anonymity.

PCG uses both qualitative and quantitative analyses to inform the process and outcome components of the CQI review. As the CQI team carries out their onsite reviews of the sampled cases, the results are posted to a secure online data collection instrument developed and hosted by PCG. Analysts use a combination of SQL and R to measure frequencies and test for statistical significance. Comparisons are drawn across the two providers and, where sufficient cases are sampled, across counties or at least across service areas. In future years, comparisons will also be drawn across review periods to measure practice improvement and to identify where practices or outcomes may be slipping. Quantitative data analysis will be used to inform the results of the surveys. Dependent on the rate of response, additional

analysis is done to identify the extent to which a family's characteristics have an influence on their satisfaction of the program. The CQI team conducts qualitative analysis of the interviews conducted with families, FSWs, and the providers, looking for common themes as well as differences. Qualitative analysis is also conducted of the open-ended question(s) included within the survey to clients. Both the qualitative and quantitative analyses study the models separately.

At the end of each semi-annual review, the CQI team meets as a group to discuss emerging trends- both in terms of successes and challenges for participating families as well as the two provider and DCFS. This information, gathered and assimilated qualitatively, is used to inform the results of the CQI reviews and provide input into promising practices and shaping recommendations for improvement.

Within a month of completing the case reviews, PCG provides DCFS with a draft report. The draft report provides answers to each of the research questions, drawing comparisons over time, including across the two FCT providers, the Intercept provider, and service areas. Each report will also include a summary of the program's strengths, areas of improvement, and recommendation for change. These reports are discussed with Area Directors and supervisors at each area's QSPR Presentation and Discussion, as applicable.

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

Pre-Print Section 9

a. **Defining Candidacy in Arkansas**

The DCFS definition of candidacy took into consideration several factors that affect the Arkansas child welfare system including the legal definition of candidacy, who and how the Division already serves as clients, and prioritizing how to best serve DCFS clients. By taking all these factors into account, pulling data from CHRIS, and looking at known risk factors, the Division determined that the factors outlined in Table 5 below qualify a child as a foster care candidate in Arkansas. Only one factor has to be present for a child to be determined a candidate; however, multiple reasons may apply. Additional descriptions of each factor follow Table 5.

Table 5 Candidacy[15]

1) Garrett's Law investigation that did not result in removal. *All children in the home will be considered a candidate.	2) A Protection Plan was put in place.
3) A TDM was held that did not result in removal.	4) High or intensive risk assessment.
5) Risk of adoption or guardianship disruption.	6) SS case opened to prevent removal.
7) A less than custody has been filed.	8) A 30-day petition has been filed.
9) Child is living with a relative caregiver (Does not include provisional or relative foster care)	10) A CACD investigation with a true finding and an in-home or unknown offender.

[15] Categories 12-17 will have to be added in a CHRIS enhancement and will not be available for selection until April 2020.

11) Reunification has occurred, and the case remains open.	12) A sibling is in foster care.
13) The parent or caregiver was in foster care as a child.	14) Failure to Thrive
15) Medical Neglect if the child is 5 or under	16) Inadequate Supervision with a child in the home 5 and under
17) Domestic Violence is a risk factor	

1) Garrett's Law (Front Door) - In SFY 2018, DCFS received 1,280 Garrett's Law reports. Statewide, DCFS substantiated 92% of these referrals, opened a case on 94%[16], and removed 15% at the time of the investigation. However, this rate fluctuates widely, and in some counties, they remove approximately half of all Garrett's Law babies during the investigation. Furthermore, DCFS removes another 7% within 12 months, and in SFY 2018, 4% were cited in a subsequent true maltreatment report over the same time period. This equated to approximately 282 newborns removed from their home due to substance abuse, these figures only capture the newborn and no siblings that are also removed as a result of the drug use. Arkansas has chosen to include this population in its definition of candidacy, due to the vulnerable age of the child, the inconsistency with which DCFS handles these cases across areas, and the frequency with which they come into care or are subsequently abused.
2) Protection Plan in place (Front Door and Tertiary Prevention) - By definition, these children are at imminent risk of coming into care. Protection plans are only completed when a safety factor has been identified and the only options are a protection plan or bringing the child into care.
3) Team Decision Meetings (Front Door and Tertiary Prevention) are only in 30 out of 75 counties at this time. In these counties they are held with every Garrett's law and any time a protection plan is put in place. However, a pilot is being done in Area 8 with triggers for TDM that align to model fidelity. These TDMs are held when a worker is considering or has done a removal. When this goes statewide, the candidacy reason would read that a TDM was held that did not result in removal or the children were returned home. For more information regarding the statewide expansion of Considered Removal TDMs, please see Arkansas's 2020-2024 Child and Family Services Plan Goal 2, Strategy 3.
4) High or Intensive Risk (Front Door and Secondary or Tertiary Prevention) - These families are at a greater danger of coming into care or experiencing subsequent maltreatment without intense intervention. In SFY 2018, 65% of children removed from the home had a current risk assessment of moderate, high, or intensive. There was missing data for approximately 15.5% of removals.[17] A risk assessment will be completed at the time of determining candidacy. While subsequent risk assessments will be completed through the life of the case, candidacy status will not change due to a lower risk score. As the law states the risk should go down as services are being provided. At any point during a case if a child goes from a low-risk assessment to a high-risk assessment they will then be designated as a candidate. [18]
5) Failed Adoption/Guardianship – Due to restrictions of the CHRIS system, DCFS was unable to pull how many children came into care for this reason in SFY 2018; however, Arkansas plans to

[16] This figure includes PS cases and FC cases.

[17] The ones with missing data more than likely had their risk assessment entered after the removal screen was completed and therefore were not captured in the data request.

[18] The state is not satisfied with our current risk assessment. We are currently working with NCCD to implement Structured Decision Making with fidelity. NCCD will be doing a risk analysis in the fall of 2019 and the new risk assessment should be in place by the end of 2020. Until that time, we will use our current risk assessment.

include this population within its definition of foster care candidates as allowed under Family First.[19]

6) In SFY 2018, 502 families were served through a supportive services case, and 3% of these children were taken into foster care. While this is a low number of overall DCFS cases and removals, it is important to capture this population because
   A. When judges open up a DCFS case to prevent removal, the children are at high risk of coming into care due to the court oversight component.
   B. While this data is not able to be pulled from CHRIS, there are cases opened because a caregiver is at a breaking point and voluntarily requests services. The caregiver normally does not want to give custody to DCFS but does also not know how to access the help they need. These children are certainly at imminent risk of coming into care, but if the child welfare system can help support the caregiver and provide services immediately, then the system may also be able to keep that child from coming into care and prevent maltreatment from ever occurring.
   C. DCFS wants to provide Family First services to families that become involved through a DR but need more intensive and longer involvement than a normal DR, which lasts between 30-60 days. As an example, families that had a DR and then a subsequent true maltreatment investigation that were then able to participate in NFA had the lowest number of subsequent maltreatment and removals. This group of families had the best outcomes from all waiver initiatives. DCFS suspects that now providing them with Triple P by opening a supportive services case to continue after the DR is closed will prevent removals and maltreatment from ever occurring.
7) Less than Custody Petitions - The current system does not have the capability of tracking how many less than custody petitions DCFS files in a year nor the outcomes of those. However, this subpopulation was included because the Division is restricting the rights of one or both parents, while saying that the child can safely remain in the home while services are provided. When there is a safety factor related to the parent, less than custody petitions also allow DCFS to leave a child in the home of a relative, if they have been in the relative's home for six months.
8) 30-day Petitions - The current system does not have the capability of tracking how many 30-day petitions have been filed. However, these are filed when a child is at substantial risk of harm or removal without intervention and the Division feels the risk level is high enough to warrant court oversight.
9) Children living with a relative/caregiver - Of the 3,289 children that entered care in SFY 2018, 244 were removed from a relative caregiver and not a biological/legal/or stepparent. This category will overlap with the supportive services to prevent removal, but it will also capture those families that are using their informal support systems, allowing DCFS to provide services to both the current caregiver and the parent as needed.
10) CACD investigations with a true finding and in-home/unknown offender - CACD investigates Priority 1 investigations. These allegations are more severe (e.g., babies with broken bones, subdural hematomas, sexual abuse, etc.).
11) Reunification has occurred – The period immediately following reunification is a vulnerable time for families. In SFY 2018, 7.3% of children who were discharged to their families re-entered foster care within 12 months. However, in SFY 2017 and SFY 2016, those rates were 8.7% and 9.9%, respectively. Families deserve to have support during this transition, and DCFS needs to do everything it can to help reunification be successful. The DCFS Parent Advisory Council has also recommended that strategies be put in place to help after reunification. In addition, categorizing

[19] 42 U.S.C. § 675(13)

this as a candidacy reason will allow for some children to return home earlier than they traditionally could by opening up an avenue to provide intensive in-home services.

12) A sibling is in foster care - If there is a safety factor that caused the removal of one child, this indicates the remaining children may be at greater risk of coming into care.
13) The parent or caregiver was in foster care as a child - While this is not data that DCFS has traditionally tracked, a pull from SFY 2018 showed that approximately 8% of children who were removed had a parent who was in foster care at some point during their childhood.[20] This designation also allows the Division to continue serving youth that have left care at either 18 or 21 with a child.
14) Failure to Thrive (FTT) – Failure to thrive is a clinical term used by pediatric clinicians to describe infants and young children, generally three years of age and younger, who fail to grow as expected based on established growth standards for age and gender. FTT can trigger an array of health problems including long-term impairments in growth, physical and cognitive development, and other problems. While FTT can have organic causes, for the hotline to accept a report of FTT the reporter must have reason to believe that the child has FTT as a result of the parent's or caretaker's neglect. For a report to be determined true, the diagnosis of FTT must be verified by a physician and there must be a preponderance of evidence that the diagnosis is at least partially a result of the parent's or caretaker's failure to provide for the needs of the child.[21] Due to the serious potential outcomes and the vulnerability of this population, Arkansas has determined it appropriate to include in its definition of candidacy.
15) Medical Neglect for a child 5 and under – Arkansas defines medical neglect as a lack of medical or mental health treatment for a condition that could cause serious or long-term harm to the child if left untreated, this includes lack of follow through with a prescribed treatment plan. These allegations must be verified by a physician, nurse, psychologist, dentist, or by direct admission from the alleged offender. Due to the serious or long-term harm to the child and the vulnerability of this age group, DCFS has determined that this child will be a candidate.
16) Inadequate Supervision for a child 5 and under – Inadequate supervision is defined as a parent or caretaker failing to supervise a child resulting in the child being left alone or in an inappropriate circumstance that creates a dangerous situation that puts the child at risk of harm. For DCFS to find true for inadequate supervision there must be a preponderance of evidence that inadequate supervision occurred and that it was a result of the parent or caretaker's neglect. Due to the vulnerability of children under the age of five, DCFS is including this in its definition of candidacy so that the Division can serve these children in their home and prevent removal or serious harm.
17) Domestic Violence is a risk factor – Under the Arkansas Child Maltreatment Act, Domestic Violence is not listed as child abuse. However, the link between domestic violence and child abuse is strong and is a complicating factor for families served by DCFS. DCFS recognized that workers need more support in assessing for domestic violence and working with families where DV has occurred. DCFS is working on ways to increase workers knowledge of DV and increase appropriate services for this population.

[20] This information is limited in that data was only able to be pulled from Arkansas' DCFS and information is only reliable from approximately 2001 to current.

[21] Arkansas Child Maltreatment Act

b. **Identifying and Reassessing Candidacy**

FFSPA requires a prevention plan to be created for every child who is determined to be a candidate. The state is eligible for reimbursement for up to 12 months after a child is identified as a candidate in a prevention plan.[22]

DCFS created a FFPSA eligibility screen to ensure workers are correctly identifying children who are FFPSA eligible. This screen can be completed in an investigation or in a case and will be done on each child in the home ages 0 through 17. This screen will be mandatory in all investigations that end with opening a new case, reopening a closed case, or connecting to a new case. Once a child is designated as a candidate, they remain a candidate for the length of the case, until 12 months has passed, or until the last day of the month in which the child turns 18. Therefore, this screen is only mandated to be completed once, but if a client is identified as a candidate and the case remains open past twelve months then candidacy will be end-dated, and the worker will receive an alert to complete this screen again, if necessary. While it is only mandatory at these times, a case worker may go in at any point during a case to complete this screen should changed circumstances then qualify a child as a foster care candidate. For example, this may occur when a child has been in foster care and returns home and a case remains open. Another example might be if three months into a case a protection plan must be put in place. This screen will also capture if a youth is FFPSA eligible due to being a youth in foster care who is pregnant or parenting, which adults in the family are eligible because they are a parent or caregiver of a candidate, and where a youth was residing at the time they were identified as a candidate.[23]

c. **Connecting Candidacy to Appropriate EBP**

Once FFPSA eligibility (either through candidacy or as a pregnant or parenting foster youth) is established, a prevention plan will be accessible to complete in CHRIS.[24] While eligibility is determined separately and must be completed on each child, the prevention plan will be a family plan that only identifies those children and parents or caregivers who are eligible. While a small timeframe is allowable between identifying someone as eligible and completing the Prevention Plan screen, once the first prevention plan is completed, it will auto-populate a creation date of the date eligibility was approved.[25] The worker will be able to choose each client that is FFSPA eligible and pick a FFSPA-eligible service. At the appropriate time, the worker will put the begin date, the end-date, and whether or not the service was successfully completed. There is also a mandatory text box for the worker to state why this particular intervention was chosen and any pertinent notes. For pregnant and parenting foster youth, the worker will choose a service that will help ensure the youth is prepared or able to parent and describe in the narrative section the foster care prevention strategy for any child born to the youth. This screen can be updated at any time but will be mandatory to update with the case plan, every three months.

As discussed in section c of the Forward, Arkansas is aware that there will be eligible clients where no appropriate FFSPA eligible service is available, either because none of the FFSPA services in the plan are available in that county, or because none of the identified services are appropriate to meet the needs

[22] 42 U.S.C. § 671(e)(3)

[23] See Appendix B for a mockup of the current screen. Details may change prior to Oct. 1, 2019.

[24] See Appendix B for a mockup of the current screen. Details may change prior to Oct. 1, 2019.

[25] This is because the ACT states eligibility for reimbursement starts the day a client is determined to be a candidate in a prevention plan, even though the date someone is identified and the date a prevention plan is created may not be the same date.

of the family at that time. There is a box on the Prevention Plan screen for a worker to check that states, “No Family First Eligible Services at this time.” The text box will still be mandatory.

This prevention plan will print along with the case plan that address all other services. Workers will not be expected to duplicate services from the prevention plan into the case plan, but rather the services in the prevention plan and the case plan should work in tandem. By allowing prevention plans to be completed on all FFSPA eligible clients even when a FFSPA service is not available, it will allow DCFS to identify what populations are underserved by the Division and where to focus attention when looking for new services or expanding services into other areas.

In addition to candidacy, most of the FFSPA services have specific eligibility requirements. These requirements are detailed in section II Title IV-E Prevention Services. DCFS staff will be trained through in-person and on-line trainings on FFSPA services and eligibility requirements as described in sections VII and VIII of this plan. By the end of the second year of FFSPA implementation, DCFS will have a flow chart available to help workers and supervisors ask the appropriate questions when looking for FFSPA eligible services. This flow chart, which will be updated as new services become available, will be developed from the established program eligibility guidelines, information gathered from the evaluation, and from input from providers across the FFSPA services spectrum.

d. **Reassessing Candidacy Definition Through Life of Family First**

DCFS recognizes that the child welfare system is constantly changing and evolving. With that in mind, it is reasonable to expect that the current definition of candidacy is not set in stone, but rather should evolve along with the needs of DCFS and the families it serves. Throughout the first five years of implementation, DCFS will actively seek feedback from partners, providers, and parents, while also analyzing data to make changes to candidacy as needed.

IV. Monitoring Child Safety and Risk

Pre-Print Section 3

DCFS policy requires FSWs to assess and address risk and safety concerns for all children receiving services. As part of the root cause analysis completed for the CFSR, it was determined that assessing and addressing risk and safety concerns continues to be an area where Arkansas struggles. Round 3 of the CFSR found that lack of ongoing risk assessments is a greater problem in in-home cases than in foster care; however, steady improvements have been made in SFY 2018 and the first half of SFY2019. Improvements can be attributed to additional staff positions, strategies to decrease staff turnover, and a focus on prevention work.

Arkansas’s current risk assessment tool was adapted from SDM and is a double-stream abuse/neglect assessment. This risk assessment tool must be used in an investigation with a true finding. Current DCFS policy reflects that the risk assessment should be used to inform case opening, however, since unsubstantiated investigations do not require a risk assessment be completed, in practice this does not factor into case opening decisions. Cases are currently opened based on either a true finding or a safety factor. Unsubstantiated investigations do not result in a case opening even in families where there is substantial risk for future maltreatment without intervention unless the family voluntarily requests services. In addition, DCFS currently has one risk assessment tool to be used at all stages of involvement with the family. Arkansas is actively addressing this in its work with Evident Change, formerly the National Council for Crime and Delinquency (NCCD).

Efforts are in place to improve training, support, and the tools used for assessing risk and safety. For example, DCFS requested assistance from Casey Family Programs and Evident Change to help in assessing and remedying potential obstacles to effectively assessing and addressing risk and safety. Work began in 2018, with Evident Change initially focusing on understanding existing practice and tools through two primary activities: an offsite review of policy and key informant interviews. DCFS is using implementation science to implement Safety Organized Practice and Structured Decision Making over a five-year period (see Arkansas's Child and Family Services Review Program Improvement Plan and 2020-2024 Child and Family Services Plan for more details regarding the work with NCCD). Further information regarding the implementation process is in Section VIII: Child Welfare Workforce Training.

Evident Change is working with DCFS to create validated assessment tools that are specific to stages of a case. These include an intake assessment, safety assessment, risk assessment, case planning tool, reunification assessment, and risk reassessment as follows:

1) Intake assessment – This assessment has two components: screening and response priority. These components are used to help the hotline worker determine if a CPS response is needed, based on local legal and regulatory requirements, and if they should be a Priority 1, Priority 2, or D.R. assignment. At this time, CACD is in agreement with implementing this tool.
2) Safety assessment – This assessment provides a structure for assessing the presence of immediate danger to a child. Workers will use this guide as a support in making decisions about whether a child may remain in the home with no intervention, may remain in the home with a protection plan in place, or must be taken into protective custody. Use of this tool will help to provide consistency in decision making across the state. This tool is to be documented with 24 hours of first contact with the victim or identified children, when there is a change in family conditions, if there is a change in the initial safety decision, and when a recommendation is made to close an in-home case.
3) Risk assessment – This is an actuarial assessment that looks at a range of family characteristics including number of prior referrals, children's ages, and caregiver behaviors that demonstrate a strong correlation with subsequent child abuse and neglect referrals to classify families by their likelihood of future involvement with the system. This risk assessment classifies families in low, moderate, high, and intensive risk levels. Workers will use this guide as a support in making decisions about case opening and intensity of services.
4) Case planning tool – This was formerly known as the family strengths and needs assessment. This tool provides a reference to ensure that all workers consider each family's strengths and needs in a clear, consistent manner and helps identify priority areas to address in the case plan.
5) Reunification assessment – This tool is used when at least one child is in out-of-home care. This tool helps ensure that local and federal policy regarding reunification, permanency planning, and termination of parental rights are effectively translated into practice. The presumptive guidelines behind this tool are based on risk of future maltreatment, demonstrated parenting interest and involvement in their children's lives, and safety of the home environment.
6) Risk reassessment – This tool is used for in-home cases and is used at regular intervals (i.e., every ninety days). This tool helps guide a worker in making decisions regarding whether a case should remain open; and if so, at what level or intensity of services.

Due to the transition to a CCWIS system taking several years, Evident Change will host these tools in their data collection system. The current plan is that, as the CCWIS system is built, the tools will be integrated into this new system. These tools will help improve consistency and accuracy in assessing and addressing risk and safety. These tools will be implemented in phases as each tool is customized for Arkansas based on state laws and preferred language. Each tool has been tested for inter-rater reliability. The intake assessment will be the first tool to be implemented in 2022. In the meantime, DCFS will

continue using the current Health and Safety Assessment which is comprised of three parts: The Health and Safety Checklist, Safety Planning, and Risk Assessment.

The Health and Safety Checklist is comprised of fourteen safety factors to help the worker determine if a child's health or safety are in immediate danger. The initial Health and Safety Checklist is completed by the DCFS investigator. If the investigation is being conducted by CACD and they identify a safety factor, they request a safety assessment from DCFS. Safety Planning is completed if DCFS identifies a safety factor. Safety planning may include the development of protection plan with the family to mitigate the identified safety factor and enhance the caregiver's protective capacity or removal of the child from the home. The protection plan is monitored by the investigator for the duration of the investigation and must be formally reassessed at thirty days. If substantial risk of harm to the child's health and safety remains at the thirty-day reassessment, then DCFS will file a petition of dependency/neglect. Protection plans can be amended as necessary.

As referenced above, if a suitable protection plan cannot be made, then the DCFS Family Service Worker (FSW) will take a 72-hour hold and petition the court for emergency custody. The identified safety factor and the protection plan or 72-hour hold is documented in CHRIS under the Health and Safety Checklist and Safety Planning screens. When a safety factor is not identified it is also documented on the Health and Safety Checklist and the Safety Planning screen is not completed. DCFS assesses for safety during every interaction with the family. If a safety factor is identified at any point during a case these same steps are to occur.

The third component of the Health and Safety Assessment is the risk assessment. The DCFS FSW completes the first risk assessment which establishes a baseline level of risk for the family.

The current risk assessment is a double-stream abuse/neglect assessment that identifies factors such as previous investigations, the presence of domestic abuse, substance abuse issues, etc. that indicate the child may be at risk of future abuse or neglect. The levels of risk are classified as low, moderate, high, and intensive. Supervisors may override and choose a higher risk level in cases where there is non-accidental physical injury to an infant, death (previous or current) of a sibling as a result of abuse or neglect, serious non-accidental physical injury requiring hospital or medical treatment, and in sexual abuse cases where the perpetrator is likely to have access to the child victim. The level of risk indicates the level of involvement to assure the child's well-being and is used to help inform the case plan in the subsequent case. DCFS assesses for risk during every interaction with the family, but the first formal risk assessment must be documented within thirty days of the receipt of the investigation and approved by the supervisor within forty-five days. This is completed prior to the opening of the supportive or protective services case. Families with a risk-assessment level of high or intensive must be seen on at least a weekly basis. The risk assessment is updated throughout the life of the case as circumstances change.

In addition, current policy requires the FSW to make face-to-face home visits weekly for the first thirty days. These visits can move to biweekly or monthly with a waiver after the first month only if the risk assessment reflects a low to moderate risk. High and intensive risk levels require weekly face-to-face visits. During these visits, the FSW is to talk privately with each child and caregiver, as well as observe the home and family interaction. In addition to the formal assessments, FSWs are to informally assess for risk and safety during each interaction with a family. With implementation of SDM and SOP, policy will be aligned to ensure required visits match the level and intensity of service recommended by the SDM tools.

DCFS is currently using the FAST as its assessment/case planning tool for in-home cases. Per policy the FAST is updated every three months at which time the case plan is also updated. As the prevention plan is an addendum to the case plan it will also be updated at this time. This provides for a reexamination of the prevention plan and whether or not the risk of the child entering care remains high despite the

provision of services or programs. These frequent updates allow for the worker and family to assess if the current services are still appropriate, if additional supports should be put in place to help the family succeed, or if an altogether new strategy is needed. Should DCFS switch tools in the future, they will still be updated every three months per policy.

The Health and Safety Assessment, FAST, Prevention Plan, and Case Plan screens are all responsibilities of the DCFS FSW and is informed by the family, the family's support system, service providers, and other involved parties. DCFS closes non-court involved cases when both the FSW and the family agree that services are no longer needed and there is low risk of future maltreatment or that the needs of the family are best met by one or more referrals to other service providers outside of DCFS contracted services.

V. Evaluation Strategy and Waiver Request

Pre-Print Section 2

The Family First Services and Prevention Act requires that each program listed in a State's Five-Year Title IV-E Prevention Program Plan have a well-designed and rigorous evaluation strategy, unless granted a waiver from HHS. HHS may waive this requirement if they deem the evidence of the effectiveness of the practice to be profound and the state to meet the continuous quality improvement standard regarding the practice.[26] DCFS is requesting a waiver for Intercept. Please see p. 36 for more information.

Theory of Change

DCFS' theory of change asserts that families who are struggling with mental health conditions, substance abuse, the lack of parenting skills and problematic family dynamics due to deficits in the five protective factors (Nurturing and Attachment, Knowledge of Parenting and Child Development, Parental Resilience, Social Connections, Concrete Support, and Social and Emotional Competence of Children)[27] are at greater risk for child abuse and neglect and are at greater risk of their children being brought into care. Therefore, if DCFS provides families whose children are at risk of being brought into foster care with services that address these core issues then family functioning will improve, less children will enter foster care, and children can remain safely in their home. While DCFS has services that address mental health and substance abuse issues the first phase of Family First implementation really focuses on parenting skills and the protective factors.

[26] ACYF-CB-IM-18-02: http://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf

[27] Center for the Study of Social Policy


Continued training and coaching
Continued inter-agency collaboration
Continued communication plan implementation
Enhancements to Statewide Automated Child Welfare Information System (SACWIS) followed by Comprehensive Child Welfare Information System (CCWIS) implementation
Policy development
Implementation Drivers
Children ages 0-18
Foster youth who are parents
Parents/other caregivers
Target Population
SafeCare
Positive Parenting Program
YVIntercept™
Family Centered Treatment
Interventions
Increased positive parent/child interaction
Improved parents' care of child's health
Enhanced home safety
Measurable gains in individual self-worth
Increased parental empathy in meeting their children's and their own needs in healthy ways
Increased use of dignified, non-violent disciplinary strategies and practices
Increased nurturing parenting beliefs and use of skills and strategies
Reduced hurtful/harmful behaviors affecting family functioning
Decreased length of time spent in residential, psychiatric, or other out-of-home placement
Decreased emotional and behavioral problems in youth
Decreased substance abuse and involvement with juvenile justice
Development of emotional and functioning balance in family so the family system can cope effectively with individual members' intrinsic challenges
Short-Term Outcomes
Reduced future maltreatment reports
Reduced foster care entry, re-entry, or both
Reduced overall foster care population
Long-Term Outcomes
Family First Prevention Services
Theory of Change
DHS Division of Children & Family Services
ARKANSAS DEPARTMENT OF HUMAN SERVICES
AR

Evaluation

Initially DCFS contracted with an independent evaluator, the University of Arkansas for Medical Sciences (UAMS), to conduct a well-designed and rigorous outcomes evaluation of SafeCare, Family Centered Treatment, and Intercept. However, with the IV-E Prevention Services Clearinghouse rating of Intercept now being "Well-Supported," Arkansas is requesting with this submission of its IV-E Prevention Plan to cease the UAMS evaluation specific to Intercept.

Request for Waiver of Family First Evaluation Requirement: Compelling Evidence Review for Intercept

The request for this evaluation waiver for Intercept is due to the compelling evidence associated with the reviews conducted by the IV-E Prevention Services Clearinghouse that resulted in the well-supported rating for Intercept. Specifically, the evidence in favor of utilizing Intercept to prevent entry into out-of-home care – a key goal of the Family First Prevention Services Act -- in Arkansas is compelling.

Two well-designed studies (of which Study 10899 consists of two parts: 2020a: "Do intensive in-home services prevent placement?" and 2020b: "Do intensive in-home services promote permanency?") conducted by Huhr and Wulczyn have demonstrated Intercept's positive outcomes for families in terms of preventing entry into foster care as well as increasing the likelihood of permanency. More specifically, the first Huhr and Wulczyn study of Intercept found that the program had a statistically significant impact on reducing the likelihood of out-of-home placement for children at risk of placement who were referred to the Intercept by the Tennessee Department of Children's Services (DCS) between 01/01/2013 and 06/30/2018. Findings also indicated that the sustained effect of Intercept is more pronounced with first 12-months and also persisted beyond twelve months.[28]

In the second report, Huhr and Wulczyn reassessed the impact of Intercept on placement prevention with a separate group of children more recently reported for maltreatment between the periods of 07/01/2018 and 12/31/2020. Consistent with the findings from the first study, the second evaluation of the Intercept program found that this intervention reduces the likelihood of placement. Among children referred to Intercept, the average treatment effect shows that the risk of placement was 37 percent lower than the children in the comparison group.[29]

Further, these studies regarding Intercept's impact on out-of-home placement prevention span almost seven years' worth of client services and related data. These included participants from across the state of Tennessee indicating that the efficacy of this intervention applies to a wide variety of locations (e.g., urban and rural) and clients (e.g., age, race, ethnicity, gender, various underlying problems, etc.). With the demonstrated success of Intercept in Tennessee, Arkansas anticipates similar positive outcomes given that the two states are suitable comparison states when taking into account geography, shared history, and similar population characteristics such as relatively low educational attainment and a high rate of adverse childhood experiences.

In fact, Arkansas-specific data regarding Intercept to date further supports this evaluation waiver request when comparing entries into foster care for the year preceding the implementation of the Intensive In-Home Services programs (CY 2018) to the entries that occurred the year in which Intercept was fully implemented and established in the original 37 counties (CY 2020). Comparing 2018 to 2020, the number of entries in each of these counties decreased. Overall, the number of entries decreased by 36 percent

[28] The Center for State Child Welfare Data: "Do Intensive In-Home Services Prevent Placement?: A Case Study of Youth Villages' Intercept Program." Scott Huhr and Fred Wulczyn. January 2020.

[29] "The Impact of Youth Villages' Intercept Program on Placement Prevention: A Second Look." Executive Summary, September 2021. https://fcda.chapinhall.org/wp-content/uploads/2021/08/Executive-Summary_third_study.pdf

for these counties (see chart below for more detail – provided by Evident Change from data pulled from DCFS SACWIS).

COUNTY	2018 Entries	2020 Entries
Cleburne	36	33
Crittenden	71	53
Cross	42	32
Independence	68	47
Jackson	44	38
Mississippi	89	52
Poinsett	91	31
White	110	68
Woodruff	19	13
	570	**367**

In addition, the CQI reviews conducted via a contract with the Public Consulting Group (PCG) have also demonstrated the positive effects of Intercept among Arkansas clients. For example, in the most recent CQI report regarding Intercept (which included interviews and file reviews conducted from October 2021-December 2021 regarding services rendered from October 1, 2020 - March 31, 2021):

- 86% of respondents strongly agreed that Intercept interventions consistently addressed their family's needs.
- 78% strongly agreed that the specialist helped their family increase factors important to their long-term success
- The majority of families, 62%, reported being more supported by community partners after participating in Intercept.
- 0% of families discharged from Intercept had a new DCFS investigation during treatment.[30]

The required ACYF-CB-PI-18-09 Attachment II: "State Request for Waiver of Evaluation Requirement for a Well-Supported Practice" for this request is attached to this submission. The CQI reviews conducted by PCG will continue for Intercept as well as for FCT and SafeCare.

Evaluation Plan for Family Centered Treatment and SafeCare

The UAMS evaluation for FCT and SafeCare will remain in place. The overall goals of the evaluation are to determine if each service is successful of improving child safety, permanency, and well-being as measured by reductions in the removal of children into foster care, maltreatment and subsequent

[30] "Arkansas Family First Prevention Services Act Continuous Quality Improvement: Family Centered Treatment (FCT) & Intercept Review." Public Consulting Group. February 4, 2022.

maltreatment, and future involvement with the child welfare system. As implementation expands, more programs will be added to the evaluation strategy either through an amendment to the current contract or through an additional procurement process.

As outlined above, DCFS will use the outcomes evaluation, conducted by UAMS (as applicable), and the results from the CQI process, conducted by PCG, to examine its IHPI collectively to help guide decisions about implementation, expansion, and monitoring outcomes.

Program Description

Family Centered Treatment: As detailed in the California Evidence-Based Clearinghouse for Child Welfare (CEBC)[31], FCT is a strengths-based, trauma informed, and evidence-based family preservation model that provides services to families directly in their homes. FCT is designed for families faced with disruption or dissolution of their family. FCT targets families with members at imminent risk of placement into (or needing intensive services to return from) treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. As such it provides services to children/adolescents who have one or more of the following: adjustment disorder, post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, depression, mood disorder, bipolar, disruptive behavior, abusive and neglectful family situations, exposure to violence and domestic violence, and involvement in juvenile crime. It also provides services to the parents/caregivers of these children and parents who experience domestic violence and/or substance abuse.

FCT has six main goals and treatment services typically last 4-6 months:

1. Enable family stability via preservation of or development of a family placement
2. Enable the necessary changes in the critical areas of family functioning that are the underlying causes for the risk of family dissolution.
3. Bring a reduction in hurtful and harmful behaviors affecting family functioning.
4. Develop an emotional and functioning balance in the family so that the family system can cope effectively with any individual member's intrinsic or unresolvable challenges.
5. Enable changes in referred client behavior to include family system involvement so that changes are not dependent upon the therapist.
6. Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability.

SafeCare®: SafeCare® is a structured, evidence-based home visiting program that involves a SafeCare provider and parent(s) working together to promote positive interaction between the parent(s) and their children. This is done through parent skill building in the home, including modeling and teaching role-play, which helps parents improve their parenting and decision-making skills, as well as knowledge of their child's health and safety needs. Delivered by providers who receive intensive coaching using a model created and overseen by the National SafeCare Training and Research Center (NSTRC), the program is structured into three distinct modules: Home Safety, Child Health, and Parent-Infant Interaction (PII) or Parent-Child Interaction (PCI), the last of which depends on the child's age at enrollment. Each module is conducted over six 1-1.5-hour sessions and families are typically enrolled for 18 to 22 weeks. All modules use a similar teaching model: An initial assessment session, four sessions of training, and a final re-assessment session.

[31] http://www.cebc4cw.org/program/family-centered-treatment

Evaluation Questions

UAMS will conduct a rigorous quantitative outcomes evaluation using a quasi-experimental design. The research questions specific to Family Centered Treatment and SafeCare) will be:

Child Safety Outcomes

1. Will families served by IHPI have reduced entry into foster at 6, 12,18, and 24 months following completion of the intervention as compared to a propensity matched comparison sample?

2. Will families served by IHPI have reduced entry into foster care during the treatment period for IHPI and propensity-matched non-IHPI families? The sample for this research question will include families who were not involved with IHPI as a reunification case.

3. Will families served by IHPI have reduced true findings and/or open cases after program closure at 6, 12, 18, and 24 months following completion of the intervention as compared to a propensity-matched comparison sample?

Permanency Outcomes

4. Will families served by IHPI have increased permanency at 6, 12, 18, and 24 months following completion of the intervention as compared to a propensity-matched comparison sample? The sample for this research question will include families who were involved with IHPI as a reunification case to see if IHPI families were more likely to be reunified than propensity-matched non-IHPI families.

Well-Being Outcomes

5. Will families served by IHPI have increased family functioning from entry into to exit from protective services as compared to a propensity-matched comparison sample?

6. Will families served by IHPI have increased well-being from entry into to exit from foster care compared to a propensity-matched comparison sample of children who were reunified with their family? The sample for this research question will include families who were involved with IHPI as a reunification case to see if IHPI supported the child's well-being compared to propensity-matched non-IHPI children.

Outcomes Measures for FCT and SafeCare®

Extracts of quantitative case data from CHRIS, DCFS' case management system, will be used to measure all outcomes in the evaluation of FCT and SafeCare®. CHRIS extracts will be generated at least semi-annually. CHRIS data include family and child characteristics and FFPSA candidacy definitions. CHRIS data also include case outcomes and dates of relevant case outcomes. The specific dates which will be used in the evaluation include the date of a true finding, and dates of reunification and/or subsequent removal. Family Service Workers also enter intervention information into CHRIS including the date of referral for FCT and SafeCare®, date of program inception and completion, and whether the family was successful in meeting program goals. The dates of program referral, start, completion, and successful completion of program goals will be verified with billing data which is closely monitored for accuracy.

The Family Advocacy and Support Tool (FAST) assessments are designed for use with the entire family. AR uses the FAST tool within thirty days of protective services case initiation and completes the tool every three months. The Arkansas FAST includes multiple indicators of family functioning, including

collaboration and supportive relationships among family members, communication and role appropriateness, family conflict and safety, financial resources, housing condition, and residential stability. In addition to general family functioning, the Arkansas FAST includes multiple indicators of the child's status, including relationships with caregiver and others, health status, mental health status and adjustment to trauma, cognitive skills and educational status, and self-regulation and interpersonal skills. Items identified as a '0' are often strengths that can be used in strength-based planning. Items rated a '1' should be monitored and preventive efforts might be indicated. Items rated a '2' or '3' are actionable and should be addressed in the intervention plan.

The Child and Adolescent Needs and Strengths (CANS) assessments are used in Arkansas with youth in out of home placements, with two unique tools created to assess the strengths and needs of children and youth, one for those ages 0–4 and a second for those five years of age and older.

Both the FAST and the CANS will be replaced with the Structured Decision Making (SDM) case planning, reunification, and risk reassessment tools. The implementation date for these SDM tools is currently planned for spring 2023.

The general method of analysis for determining the success of FCT and SafeCare® on outcomes of interest will be a prospective cohort analysis. Each case is measured from a defined starting point that is relevant to the outcomes being analyzed, for example, referral of a case to the intervention. From this point in time, prospective data were analyzed to determine whether the outcome occurred within specified time frames as described in the research questions above.

Statistical techniques and quasi-experimental methods for FCT and SafeCare

In addition to descriptive and bivariate analyses, the evaluators will make use of a variety of non-experimental analytic techniques to measure the impact of each of these services. As in most applied policy research, researchers are generally unable to randomly assign some populations to receive the policy interventions and others to a control group. In the absence of experimental methods, we look to quasi-experimental methods.

Propensity matched analyses will be used to examine each of the outcomes noted above for each of the interventions. To reduce selection bias, intervention children will be matched with non-intervention children based on 1:1 propensity matching, as follows. First, a logistic regression model will be fitted to estimate the probability of a child being assigned to the intervention using the child's demographics, mother's demographics, parent and family characteristics used to determine candidacy, and geographic and socioeconomic indicators. These independent variables specifically included the child's gender and age, the mother's race/ethnicity, the number of children in the household, candidacy reasons, and past history or open protective services support, and two indicators based on the family ZIP-code, the rural-urban commuting area code (RUCA) and the ZIP-code-level median household income. Median household income quartiles will be derived from assigning the family address a median household income based on the ZIP-code in which they resided at the time of referral.

A greedy matching algorithm will then be used to match FCT or SafeCare and non-intervention children (controls) based on a 1:1 match of those with identical or near identical model-derived propensity to be in each of the intervention groups. The SAS procedure proc psmatch will be used to perform both the estimation of propensity score and matching. Exact match may be made on some key characteristics (gender, race/ethnicity, candidacy, and RUCA) if it leads to an improvement of overall balance across covariates. All statistical analyses will be performed using the SAS system for Windows.

To test the association of FCT or SafeCare enrollment and outcomes, UAMS will fit outcome-specific generalized linear models using the SAS proc glimmix procedure. Matched pairs identified for each of the

interventions will be accounted for in individual generalized linear models by using random variable indicator for the matched-pairs dyad. An intent-to-treat design will be used to test differences in outcomes. If sample sizes are sufficient, additional sensitivity analysis may be conducted to subsample participants who successfully completed the each of the interventions. FCT and SafeCare service delivery report data, including dosage/completion data, will be drawn from child/family-level service delivery report data that contracted providers are required to produce and submit to DCFS. Where sufficient service delivery data exists, the preferred method for coding of service delivery data will be as an ordered or continuous variable, specifying dosage from zero to full completion of the intervention. In this way, evaluators will be able to determine the extent to which partial completion of an intervention may impact the intended outcome, as well as allowing for within-group comparisons.

Sample

Family Centered Treatment: As described, FCT will be provided by two contractors for services in a total of 28 counties. St. Francis Ministries has implemented FCT in 19 counties in the Northern and Eastern parts of Arkansas. Youth Advocate Programs (YAP) will be implementing FCT in an additional 21 counties in the Northern and Southern parts of Arkansas.

Eligible families are those with children aged 0-18. Referrals to FCT are provided from DCFS based on candidacy guidelines. The most common candidacy reasons for referral will include items 2, 3, 4, 5, 6, 11, 12, 13, and 17 as outline in Table 5. The two providers, St. Francis and YAP, will serve approximately 350 families (or an estimated 840 children[32]) annually. St. Francis and YAP are contracted to serve 121 and 130 families per year, respectively.

SafeCare®: SafeCare® will be provided in all Arkansas counties through a central hub, Arkansas Children's Hospital. Eligible families are those with children aged 0-5. Since this program started prior to the passage of Family First, referral criteria for SafeCare included a child who is the subject of a Garrett's Law investigation or a protective services case for neglect. The most common candidacy reasons are 1 and 16.

According to the DCFS Annual Report Card for SFY 2019[33], there were 5,054 families (12,320 children) in protective services and another 652 families in supportive services. Of the children who began receiving in-home protective services cases one year prior to SFY 2019, six percent experienced a true report of maltreatment within one year. Children ages zero to five made up nearly half (48%) of children involved in in-home protective services cases at the end of SFY 2019.

Power Analysis

UAMS performed a calculation to determine the power to correctly reject null hypothesis, given sample sizes and minimum effect of differences between each of the interventions, FCT, or SafeCare and non-intervention populations (control) to conclude success of each of the interventions. UAMS chose to determine power based on reported effects of each intervention. UAMS computed a priori power analyses, (using G*Power 3.1.9.4)[34], to determine the required sample size given our expected effect sizes.

Family Centered Treatment: To obtain the expected effect sizes, UAMS used data reported for FCT in the state of Indiana in which there was a significant difference in family dissolution, with families in FCT significantly more likely to remain intact than non-FCT families (55.61% vs. 39.04%; d=.34). They also

[32] SFY 2019 services reflect 2.4 children per household

[33] https://humanservices.arkansas.gov/images/uploads/dcfs/publications/ARC_SFY_2019-Final.pdf

[34] http://www.psychologie.hhu.de/arbeitsgruppe/allgemeine-psychologie-und-arbeitspsychologie/gpower.html

opted to determine the necessary sample to detect a smaller difference in which families in FCT were less likely to repeat true findings at 6 months post-intervention than non-FCT families (1.68% vs. 4.35%; d=.16), which was not significant.[35]

Based on chi-square test analysis, power estimate of at least 0.80, and alpha level of .05, the total sample would have to be 141 to detect the larger effect (d=.36) and 635 to detect the smaller effect (d=.16). Computing sensitivity using the same assumptions (power=0.80, alpha=.05), our estimated sample of 700 could detect an effect size d=.15. UAMS also computed the effect size for a smaller sample (250 matched pairs), a total sample of 500 could detect an effect size d=.18. Therefore, even if the sample is smaller than anticipated, we should be able to detect effects that are small to moderate in size.

SafeCare®: To obtain the expected effect sizes, UAMS used data reported for SafeCare® in the state of Colorado[36] in which families in Safecare® were significantly less likely to have a founded child maltreatment complaint than propensity-matched comparison families (OR=0.52). Based on chi-square test analysis, power estimate of at least 0.80, and alpha level of .05, the total sample would have to be 986, with 493 families in each group, to detect the comparable differences as reported in Colorado. Computing sensitivity using the same assumptions (power=0.80, alpha=.05), our estimated sample of 1,476 could detect small differences (d=.09) between the groups.

Challenges and Limitations

There are limitations to the proposed evaluation. The sole reliance on administrative data for outcomes of the current study is one limitation. There are some mechanisms in place at the state level to ensure the correctness and completeness of data. Area supervisors review candidacy with family service workers to ensure the correct candidacy reasons are included in the case files. There is also a nightly verification of social security numbers (SSN) of individuals with open cases, which can be used to correct the SSNs within the file and to ensure unduplicated case numbers for analysis. That said, there are limited resources to conduct data cleaning of individual data elements. As such, there will likely be some data loss due to out of date or range values. The UAMS evaluation team will work with DCFS to correct data elements obtained during the data extraction. For example, there are opportunities to identify out of range dates, such as those that occur in the distant past or the future, which will be done to maximize data correctness. It is also possible that enhancements to CHRIS may be required to facilitate documentation. In this case, this may result in a lack of available data and a backlog of information that would require retroactive data entry.

The FAST tool provides opportunities to document changes within families; however, the assessment windows on which Arkansas administers the tool are not directly tied to additional interventions. The FAST is conducted within 30 days of protective services case initiation and completes the tool again every 3 months. Therefore, the use of this tool does not necessarily reflect the beginning and end of FCT or SafeCare services, but rather more closely replicates the beginning and end of protective services.

An additional limitation is inherent in the quasi-experimental design. Randomization is the best method for concluding causation. While propensity matching has strengths for application in child welfare settings, it is possible that unmeasured confounding variables may be present, which would lead to biased results. Another limitation of our proposed analytic plan may be our ability to identify a fully matched comparison

[35] http://www.campbellcollaboration.org/escalc/html/EffectSizeCalculator-SMD20.php

[36] http://www.chhs.colostate.edu/ssw/wp-content/uploads/sites/7/2019/10/SafeCare-Colorado-Project-Evaluation-Report-2014-2017_final_corrected.pdf

population for either intervention. It is unclear from the sampling whether a matched comparison group within the counties where FCT is available.

While FCT will not be available in the quantity to serve any eligible family, there are additional services available within the counties served, including other evidence-based programs. If it is not possible to identify a comparison group for interventions within the counties in which they are available, UAMS will propensity match for a control group within the state, matching on the characteristics described above and on ZIP-code computed RUCA and income to identify a matched sample of families where each respective intervention was not available within the state. SafeCare is available statewide; rural/urban classification will be included as a match to assure equivalence in region. Further, power analyses are based on the full sample of families for whom intervention services are expected, analyses for subsamples appear sufficiently powered to demonstrate a small effect for FCT in the intent to treat design, but large attrition may create samples for research question 2 or 3 that are underpowered.

If it is not possible to identify a comparison group for FCT within the 40 counties in which FCT is available, UAMS will propensity match for a control group within the state, matching on the characteristics described above and on ZIP-code computed RUCA and income to identify a matched sample of families where each respective intervention was not available within the state. Further, power analyses are based on the full sample of families for whom intervention services are expected, analyses for subsamples appear sufficiently powered to demonstrate a small effect for FCT and a moderate effect for Intercept in the intent to treat design, but large attrition from either intervention may create samples for research question 2 or 3 that are underpowered.

Evaluation Team

The University of Arkansas for Medical Sciences (UAMS) is contracted to develop and implement the evaluation. All personnel are employed by UAMS in the College of Medicine's Department of Family and Preventive Medicine (DFPM), Research and Evaluation Division. Dr. Lorraine McKelvey, Associate Professor, leads the evaluation team. Dr. McKelvey earned her doctoral degree in Developmental Psychology specializing in Applied Developmental Science from Michigan State University. Dr. McKelvey has home visiting research for nearly two decades. She was a member of the research consortium of the national Early Head Start Research Project; a co-investigator of the Pew Charitable Trusts' HV Campaign project that examined the elements of home-based EHS services most related to improved child outcomes: and conducted research of a home visiting program for teen parents using the Healthy Families America (HFA) model. Dr. McKelvey is the lead evaluator for the Arkansas' Maternal, Infant, and Early Childhood Home Visiting programs (HFA, Parents as Teachers, Home Instruction for the Parents of Preschool Youngsters, and Following Baby Back Home) and SafeCare.

See Table 6 for which services will be formally evaluated, for which DCFS is considering requesting waivers for in the future, and which services DCFS will claim FFPSA funding. Information in Table 6 assumes waiver approval for transitional payments until rated on the Title IV-E Prevention Services Clearinghouse and assumes implementation of service occurs on schedule. Adjustments will be made accordingly.

Table 6 Evaluation Type

Intervention	Category	CQI - (Evaluation Waiver- future consideration)	Formal Contracted Evaluation	State CQI and Contract Monitoring	Claiming FFPSA
SafeCare	In-Home Parenting		✓	✓	
Triple P	In-Home Parenting			✓	
Intercept	In-Home Parenting	✓		✓	✓
Family Centered Treatment	In-Home Parenting		✓	✓	✓
Home Builders	In-Home Parenting			✓	
TF-CBT	Mental Health			✓	
PCIT	Mental Health	✓		✓	
CPT	Mental Health	✓		✓	
Child Parent Psycho-therapy	Mental Health	✓		✓	
Functional Family Therapy	Mental Health	✓		✓	
Arkansas Cares	Substance Abuse			✓	
MI (DCFS Staff)	Substance Abuse			✓	

DCFS is committed to continuous quality improvement through contract monitoring, evaluation, and CQI. Each contract is overseen by a program manager or an Assistant Director. SafeCare, Intensive In-Home Services (IIHS), IFS, and Triple P are all monitored by the In-Home Program Manager. Through initial implementation of Intensive In-Home Services, monthly meetings with the providers are held to discuss implementation barriers and successes. Feedback from field staff is incorporated into these monthly meetings. Providers must also submit a certification of compliance each month along with a monthly report. The information provided in the monthly report is changed as needed to ensure the right information is being reported. Along with the monthly reports, each IIHS provider must submit semiannual and annual reports on the outcomes they are achieving. Regular provider meetings are also held with SafeCare, IFS, and Triple P: Triple P is a monthly meeting; SafeCare is every other month, and IFS is

every quarter. All counseling and substance abuse contracts are monitored by the In-Home Services Program Manager. DCFS is poised to use the feedback from the evaluation and CQI to improve program implementation, DCFS practice, and refining processes.

VI. Prevention Caseloads

Pre-Print Section 7

DCFS does not have a set ratio of cases by type for frontline case workers. Arkansas is a very rural state, with 42% of its population residing in a rural county; this is a stark comparison to the national profile of only 15% of the population living in a rural area. In rural counties, there is a limited number of staff because positions are assigned based on the need (i.e., number of cases in a county). Due to these dynamics, the structure of each DCFS office varies by county. Some county offices have FSWs that work investigations, foster care, and in-home cases, where others have designated investigation units and units with mixed caseloads of foster care and in-home, while others still, have designated staff for each role.

DCFS' current goal is to maintain caseloads at 20 or under. While caseload averages are slightly skewed by graduated caseloads[38], and some areas struggle with caseload sizes much more (e.g., within SFY2018, Area 1 had an average high of 39 and an average low of 25.2, whereas Area 10 had a high of 17.3 and a low of 15), DCFS still made great strides in lowering caseload sizes prior to the implementation of Family First in Arkansas. In 2016, the average statewide caseload was 28, with six counties averaging caseloads above 40 and three above 50. As of June 2019, the statewide average was 18.7, no county had an average caseload size above 40, and 80% of the state had average caseloads 25 and below. In part because of the COVID pandemic and increased staff turnover discussed in the Introduction section of this plan, caseloads have seen an overall increase starting in June 2020, thought the statewide average caseload did not exceed the Division's goal of 20 until September 2020. October 2021 saw the highest average statewide caseload since 2016 at an average of 25.5 cases per worker. As of February 28, 2022, the average FSW caseload statewide had decreased slightly to 24.5 cases, with Area 10 having the lowest average caseload at 13.1 and Area 4 having the highest average caseload at 35.3.

Caseloads are monitored at the unit, county, area, and statewide level through reports generated from Evident Change. In addition, the Community Services Unit monitors to ensure graduated case load guidelines are being followed.[37]

DCFS has also partnered with Evident Change to implement SafeMeasures (see Arkansas's 2020-2024 Child and Family Services Plan (CFSP) Goal 4, Strategy 10). While SafeMeasures is a case management tool helping workers manage their workflow, it also allows real time data from the worker level to the statewide level. SafeMeasures allows supervisors and county supervisors to more easily monitor caseload sizes on a daily basis.

DCFS has implemented strategies to address caseload size and retention. Prior to the launch of Family First this included implementing a graduated caseload protocol as one example. In 2021, the Division put forth several retention strategies such as:

[37] DCFS implemented graduated caseloads in 2017 to ensure that new workers were assigned cases in a structured manner.

- Holding the first Leadership Academy for selected DCFS Supervisors with the support of the Division's National Child Welfare Workforce Institute (NCWWI) grant in partnership with the University of Arkansas at Little Rock;
- Allowing staff to claim overtime when more than 40 hours are worked in a week (rather than requiring staff to first bank 240 hours of comp time as was the previous mandate);
- Implementing an on-call pay differential for staff at 20% of their base rate of pay when officially assigned to on-call;
- Developing a career service ladder for FSWs.

Along with monitoring DCFS caseloads, contracts with DCFS In-Home Parenting EBPs include limitations on case load sizes. SafeCare staff have a full caseload at 12 families and can have no more than 15 (note that for SafeCare each caregiver in the home is counted as a separate case to align with the other Home Visiting Programs). All Intensive In-Home Services (Intercept and Family Centered Treatment) may have no more than 5 cases per worker. Triple P does not have a set number for a full-caseload, but rather use a work unit breakdown of direct service, time spent traveling to the family's homes, and the preparation work needed to determine when a worker has a full case load.

VII. Child Welfare Workforce Support

Pre-Print Section 5

The leadership at DCFS recognizes that the Division has several initiatives at this time (e.g., Structured Decision Making, Safety Organized Practice, restructuring Team Decision Making, several new services including SafeCare and Intensive In-Home services, and implementing Family First). In the past, DCFS has struggled with presenting new initiatives in a cohesive way so that front line staff sees each piece as part of a whole and as integral to their work. This has resulted in inconsistency in implementation and a workforce that sees new initiatives as another checkbox instead of as a framework in which to do their job well. DCFS leadership has learned from this experience and is mitigating that with the following steps.

First, DCFS held a series of Zoom meetings called "Family First Fits Us" to discuss what Family First is, how it aligns with the DCFS value that every child in Arkansas deserves a safe, stable, and nurturing family every day, and to inform staff of Arkansas's intent to implement Family First on Oct. 1, 2019. These provided high level overviews and were followed up by in person trainings for each area on the specifics of how to assess for eligibility, how to complete a prevention plan, and how to choose an appropriate evidence-based practice if available. There were also follow up trainings for the changes occurring in foster care placements such as the recent series of Zoom webinars offered to staff in spring 2022 regarding QRTP referrals and services.

As a follow up to the introductory Zoom meetings and to help support the implementation, the In-Home Program Manager conducted coaching calls with supervisors to further their understanding of candidacy, prevention plans, and the chosen EBPs. These coaching calls had several purposes:

1) How to determine candidacy correctly.
2) How to conduct prevention planning in a high-quality manner and how to use them in conjunction with the case plan.
3) How to determine which, if any EBP, is a good fit for a family.
4) How all these pieces fit together to improve practice.

Along with best practice issues, these coaching calls helped to address any issues with the technical aspects of filling the screens out correctly. These coaching calls were held at least by area with some areas having multiple calls based on the number of supervisors. These calls were held monthly during initial implementation and continue to be held as needed. Coaching calls, Zoom meetings, or face-to-face sessions may also be provided to caseworkers if requested by county or unit supervisors. The In-Home Program Manager and Specialist monitor the CHRIS Net reports made for candidacy and prevention plans to gauge where more training or coaching is needed as well.

Traditionally, when new services are added, “Kick-Offs” are held to introduce the new service and provider to staff. When appropriate, “kick-offs” will be held when new Family First eligible services are added and become available in an area. DCFS has done “kick-offs” in each area as SafeCare and IIHS have rolled out. DCFS planned to implement “Service Cafés” in year two of implementation. These would serve to introduce staff to providers in their area and give them a chance to sit down and learn more about the service and ask questions, as well as allow providers to have the same opportunity. At each “Service Café” a portion of the time would be spent on helping workers “connect the dots” on how these services fit into Family First either as a family first eligible service or as a support to the EBPs. Due to COVID-19, these “Service Cafes” had to be put on hold.

The work DCFS is doing in collaboration with Evident Change is integral to the success of its In-Home program and Family First implementation. Evident Change is providing the support necessary to write policy revisions, create validated assessment tools, train, and coach staff on how to implement the safety-organized practice model and SDM. These training and coaching efforts are vital to support practice change and use SDM to fidelity. Evident Change will also be providing continuous quality improvement activities over the next five years.

VIII. Child Welfare Workforce Training

Pre-Print Section 6

Building a strong workforce is a critical component in the Division’s efforts to build upon successes thus far in our system improvements. Making sure that our workers have the tools they need, giving them a manageable and equitable caseload, supporting and encouraging them, and ensuring the best legal support possible all combine to lead the way of our work in Phase Three over the last year.

DCFS partners with MidSouth, the community service branch of the University of Arkansas at Little Rock (UALR) School of Social Work, to provide new worker training for all Program Assistants (support role staff), Family Service Workers, and Supervisors. The Arkansas Academic Partnership in Public Child Welfare has nine IV-E university training partners, including UALR, that provide field training during the first year of employment for FSWs and supervisors as well as the quarterly in-service trainings mentioned in section VII. These trainings are to ensure that all front-line staff are competent, professional, trauma-informed, and have the skills necessary to do this work in a manner consistent with DCFS values. Evident Change will be providing training and coaching for the implementation of SDM and SOP, which are foundational to accurately assessing risk and safety, over the course of implementation. Furthermore, these concepts as well as candidacy, prevention planning, and EBPs will be written into the curriculum for ongoing training of new FSWs.

DCFS caseworkers are hired as generalist family service workers and are expected to be able to perform all duties associated with front line casework. DCFS has a hybrid training model of online (self-directed) training, field training (as mentioned above). New FSWs participate in a five-week foundational training provided by Mid-South that addresses the Division’s Practice Model, trauma-informed child welfare

practice, the dynamics of maltreatment, and assessments (CANS/FAST). In addition, all FSWs attend week-long concentration trainings through Mid-South in the areas of investigations, in-home cases, and foster care. While Differential Response (DR). is touched upon in new family service worker training, a separate training provided by the DR Program Manager and Specialist specifically for DR is mandatory for any worker assigned to DR.

A Worker Readiness Assessment Meeting (WRAM) is held after an employee has worked for eight months. At this time the FSW, field trainer, and FSW supervisor review the FSW's training status and develop a plan for training activities needed in the remaining four months of the worker's first year of employment. Information from the WRAM is also used to help the supervisor guide the individual assessment, completed at the 9-month mark, that determines whether the FSW is ready to complete the graduated caseloads and receive a full caseload.

DCFS also has a mandatory trauma training each year in addition to quarterly trainings for continuing education. Topics covered by Quarterly training vary by each Area. During the first year of Family First, DCFS ensured alignment of Family First values with the approved topics while assessing the need for additional trainings. This has been a continuous process based on continued implementation needs and feedback from staff, providers, parents, and other stakeholders.

For more information regarding child welfare workforce training, please see the state's 2020-2024 State Training Plan (Attachment H of Arkansas's 2020-2024 Child and Family Services Plan).

IX. Consultation and Coordination

Pre-Print Section 4

DCFS is committed to ensuring community engagement and stakeholder input in the implementation and expansion of Family First. In the recent past, DCFS conducted 44 focus groups across the state with stakeholders as part of its Child and Family Services Review (CFSR) Statewide Assessment and, as part of its root cause analysis efforts related to the CFSR Program Improvement Plan development, these additional focus groups were held: ten with front line workers and supervisors, one with Area Directors, three with agency attorneys, and three with legal stakeholders including judges, parent counsel, and attorney's ad litem, one with Youth Advisory Board, and one with the Parent Advisory Council. Although not directly tied to Family First implementation, the feedback from these focus groups helped inform planning for Family First implementation.

The Division also held Family First Provider meetings with providers from across the state that serve DCFS clients, through foster care services and in-home services, to discuss the Family First Prevention Services Act and what it means for Arkansas families and for them. These meetings were to discuss services already in place, RFQs and RFPs being issued, and to elicit feedback from them regarding the direction DCFS is taking. The Assistant Director of Placement Support and Community Outreach, along with others in her unit, had one-on-one phone calls with placement providers to help them work through what FFPSA would mean for their facilities to help them to transition into FFPSA compliant models. DCFS also presented at the Children in the Courts Conference on Family First, which engaged the legal community, including judges, attorneys ad litem, parent counsel, and agency attorneys.

In June of 2018, the Division started the Parent Advisory Council (PAC). This council is made up of parents who have been involved with DCFS either through an investigation, a protective services case, a D.R., or have had their children placed in foster care. The PAC gave feedback and approval on the definition of candidacy and will continue to be involved in providing feedback and helping shape the

direction of in-home services in Arkansas.[38] In conjunction with the work the PAC will do as its own council, they will also be represented in workgroups and will eventually assist in trainings and messaging efforts. During the COVID-19 pandemic, maintaining engagement with the PAC has admittedly been challenging.

The Division and ARBEST have collaborated in the past and are interested in collaborating again on the effort to increase access to trauma-informed therapy for adults. As discussed in section II, ARBEST's mission is to build a trauma-informed mental health system. They are best known for providing training for mental health professionals in trauma-informed therapeutic modalities. They have done significant work in training therapists across the state in TF-CBT and other trauma informed therapy for children and families. ARBEST is now looking at training clinicians in trauma treatment for adults.

For more information on the Division's overall collaboration efforts, to include Family First implementation, please see the Collaboration Section of Arkansas's 2020-2024 Child and Family Services Plan.

X. Assurance on Prevention Program Reporting

Pre-Print Section 8

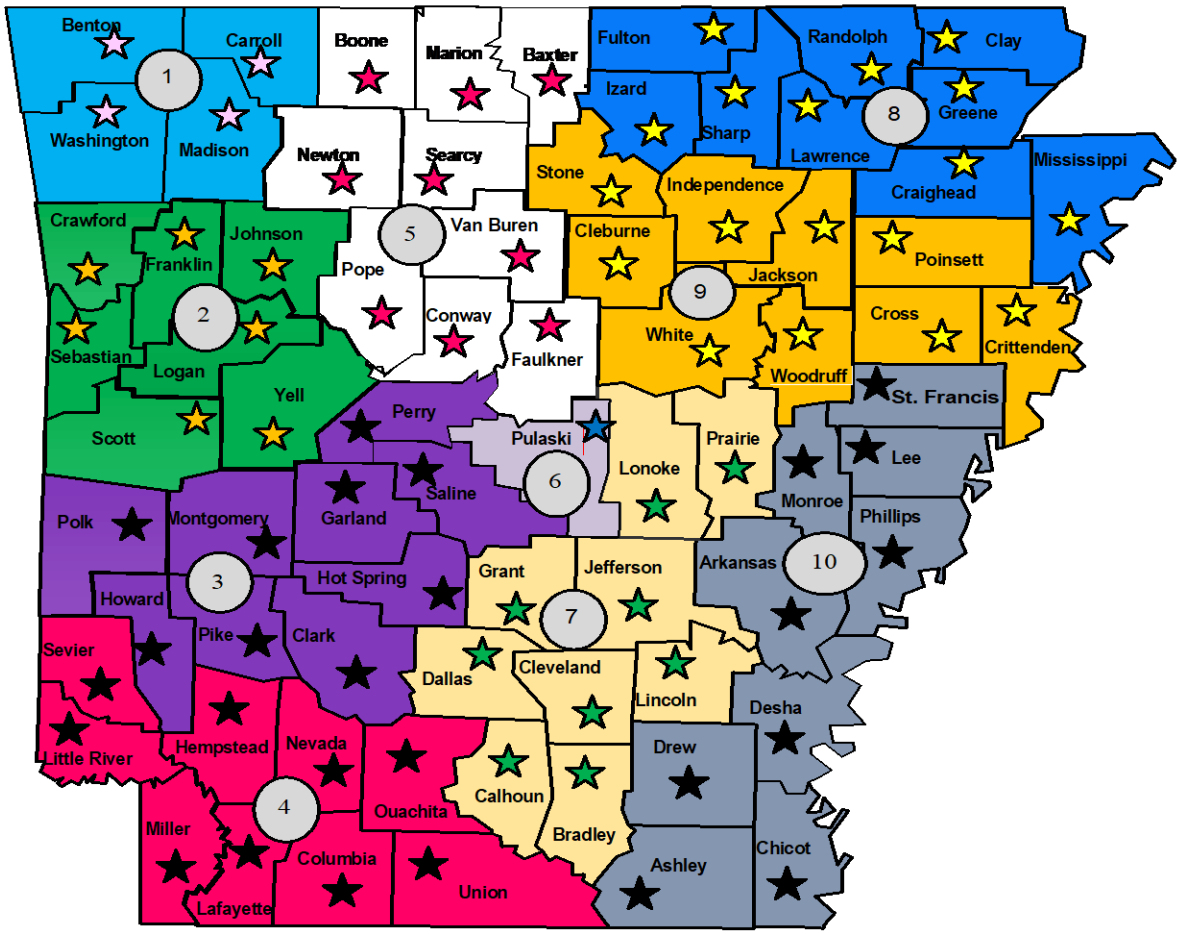
Arkansas provides such assurances that the state will report to the Secretary such information and data as the Secretary my require with respect to the provision title IV-E prevention programs and services, including information and data necessary to determine the performance measures.[39] **See Appendix A – Attachment I.**

[38] Several PAC members completed NFA and wish for the Division to expand access to NFA.

[39] Family First Services and Prevention Act, Section 471(e)(5)(B)(x)

Appendix A: Service Coverage Maps

SafeCare – Coverage 2022

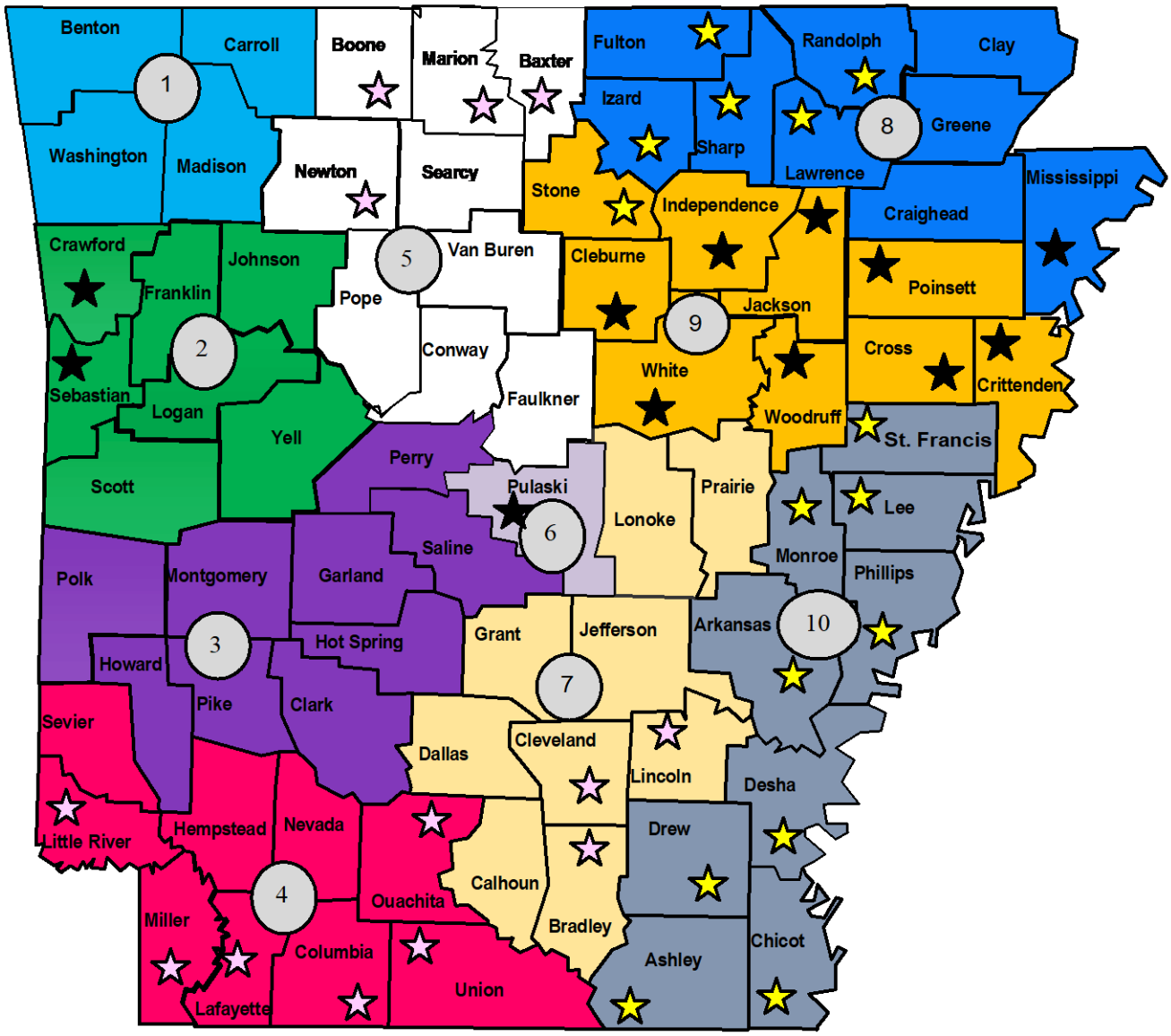


KEY

Area	Local Implementing Agency	Rollout Schedule	Area	Local Implementing Agency	Rollout Schedule
1	EOA of Washington County	Active	6	Arkansas Children's Hospital	Active
2	Western Arkansas Guidance and Counseling	Active	7	People Advocating Transitions Center (PAT)	Active
3	Compact	Active	8	Mid-South Health Systems	Active
4	Compact	Active	9	Mid-South Health Systems	Active
5	Arkansas Tech University	Active	10	PAT Center	Active

Appendix A: Service Coverage Maps

Intensive In-Home– Coverage 2022

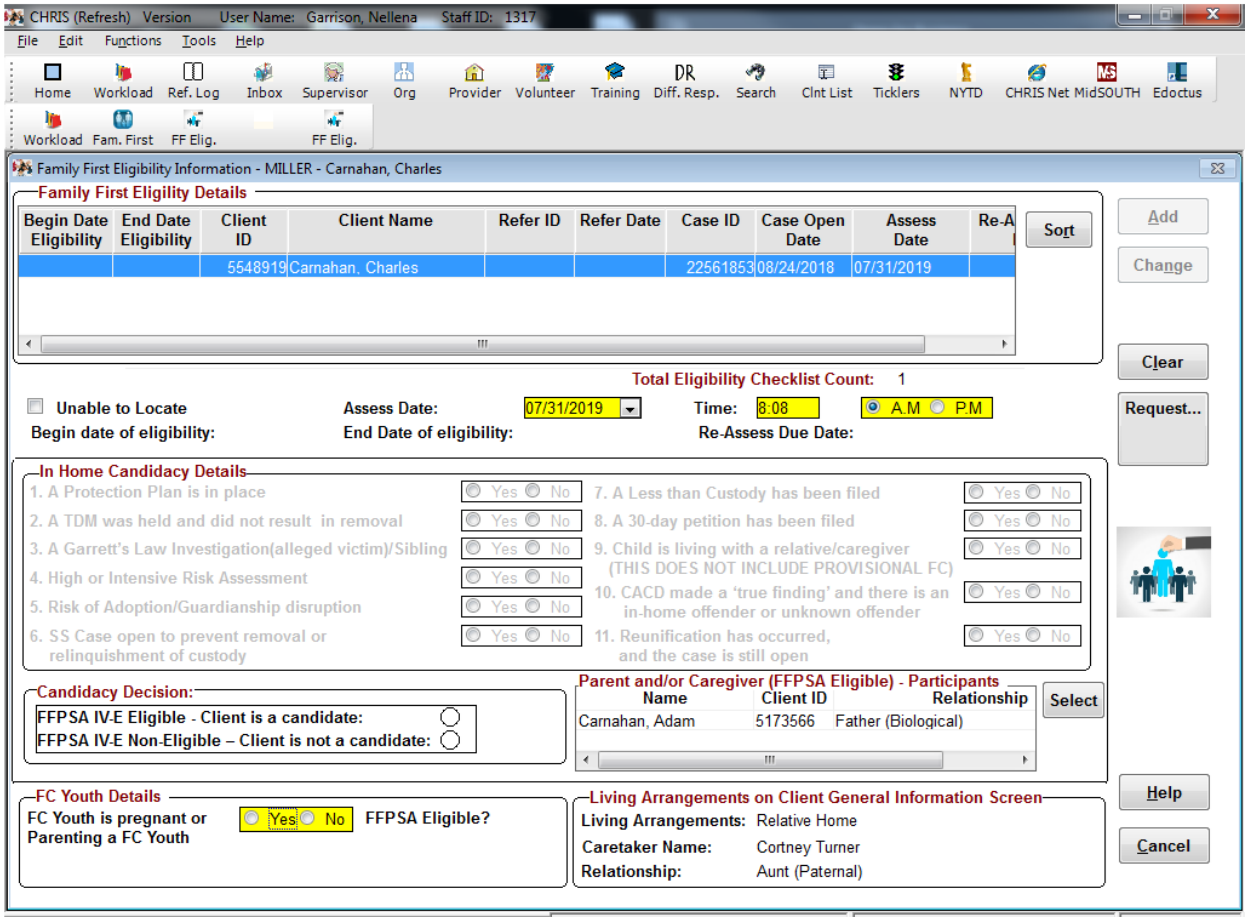


KEY

Provider	DCFS Areas/Counties
Youth Advocate Program	Area 4: Little River, Miller, Lafayette, Columbia, Ouachita, Union; Area 5: Bradley, Cleveland, Lincoln; Area 7: Boone, Newton, Marion, Baxter
Youth Villages	Area 2: Sebastian, Crawford; Area 6: Pulaski; Area 9: Crittenden, Cross, Poinsett, Woodruff, Jackson, White, Cleburne, Independence; Area 8: Mississippi
St. Francis	Area 8: Fulton, Izard, Sharp, Randolph, Lawrence; Area 9: Stone

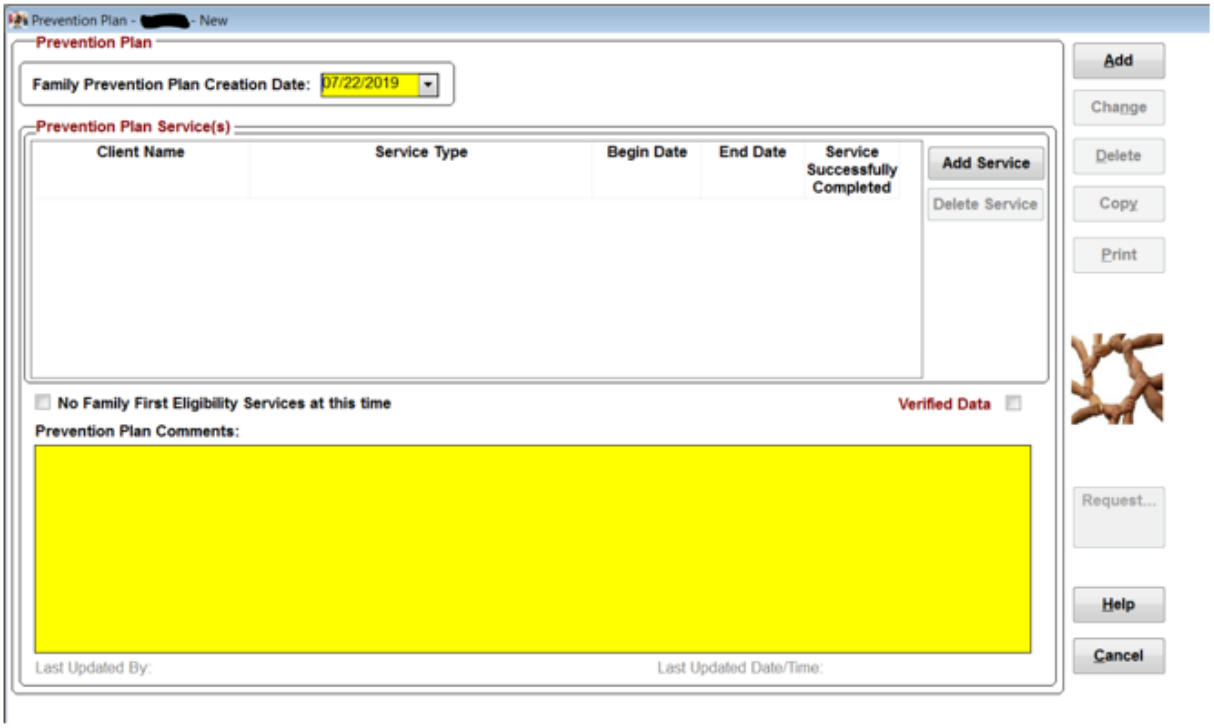
Appendix B: Eligibility and Prevention Plan Mock Ups

Family First Eligibility screen



Appendix B: Eligibility and Prevention Plan Mock Ups

Prevention Plan Screen



Appendix C: Attachments

Please see the following Attachments (provided in separate files) included within this plan:

ATTACHMENT I: State Title IV-E prevention program reporting assurance

ATTACHMENT II: State request for waiver of evaluation requirement for a well-supported practice

ATTACHMENT III: State assurance of trauma-informed service-delivery

ATTACHMENT IV: State annual maintenance of effort (MOE) report

ATTACHMENT V: Required Documentation of Independent Systematic Review for Transitional Payments