

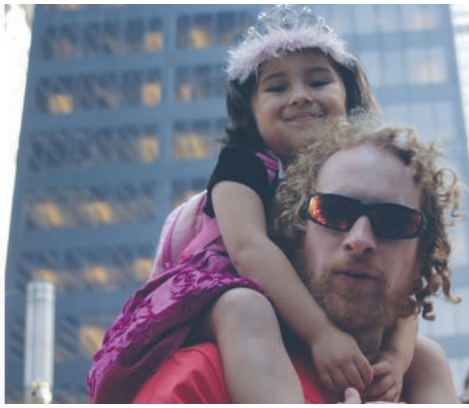

Utah Title IV-E Prevention Program

Five-Year Plan FFY 2020-2024

Amendment #2
December 21, 2021



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- Functional Family Therapy (original with no change)
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- Parents as Teachers (original with no change)
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Introduction

The Family First Prevention Services Act (FFPSA) (Public Law 115-123) authorizes new 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 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 Human Services (DHS) is electing to implement the Title IV-E prevention program as authorized by FFPSA. As instructed in ACYF-CB-PI-18-09, the following is Utah's five-year prevention plan for FFY 2020 through FFY 2024. This plan builds upon Utah's Title IV-E waiver project, HomeWorks, which focused on strengthening parents' capacity to safely care for their children and safely reducing the need for foster care.

Utah's initial state Title IV-E Prevention Program Plan is deliberately modest in scope. Our intent is to first solidify a basic operational foundation, utilizing principles of implementation science, and then to expand capacity through subsequent amendments to the plan.

The prevention service array will be expanded through plan amendments as additional evidence-based services are approved through the Title IV-E prevention services clearinghouse or are reviewed and approved through independent systematic reviews conducted as part of the transitional payment review process authorized by the Children Bureau through ACYF-CB-PI-19-06, and based on availability of services in Utah. Expansion may also include extending prevention services 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 Department of Human Services 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 candidate in a prevention plan.

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 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 candidate in a prevention plan.

B. Evidence-Based Services and Programs

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

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 is a new service being implemented in Utah. To implement, the following steps are being completed: • Contract with FFT Certified Trainers to provide training to multiple sites, preferably representing both urban and rural areas, in order to establish a network of providers credentialed to provide FFT. • Work with FFT trainers to identify start up resources necessary to support implementation. • Have providers apply for acceptance into FFT and, when accepted, offer funding for start-up resources. • Fund and host training sessions for prospective FFT providers. • Grant funds for start-up costs to new providers, which may include training costs for each site for the first 2 years, access to Youth Outcomes Questionnaire (YOQ) assessment protocols, and technology resources unique to FFT. • Establish contracts with qualified providers, using specific FFT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets 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	See Section 2.C. Continuous Quality Improvement Overall Strategy.

Outcome Data and Information Learned in Monitoring to Improve Practice ***FFT***	DHS will monitor fidelity and outcomes related to the implementation of FFT using program specific tools as a foundation, along with the CQI overall strategy described in Section 2.C. Fidelity and outcome measures are reported to FFT LLC on an ongoing basis in all FFT sites. DHS is engaged with FFT LLC and providers to deploy FFT to multiple sites across the state of Utah. DHS 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 was 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***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations,

	ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. • Based on input from each of these sources, DHS selected FFT as an intervention to be included in the prevention service array.
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***	DHS 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 or with same-room coaching. 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 is a new service to be offered through contracts by DHS in Utah. To implement, the following steps are being completed: • Contract with PCIT Master Level trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of providers credentialed to provide PCIT. • Work with PCIT Master Level trainers to identify start up resources necessary to support implementation. • Have providers apply for acceptance to participate in state-sponsored training for PCIT. • Fund and host training sessions for prospective PCIT providers. 23 clinicians participated in the first PCIT training session. • Explore options and capacity to grant funds for start-up costs to new providers, which may include technology resources unique to PCIT. • Establish contracts with qualified providers, using specific PCIT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets 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. Continuous Quality Improvement Overall Strategy. DHS 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. DHS is engaged with PCIT International to train and provide technical assistance to providers. The DHS quality and design specialist assigned to PCIT maintains close coordination with PCIT International staff and providers in support of implementation. 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 (DPICS-IV)*. 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 (ECBI)*. 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***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. • Providers participated in a feedback group providing information on existing services and interest in providing new EBP services. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. • Based on input from each of these sources, DHS selected PCIT as an intervention to be included in the prevention service array.
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***	DHS 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	***Parents as Teachers (PAT)***
Service Description ***PAT***	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: Personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, child care centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training.
Level of Evidence ***PAT***	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category ***PAT***	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual ***PAT***	PAT will be implemented without adaptation. PAT has a Model Implementation Library with resources available to those who receive PAT training. Depending on the ages of the families served, the PAT Foundational Curriculum is available to support families with children prenatal to age 3, and the PAT Foundational 2 Curriculum is available to support families with children ages 3 through Kindergarten. PAT website: **https://parentsasteachers.org/resources-tools**

Plan to Implement ***PAT***	Parents as Teachers programs have been used for primary prevention in a limited number of sites in Utah, but generally have not broadly served at-risk children and families involved with DCFS who will qualify as prevention candidates. To implement as a service under Utah's Title IV-E prevention program plan, the following steps are being completed: • Starting first with PAT offered by Prevent Child Abuse Utah (PCAU), which is a Blue Ribbon Affiliate PAT Program, determine interest and contract with local health departments and other sites that are current PAT affiliates to expand their population served to include prevention candidates. • Identify local health departments or other sites that are not currently PAT providers but that are willing to become PAT providers. Assist in standing up new programs (by helping fund initial trainings, affiliation costs, etc.). • Create an expansion plan to develop PAT programming in rural areas through the local health departments or other community providers, including expansion of the PCAU PAT program to target counties. • Establish contracts with qualified providers, using specific PAT rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on PAT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve ***PAT***	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 PAT, Utah expects to see the following outcomes for children and families receiving this service: Increased child safety, improved child behavioral and emotional functioning, increased positive parenting practices, and improved parent/caregiver mental or emotional health.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in	See Section 2.C. Continuous Quality Improvement Overall Strategy. DHS will monitor fidelity and outcomes related to the implementation of PAT using program specific tools as a foundation,

Monitoring to Improve Practice ***PAT***	along with the CQI overall strategy described in Section 2.C. DHS is requiring PAT programs with department contracts to maintain PAT affiliate status and utilize developer processes to measure progress and program fidelity. Program will verify affiliation by providing PAT affiliate certification to DHS. To help achieve fidelity to the PAT model, the PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. In addition, affiliates are expected to participate in the affiliate quality endorsement and improvement. The PAT National Center provides ongoing technical assistance to any organization that is implementing the Parents as Teachers model and requests assistance. Each state is assigned a National Center technical assistance provider who provides state-wide information as well as one-on-one work with the programs. Technical assistance is provided on a variety of topics with a focus on meeting the Parents as Teachers essential requirements. These essential requirements focus on staffing and staff oversight, visit frequency, delivering home visits, using the required forms, screenings and participating in model fidelity reviews. In addition to these fidelity processes, providers will be required to report fidelity and outcome measures to DHS on a quarterly basis. DHS will work with the PAT National Center and with providers to further incorporate the annual data gathered for the PAT National Center into overall program development, as well as for ongoing technical assistance. Providers of PAT are required to implement fidelity monitoring and outcome measurement using PAT planning and reporting tools. Following are key tools used in PAT: • *Guidance on Continuing Quality Improvement*. Provides instructions for CQI using the plan, do, study, act (PDSA) process, including how to complete the PDSA worksheet. • *PDSA Worksheet*. Tool to guide the PDSA process. • *PAT Quality Assurance Blueprint*. Outlines the tasks and activities that PAT affiliate supervisors should engage in to monitor and strengthen services, supervision and professional development, and administration. • *2020 Essential Requirements. Describes PAT program elements and how they are measured.*

	• *Performance Measures Report for Service Delivery Essential Requirements*. Depicts affiliate's performance on the service delivery essential requirements based on the affiliate's data, and assists in understanding level of fidelity and in planning CQI efforts.
How Selected ***PAT***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. The number of children served in DCFS in the 0-5 age range supported targeting services to this age group. • PAT was already available in the state in some capacity, including DCFS contracts funded by CBCAP. • Local health departments are available in all areas of the state, including rural and frontier areas, and have shown in some areas that this service is a good match for their structure. • Based on input from each of these sources, DHS selected PAT as an intervention to be included in the prevention service array.
Target Population ***PAT***	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population.
Assurance for Trauma-informed Service Delivery ***PAT***	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process) ***PAT***	DHS is requesting a waiver for evaluation of PAT, 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	***Motivational Interviewing (MI)***
Service Description ***MI***	Motivational interviewing (MI) is a method of counseling clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of these goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible. These clinical strategies include the use of open-ended questions and reflective listening. MI can be used to promote behavior change with a range of target populations and for a variety of problem areas.
Level of Evidence ***MI***	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category ***MI***	Substance Abuse Prevention and Treatment and Mental Health Prevention and Treatment
Version of Book or Manual ***MI***	Miller, W.R. & Rollnick, S. (2012). Motivational Interviewing, Third Edition: Helping People Change. Guilford Press.
Plan to Implement ***MI***	Prior to implementation of the Title IV-E Prevention Program in Utah, providers have used MI as a component of their therapeutic intervention for treatment and primary prevention broadly, but generally have not specifically targeted this service towards at-risk children and families involved with DHS who will qualify as prevention candidates. MI provided distinctly through contracts will be new for DHS. To implement under the Prevention Program, the following steps are being completed: • Contract with Motivational Interviewing Network of Trainers (MINT) Certified trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of MI providers.

	• Identify local mental health and substance use disorder providers that are not currently MI trained who are interested in having their staff receive MI training. • Have providers apply for acceptance to participate in state-sponsored training for MI for clinicians and non-clinicians serving mental health and substance use disorder populations. • Analyze applications and select providers for participation, taking into consideration geographic location, target population (MH/ SUD, adults/youth), and clinicians/non-clinicians in order to have as broad a representation as possible within and across training cohorts. • Fund and host training sessions for prospective MI providers. Provide training annually for 50 plus clinicians and non-clinicians within mental health and substance use disorder programs. • Establish contracts with qualified mental health and substance use disorder providers, using specific MI enhanced rates and billing codes to capture required client and payment data. • Provide contractors use of LYSSN[1], which is a technology-supported, measurement-based application that assesses therapy session fidelity to MI benchmarks and provides interactive feedback to improve practice. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on MI and inclusion criteria for appropriate referrals for prevention candidates and their parents or kin caregivers to mental health or substance use disorder providers, based on client needs and client's readiness for behavioral change. • MI will be provided in conjunction with other mental health or substance use disorder treatment modalities to help clients move from pre-contemplation, contemplation, or preparation to action and maintenance, and through recurrence. • If MI is provided in conjunction with another EBP included in the Title IV-E Prevention Program Plan, evaluation of that EBP will take into account inclusion of MI in data gathered and analyzed for treatment or comparison populations.
Outcomes Expected to Improve ***MI***	Consistent with the outcome identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for Motivational

[1] *https://www.lyssn.io/*

	Interviewing, Utah expects to see improvement in the outcome of adult well-being specific to parent/caregiver substance use. We also expect to see improvement in outcomes for youth and adults for behavioral change related to mental health.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice ***MI***	See Section 2.C. Continuous Quality Improvement Overall Strategy. DHS will monitor fidelity and outcomes related to the implementation of MI in accordance with the CQI overall strategy described in Section 2.C. DHS is requiring MI programs with department contracts to obtain MI training and supervision from a MINT level trainer. Providers of MI will be required to implement fidelity monitoring and outcome measurement using MI fidelity and outcome measurement tools identified by DHS and internal programmatic monitoring processes. DHS has selected LYSSN as a tool for providers to measure fidelity and reinforce practice. Provider audio recorded therapy sessions will be evaluated through the LYSSN AI technology. This comprehensive tool will be used to measure the use of open-ended questions and reflective listening in order to monitor fidelity with MI interventions. LYSSN will provide feedback on specific sessions directly to clinicians, but can provide summarized reports to DHS to inform fidelity of implementation overall and identify needs for technical assistance. DHS will also provide onsite monitoring of MI providers through monitoring reviews. Provider interviews, review of documentation including completion of training and clinical supervision, review of fidelity monitoring tools and processes, and review of clinical notes will be included in these reviews. Using our existing monitoring processes in combination with fidelity and outcome data generated by providers and contained in Utah's CCWIS, DHS will work with providers to incorporate findings from the data and outcomes to support overall program development. DHS will work with program, implementation and/or fidelity experts to provide technical assistance as necessary.
How Selected ***MI***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations,

	ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. The number of adults served in DCFS supported targeting services to caregivers whose children were at risk of removal due to substance use issues. • DJJS program experts indicated that adolescent substance abuse is a major factor bringing youth into DJJS custody. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers and identified that MI was widely available in the state. • Providers with clinicians eligible to receive training in MI are available in all areas of the state, including rural and frontier areas, and have shown that MI can be delivered under their current structure. • DHS consistently sponsors MI training for which providers are eligible. • Based on input from each of these sources, DHS selected MI as an intervention to be included in the prevention service array.
Target Population ***MI***	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas.2 The population we plan to target with MI is adults and children with substance use or mental health needs. Needs are identified through the prevention candidacy eligibility determination process, utilizing the UFACET for children, parents, and caregivers, and needs are more specifically analyzed through clinicians providing mental health or substance use disorder treatment services.
Assurance for Trauma-informed Service Delivery ***MI***	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process) ***MI***	DHS is requesting a waiver for evaluation of MI, 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] https://preventionservices.abtsites.com/programs/142/show

	2.B. below for supporting documentation that the effectiveness of the Motivational Interviewing 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***	The original SafeCare Manual was published in 2002. Citation: Lutzker, J. R., & Bigelow, K. M. (2002). *Reducing child maltreatment: A guidebook for parent services.* New York: Guilford Press. A more provider-friendly manual has been developed and revised by the National SafeCare Training and Research Center (NSTRC), and this version is made available to SafeCare providers during the workshop training process.
Plan to Implement ***SC***	SafeCare is a new service to be offered through contracts by DHS in Utah. To implement, the following steps will be completed:

	• DHS will contract with NSTRC at Georgia State University for training and support to community non-profit agencies and their in-home providers in adopting SafeCare and delivering it to Utah families with fidelity. • Identify start up resources necessary to support implementation of SafeCare by community-based non-profit agencies. • Complete pre-implementation activities such as having community-based non-profit agencies apply for acceptance to participate in state-sponsored training for SafeCare and evaluating agency readiness. • Complete initial implementation activities such as tailoring training plan to local needs, service orientation, supervisor and stakeholder overview, and four-day in-home provider workshops on each module of the curriculum. • Establish 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 informational packets 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 for SafeCare, Utah expects to see the following outcomes for children and families receiving this service: Increased positive parent-child interaction, enhanced home safety and parent supervision, and reduced future incidents of child maltreatment.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in	See Section 2.C. Continuous Quality Improvement Overall Strategy. DHS 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

Monitoring to Improve Practice ***SC***	2.C. DHS 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, DHS 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 proficient 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 accreditation reviews of each community-based non-profit agency on an annual basis 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. In addition to these fidelity processes, providers will be required to report fidelity and client progress towards outcome measures to DHS on a designated time frame. Information gleaned from all of these sources will support and reinforce quality practice, and identify needs for technical assistance and support. Providers of SafeCare are required to implement SafeCare module assessments pre- and post-training to reinforce fidelity and measure parent behavior change. 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

	service, 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***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-based tool developed as part of Utah's Title IV-E waiver. The number of children served in DCFS in the 0-5 age range supported targeting services to this age group. • Initially, only longer-term home visiting models were considered for the child 0-5 age range, but based on further analysis, a need for a shorter term parenting intervention was identified. An existing peer parent program was analyzed, and peer parent program administrators expressed a desire for a more effective curriculum for younger children than the one they were using. • The DHS subject matter expert workgroup expanded their review for in-home parenting skills programs, which included SafeCare. • The research data and structure and support offered by the developer for implementation of SafeCare were compelling. • Based on the analysis and input from stakeholders, DHS selected SafeCare as an intervention to be included in the prevention service array.

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 SafeCare will be conducted by the University of Utah Social Research Institute. The SafeCare Evaluation Strategy is contained in Appendix A. Also, see Section 2, Evaluation Strategy below.

Service	***Trauma Focused Cognitive Behavioral Therapy (TF-CBT)***
Service Description ***TF-CBT***	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a program for children and adolescents who have symptoms associated with trauma exposure. TF-CBT is intended to treat children/adolescents who have post-traumatic stress disorder (PTSD) symptoms, dysfunctional feelings or thoughts, or behavioral problems. The intervention also supports caregivers in overcoming their personal distress, implementing effective parenting skills, and fostering positive interactions with their child/adolescent. After ensuring safety of the child/adolescent, TF-CBT is structured into three phases that include: (1) skill building for the child/adolescent's self-regulation and the caregiver's behavior management and supportive care abilities, (2) addressing the traumatic experience, and (3) joint therapy sessions between caregiver and child/adolescent. TF-CBT is usually administered in clinical office settings of 12 to 16 weekly sessions for about one hour, though this can range. During these sessions, the therapist may meet with the caregiver and child/adolescent separately or jointly. This program is administered by licensed mental health professionals who have received TF-CBT training and certification.
Level of Evidence ***TF-CBT***	Promising (by the Title IV-E Prevention Services Clearinghouse)

Service Category ***TF-CBT***	Mental Health Programs and Services
Version of Book/Manual ***TF-CBT***	Cohen, J. A., Mannarino, A.P., & Deblinger, E. (2017). Treating Trauma and Traumatic Grief in Children and Adolescents, Second Edition. New York, NY: Guilford Press
Plan to Implement ***TF-CBT***	Prior to implementation of the Title IV-E Prevention Program in Utah, providers have used TF-CBT as a component of their therapeutic intervention for treatment and primary prevention in a limited number of sites, but generally have not broadly served at-risk children and families involved with DHS who will qualify as prevention candidates. TF-CBT provided as a discrete service through contracts will be new for DHS. To implement under the Prevention Program, the following steps are being completed: • Contract with TF-CBT Certified trainers to provide training to clinicians working in multiple sites across the state, both urban and rural, in order to establish a network of providers credentialed to provide TF-CBT. • Identify local providers that are not currently TF-CBT Certified who are willing to become TF-CBT Certified. • Have providers apply for acceptance to participate in state-sponsored training for TF-CBT. • Fund and host training sessions for prospective TF-CBT providers. 20 clinicians participated in the first TF-CBT training session. • Establish contracts with qualified providers, using specific TF-CBT enhanced rates and billing codes to capture required client and payment data. • Distribute informational packets to caseworkers and other potential referral sources to facilitate the referral process as the service becomes available in specific geographic areas. • Train caseworkers on TF-CBT and inclusion criteria for appropriate referrals for children that are candidates and their parents or kin caregivers.
Outcomes Expected to Improve ***TF-CBT***	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 TF-CBT, Utah expects to see the following outcomes for children and families receiving this service: Improved child behavioral and emotional functioning and improved positive parenting practices.

Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice ***TF-CBT***	See Section 2.C. Continuous Quality Improvement Overall Strategy. DHS will monitor fidelity and outcomes related to the implementation of TF-CBT using program specific tools along with the CQI overall strategy described in Section 2.C. DHS is requiring new TF-CBT programs with department contracts to obtain and maintain TF-CBT certification. The DHS quality and design specialist assigned to TF-CBT will coordinate with TF-CBT Certified trainers in support of implementation. Providers of TF-CBT are required to implement fidelity monitoring and outcome measurement using TF-CBT fidelity monitoring tools, internal programmatic monitoring processes, as well as fidelity and outcome measurement tools that will be identified or developed as part of the evaluation conducted by the University of Utah Social Research Institute (SRI). The following is a key tool used in TF-CBT: • TF-CBT Brief Practice Fidelity Checklist. This tool is used throughout the course of treatment to track components addressed in each session as well as caregiver inclusion in sessions. The tool is available at: https://tfcbt.org/tf-cbt-brief-practice-fidelity-checklist/. DHS will also provide onsite monitoring of TF-CBT providers through monitoring reviews. Provider interviews, review of documentation including completion of training and clinical supervision, review of fidelity monitoring tools and processes, and review of clinical notes will be included in these reviews. Using our existing monitoring processes in combination with fidelity and outcome data generated by providers and contained in Utah's CCWIS, DHS will work with providers to incorporate findings from the data and outcomes to support overall program development. DHS will work with program, implementation and/or fidelity experts to provide technical assistance as necessary.
How Selected ***TF-CBT***	• A DHS subject matter expert workgroup reviewed at length numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • DCFS analyzed needs of children and adults served through HomeWorks cases, the potential prevention services population, using data from the Utah Family and Children Engagement Tool (UFACET), a CANS/FAST-

	based tool developed as part of Utah's Title IV-E waiver. The number of children served in DCFS supported targeting services to children with symptoms related to trauma exposure. • DHS conducted a survey to gather stakeholder input regarding EBPs and evaluated current availability of EBPs through a survey of existing providers. Survey results identified that TF-CBT was already available in the state in some capacity. • Providers with clinicians eligible to receive training in TF-CBT are available in all areas of the state, including rural and frontier areas, and have shown that TF-CBT can be delivered under their current structure. • Based on input from each of these sources, DHS selected TF-CBT as an intervention to be included in the prevention service array.
Target Population ***TF-CBT***	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained.
Assurance for Trauma-informed Service Delivery ***TF-CBT***	See Attachment III, State Assurance of Trauma-Informed Service-Delivery
How Evaluated (Well-Designed and Rigorous Process) ***TF-CBT***	As required for services that are rated as promising, a well-designed and rigorous evaluation of TF-CBT will be conducted by the University of Utah Social Research Institute. The TF-CBT Evaluation Strategy is contained in Appendix B. Also, see Section 2, Evaluation Strategy below.

Service	***Families First (FF)***
Service Description ***FF***	The Families First program is an in-home, skill-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. Families First seeks to promote child safety, child permanency, child well-being and

	adult well-being. Families First 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. Families First is typically provided at a family's residence to ensure 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 skill-acquisition and successful completion of the model's six phases.
A Level of Evidence ***FF***	Well-Supported (through independent systematic review under the Transitional Payments for the Title IV-E Prevention and Family Services and Programs process, ACYF-CB-PI-19-06). See Appendix C.
Service Category ***FF***	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual ***FF***	Families First Program Manual, Utah Youth Village, Salt Lake City, Utah, 2019. (The manual is proprietary and may be purchased from Utah Youth Village. For more information about the manual, contact Utah Youth Village at www.utahyouthvillage.org.)
Plan to Implement ***FF***	Families First 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 implement under Utah's Title IV-E Prevention Plan, the following steps will be completed: • Continue to maintain a DHS contract with Utah Youth Village to provide Families First to families with children or youth who are candidates for foster care under the prevention program. • Make Families First available to candidates for foster care under the prevention program through both the Division of Child and

	Family Services and through the Division of Juvenile Justice Services. • Expand capacity for Families First 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 addition of Families First to the Title IV-E Prevention Program to facilitate continuing referrals, particularly as the service becomes available in additional geographic areas. • Train caseworkers on Families First 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 for Families First, 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. Continuous Quality Improvement Overall Strategy. DHS will monitor fidelity and outcomes related to the implementation of Families First 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 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."

	Families First 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. DHS will verify through monitoring reviews that Families First implements fidelity monitoring and outcome measurements using Families First 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. DHS data will also be utilized to determine outcome results. The outcomes that will be measured are child safety (repeat maltreatment) and child well-being (recidivism for delinquent behavior). Using existing monitoring processes in combination with fidelity and outcome data generated by providers and contained in Utah's CCWIS, DHS will work with Families First to incorporate findings from the data and outcomes to support overall program development. DHS will work with program, implementation and/or fidelity experts to provide technical assistance as necessary.
How Selected ***FF***	• Families First is an in-home parent skills-based training that has been utilized in child welfare and juvenile justice in Utah for several years. In conjunction with Utah's Title IV-E child welfare waiver, Utah Youth Village expanded availability of Families First to all DCFS geographic regions in the state. • A DHS subject matter expert workgroup reviewed numerous EBPs, both available in Utah and not available in Utah, including consideration of fit with needs, populations, ages, evidence base, sustainability, availability, rural, urban, and frontier availability and fit, saturation, and cultural fit. • The workgroup determined that if research on Families First could demonstrate the program would meet the evidence-based criteria required under the Family First Prevention

	Services Act, this service would be added to Utah's Title IV-E Prevention Program Plan. • Multiple research projects were completed for Families First, and, through independent systematic review, it was determined that this service would meet the Title IV-E Prevention Services Clearinghouse rigor. • Based on the experience with the service and research results, DHS selected Families First as an intervention to be included in the Title IV-E Prevention Program service array.
Target Population ***FF***	Families First is an evidence-based, parent-training curriculum for parents and children age 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***	As required for services that are rated by an entity other than the Title IV-E Prevention Services Clearinghouse, a well-designed and rigorous evaluation of Families First will be conducted by the University of Utah Social Research Institute. The Families First Evaluation Strategy is contained in Appendix D. Also, see Section 2, Evaluation Strategy below.

SECTION 2. Evaluation Strategy and Waiver Request

Essential to an investment in evidence-based services under the Family First Prevention Services Act by the Utah Department of Human Services (DHS) is a commitment to continuous quality improvement and well-designed and rigorous evaluation activities. Continuous quality improvement activities will be performed under the direction of the Office of Quality and Design (OQD), within DHS. Evaluation activities will be under the oversight of the OQD Management Information Center and conducted by contract through the University of Utah, Social Research Institute (SRI). SRI is a long-time partner of DHS, having recently 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 Department of Human Services is not implementing any allowable promising or supported EBPs rated by the Title IV-E Prevention Services Clearinghouse with this submission. DHS expects to submit plan amendments in the future to incorporate additional evidence-based services approved by the Clearinghouse or approved through independent systematic review in accordance with the transitional payment review process issued by the Children's Bureau on July 18, 2019.[3] Full evaluation designs will be included with future plan amendments for any promising or supported services approved by Clearinghouse or for any promising, supported, or well-supported services for which the level of evidence was determined through independent systematic review. For well-supported services approved by the Clearinghouse, which includes FFT, PCIT, and PAT with this submission, a request to waive evaluation requirements may be submitted with documentation of compelling evidence of the program's effectiveness and verification that continuous quality improvement requirements will be met.

A well-designed, rigorous evaluation plan will be developed for each program or service approved in Utah's Title IV-E Prevention Plan for which no evaluation waiver has been granted. *The Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures*[4] and the *Evaluation Plan Development Tip Sheet*[5] 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 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 programs 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.

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[3] U.S. Department of Health and Human Services, Administration for Children, Youth, and Families, ACYF-CB-PI-19-06.

[4] https://preventionservices.abtsites.com/themes/ffc_theme/pdf/psc_handbook_v1_final_508_compliant.pdf

[5] U.S. Department of Health and Human Services, Administration for Children and Families, ACYF-CB-IM-19 issued on August 13, 2019.

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.

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., continuous quality improvement 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[6]:

> *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 continuous quality improvement requirements with regard to the practice.*[7]

[6] In accordance with Public Law 115-123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018, The U.S. Department of Health and Human Services Administration on Children, Youth and Families

[7] U.S. Department of Health and Human Services, Administration for Children and Families, ACYF-CB-IM-18-02 issued on August 13, 2019. https://www.acf.hhs.gov/sites/default/files/cb/im1802.pdf

DHS 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) Functional Family Therapy, (2) Parent Child Interaction Therapy, (3) Parents as Teachers, and (4) Motivational Interviewing. Documentation of compelling evidence for each program or service is described below.

Compelling Evidence of Effectiveness of the Practice

Functional Family Therapy (FFT)

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 DHS 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 Office, 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[8] effects on child behavioral and emotional functioning, child substance use, child delinquent behavior, and family functioning, which are desired outcomes for the DHS prevention service array. Unfavorable effects were minimal. These findings are summarized in the table below[9].

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

[8] 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).

[9] Title IV-E Prevention Services Clearinghouse. Functional Family Therapy. Summary of Findings. https://preventionservices.abtsites.com/programs/108/show

Outcome	Effective Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
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[10].

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.[11]"

Finally, the Pew Foundation Results First Clearinghouse[12], 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

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

[11] https://www.ojjdp.gov/MPG/Topic/Details/79

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

considered together, led DHS 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.

The review by the Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable[13] 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 DHS prevention service array. There were no unfavorable effects. These findings are summarized in the table below[14].

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

[13] 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).

[14] https://preventionservices.abtsites.com/programs/105/show

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 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.[15] Also, the Pew Foundation Results First Clearinghouse[16], 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[17]."

Parents as Teachers (PAT)

The effectiveness of Parents as Teachers has been demonstrated through multiple studies and reports, which, when considered together, led DHS to conclude that the program's effectiveness is compelling for Utah's child welfare population and for youth in foster care or involved with juvenile justice who are pregnant or parenting. This conclusion is supported by the Title IV-E Prevention Services Clearinghouse's Summary of Findings, which reflects findings from six studies that were eligible for review, from studies cited by PAT, and also from a comprehensive literature review contained in the Home Visiting Evidence of Effectiveness (HomVEE) review, reported by the Office of Planning, Research and Evaluation in September 2019.

A review of PAT research by the Title IV-E Prevention Services Clearinghouse shows that PAT had favorable[18] impacts on child safety as well as child social and cognitive functions, which are key outcomes DHS is seeking to attain through its prevention service array, and also corresponds to needs of parents with young children identified through the Utah Child and

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

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

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

[18] 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).

Family Engagement Tool. Also of importance, according to the Title IV-E Prevention Services Clearinghouse review, PAT has produced very limited unfavorable impacts on outcomes. A summary of this review's findings can be found in the table below[19].

Parents as Teachers 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	0.11 4	2 (6)	4825	Favorable: 2 No Effect: 3 Unfavorable: 0
Child permanency	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.07 -2	2 (11)	640	Favorable: 0 No Effect: 10 Unfavorable: 1
Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable:

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.

In addition, current studies of PAT show a significant impact on a number of outcomes vital to the child welfare system. In March of 2019, Parents as Teachers published a Fact Sheet, *Prevention of Child Abuse and Neglect,* reporting the following impacts of PAT on child abuse and neglect:

- *In one of the largest research studies in the U.S. conducted to investigate the impact of home visiting on child maltreatment, researchers found a 22 percent decreased likelihood of substantiated cases of child maltreatment (as reported by Child Protective Services) for Parents as Teachers families compared to the non-PAT families.*

[19] Title IV-E Prevention Services Clearinghouse. Parents as Teachers. Summary of Findings. https://preventionservices.abtsites.com/programs/111/show

- *In a randomized-controlled trial of Parents as Teachers for CPS-involved families, the program was associated with a significantly lower likelihood of CPS for non-depressed mothers.*
- *Parents as Teachers participation was related to 50 percent fewer cases of suspected abuse and/or neglect. Parents as Teachers in Maine, focusing on families with involvement with Child Protective Services, found that once entered into a Parents as Teachers program 95 percent of families had no further substantiated reports or allegations of child abuse.*[20]

Complementing the Title IV-E Prevention Services Clearinghouse's findings showing PAT's effectiveness, results from The Home Visiting Evidence of Effectiveness (HomVEE) [21] review recently published in September 2019, which reviewed the evidence of effectiveness of 21 home visiting programs, reported that most home visiting models, including PAT, had favorable impacts on primary measures of child development and school readiness and positive parenting practices. The study also showed that PAT participants sustained favorable impacts for at least one year after beginning the program [22]. In addition, the HomVEE report provides evidence that minimum standards for fidelity have been met in the areas of supervision, frequency of visits, pre-service training, use of fidelity tools, and an established system for fidelity monitoring[23].

As DHS implements evidence-based prevention programs, our goal is to have programs with sustained and favorable outcomes, and to have programs that are successfully implemented at the local level. Prevent Child Abuse Utah's Parents as Teachers program became a PAT affiliate in 2011. In the PAT model, affiliates are given several years to build training, services, and model fidelity through internal systems changes, continuous quality improvement, and feedback through the regional and national support systems to develop and prepare to meet the standards of a Blue Ribbon affiliate. The Quality Endorsement and Improvement Review Process takes 18 months to complete and allows a national committee, independent of the local PAT agency, to analyze policies, procedures and services at all levels -- fiduciary, supervisory, employment policy, professional development, services to families, and documentation -- to determine if the model is being provided with fidelity. In October 2018, Prevent Child Abuse Utah's Parents as Teachers was recognized as a Blue Ribbon affiliate. This award signifies that PCAU is a high fidelity model, meeting the Parents as Teachers essential requirements and excelling in the additional 100 PAT standards. PCAU received notification in November 2019 that this level of quality was achieved again, furthering DHS confidence in the effectiveness of this model.

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[20] *Prevention of Child Abuse and Neglect, Parents as Teachers, March 2019*, page 1: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

[21] *Prevention of Child Abuse and Neglect, Parents as Teachers, March 2019*, page 1: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

[22] *Prevention of Child Abuse and Neglect, Parents as Teachers, March 2019*, page 1: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

[23] *Prevention of Child Abuse and Neglect, Parents as Teachers, March 2019*, page 1: https://static1.squarespace.com/static/56be46a6b6aa60dbb45e41a5/t/5c9d2c9deb39313e7359ded9/1553804446421/Fact-Sheet_ChildAbuseandNeglectPrevention.pdf

Motivational Interviewing (MI)

The effectiveness of Motivational Interviewing (MI) has been demonstrated through multiple studies and inclusion as effective in multiple clearinghouses and reports, which, when considered together, led DHS 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 75 studies that were eligible to review, of which 13 were rated high and 8 were rated moderate. The effectiveness of MI is also supported by the California Evidence-Based Clearinghouse for Child Welfare, Office of Justice Crime Solutions, and the Center for Evidence-Based Practices.

The review by the Title IV-E Prevention Services Clearinghouse resulted in a rating of well-supported, and shows that MI had favorable[24] impact on adult well-being specific to parent/caregiver substance use, which is an important outcome for the DHS prevention service array. The review identified two unfavorable effects. These findings are summarized in the table below[25].

Motivational Interviewing 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 well-being: Substance use	0.02 0	5 (33)	1634	Favorable: 0 No Effect: 33 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.00 0	3 (5)	1464	Favorable: 0 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver substance use	0.08 3	15 (109)	6066	Favorable: 16 No Effect: 91 Unfavorable: 2

[24] 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).

[25] https://preventionservices.abtsites.com/programs/142/show

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Adult well-being: Parent/caregiver criminal behavior	-0.01 0	2 (7)	1610	Favorable: 0 No Effect: 7 Unfavorable: 0
Adult well-being: Family functioning	0.10 4	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver physical health	0.02 0	4 (10)	2158	Favorable: 0 No Effect: 10 Unfavorable: 0
Adult well-being: Economic and housing stability	-0.02 0	1 (1)	777	Favorable: 0 No Effect: 1 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 findings reported for this program or service are derived from eligible, prioritized studies rated as moderate or high on study design and execution and do not represent the findings from all eligible studies of the program or service.

The California Evidence-Based Clearinghouse for Child Welfare rated MI as having well-supported research evidence with medium relevance for child welfare in the categories of motivation and engagement programs and substance abuse treatment for adults. [26] CEBC reported that research determined that with MI there was higher attendance in treatment for substance using adults, increased motivation to change, and reduced drinking in young adults.

In addition, the National Institute of Justice's CrimeSolutions.gov[27], which is a web-based clearinghouse of programs and practices, reviewed 12 studies and concluded that individuals in the MI treatment groups significantly reduced their use of substances compared with individuals in the no-treatment control groups.

[26] https://www.cebc4cw.org/program/motivational-interviewing/

[27] https://www.crimesolutions.gov/PracticeDetails.aspx?ID=31

Finally, the Center for Evidence-Based Practices[28] at Case Western Reserve University, a technical-assistance organization that promotes recovery among people with mental illness, substance use disorders, and co-occurring disorders through the implementation of evidence-based practices and emerging best practices in behavioral healthcare, reports that MI "can help clients discover their own interest in considering and/or making a change in their life (e.g., managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs), examine their ambivalence about the change, plan for and begin the process of change, and strengthen their commitment to change."

C. Continuous Quality Improvement (CQI) Overall Strategy

The Utah Department of Human Services (DHS) is committed to ensuring that evidence-based programs and services provided to children, youth, and families are delivered to fidelity, and most importantly, that they are effective. In support of this, DHS has developed a multi-layered approach to continuous quality improvement of evidence-based programs and services, which meets the continuous quality improvement requirements in subparagraph 471(e)(5)(B)(iii)(II).

DHS has embedded its fidelity monitoring, outcome measurement, and evaluation activities for evidence-based programs into its broader continuous quality improvement efforts within the DHS Office of Quality and Design (OQD). OQD is responsible for the design and development of the service array for individuals and families served by the Department and its divisions. It also has responsibility for coordinating the provider network; for quality management, data, and evaluation relative to services; and for internal quality assurance including quality case reviews. OQD has designated a clinical quality and design specialist with subject matter expertise as the lead for the CQI process for each evidence-based program. These quality and design specialists work with developers, providers, evaluation, data, and quality management staff to coordinate implementation of the evidence-based program. They also ensure that each evidence-based program is deployed and implemented effectively, and ensure that quality management, outcome measurement, evaluation, and technical assistance efforts are coordinated in a manner to produce continuous quality improvement.

In collaboration with program developers, subject matter experts, and the University of Utah Social Research Institute (SRI), OQD 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, DHS 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.

[28] https://www.centerforebp.case.edu/practices/mi

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

Outcomes are measured both by the provider and at the DHS level. At the provider level outcomes are measured specific to the targets of the intervention. These outcomes will be reported regularly to DHS as part of the CQI process. Outcomes measured at the DHS level include items such as safety (protective services findings), permanency (including entry into foster care), family well-being (through UFACET, Utah's version of the CANS) and risk reduction (particularly for juvenile justice involved youth).

On approximately a quarterly basis, quality management staff will review fidelity and outcome data to identify strengths and needs in implementation within and across providers. Trends and other observations in these reviews will be shared with providers in support of quality improvement. Quality and design specialists will regularly facilitate convenings with providers in conjunction with these reviews in order to discuss findings, provide technical assistance, and support peer learning. In support of quality improvement, DHS is establishing technical assistance agreements with developers and other subject matter experts to provide support in program implementation and technical assistance to DHS and providers. When needed, these convenings may also include technical assistance with developers and other subject matter experts. When more individualized assistance is identified as needed, quality management staff will provide technical assistance directly with providers, and will engage developers or other experts as needed to provide support.

In addition to this on-going support, quality management staff will conduct implementation reviews that involve verification of fidelity and outcome measurement processes at the provider level and review of outcome measurement and evaluation trends. During these reviews, providers and quality management staff identify areas of strength and needs, and establish a collaborative quality improvement plan for providers. These reviews occur on an annual or more frequent basis according to need.

DHS will monitor fidelity and outcomes utilizing the CQI overall strategy for each evidence-based program and service. Program or service specific fidelity processes and tools that will be utilized as part of the CQI process are described for each specific service in Section 1.B.

SECTION 3. Monitoring Child Safety

A. Periodic Risk Assessment

DCFS will monitor and oversee the safety of children who receive prevention services under Utah's Title IV-E prevention 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 ongoing 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 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.

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 caseworker will complete the SDM Risk Assessment.

The initial SDM Risk Assessment is required within 45 days of the case open date and before the creation of the Child and Family Plan. The SDM Risk Assessment rating defaults to "very 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
Very High	**Four** face-to-face per month with caregiver and child	**Two** 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 shall 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.	

DJJS also monitors youth safety on an ongoing basis through caseworker contacts with youth and families. 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 away from the residence when needed for youth or parent safety.

B. Prevention Plan Review

Prevention plans are routinely reexamined to help monitor and track the child and parent or kin caregiver's progress during the provision of services. The written plan is developed with input from the Child and Family Team, and is tracked and adapted 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 written plan will be reviewed as needed, and updated at a minimum of every six months.

SECTION 4. Consultation and Coordination

A. Consultation

The Department of Human Services has consulted with other state agencies responsible for administering mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services. DHS established a steering committee to oversee and guide overall implementation of provisions of the Family First Prevention Services Act. The steering committee consists of members of executive leadership within the department, including the executive director, and directors of multiple divisions and offices within the department, and other key staff. A parent representative also participated in meetings of the steering committee.

The steering committee created several multi-agency committees to address implementation of the Family First Prevention Services Act. Multi-agency committees have included state office and regional office representatives from the Division of Substance Abuse and Mental Health, the Division of Services for People with Disabilities, Division of Juvenile Justice Service, System of Care, the Division of Child and Family Services, the Office of Quality and Design, and Office of the Attorney General. Multi-agency committees also consulted with additional state agencies, community organizations, private providers, and EBP developers and trainers.

In-person meetings were held with community providers in order to gain their feedback. A statewide provider survey was conducted asking about availability of current services and interest in being trained in approved EBPs. DHS has also met with the Department of Health Office of Home Visiting to assist with aligning services for at risk families, without duplicating efforts, and has consulted with the DOH Medicaid office on FFPSA related issues.

Consultation efforts helped guide selection of the service array for the Utah's Title IV-E Prevention Plan, and will continue to guide development of a continuum of mental health and substance abuse prevention and treatment services, and in-home parent skill-based programs, to be added through future plan amendments.

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 activities 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 will 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 will continue 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 concrete needs such as 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. 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 at home.

SECTION 5. Child Welfare Workforce Support

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

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 and DJJS also have 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.

For DCFS, all training provided by DCFS to 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 review and quantitative case process reviews. Department operational excellence initiatives that are currently underway will also provide support to workers to enhance quality casework and focus caseworker time on critical case activities most important to help achieve positive outcomes for children and families.

All of these state agency supportive activities will 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.

SECTION 6. Child Welfare Workforce Training

DCFS and DJJS 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 for prevention services will serve as a reinforcement of training for overall good case practice.

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. For prevention training, additional emphasis will be given to incorporating those assessed needs into the written prevention plan in a way that identifies the strategy to allow the child to remain safely at home or with a kin caregiver, and connecting to appropriate evidence-based trauma-informed services and programs. The training will reinforce the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the importance and priority of kinship placement in the event a child cannot safely remain at home.

Prevention training will provided to existing caseworkers, supervisors, and administrators at the local level. The prevention services concepts will also be incorporated into new employee Practice Model training, which will include 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 Plan to help workers understand the service target population, needs the service addresses, and availability.

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

Caseworker training will address assessment of youth and family strengths and needs with the UFACET, and will also address 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. Casework skills will be further strengthened with training on Motivational Interviewing and High Fidelity Wrap-Around. Supervisors will provide feedback of critical Youth Services processes. Supervisors will observe and rate the worker's 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 DJJS have established processes to determine, manage, and oversee caseload size and type for prevention caseworkers.

In DCFS, prevention cases will be 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 region and office staff resources, specialization is encouraged. For example, in larger offices, some teams will specialize in managing in-home cases. Some smaller offices will have individual workers that specialize in managing in-home cases. In more rural, smaller 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 target caseload standard for caseworkers managing prevention cases is a ratio of 1:12 for DCFS.

Overseeing caseload size and type is essential. Manageable caseloads and workloads can make a significant difference in a caseworker's ability to spend adequate time with children and families and on completing critical case activities, and ultimately having a positive impact on outcomes for children and families. One of our strategies to make caseloads and workloads more manageable is use of a workload report that is available to region staff. The formula used in the report converts "caseload" to "workload." Caseload is defined as the number of cases (children or families) assigned to an individual worker in a given time period. Workload is defined as the amount of work required to successfully manage assigned cases and bring them to resolution. Supervisors and region administrators are able to consider both caseload and workload when new case assignments are given and in monitoring child and family progress and overall worker progress. Successfully managing caseworkers' workload can help caseworkers be in a position to better serve the children and families on their caseload.

DCFS state administration and region administration will continue to provide oversight to the caseload size and case type for caseworkers. The state Data Administrator provides monthly data reports to state and region administrators. Reports include information about caseloads, and new and closed cases for CPS, foster care, and in-home services cases, which will include prevention candidates. Each of the state's five regions has a practice improvement coordinator that monitors region and team specific caseload data, including overall number of cases and the different case types.

JJS has Youth Services Centers located at multiuse facilities throughout the state. Prevention cases will be managed by Youth Services administration and workers. JJS will be implementing a team approach to the prevention caseload. A team will consist of one Supervisor/Coach, two Youth Service workers/facilitators, and two or three Peer Support workers. One team can manage a caseload of up to twenty-five families. In rural areas, a team may have a reduced number of Youth Services workers and Peer Support workers based on the need of the community. Caseload oversight and targeted outcomes will be reviewed on a regular basis by the local facility Assistant Program Director and by the JJS Executive Management Team.

SECTION 8. Assurance on Prevention Program Reporting

The Utah Department of Human Services provides an assurance in Attachment I that DHS 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 Plan. This will include data necessary to determine performance measures for the state and compliance. Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019. 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 in a kinship placement with receipt of approved evidence-based services under the child's prevention plan. For the purpose of this document, the term "prevention candidate" is equivalent to the Federal term "child who is a candidate for foster care" and the term "serious risk" is equivalent to the Federal term "imminent risk."

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 serious risk of entering or reentering foster care, but able to remain safely in the home or kinship placement as long as mental health, substance use disorder, or in-home parenting skill-based programs or services for the child, parent or kin caregiver are provided. To be eligible for Title IV-E Prevention Services, the child's prevention candidate status must be designated in the child's prevention plan prior to provision of services. 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.

A child may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of individual parents, children, or kinship caregiver that may affect the parents' ability to safely care for and nurture their children.

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

- Child maltreatment, including abuse or neglect
- Substance use or addiction
- Mental illness
- Lack of parenting skills
- Limited capacity to function in parenting roles
- Parents' inability or need for additional support to address serious needs of a child related to the child's behavior
- Developmental delays
- Physical or intellectual disability
- Adoption or guardianship arrangements that are at risk of disruption

Kin caregiver defined in Utah Code Section 78A-6-307 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 an adoptive 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 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

Child and family eligibility for the Title IV-E Prevention Program is determined through assessments conducted by caseworkers for the Division of Child and Family Services (DCFS) or the Division of Juvenile Justice Services (DJJS), utilizing designated assessment tools. These assessments (of children identified in a prevention plan) determine if the child is at serious risk of entering foster, but can remain safely in the home or in a kinship placement as long as the title IV-E prevention services that are necessary to prevent the entry of the child into foster care are provided.

DCFS caseworkers assess children and families utilizing safety and risk assessment tools and through a functional assessment, which together identify a child's risk of entry into foster care and the child and family's needs related to mental health, substance abuse, and/or parenting skills.

Structured Decision Making (SDM) Safety and Risk Assessments are utilized during a child protective services investigation or assessment, and identify if a child can remain safely at home with a safety plan, and if families have needs related to substance use, mental health, and/or parenting skills.

The Utah Family and Child Engagement Tool (UFACET) is a functional assessment completed with the family at the beginning of an ongoing case that also informs the prevention candidate determination. 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 and Chapin Hall.

UFACET is used to create a shared understanding of the reasons for agency involvement and to create plans and strategies 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 to supports the kin caregiver needs in order to maintain the child in the home. The Substitute Caregiver section is completed for each individual kin caregiver.

When needs justify opening a child welfare ongoing in-home services case, the SDM results and UFACET items requiring action are both taken into account to determine if the child is a prevention candidate.

DCFS will develop an individualized Child and Family Plan based on the needs requiring action identified in UFACET and with input of the child and family team. For children that are prevention candidates, evidence based programming in the areas of substance use, mental health, and parenting skills will be incorporated into the Child and Family Plan, which serves as the child's prevention plan. Candidate status is confirmed through finalization of the child's prevention plan.

DJJS caseworkers assess youth and families utilizing UFACET and a risk assessment tool, which identify a youth's risk of entry into foster care and the youth and family's needs related to mental health, substance abuse, and/or parenting skills.

Title IV-E prevention services tie to DJJS 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 a Utah Family and Children Engagement Tool (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 Protective and Risk Assessment (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 showed 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 were 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).

A youth is considered a candidate for foster care when a youth scores "moderate" or "high" on the PRA and is assessed as having one or more risk factors that identify the need for mental

health, substance abuse, or in-home parenting skills services. A youth is also considered a candidate for foster care when UFACET-Family Focused items are assessed as requiring action.

DJJS 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, which serves as the child's prevention plan. Candidate status is confirmed through finalization of the child's prevention plan.

A child may be reassessed for prevention candidate status at the end of each 12-month prevention episode utilizing the processes described above, based on continuing serious risk for entry into foster care and continuing need for evidence-based prevention services to prevent the entry of the child into foster care. Candidate status is confirmed through a new prevention plan.