Title IV-E Prevention Program Plan

FFY 2025-2029

Utah Department of
Health & Human Services
Child & Family Services

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INTRODUCTION

The Family First Prevention Services Act (FFPSA) (Public Law 115-123) authorizes optional Title IV-E funding for time-limited prevention services for mental health and substance abuse prevention and treatment and for in-home parent skills based programs. These evidence-based prevention services and programs may be provided for children who are candidates for foster care and their parents or kin caregivers. The overall goal of the Title IV-E Prevention Program is to prevent the need for foster care placement and the corresponding trauma of unnecessary parent-child separation.

The Utah Department of Health and Human Services (DHHS) is electing to continue implementation of the Title IV-E Prevention Program as authorized by FFPSA. As instructed in ACYF-CB-PI-24-07, the following is Utah's five-year Title IV-E Prevention Program Plan for FFY 2025 through FFY 2029. This plan continues to focus on strengthening parents' capacity to safely care for their children and safely reducing the need for foster care.

Utah's Title IV-E Prevention Program Plan continues to be deliberately modest in scope, with the new plan being simplified and slightly scaled back from the prior plan due to limited administrative and program capacity. In this plan, the process for determining that a child is a candidate for foster care has been simplified, consistent with processes established by other states. In addition, three evidence-based services are being dropped from the plan due to limited capacity and resources for ensuring fidelity and conducting required evaluations.

Under this plan, a basic operational foundation for Title IV-E prevention will be maintained, and when feasible, the Title IV-E Prevention Program Plan scope will be expanded through subsequent amendments to the plan. For example, the prevention service array may be expanded through plan amendments to include additional evidence-based services approved through the Title IV-E Prevention Services Clearinghouse. Future amendments may also include extending prevention services through community pathways to children at imminent risk of

entering foster care that are not currently receiving ongoing services through the child welfare or juvenile justice systems and to their parents or kin caregivers.

SECTION 1. Service Description and Oversight

A. Service Categories

The Utah DHHS will provide services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregiver's needs for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. Categories of prevention services and programs include:

Mental Health and Substance Abuse Prevention and Treatment Services

Approved evidence-based mental health and substance abuse prevention and treatment services will be provided by a qualified clinician to a child or to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a prevention candidate in a prevention plan and prevention services are initiated.

In-Home Parent Skill-Based Programs

Approved, evidence-based in-home parent skill-based programs will be provided to a child and to the child's parents or kin caregivers for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan and prevention services are initiated.

B. Evidence-Based Services and Programs

The evidence based services and programs selected for Utah's five-year Title IV-E Prevention Program Plan are listed in the tables below.

Service	*Families First-Utah Youth Village (FF)*
Service Description *FF*	The Families First program, developed by Utah Youth Village, is an in-home, skills-based intervention designed to teach parents, youth, and children skills to change problematic behaviors occurring in the home and to improve family well-being and family functioning. FF seeks to promote child safety, child permanency, child well-being and adult well-being. The Families First program follows a trauma-informed, structured phases approach where intensity and duration are adjusted based upon the Risk, Needs, Responsivity Model. The service also utilizes the Teaching-Family Model as the skill delivery model for program implementation. Examples of skills taught to parents include maintaining discipline without anger or violence, accountability, positive social skills, effective communication, and setting and maintaining boundaries. Children are also taught complementary social skills to reduce unwanted behaviors. The Families First program is typically provided at a family's residence to increase the likelihood of accurate assessment and observation, and to enable teaching, positive reinforcement, modeling, and role-playing to occur in a natural and comfortable environment for the family. Families typically receive 8-10 hours of service per week over 8-12 weeks. Completion of the program is based on skills-acquisition and successful completion of the model's six phases.

A Level of Evidence *FF*	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category *FF*	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual *FF*	Utah Youth Village. (2021). *Families First program manual*
Plan to Implement *FF*	• The Families First program was implemented under Utah's FFY 2019-2024 Title IV-E Prevention Program Plan. Utah plans to sustain this service during the FFY 2025-2029 Title IV-E Prevention Program Plan. The Families First program has been available in Utah since 1993 and was added as a service under Utah's Title IV-E child welfare demonstration project in 2016. To sustain implementation under Utah's Title IV-E Prevention Program Plan, the following steps will be completed: • Continue to maintain a DHHS contract with Utah Youth Village to provide The Families First program to families with children or youth who are candidates for foster care under the prevention program. • Make the Families First program available to candidates for foster care under the prevention program through both the Division of Child and Family Services (DCFS) and through the Division of Juvenile Justice and Youth Services (JJYS). • Expand capacity for the Families First program to be provided to more communities within each of the five DCFS geographic regions in the state, particularly in rural areas, to the extent that funding and need supports. • Distribute information to caseworkers about the availability of the Families First program under the Title IV-E Prevention Program to facilitate continuing referrals, particularly as the service becomes available in additional geographic areas.

	• Train caseworkers on the Families First program and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve *FF*	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for the Families First program - Utah Youth Village, Utah expects to see the following outcomes for children and families receiving this service: Increased child safety (reduced repeat maltreatment); Increased child well-being (reduced recidivism for delinquent behavior).
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice *FF*	See Section 2.C. CQI Overall Strategy. DHHS will monitor fidelity and outcomes related to the implementation of FF by verifying that program specific fidelity processes are completed, along with the CQI overall strategy described in Section 2.C. Utah Youth Village, with its The Families First program, is accredited by the Teaching Family Association. To maintain this status, the program must "recertify" annually by submitting information that demonstrates implementation fidelity to the Teaching Family Model. Additionally, every three years the program undergoes a rigorous site review that involves in-person observation of the service, documentation review, and interviews of staff, clients and other consumers. The elements that are assessed and monitored for fidelity to the Teaching Family Model include training, evaluation, consultation, and direct in-home observation, referred to as "service delivery." The Families First program in-home workers participate in a defined training program followed by regular consultation and

	in-home observation of their direct work with families, which continues after certification has been attained. In-home workers also participate in formal evaluations by a neutral evaluator at six months, twelve months, and annually thereafter. The evaluation is a comprehensive review of all aspects of fidelity to the Teaching Family Model, including direct in-home observation, review of written documentation, and anonymous reviews by clients, referring workers, co-workers, and other professionals who may be involved in the service. DHHS will verify through monitoring reviews that The Families First program implements fidelity monitoring and outcome measurements using the Families First program fidelity monitoring tools and internal programmatic monitoring processes. UYV measures of improvement in Y-OQ scores for youth, and parent survey data on skills learned, goals met, and family completion of the program will be included in the reviews. Using existing monitoring processes in combination with fidelity and outcome data generated by providers and contained in Utah's CCWIS, DHHS will work with the Families First program to incorporate findings from the data and outcomes to support overall program development. DHHS will work with program implementation and/or fidelity experts to provide technical assistance as necessary.
How Selected *FF*	DHHS subject matter experts reviewed service utilization and client outcomes during the first plan period. Based on positive results, DHHS determined to maintain the service in the FFY 2025-2029 plan.
Target Population *FF*	The Families First program is an evidence-based, parent-training curriculum for parents and children ages 0-17 who are at-risk as a result of family conflict, lack of parenting skills, child abuse, childhood emotional issues, or disruptive behavioral problems.

Assurance for Trauma-informed Service Delivery *FF*	See Attachment III. *State Assurance of Trauma-Informed Service-Delivery*.
How Evaluated (Well-Designed and Rigorous Process) *FF*	DHHS is requesting a waiver for evaluation of the Families First program, which has been rated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II. *State Request for Waiver of Evaluation Requirement for a Well-Supported Practice*, and Section 2.B. below for supporting documentation that the effectiveness of the Families First program is compelling.

Service	*Functional Family Therapy (FFT)*
Service Description *FFT*	Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11- to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in five phases that consist of (1) developing a positive relationship between therapist/program and family, (2) increasing hope for change and decrease blame/conflict, (3) identifying specific needs and characteristics of the family, (4) supporting individual skill-building of youth and family, and (5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months. Master's level therapists provide FFT. They work as part of an FFT-supervised unit and receive ongoing support from their local unit and FFT LLC.
Level of Evidence *FFT*	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category *FFT*	Mental Health Programs and Services
Version of Book or Manual *FFT*	FFT will be implemented without adaptation. 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.
Plan to Implement *FFT*	• FFT was implemented under Utah's FFY 2019-2024 Title IV-E Prevention Program Plan. This service will continue to be included in the FFY 2025-2029 Title IV-E Prevention Program Plan. Maintain a contract with the developer to allow continuing access to the FFT database in order to verify fidelity on an ongoing basis. Contract with FFT Certified Trainers to provide training to additional sites, as needed to sustain or expand service, preferably

	representing both urban and rural areas, in order to establish a network of providers credentialed to provide FFT. • Maintain contracts with qualified providers, using specific FFT enhanced rates and billing codes to process payments and to capture required client and payment data. • Distribute information to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on FFT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve *FFT*	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, Utah expects to see the following outcomes for children and families receiving this service: Improved family functioning and skills, reduced family conflict, improved youth behavior, and reduced youth recidivism and alcohol and drug use.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice *FFT*	• See Section 2.C. CQI Overall Strategy. • DHHS will monitor fidelity and outcomes related to implementation of FFT using program specific tools as a foundation, along with the CQI strategy described in Section 2.C. Fidelity and outcome measures are reported to FFT LLC on an ongoing basis by the providers in all FFT sites. DHHS is engaged with FFT LLC and providers to deploy FFT to multiple sites across the state of Utah. DHHS will coordinate with FFT LLC and providers for ongoing technical assistance and will obtain fidelity and outcome measures for all sites on a regular basis.

	• Implementation of FFT includes intensive procedures for monitoring quality of implementation on a continuous basis. Information is captured from multiple perspectives (family members, therapists, and clinical supervisors). The two measures that are utilized to represent therapist fidelity to the model are the Weekly Supervision Checklist and the Global Therapist Ratings, which are available through FFT LLC. • *Weekly Supervision Checklist:* Following every clinical staffing, the clinical supervisor completes a fidelity rating for the case that is reviewed for each therapist. This fidelity rating reflects the degree of adherence and competence for that therapist's work in that case in a specific session. Thus, the weekly supervision ratings are not global, but specific to a single case presentation. Over the course of the year, a therapist may receive up to 50 ratings, which provides the supervisor with critical information about the therapist's progress in implementing FFT. • *Global Therapist Ratings:* Three times per year the clinical supervisor rates each therapist's overall adherence and competence in FFT. The Global Therapist Rating (GTR) allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each phase and general FFT counseling skills. The GTR specifically targets time period measures with the hope of displaying therapist growth. With respect to the GTR, supervisors are encouraged to utilize the comments box under each phase to target specific strengths and specific phase areas of growth.
How Selected *FFT*	DHHS subject matter experts reviewed service utilization and client outcomes during the first plan period. Based on positive results, DHHS determined to maintain the service in the FFY 2025-2029 prevention plan.

Target Population *FFT*	FFT is intended for 11- to 18-year-old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
Assurance for Trauma-informed Service Delivery *FFT*	See Attachment III. *State Assurance of Trauma-Informed Service-Delivery*.
How Evaluated (Well-Designed and Rigorous Process) *FFT*	DHHS is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II. *State Request for Waiver of Evaluation Requirement for a Well-Supported Practice*, and Section 2.B. below for supporting documentation that the effectiveness of the practice is compelling.

Service	*Parent Child Interaction Therapy (PCIT)*
Service Description *PCIT*	In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two- to seven-year-old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach parents and caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents and caregivers from behind a one-way mirror, with same-room coaching, or via telehealth platform. Parents and caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and their parents or caregivers.
Level of Evidence *PCIT*	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category *PCIT*	Mental Health Programs and Services
Version of Book or Manual *PCIT*	PCIT will be implemented without adaptation. The Parent-Child Interaction Therapy Protocol. *Eyberg, S. & Funderburk, B. (2011)* Parent-Child Interaction Therapy Protocol: 2011. *PCIT International, Inc.*
Plan to Implement *PCIT*	• PCIT was implemented under Utah's FFY 2019-2024 Title IV-E Prevention Program Plan. This service will continue to be included in the FFY 2025-2029 Title IV-E Prevention Program Plan. • Maintain contracts with qualified providers, using specific PCIT enhanced rates and billing codes to process

	payments and to capture required client and payment data. • Distribute information to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PCIT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve *PCIT*	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, Utah expects to see the following outcomes for children and families receiving this service: Improved parenting knowledge, increased positive parenting practices, improved parent and child interactions, decreased child behavior and attention problems, and improved parent/caregiver emotional health.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice *PCIT*	See Section 2.C. CQI Overall Strategy. DHHS will monitor fidelity and outcomes related to the implementation of PCIT using program specific tools as a foundation, along with the CQI overall strategy in Section 2.C. As an assessment-driven treatment, PCIT is guided by weekly data from the Eyberg Child Behavior Inventory (ECBI) and the Dyadic Parent-Child Interaction Coding System (DPICS). These standardized instruments are supplemented by additional measures the clinician may select for careful tracking of presenting concerns of families during treatment. Providers of PCIT are required to implement fidelity monitoring and outcome measurement using these PCIT tools, which are available through PCIT International. Following are key assessment tools used in PCIT:

	• *Dyadic Parent-Child Interaction Coding System Comprehensive Manual for Research and Training 4th edition.* The DPICS is a behavioral coding system that measures the quality of parent-child social interactions. It is used to monitor progress in parenting skills during treatment and provides an objective, well-validated measure of changes in child compliance after treatment. • *Eyberg Child Behavior Inventory*. The ECBI is a 36-item parent report instrument used to assess common child behavior problems that occur with high frequency among children with disruptive behavior disorders. It is sensitive to changes with treatment and used to monitor weekly progress in PCIT. • *Therapy Attitude Inventory.* The TAI is a 10-item parent-report scale of satisfaction with the process and outcome of therapy. • *CDI Homework Sheet*. This form is a fillable PDF to track homework assigned to parents and children
How Selected *PCIT*	DHHS subject matter experts reviewed service utilization and client outcomes during the first plan period. Based on positive results, DHHS determined to maintain the service in the FFY 2025-2029 plan.
Target Population *PCIT*	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma-informed Service Delivery *PCIT*	See Attachment III. *State Assurance of Trauma-Informed Service-Delivery*.
How Evaluated (Well-Designed and Rigorous Process) *PCIT*	DHHS is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II. *State Request for Waiver of Evaluation Requirement for a Well-Supported Practice*, and Section 2.B. below for supporting documentation that the effectiveness of the practice is compelling.

Service	*SafeCare (SC)*
Service Description *SC*	SafeCare is a home-based parenting skills program for parents of children 5 years old or younger who are at-risk for or have been reported for child neglect or physical abuse. SafeCare providers work with families in their homes to improve parents' skills in three areas: parent-infant/child interactions, home safety, and child health. SafeCare targets multiple risk factors for abuse and neglect, including enhancing positive parent-infant/child interactions, promoting a safer home environment and appropriate supervision, reducing risk for unintentional injury, and encouraging systematic parental health decision making. SafeCare is structured but flexible in its delivery. It is designed to be completed in 18 sessions (6 sessions per each of the 3 modules). The actual length of the program for each family will depend on the parent's initial skills and rate of skill acquisition; it may be shorter or longer. Each session typically lasts 50 to 90 minutes depending on the session focus. Sessions are typically conducted weekly and scheduled when the parent and child routines of focus are most likely to occur (e.g., nap time, bath time). SafeCare delivery is best when delivered no more than twice a week, and no less than every two weeks to optimize skill acquisition and retention.
Level of Evidence *SC*	Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category *SC*	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual *SC*	Lutzker, J. R. (2016). SafeCare provider manual (version 4.1.1).
Plan to Implement *SC*	SafeCare was implemented during the last part of Utah's FFY 2019-2024 Title IV-E Prevention Program Plan. Utah plans to

	expand and sustain this service during the FFY 2025-2029 Title IV-E Prevention Program Plan. • Maintain contracts with community-based non-profit agencies using specific SafeCare rates and billing codes to capture required client and payment data. • Complete full implementation and sustainability activities such as coaching of in-home providers, certification of in-home providers, transition to coaching by community-based non-profit agency staff, annual accreditation, and transition to training by community-based non-profit agency staff. • Distribute information to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on SafeCare and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve *SC*	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for SafeCare, Utah expects to see the following outcome for children and families receiving this service: Improved child permanency: reduction in out of home placement
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice *SC*	See Section 2.C. CQI Overall Strategy. DHHS will monitor fidelity and outcomes related to the implementation of SafeCare using program specific tools as a foundation, along with the CQI overall strategy described in Section 2.C. DHHS is requiring community-based non-profit agencies providing SafeCare to utilize developer processes to measure progress and program fidelity. Agencies will verify they are meeting NSTRC requirements. In addition, DHHS will have access to NSTRC reports for specific agencies to verify agency

	progress and program fidelity. To help achieve fidelity to SafeCare, NSTRC assigns a coach to each individual in-home provider. Coaches work one-on-one with in-home providers in preparation and debriefing of a designated number of training sessions. In addition, sessions are recorded, then reviewed and scored by coaches to help guide providers towards proficiency. As proficiency increases, the frequency of sessions being recorded and analyzed by a coach is reduced over time, but not discontinued. In-home providers of SafeCare can transition to become coaches over a period of time, and eventually could become trainers. This ultimately enables community-based non-profit agencies to sustain the program over time with less need for external support. NSTRC will also conduct annual accreditation reviews of each community-based non-profit agency after certification of in-home providers has been attained. NSTRC will provide technical assistance and support to help agencies maintain accreditation to sustain SafeCare implementation with fidelity. Providers of SafeCare are required to implement SafeCare module assessments pre- and post-training to reinforce fidelity and measure parent behavior change. The following are key tools used in SafeCare: • Home Accident Prevention Inventory (HAPI). This tool is used to measure safety based on the presence of 10 categories of hazard items in the home. • Sick or Injured Child Checklist (SICC). SICC measures parenting skills related to child health such as when to use emergency services, call their doctor, or care for their child at home, identifying symptoms and managing the child's care. • Child Planned Activities Training (cPAT) Checklist. cPAT scores parent behaviors before, during, and after

	planned activities, measuring behaviors such as preparing for the activity in advance, praising desired behavior during the activity, and giving the child a warning that the activity is ending. A separate version is available for infants. • Child Planned Activities Independent Play (cPAT IP) Checklist. The cPAT IP measures parent's behaviors before, during, and after a time period where the child needs to play independently, scoring behaviors such as explaining the time period for the activity, checking on the child often, and spending individual time with the child after the independent play. This tool is not used for infants.
How Selected *SC*	DHHS subject matter experts reviewed service utilization and client outcomes during the first plan period and determined to maintain the service in the FFY 2025-2029 plan.
Target Population *SC*	SafeCare is an evidence-based, parent-training curriculum for parents of children ages 0-5 who are at-risk for or have been reported for child neglect or physical abuse. Pregnant and parenting foster youth may also be included as part of the target population.
Assurance for Trauma-informed Service Delivery *SC*	See Attachment III. *State Assurance of Trauma-Informed Service-Delivery*.
How Evaluated (Well-Designed and Rigorous Process) *SC*	As required for services that are rated supported by the Title IV-E Prevention Services Clearinghouse, a well-designed and rigorous evaluation of SC is in the process of being initiated by the University of Utah Social Research Institute. The SafeCare Evaluation Strategy is contained in Appendix A. Also see Section 2, Evaluation Strategy below.

SECTION 2. Evaluation Strategy and Waiver Request

Essential to an investment in evidence-based services under FFPSA by DHHS is a commitment to CQI and well-designed and rigorous evaluation activities. CQI activities will be performed under the direction of the Office of Coordinated Care and Regional Supports (CCRS) within DHHS. Evaluation activities will be under the oversight of the Office of Research and Evaluation and conducted by contract through the University of Utah, Social Research Institute (SRI). SRI is a long-time partner of DHHS, having previously completed the evaluation of Utah's Title IV-E Waiver Child Welfare Demonstration Project, HomeWorks. Evaluation activities may also extend to other university research partners in the future as additional services are incorporated into the five-year plan. CQI and evaluation activities will work in tandem to assess fidelity to program models, to evaluate program effectiveness, to assess outcomes for children and families, and to inform overall program and system improvements.

A. Evaluation Strategy

The Utah DHHS is including SafeCare, a supported evidence-based program (EBP) rated by the Title IV-E Prevention Services Clearinghouse, with this submission. The previously approved SC evaluation design has been included with this renewed plan submission. DHHS expects to submit plan amendments in the future to incorporate additional evidence-based services approved by the Clearinghouse. Full evaluation designs will be included with future plan amendments for any promising or supported services approved by Clearinghouse.

For well-supported services included in this plan and approved by the Clearinghouse, which include the Families First program - Utah Youth Village, FFT, and PCIT, a request to waive evaluation requirements with documentation of compelling evidence of the program's effectiveness and verification that CQI requirements is included in this submission.

A well-designed, rigorous evaluation plan will be developed for each program or service approved in Utah's Title IV-E Prevention Program Plan for which no

evaluation waiver has been granted. *The Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures Version 2*[1] and the *Evaluation Plan Development Tip Sheet*[2] provided by the Children's Bureau will be utilized to guide development of each evaluation plan.

The following evaluation approach will guide development of a detailed evaluation design for programs or services requiring evaluations that are submitted under a future plan amendment.

The evaluation of each program or service that is being newly implemented will generally consist of two studies: a process evaluation and an outcomes evaluation. The evaluation of programs or services that are well established and have a history of operating with fidelity may consist only of an outcome evaluation. Examples of research questions for process evaluations include: (1) Was the program implemented as the model intended? (2) To what extent did each program reach the intended target population? (3) Was implementation supported in a way that optimized fidelity to the model, effective operations, and successful outcomes? Examples of research questions for outcome evaluations include: (1) To what extent did the evidence-based program or service meet anticipated outcomes? (2) Was there a significant difference of outcomes for the intervention group compared to a similar group from a pre-intervention time frame?

The scope of each evaluation plan will take into account existing evaluation activities or measures being completed by service or program developers and may result in a request to the Secretary for approval for participation in an ongoing, cross-site evaluation.

In accordance with the *Evaluation Plan Development Tip Sheet*, the key components listed below will be considered in developing well-designed, rigorous evaluation plans for specific evidence-based programs or services.

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[1] https://preventionservices.acf.hhs.gov/resources/handbook-of-standards-and-procedures-2

[2] U.S. DHHS, Administration for Children and Families, ACYF-CB-IM-19-04 issued on August 13, 2019.

Program or Service Background

Provides context of the current situation to better understand the need for the intervention and its objective.

- Describe the treatment or intervention, the target population, and the goal or desired outcome.
- Articulate the theory of change. Define the key issues/problems the intervention seeks to address; and theoretical or causal links between intervention activities and expected changes. State the key questions the research or study will address.

Evaluation Design

Communicates the framework or process to be followed.

- Determine the type of evaluation (process, outcome, or cost).
- List relevant performance targets and associated indicators/measures.
- Define the sources and methodologies for measures.
- Describe the research design (RCT, QED/propensity scoring, etc.), if applicable, and/or provide the evaluation criteria and procedures for review.
- Map the process using a logic model and specify short- and long-term outcomes.

Data Collection

Provides the raw material needed to calculate results and to assess program effectiveness.

- Confirm that all indicators are noted on the logic model.
- Ensure indicators are discrete and quantifiable.
- List and explain tools, instruments, and/or other methods of data collection.
- Determine frequency intervals for extraction.
- Develop a sampling plan, if appropriate.

Data Analysis

Cleanses, transforms, and models data to confirm whether the intervention fulfills its purpose.

- For quantitative data, describe specific statistical methods to be used to analyze data. Identify statistical software applications and packages, and strategies to address anomalies (outliers, missing data, etc.). Describe how results will be presented to mitigate bias and to ensure objectivity.
- For qualitative data, describe analysis methods to be used to analyze qualitative data. Indicate strategies to minimize personal bias of observers/data collectors.
- Describe how results are validated using multiple data sources to corroborate accuracy.
- List potential confounding factors and efforts to manage effects.
- Articulate potential weaknesses or limitations in the selected research design and explain how these will be addressed or minimized.

Distribution of Reports and Use of Findings

Promote transparency and make information about programs and services available to the public.

- Identify appropriate reports and level of detail for different audiences.
- Indicate the frequency and format of methods for communicating evaluation findings.
- Describe plans for disseminating evaluation findings.
- Explain whether and how findings that emerge during the evaluation will inform intervention activities and program/organizational improvements (e.g., CQI plan).

Logistics

Coordinate staffing, timelines, budgets, and other infrastructures needed to perform program and service evaluations.

- Staffing. Determine the level of staffing resources needed. Describe the evaluation roles and responsibilities of staff and others. List their relevant knowledge, skills, and experience. Identify entities/organizations outside the core evaluation team that will be involved in the evaluation and specify their roles and responsibilities. Utah is still exploring whether some evaluation functions will use external consultants.
- Timelines. Provide a timeline that specifies the estimated start and end dates of all major evaluation activities, including initial planning and startup, staff recruitment and training, IRB approval, instrument development, data collection, data analysis, submission of reports, and other dissemination activities.
- Budget. Estimate costs for staff salaries, administrative overhead, external consultants, data collection, statistical software, printing, supplies, equipment, or other expenses.
- Data security, informed consent procedures, and institutional review board (IRB) approval. Describe protocols for maintaining the security and confidentiality of electronic and hard-copy data sources. Determine procedures for obtaining informed consent, as needed. Identify the IRB that will review and approve the evaluation and associated research activities including the process for obtaining IRB approval.

B. Waiver Request

On April 12, 2018, the Children's Bureau issued the following information regarding evaluation strategies for services reimbursable through Family First:

> *The state must have a well-designed and rigorous evaluation strategy for any promising, supported, or well-supported practice. HHS may waive this requirement if HHS deems the evidence of the effectiveness of the practice to be compelling and the state meets the CQI requirements with regard to the practice.*[3]

DHHS is submitting Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice, for the following well-supported services for which the evidence of the effectiveness of the practice is compelling: (1) Families First-Utah Youth Village, (2) Functional Family Therapy, and (3) Parent Child Interaction Therapy. Documentation of compelling evidence for each program or service is described below.

Compelling Evidence of Effectiveness of the Practice

Families First – Utah Youth Village

The effectiveness of the Families First program – Utah Youth Village has been demonstrated through multiple studies and inclusion as evidence-based in two clearinghouses, which, when considered together, led DHHS to conclude that the program's effectiveness is compelling for Utah's child welfare and juvenile justice populations.

For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from three evaluations that were eligible to review that resulted in a well-supported rating. It is also supported by the California Evidence-Based Clearinghouse for Child Welfare.

[3] U.S. DHHS, Administration for Children and Families, ACYF-CB-IM-18-02 issued on April 12, 2018. https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf

The review by the Title IV-E Prevention Services Clearinghouse shows that the Families First program had favorable[4] effects on child safety and child well-being, specific to child delinquent behavior, which are desired outcomes for the DHHS prevention service array. No unfavorable effects were identified. These findings are summarized in the table below[5].

Families First Program – Utah Youth Village Summary of Findings

Title IV-E Prevention Services Clearinghouse

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	0.32 12	1 (1)	830	Favorable: 1 No Effect: 0 Unfavorable: 0
Child well-being: Delinquent behavior	0.07 2	2 (9)	3521	Favorable: 6 No Effect: 3 Unfavorable: 0
Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.				

The California Evidence-Based Clearinghouse for Child Welfare rated the Families First program as having promising research evidence with medium relevance for child welfare in the categories of disruptive behavior treatment (child and adolescent) and home visiting programs for child well-being[6].

[4] According to the Title IV – E Prevention Services Handbook of Standards and Procedures, impact estimates that are favorable (statistically significant and in the desired direction).

[5] Title IV-E Prevention Services Clearinghouse. Families First - Utah Youth Village Model. Summary of Findings. https://preventionservices.acf.hhs.gov/programs/392/show

[6] https://www.cebc4cw.org/program/families-first/

Functional Family Therapy

The effectiveness of Functional Family Therapy (FFT) has been demonstrated through multiple studies and inclusion as evidence-based in multiple clearinghouses, which, when considered together, led DHHS to conclude that the program's effectiveness is compelling for Utah's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from nine evaluations that were eligible to review. It is also supported by the California Evidence-Based Clearinghouse for Child Welfare, by the Office of Juvenile Justice and Delinquency Prevention, and by the Pew's Results First Clearinghouse.

The review by the Title IV-E Prevention Services Clearinghouse shows that FFT had favorable[7] effects on child behavioral and emotional functioning, child substance use, child delinquent behavior, and family functioning, which are desired outcomes for the DHHS prevention service array. Unfavorable effects were minimal. These findings are summarized in the table below[8].

[7] According to the Title IV – E Prevention Services Handbook of Standards and Procedures, impact estimates that are favorable (statistically significant and in the desired direction).

[8] Title IV-E Prevention Services Clearinghouse. Functional Family Therapy. Summary of Findings. https://preventionservices.acf.hhs.gov/programs/108/show

Functional Family Therapy Summary of Findings

Title IV-E Prevention Services Clearinghouse

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.16 6	4 (26)	390	Favorable: 2 No Effect: 23 Unfavorable: 1
Child well-being: Substance use	0.49 18	1 (18)	52	Favorable: 9 No Effect: 9 Unfavorable: 0
Child well-being: Delinquent behavior	0.05 1	5 (20)	8636	Favorable: 4 No Effect: 16 Unfavorable: 0
Adult well-being: Positive parenting practices	0.02 0	2 (9)	163	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Family functioning	0.30 11	1 (15)	52	Favorable: 1 No Effect: 14 Unfavorable: 0
Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.				

The California Evidence-Based Clearinghouse for Child Welfare rated FFT as having supported research evidence with medium relevance for child welfare in the categories of alternatives to long-term care programs, behavioral management programs for adolescents in child welfare, disruptive behavior treatment (child and adolescent), and for substance use treatment for adolescents[9].

[9] https://www.cebc4cw.org/program/functional-family-therapy/

In addition, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice, which works to prevent juvenile delinquency, improve the juvenile justice system, and protect children, identified FFT as a Model Program with an effective rating. OJJDP stated, "This is a family-based prevention and intervention program for dysfunctional youth, ages 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral problems. The program is rated Effective. Program participants showed a statistically significant reduction in general recidivism and risky behavior, compared with control group participants. However, there were no differences between groups on felony recidivism or caregiver strengths and needs.[10]"
Finally, the Pew Foundation Results First Clearinghouse[11], which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for FFT, citing the CrimesSolution.gov clearinghouse as the source of information. This source indicated that outcome areas for FFT include recidivism, life domain, child behavior emotional needs, child risk behaviors, child strengths, acculturation, caregiver strengths, and caregiver needs.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) has been demonstrated as effective through numerous studies and inclusion as evidence-based in multiple clearinghouses and reports, which, when considered together, led DHHS to conclude that the program's effectiveness is compelling for Utah's child welfare and juvenile justice populations. For example, this conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from 21 studies that were eligible to review. PCIT is also supported by the California Evidence-Based Clearinghouse for Child Welfare, and the Office of Juvenile Justice and Delinquency Prevention.

[10] https://www.ojjdp.gov/MPG/Topic/Details/79; https://ojjdp.ojp.gov/library/publications/functional-family-therapy

[11] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

The review by the Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable[12] and statistically significant impacts on child behavioral and emotional functioning, positive parenting practices, and parent/caregiver mental or emotional health, which are key outcomes for the DHHS prevention service array. There were no unfavorable effects. These findings are summarized in the table below[13].

Parent Child Interaction Therapy Summary of Findings

Title IV-E Prevention Services Clearinghouse

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92 * 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46 * 42	8 (25)	422	Favorable: 20 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.58 * 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10 Unfavorable: 0

**Statistically significant*

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

[12] According to the Title IV – E Prevention Services Handbook of Standards and Procedures, impact estimates that are favorable (statistically significant and in the desired direction).

[13] https://preventionservices.acf.hhs.gov/programs/105/show

The California Evidence-Based Clearinghouse for Child Welfare rated PCIT as having well-supported research evidence with medium relevance for child welfare in the categories of disruptive behavior treatment (child and adolescent), and parent training programs that address behavior problems in child and adolescents.[14] Also, the Pew Foundation Results First Clearinghouse[15], which is an online resource that brings together information on the effectiveness of social policy programs from nine national clearinghouses, also reported a rating of effective at the highest level for PCIT, citing the California-Evidence Based Clearinghouse as the source for the information.

In addition, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) within the U.S. Department of Justice, which works to prevent juvenile delinquency, improve the juvenile justice system, and protect children, identified PCIT as a Model Program with an effective rating. OJJDP stated, "The program teaches parents new interaction and discipline skills to reduce child problem behaviors and child abuse by improving relationships and responses to difficult behavior. The program is rated Effective. Program children were more compliant with less behavior problems than the wait list group. The treatment group parents gave more praise and fewer criticisms and improved negative aspects of their parenting. There were fewer re-reports of physical abuse[16]."

C. Continuous Quality Improvement Overall Strategy

DHHS is committed to ensuring that evidence-based programs and services provided to children, youth, and their families are effective and delivered to fidelity. DHHS has developed a multi-layered approach to Continuous Quality Improvement (CQI) of evidence-based programs and services, which meets the CQI requirements in subparagraph 471(e)(5)(B)(iii)(II).

[14] Title IV-E Prevention Services Clearinghouse, Parent Child Interaction Therapy, Summary of Findings. https://www.cebc4cw.org/program/parent-child-interaction-therapy/

[15] https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database

[16] https://www.ojjdp.gov/MPG/Topic/Details/19

Fidelity monitoring, outcome measurement, and evaluation activities for evidence-based programs are managed through CCRS. CCRS, in conjunction with DCFS and JJYS, is responsible for the design and development of the service array for children and youth and their families served by the Department and its divisions. It also has responsibility for coordinating with the provider network for quality management, data, and evaluation relative to services; and for internal quality assurance including quality case reviews. CCRS has designated a clinical team with subject matter expertise to lead the quality assurance process for each evidence-based program. These clinical specialists work with developers, providers, evaluation, data, and quality assurance staff to coordinate and ensure quality management, outcome measurement, evaluation, and technical assistance efforts are coordinated in a manner to produce CQI.

In collaboration with program developers, subject matter experts, and the University of Utah Social Research Institute (SRI), CCRS establishes an on-going fidelity monitoring and outcome measurement process for each evidence-based program deployed. Where a developer provides a fidelity monitoring process or fidelity monitoring tools and an outcome measurement process or outcome measurement tools, these tools are utilized as part of on-going fidelity monitoring. If these tools are not provided by a developer, DHHS works with the developer or other subject matter experts, as well as SRI, to identify the core elements of the program that are critical to the integrity of the program to be used for fidelity monitoring as well as outcome measurement procedures.

Providers are critical partners in the CQI process. As services are delivered, providers implement fidelity monitoring procedures as delineated for the program. Clinical specialists work closely with providers, developers, trainers, and quality management staff to ensure providers receive regular technical assistance in the implementation of the evidence-based program as needed.

Outcomes are measured both by the provider and at DHHS. Provider outcomes are measured specific to the targets of the intervention. These outcomes will be reported regularly to DHHS as part of the CQI process. Fidelity monitoring of implemented practices will happen annually and more often as needed. Outcomes

measured at the DHHS level include items such as safety (protective services findings), permanency (including entry into foster care), family well-being (through the Utah Family and Child Engagement Tool (UFACET), Utah's version of the CANS) and risk reduction (particularly for juvenile justice involved youth).

CCRS will review fidelity and outcome data on a quarterly basis. Trends and other observations in these reviews will be shared with providers in support of quality improvement. Clinical Specialists will regularly meet with providers to discuss findings and provide technical assistance. When needed, these meetings may include technical assistance with developers and other subject matter experts.

SECTION 3. Monitoring Child Safety

DCFS will monitor and oversee the safety of children who receive prevention services under Utah's Title IV-E Prevention Program Plan. Children's safety is paramount and is central to child well-being. Children must be protected from the trauma of abuse and neglect. When safe to do so, children must also be protected from the compounding trauma of separation from their families by effectively utilizing prevention services. Assessing safety and risk is an ongoing process throughout the entire in-home services case.

DCFS uses a variety of tools and practices to assess and monitor the safety of children receiving prevention services. Structured Decision Making (SDM) tools are used to assess and monitor the safety and risk of children and families. The SDM Safety and Risk Assessments are used to:

- Help determine which families are appropriate for prevention services.
- Assist with the development of safety plans.
- Identify the level of intensity needed for intervention with a family, including how frequently the family needs to be seen.
- Determine when it is appropriate to recommend closing an in-home services case.

SDM Safety Assessment

The SDM Safety Assessment is used to identify possible threats to a child's safety and what interventions are necessary to protect a child from threats to their safety. The final outcome of the SDM Safety Assessment helps guide the decision about the need for immediate intervention with the family. Interventions may include a safety plan that is implemented immediately to control or mitigate the identified threat. The caseworker will complete an SDM Safety Plan for all children in the household when any threat to safety has been identified.

When an in-home services case is opened as a result of a child protective services (CPS) case, the CPS caseworker will complete the initial SDM Safety Assessment prior to referring the case for in-home services. If the in-home services case is not the result of a CPS case, the ongoing caseworker will complete the SDM Safety Assessment. The initial SDM Safety Assessment is required during the first face-to-face contact with the children. The SDM Safety Assessment is completed on each household.

Assessing child safety is a critical consideration throughout DCFS involvement with the family. Threats to safety will be evaluated during each contact with the family, and an SDM Safety Assessment will be completed whenever a change in the family's circumstances poses a safety concern, prior to removing from or returning a child home, or prior to an SDM Safety Plan being changed or concluded.

A final SDM Safety Assessment is required prior to closure of an in-home services case at the final face-to-face contact with the family. Resolution of any identified safety threat must be documented in the case record.

SDM Risk Assessments

Initial and ongoing assessment of risk is another key component of prevention services. The SDM Risk Assessment and SDM Risk Reassessment are used to help identify the level of risk of future maltreatment.

The initial SDM Risk Assessment is completed in conjunction with the Initial SDM Safety Assessment to determine if ongoing services should be opened.

When an in-home services case is opened as a result of a CPS case, the CPS caseworker completes the initial SDM Risk Assessment prior to referring the case for in-home services. If the in-home services case is not the result of a CPS case, the ongoing caseworker will complete the SDM Risk Assessment before the creation of the Child and Family Plan. The SDM Risk Assessment rating defaults to " high" until the SDM Risk Assessment has been completed. The SDM Risk Assessment is completed on each household.

The SDM Risk Reassessment is used to determine if the likelihood of future harm has been sufficiently reduced to support case closure or if the family will continue to receive services.

The SDM Risk Reassessment is completed or updated at a minimum of every six months. An SDM Risk Reassessment needs to be completed sooner if there are new circumstances or new information that would affect risk.

Client Contacts

Client contacts are used to help monitor safety and ongoing assessment of risk. Regular and purposeful visiting with the child and family enables the caseworker to assess how well the parents and other caregivers are meeting the children's needs for safety and well-being, as well as the family's progress towards case goal achievement. Private conversations with the children outside the presence of the caregiver are used as part of the ongoing monitoring of the child's safety.

Client contacts and home visiting standards for each case are determined based on the outcome of the SDM Risk Assessments. The SDM Risk Assessment makes the initial determination of the frequency of contact. When a Risk Reassessment is completed, the new risk level guides minimum contact standards that remain in

effect until the next reassessment is completed. The contact matrix below specifies the frequency of contacts associated with each risk classification.

Ongoing Worker Minimum Contact Guidelines for In-home Services		
Risk Level	Caregiver and Child Contacts	Location
Low	One face-to-face per month with caregiver and child	Must be in caregiver's residence
Moderate	Two face-to-face per month with caregiver and child	One must be in caregiver's residence
High	Three face-to-face per month with caregiver and child	One must be in caregiver's residence
Additional Considerations		
Contact Definition	Each required contact shall include at least one caregiver and one child. During the course of a month, each caregiver and each child in the household are to be contacted at least once.	
Designated Contacts	The ongoing worker/supervisor/service team may delegate face-to-face contacts to providers with a professional relationship to the agency and/or other agency staff, such as social work aides. However, the ongoing worker must always maintain at least one face-to-face contact per month with the caregiver and child, as well as monthly contact with the service provider designated to replace the ongoing worker's face-to-face contacts.	

JJYS also monitors youth safety on an ongoing basis. The primary method of monitoring youth safety is through caseworker contacts with youth and families. Caseworkers meet with the youth and family weekly to provide support and supervision while they are receiving services from the JJYS Youth Services Program, which is an observation of the youth's safety. Risk and protective factors are also assessed quarterly using the Protective and Risk Assessment, for youth with a delinquency history. In addition, when family conflict is identified as a need through the UFACET, a safety plan is established with the family to provide for

temporary crisis support for the youth, which may include temporarily absence from the residence when needed for youth or parent safety. In addition, suicide screening is completed for all youth using the Columbia severity rating scale.

B. Prevention Plan Review

In DCFS, prevention plans are routinely reexamined to help monitor and track the child and parent or kin caregiver's progress and child's risk level during the provision of services. This is done through contacts with parents and children, including in home visits and child and family team meetings. The written plan is developed with input from the Child and Family Team, and is modified as needed throughout the case. All parents and kin caregivers will have the opportunity to participate in the development and reexamination of the written plan. All children listed on the plan who are developmentally appropriate will have the opportunity to participate in the development of the plan to the degree that they are capable of contributing. The Child and Family Team should include the family's formal and informal supports, including service and treatment providers. Updated UFACET and SDM risk assessments may be used to inform the plan review. The prevention plan is reviewed on an ongoing basis throughout the case and updated at least every six months, taking into account progress and continuing need for Title IV-E prevention and other services and risk of entry into foster care.

While it is rare for a child with an open DCFS in-home case to continue to need Title IV-E prevention services beyond 12 months, in the event that a child continues to be at imminent risk of entry into foster care despite receiving IV-E prevention services, the same process that was initially used to determine the child's eligibility as a prevention candidate, as described in Section 9.B, is used to determine continuing eligibility. The assessment tools are updated, including UFACET and SDM, determining if, despite receiving services, the child continues to be at imminent risk of entry into foster care, can be safely maintained in the home with provision of prevention services, and a new prevention plan is prepared. The finalization of the child's new prevention plan confirms that the child continues to be at imminent risk of entry into foster care and continues to qualify as a

prevention candidate.

JJYS creates a Family Plan with the assistance of the parents to monitor their progress while they are receiving services. Progress on plan implementation and youth safety are monitored through weekly caseworker visits with the youth and family. The plan is updated if there are any significant changes.

For JJYS, it is also rare for a youth to continue to need Title IV-E prevention services beyond 12 months. In the event a youth continues to be at imminent risk of entry into foster care, despite receiving IV-E prevention services, the same process that was initially used to determine the youth's eligibility as a prevention candidate, as described in Section 9.B, is used to determine continuing eligibility. A UFACET is updated and a new Family Plan is developed for continuation beyond 12 months. The finalization of the youth's plan confirms that the youth continues to be at imminent risk of entry into foster care and continues to qualify as a prevention candidate.

SECTION 4. Consultation and Coordination

A. Consultation

In preparation for Utah's initial Title IV-E Prevention Program Plan, broad consultation was conducted with state agencies responsible for administering child welfare, juvenile justice and youth services, mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services programs. Parent representation was also included through the FFPSA steering committee. Consultation efforts helped guide the initial plan development and selection of the service array for Utah's Title IV-E Prevention Program Plan.

The Title IV-E Prevention Program Plan was implemented and supported during the first five-year plan period under a Title-IVE Prevention leadership group consisting of administrators and program staff in DHHS from DCFS, JJYS, and CCRS. Extensive consultation among this group took place as a new five-year plan period

approached. As renewal of the plan was considered, and decisions were made to simplify and scale back the plan, additional consultation was not conducted for this submission.

Plans are underway to participate in a larger prevention continuum as future amendments to Utah's Title IV-E Prevention Program Plan are considered, including community pathways. Preliminary consultation has begun with an extended group of partners as expansion options are being considered, and will include youth, parents, and kinship caregivers.

B. Coordination

Services provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with services provided under Title IV-B Parts 1 and 2 of the Social Security Act. Title IV-B Part 1 funds are primarily used for child welfare caseworker costs. In this capacity, these funds support critical efforts essential to caseworker activities with children and families. Title IV-B Parts 2 funds were shifted during the IV-E waiver to maximize support for HomeWorks implementation and continue to be used post-waiver to support in-home and prevention services goals, within allowable funding parameters, to strengthen parents' capacity to safely care for their children and safely reduce the need for foster care.

The proportion of PSSF funds allocated to Family Preservation continues to exceed the minimum proportion requirement of 20%, which will enable caseworkers to have additional resources beyond specific prevention EBPs available to support families, such as for a family's temporary concrete needs, e.g., assistance with rent or utilities or other one-time costs. PSSF Family Support funds will continue to be allocated to support expansion or start-up of additional services for community services that may not yet be available as EBPs under the clearinghouse or to serve clients that don't qualify for Title IV-E prevention services. PSSF Adoption Promotion and Support Services funds may be used for post-adoption services outside of the EBP service array that help prevent reentry of children into foster care. PSSF Family Reunification funds may be used to help facilitate return of a child home from foster care, after which the child may be identified as a prevention candidate and

receive supportive EBP services under Title IV-E and non-EBP resources under PSSF within the allowable funding period to safely sustain the child's return home.

SECTION 5. Child Welfare Workforce Support

In Utah, child welfare and juvenile justice services are state administered and state supervised. Both DCFS and JJYS are committed to supporting and enhancing a competent, skilled and professional workforce, and providing state agency support to staff working in field offices throughout the state.

DCFS frontline caseworkers have the support of supervisors, mid-level managers, and local level administrators, in addition to statewide leadership at both the division and department levels. One of the DCFS overarching Practice Model Principles is Organizational Competence, which is that "Committed, qualified, trained, and skilled staff, supported by an effectively structured organization, helps ensure positive outcomes for children and families."

DCFS has state agency training teams that support development of competency and skills of the workforce in delivering quality casework and trauma-informed and evidence-based services.

All training provided by DCFS to its employees, providers, and families is based on the DCFS Practice Model, the foundation on which all policies, procedures, programs, and services are anchored. This model provides caseworkers a structure for approaching work with children and families. Practice Model Principles include protection, development, permanency, cultural responsiveness, partnership, organizational competence, and professional competence.

The Practice Model Principles are at the core of the five Practice Skills, which constitute the framework for all agency training. The five Practice Skills are designed to "put the agency's values into action" and are universally applied by workers across all of the division's programs and services. The Practice Model Skills include engaging, teaming, assessing, planning, and intervening.

Workforce skills are assessed and strengthened through the support of supervisors, trainers, and administrators, and are also measured and reinforced through qualitative case reviews and quantitative case process reviews.

All of these state agency supportive activities enhance implementation of the Title IV-E Prevention Plan, by ensuring that the workforce is qualified, and that caseworkers develop appropriate prevention plans and conduct risk assessments to ensure ongoing child safety.

JJYS frontline caseworkers receive support from supervisors, assistant program directors, program directors and administration. The Youth Service Model is a “No Wrong Door” approach to early intervention. Through this model, JJYS staff are supported in delivering evidence-based, individualized youth and family plans with early screening, assessment, plan management, and comprehensive access to services-all driven by the youth and family strengths and needs.

JJYS also has a state agency training team that supports development of competency and skills of the workforce in delivering quality casework and trauma-informed and evidence-based services. All JJYS staff attend New Employee Training as well as Integrated Crisis Response Training. In addition, staff also receive ongoing training to assist them in the workforce and in the community, such as Dialectic Behavioral Theory, Motivational Interviewing, and Strengthening Families training.

SECTION 6. Child Welfare Workforce Training

DCFS and JJYS are committed to having a prepared, well-trained workforce. Both agencies provide training and support for caseworkers in assessing what children and their families need, connecting to families served, knowing how to access and deliver needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services.

In DCFS, casework for prevention services aligns with the practice model, which focuses on the skills of engaging, assessing, teaming, planning, and intervening. As such, DCFS training for caseworkers reinforces overall quality case practice, including prevention services.

Caseworker training addresses engaging families in a trauma-informed way to conduct safety and risk assessments using SDM and to assess overall family strengths and needs with UFACET. Training is provided to guide caseworkers in incorporating assessed needs into the written prevention plan in a way that identifies the strategy and services to allow the child to remain safely at home or with a kin caregiver and reinforces the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the priority of kinship placement in the event a child cannot safely remain at home. These concepts are also incorporated into new employee Practice Model training, which includes in-class training, simulation training, and field experience.

Additional resources will also be provided to caseworkers for each of the specific evidence-based mental health, substance abuse, and in-home parent skills services included in Utah's Title IV-E Prevention Program Plan to help workers understand the service target population, needs the service addresses, and availability.

In JJYS, core training and support provided to all Youth Services workers will also address and reinforce requirements for prevention services.

Caseworker training addresses assessment of youth and family strengths and needs with the UFACET, and also addresses identifying risk and protective factors using the Protective and Risk Assessment (PRA). Training will also be provided on case planning, which focuses on skills needed to engage with a youth and family, reducing risk through building skills and assisting the youth to remain or transition back into their community. Caseworkers skills will be further strengthened with training on evidence-based models used by providers and education on what services contract providers are able to provide. Supervisors provide feedback of critical Youth Services processes. Supervisors will observe and rate the workers' use of motivational interviewing skills with youth and families, assessment scoring, coordination of child and family team meetings, and developing Youth and Family Plans.

SECTION 7. Prevention Caseloads

DCFS and JJYS have established processes to determine, manage, and oversee caseload size and type for caseworkers.

DCFS prevention cases are managed by region caseworkers with "ongoing services" caseloads. Ongoing services refer to both in-home cases and foster care cases. Prevention services are a component of in-home services. Whenever possible, within existing regions and office staff resources, specialization is encouraged. For example, in larger offices, some teams will specialize in managing in-home cases. Some smaller offices have individual workers that specialize in managing in-home cases. In more rural offices, ongoing workers that manage combined in-home and foster care cases will be assigned prevention cases. Administrative costs related to mixed caseloads will be differentiated through the cost allocation process. The DCFS target caseload standard for caseworkers managing prevention cases is a ratio of 1:15.

Overseeing caseload size and type is essential. Manageable caseloads can make a significant difference in a caseworker's ability to spend adequate time with children and families and on completing critical case activities, ultimately having a positive impact on outcomes for children and families. Caseload is defined as the number of cases (children or families) assigned to an individual worker in a given time period. Supervisors and region administrators consider caseload when new case assignments are given and in monitoring child and family progress and overall worker progress.

DCFS state administration and region administration will continue to provide oversight to the caseload size and case type for caseworkers.

JJYS has Youth Services Centers located at multi-use facilities throughout the state. Prevention cases are managed by Youth Services administration and workers. JJYS has implemented a team approach to the prevention caseload. A team consists of one Supervisor and Youth Service workers/facilitators. One caseworker can manage an average caseload of twenty families. In rural areas, there may be a reduced number of Youth Services workers based on the needs of the community. Caseload oversight and targeted outcomes are reviewed on a regular basis by the local facility Assistant Program Director and by the JJYS Executive Management Team.

SECTION 8. Assurance on Prevention Program Reporting

DHHS provides an assurance in Attachment I that DHHS will report to the Secretary required information and data with respect to the provision of services and programs included in Utah's Title IV-E Prevention Program Plan. This will include data necessary to determine performance measures for the state and compliance. Data is reported as specified in the applicable technical bulletins for Title IV-E Prevention Data Elements.

See Attachment I. *State Title IV-E Prevention Program Reporting Assurance*.

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

Child and family eligibility for the Title IV-E Prevention Program is based on a child being at imminent risk of entry into foster care, but able to safely remain at home or residing with a kin caregiver with receipt of approved evidence-based services under the child's prevention plan.

For the purpose of this plan, the term "prevention candidate" is equivalent to the Federal term "child who is a candidate for foster care." The term "Imminent risk" means that a child and family's circumstances require a defined case plan to be put into place; that the plan must identify interventions, services, and/or supports to be provided to the child, parent or kin caregiver; and the purpose of providing these interventions, services, and/or supports is to prevent entry into foster care.

A child in foster care who is a pregnant or parenting foster youth is also eligible for prevention services under the Title IV-E Prevention Program.

A. Prevention Candidate Definition

For the purposes of the Title IV-E Prevention Program, a child under age 18 is a prevention candidate when at imminent risk of entering or reentering foster care, but able to remain safely in the home or residing with a kin caregiver as long as services to prevent the need for removal are provided to the child, parent or kin caregiver.

To be eligible for the Title IV-E Prevention Program, the child must have an open child welfare or juvenile justice case and a finalized prevention plan prior to provision of services.

The following types of open child welfare case scenarios apply for the Title IV-E Prevention Program:

- In-home services, which includes:

    - Court-ordered protective supervision cases
    - Voluntary in-home services (collaborative cases)
    - Post-reunification services cases (former foster child at risk of reentry into in state custody)
    - Kinship services cases (child not in state custody)
- Adoption assistance cases (at risk of disruption)
- Guardianship assistance cases (at risk of disruption)

The following types of open juvenile justice cases apply for the Title IV-E Prevention Program:

- Youth services cases
- Voluntary services cases (former foster youth at risk of reentry into state custody)

Pregnant or parenting foster youth are also eligible for prevention services when services are designated in the child's foster care plan prior to provision of services.

Kin caregiver defined in Utah Code Section 80-3-102 includes the child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, stepparent, first cousin, stepsibling, sibling of the child, first cousin of the child's parent, or an adult who is a permanent guardian or natural parent of the child's sibling.

For the purpose of this plan, kin caregivers may also include individuals that are unrelated by either birth or marriage, but have an emotionally significant relationship with the child that takes on the characteristics of a family relationship.

Also, for Indian children, the definition of kin caregiver under the Indian Child Welfare Act (ICWA) (25 U.S.C. Sec. 1903) will be utilized, which includes:

- An "extended family member" as defined by the law or custom of the Indian child's tribe or,

- In the absence of such law or custom, a person who has reached the age of 18 and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent, or

An Indian custodian, as defined by ICWA case law.

Children who are under the placement and care responsibility of the state are, by definition, in foster care and are not prevention candidates when placed with a kin caregiver.

B. Prevention Candidate Determination

Caseworkers from the DCFS and JJYS determine a child's eligibility for the Title IV-E Prevention Program through finalization of a child's prevention plan, for the purpose of providing the child, parent or kin caregiver with interventions, services, or supports necessary to prevent the child's entry or reentry into foster care.

Caseworkers in the DCFS determine candidacy for the Title IV-E Prevention Program for children and families receiving child welfare services. The types of child welfare cases that participate in the Title IV-E Prevention Program include in-home services cases and adoption or guardianship cases at risk of disruption. Pregnant or parenting foster youth are also eligible for prevention services when services are designated in the child's foster care plan prior to provision of services.

For in-home services cases, children are determined to be candidates through the process of a caseworker establishing a prevention plan for each child and family, also known as the Child and Family Services Plan.

This process generally begins when a child protective services case is referred for ongoing in-home services (either voluntary/collaborative or court-ordered), or when a child transitions from foster care back home or to the home of a kinship caregiver.

The assigned caseworker is responsible for working with the family to identify any safety or risk concerns through analysis of the structured decision-making safety and risk assessment. The caseworker also assesses the family's strengths and needs to support the child remaining safely at home through completing the UFACET functional assessment with the family. UFACET is a CANS/FAST-based assessment developed as part of Utah's Title IV-E waiver project. It has been endorsed by Dr. John Lyons from the Praed Foundation.

UFACET is used to create a shared understanding of the reasons for agency involvement and to create strategies and plans to address the concerns assessed. UFACET focuses on the unique dynamics of each family and the role each individual plays in this dynamic. UFACET is comprised of four main sections: (1) Family Together, which focuses on how the family interacts with each other and the family's culture; (2) Household, which focuses on more basic needs such as finances and shelter; (3) Caregiver, in which each caregiver/parent is rated individually on their own strengths and needs related to stress management, parenting skills, mental and physical health, development and trauma; (4) Child, in which each child is rated individually on their own response to stress, social skills, mental health, education, physical health, development, and trauma. For children placed with a kin caregiver, there is also a Substitute Caregiver section in UFACET with items related kin caregiver supports needed to maintain the child in the home. The Substitute Caregiver section is completed for each individual kin caregiver.

The SDM and UFACET results are considered in the development of the Child and Family Services Plan, along with any specific issues identified in a court order, when applicable. Prevention candidate status is confirmed through finalization of the Child and Family Services Plan, and is documented in SAFE, Utah's CCWIS. Plans are reviewed every six months. The child and family team is also consulted as the Child and Family Services Plan is developed or reassessed. If the child or family still needs prevention services at 12 months, a new plan will be developed for a new prevention candidate episode.

For adoption or guardianship assistance cases that are at risk of disruption, a caseworker collaborates with the family to develop the child's prevention plan to

prevent reentry into foster care, based on the current needs of the child, parents, or kin caregivers. Prevention candidate status is confirmed through finalization of the child's prevention plan, and is documented in SAFE, Utah's CCWIS. If the child or family still needs prevention services at 12 months, a new plan will be developed for a new prevention candidate episode.

JJYS caseworkers determine candidacy for the Title IV-E Prevention Program.

The two types of juvenile justice cases that participate in Title IV-E Prevention Program include Youth Services cases and Voluntary Services cases for youth formerly in JJYS custody who are at risk of reentry. Pregnant or parenting foster youth are also eligible for prevention services when services are designated in the child's foster care plan prior to provision of services.

For Youth Service cases, youth are determined to be candidates through the process of establishing a prevention plan for each youth, also known as a Youth and Family Plan.

Youth may be referred to JJYS for Youth Services from any source, such as a school, DCFS, a grandparent, or a neighbor. Supervisors review the referral and assign a Youth Services caseworker, who reaches out to the referred family and invites them to learn more about the available youth services. If it is determined that the youth will benefit from prevention services to prevent future entry into foster care and the youth is not involved in youth probation, an assessment is completed.

The Title IV-E Prevention Program ties to JJYS implementation of a statewide Youth Services model to prevent delinquent behavior through positive youth and family development. All youth are screened to identify immediate needs and areas for future assessment. Youth and parents/guardians that move to the Youth Services assessment phase are administered the UFACET Screener if the youth has no delinquency history.

If a youth has a prior delinquency history, the youth and parents/guardians will be administered the PRA and UFACET-Family Focused.

The PRA is used by Utah's juvenile justice system to determine risk to reoffend, need for supervision, protective factors, and need for services. Separate studies show that youth scoring "low" on the assessments reoffend at a lower rate than youth scoring "moderate", and youth scoring "moderate" reoffend at a lower rate than youth scoring "high". Differences between risk levels for overall, felony, and misdemeanor reoffending are statistically significant for both assessments. With few exceptions, these findings generalize across demographic categories of gender, age at first assessment, minority status, and geographical location (DeWitt & Lizon, 2008 and DeWitt, Wetherley, & Poulson, 2016).

The JJYS caseworker will develop an individualized Youth and Family Plan based on screening results, assessments, and collateral information from allied agencies. For youth that are a prevention candidate, evidence-based programming in the areas of substance use, mental health, and parenting skills will be incorporated into the Youth and Family Plan. Prevention candidate status is confirmed through finalization of the Youth and Family Plan. The case is entered into the CARE management information system and assigned a program code specific to Title IV-E prevention.

For voluntary services cases, youth who were formerly in JJYS custody are determined to be candidates through the process of establishing a prevention plan for each youth. The process for initiating development of a youth's prevention plan and provision of services is a request from the youth who had previously been in custody and who had signed a voluntary services agreement or a request from the family. The caseworker will collaborate with the youth and parents/guardians on completing the PRA and UFACET-Family Focused. This information will be utilized to develop the Youth and Family Plan, which serves as the child's prevention plan. Prevention candidate status is confirmed through finalization of the Youth and Family Plan. The case is entered into the CARE management information system and assigned a program code specific to Title IV-E prevention.

A youth may be reassessed for prevention candidate status at the end of each 12-month prevention episode utilizing the processes described above. Prevention candidate status is confirmed through finalization of a new Youth and Family Plan.