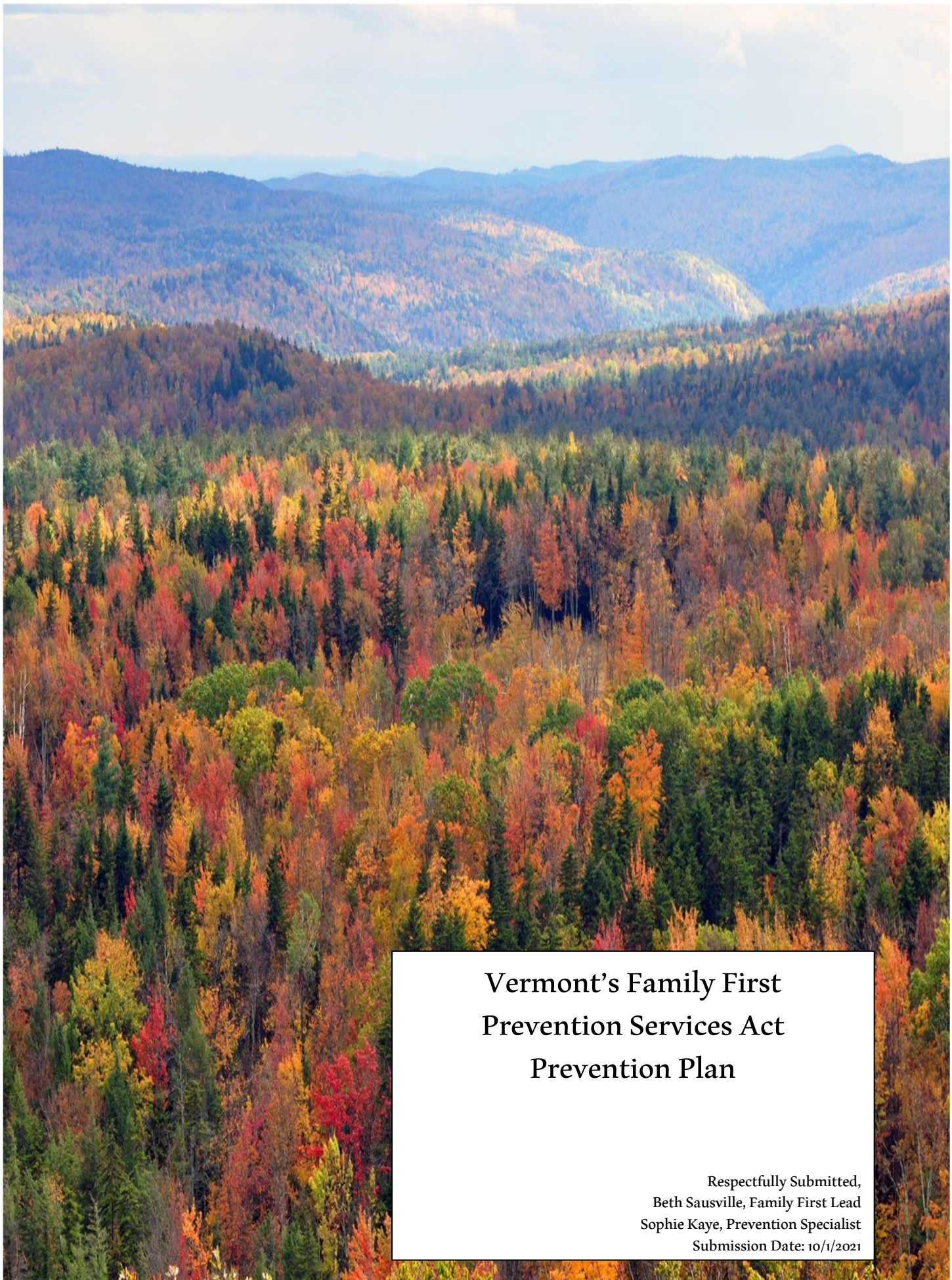


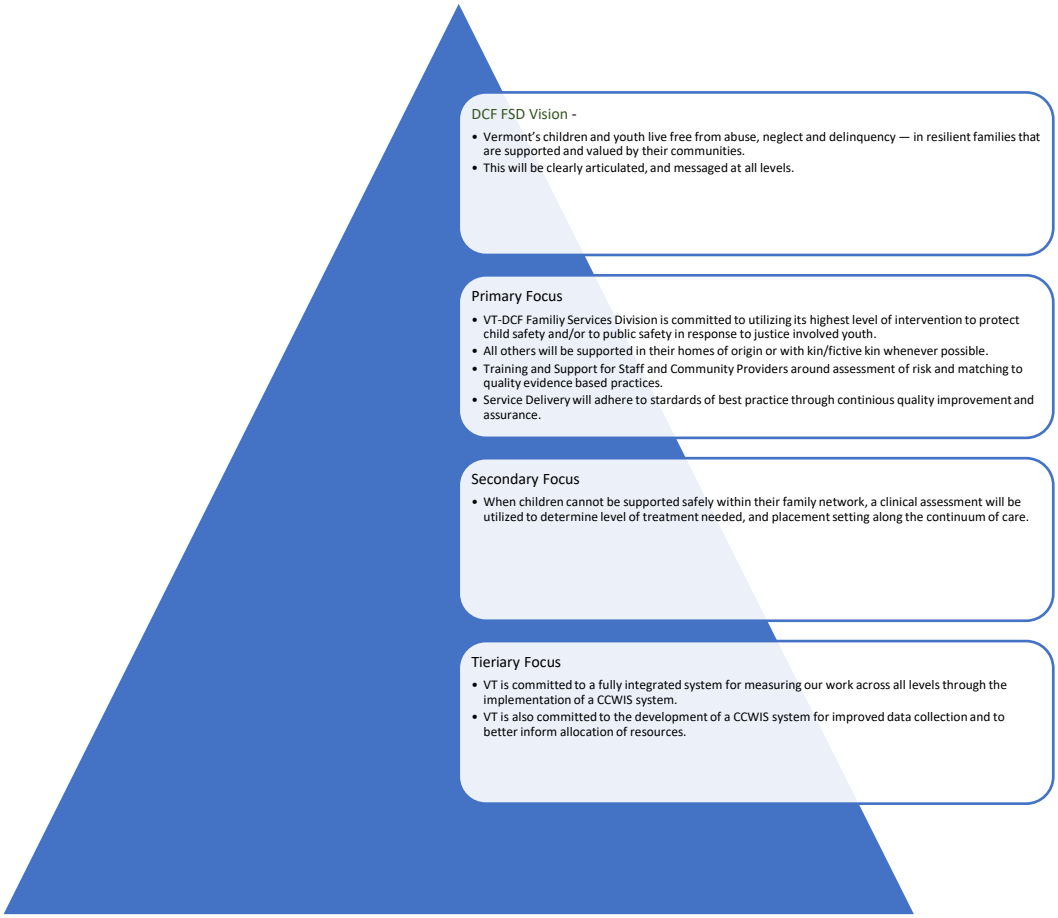
Vermont's Family First Prevention Services Act Prevention Plan

Respectfully Submitted,
Beth Sausville, Family First Lead
Sophie Kaye, Prevention Specialist
Submission Date: 10/1/2021

Contents

Executive Summary

The Family First Prevention Services Act (FFPSA) was adopted in February 2018 as part of the Bipartisan Budget Act (HR. 1892). FFPSA makes federal resources available through reimbursement for prevention services related to mental health services, substance abuse treatment and improved parenting skills for children who are at imminent risk of entering foster care or a candidate for foster care. FFPSA is designed to help the public child welfare system be focused on improving family stability, scaling up prevention services, decreasing foster care entry, and decreasing congregate care to only when clinically necessary. The Vermont Department of Children and Families, Family Services Division (DCF-FSD) has committed to use the tools in FFPSA to support this vision. DCF-FSD is focusing on preserving families in their home of origin when it is safe to do so, improving outcomes across the child welfare system, ensuring appropriate residential treatment use only when children demonstrate the clinical need for such care, and thriving financially in a post Title IV-E Waiver environment.



Introduction

Vermont's Department for Children and Families (DCF) is amidst a pivotal time in the history of child welfare. Vermont has consistently been a leader in bringing trauma-informed policies into the state's child welfare system and providing preventative services to its communities. The Family First Prevention Services Act (FFPSA or "Family First") provides a comprehensive avenue for Vermont to continue implementing policies around the state's goals of keeping children safely with their families, preventing further involvement in the child welfare and juvenile justice system through trauma-informed, strengths-based services and supporting family and, when necessary, community-based care for children and youth.

Family First ties directly to Vermont DCF's vision that: "Vermont's children and youth live free from abuse, neglect and delinquency – in resilient families that are supported and valued by their communities." Vermont has already begun to implement new policies around providing effective prevention services to families, and a focus on precise determinations of a child's need for residential care placements. Vermont has focused efforts on strengthening its system of care, including diligent recruitment, and expanding use of relative and family-friend kinship care and community-based programs to keep Vermont children and youth closely connected to their families and communities.

Family First provides an exciting opportunity for Vermont to continue this work at an even greater level and with a broader reach by enabling DCF to establish workgroups and teams with experts and stakeholders to ensure DCF is providing services to families that are accessible, effective and trauma informed. As will be discussed in greater detail throughout the Prevention Plan, DCF has created a variety of projects to address each section of Family First and how each provision will be best implemented within Vermont's unique combined child welfare and juvenile justice system.

A. **Summary of the state's strategic direction**

Vermont has recognized the value of aligning our services with standards of best practice. This includes training, support, service delivery, and messaging. Family First creates opportunity for Vermont to continue this work at an even greater level and with a broader reach by enabling DCF to establish workgroups and teams with experts and stakeholders to ensure DCF is providing services to families that are accessible, effective, equitable, and trauma informed. As will be discussed in greater detail throughout the Prevention Plan, DCF has created a variety of workgroups with experts in specific content areas to determine how each provision of Family First can be implemented optimally within Vermont DCF's unique combined child welfare and juvenile justice system. At various points throughout the process of preparing this prevention plan, individual workgroups have come together to integrate their working progress, and the formation of a Core Group has served as the central hub within the department for communication and coordination.

Our current funding structure will allow child welfare to apply Title IV-E funding to community-based service provision with aim for preventing the need for involvement in the child welfare and court system. Vermont recognizes it will be challenging to capture and measure outcome data efficiently and effectively, and a comprehensive IT system will be crucial to broadening the scope of continuous quality improvement and quality assurance practices. We are committed to moving forward with internal and external benchmarking by both adapting and building on the systems we have currently in place to tackle some of these challenges. This will mean initially offering prevention services to a population that lightly touches DCF as defined in our Candidacy Definition. Over time, as we develop our IT infrastructures, we will be able to expand those services to other populations as outlined in Vermont's candidacy definition. Our aim is for the Community Pathways population to expand, and DCF involved populations to shrink. This will be one of the key indicators of success along with the reduction of DCF caseloads.

We look forward to training and supporting our community providers to be able to assess those at greatest need for direct referrals, while expanding evidence-based prevention programming across the state. Our mission is for those at greatest need to be served timely and with quality services that demonstrate success. Our hope as funding streams develop to support this work in the community, families in need of services can receive the help they need outside of DCF-FSD involvement, and DCF-FSD intervention will be preserved for cases where risk to child safety is high, the purest function of the Division.

B. Specific overview of system transformation efforts toward increased prevention of child maltreatment and foster care reductions

DCF has experienced an increased need for foster homes over time. The presenting needs of children/youth coming into care are more complex, with traumatic-stress related disorders often at the core. Additionally, our foster care regulations often prevent DCF from placement with kin, or it may take extra time based on family history, criminal history, etc. This contributes to struggles around placement stability.

With increased effort on prevention versus intervention, our aim is for families to obtain the skills they need to parent effectively without the need for their child(ren) to enter DCF custody. While there may always be a need for traditional foster care as we know it, conceivably, it would greatly reduce this need. Even kin placements for children/youth in care often fail as the needs of the child/youth are greater than what the kin caregiver can sustain. The hope would be to support the family, including the kin network outside of the child/youth coming into care, thus negating the need to introduce further trauma.

Vermont has already taken initiative to implement new policies around providing effective prevention services to families, and a focus on precise determinations of a child's need for residential care placements through collaboration and coordination across departments in the Agency of Human Services. Vermont has focused efforts on strengthening its system of care through diligent recruitment and expanding support around relative and family-friend kinship care and community-based programs to keep Vermont children and youth closely connected to their families and communities.

C. **Specific jurisdictional considerations related to Family First**

- Legislative reforms (if applicable)

The legislative consideration currently underway is the braiding of the 60-day hearing as part of the QRTP placement process. However, the Child Protection Oversight Committee of the state legislature has been presented with regular updates around Vermont's Prevention Plan and is committed to its success.

D. **State efforts to develop a full continuum of care for preventive services**

- What partnerships are included to implement Family First and the broader prevention transformation?

VT's child welfare system has actively engaged other Departments/Divisions in its planning process, such as the Child Development Division, Economic Services, Department of Mental Health, Department of Health, Agency of Education, contracted partners, and those with lived experience in child welfare in Vermont, just to name a few. Moving forward throughout the implementation of Vermont's 5-year IV-E Prevention Plan, DCF-FSD will partner with many of these entities

to enhance the EBP's already being provided outside of DCF-FSD, creating better resource availability for families and service matching. Vermont will also initiate a robust Prevention Implementation Workgroup, providing opportunities on a continuous basis for feedback and Prevention Plan amendments. In addition to these strategies, Vermont's State Interagency Team has agreed to provide oversight and feedback as the IV-E Prevention Plan evolves over time, ensuring that other State agencies and Departments, along with family-serving entities, have the opportunity to weigh in.

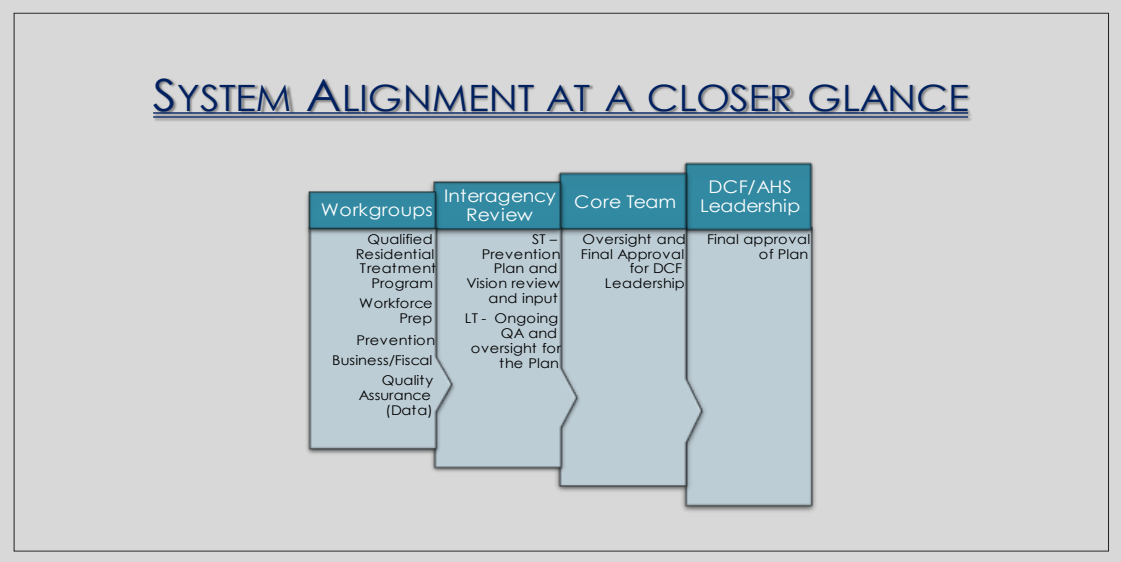
- In what ways will Family First be implemented upstream of child welfare through contracts and/or IV-E agreements?

We are planning to begin by providing preventive services to candidates involved with DCF Family Services through open family support cases and Conditional Custody Orders (as specified in Vermont's candidacy definition in Section 2). However, Vermont's vision for FFPSA is that, over time, we will train and support our key stakeholders, so that in the future, the funding would follow the child/youth/family. This will mean that their needs can be met without ever having to enter the child welfare system. We also recognize the need to expand our array of prevention-based services over time. While we are starting this process with well supported programs housed within our own Department/Division, the hope would be to partner with other organizations who are providing well supported prevention services such as Multi Systemic Therapy, delivered by Mental Health providers, or Parents as Teachers, an approach held within our Parent Child Center network. There are also several others that have demonstrated success in VT, and we hope for their consideration as well supported on the Clearinghouse in the future. Examples of those are Child Parent Psychotherapy, Strengthening Families, and Nurturing Parents Program.

E. **How stakeholders and partners were consulted in and contributed to the development of this prevention plan**

The Prevention Workgroup has been 80+ strong since its inception, comprised of internal and external stakeholders, including representatives from the areas of mental health, substance use, parenting, as well as individuals with lived experience. The collective work of this workgroup gave recommendations around how Vermont will define Candidacy, as well as our EBP selection. The Prevention Workgroup will transition into a Prevention Implementation Workgroup as Vermont begins to implement its Prevention Plan and will include additional members, such as providers of the selected EBP's.

Going forward in our Implementation Phase, we plan to engage an Interagency Group to serve in an Advisory Role, to actively oversee and weigh in on how our Prevention Plan is serving those in need. As we reach the point where the funding can follow the child/youth/family then it is possible the Interagency Team could interweave with the Core Team.



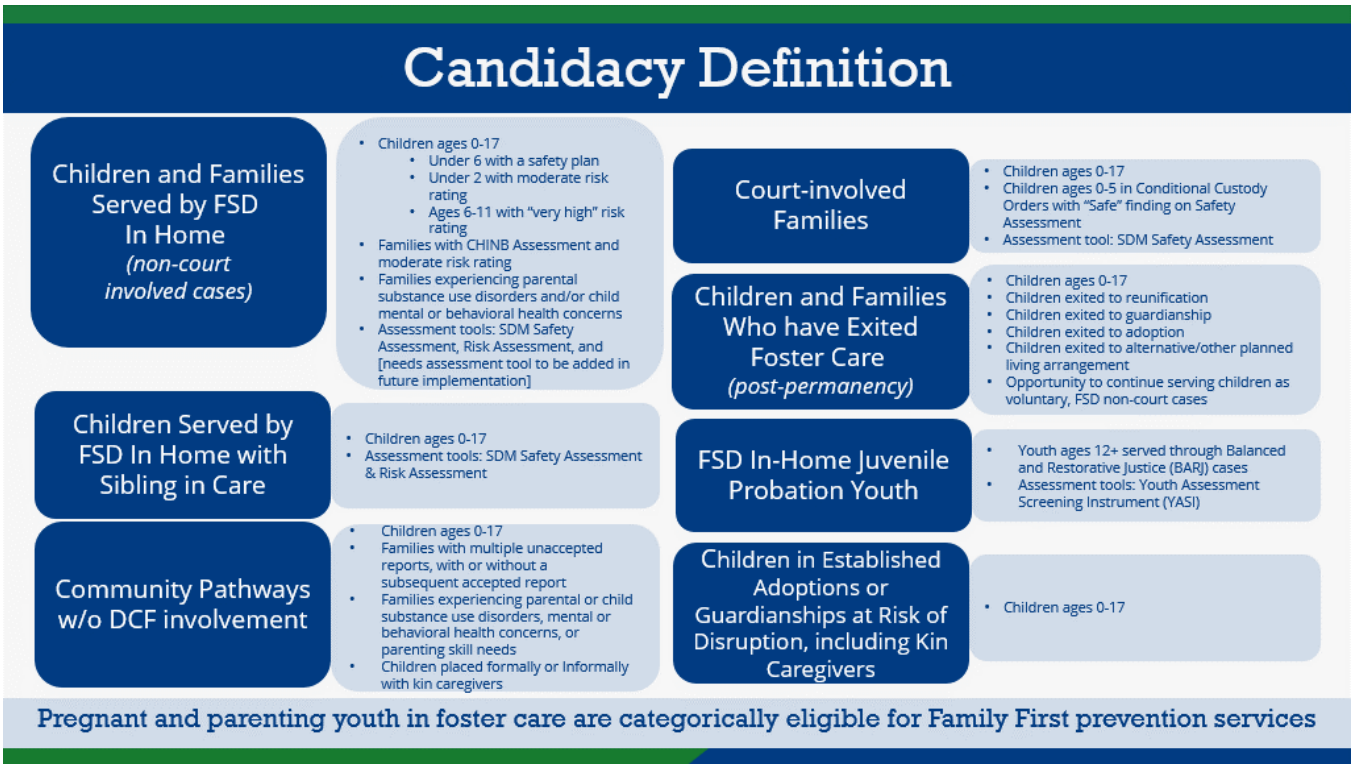
F. **How the state will consult and coordinate with sister agencies, private providers, and community organizations to develop full continuum of care (pre-print section 4)**

As we have mentioned within this Section and throughout Vermont's Prevention Plan, Family Services is committed to consulting and coordinating with its sister agencies, private providers, and community organizations to develop a full continuum of care and to support our collective overarching vision of increasing effective prevention services and decreasing the need for children and families to intersect with the child welfare system. Family Services has developed several interagency and interdepartmental workgroups, teams, and meetings to ensure agencies and providers are in consistent communication and collaboration. These workgroups and teams have existed prior to the introduction of Family First, which offers an opportunity for Vermont to re-energize its collaboration efforts to include a more targeted focus on ensuring the goals of Family First are a success and that there will be a full continuum of care. Vermont believes that this success is only possible if agencies, providers, and organizations work together as a larger team to increase well-being of children and families throughout Vermont.

Eligibility and Candidacy Identification (Child and Family Eligibility for Title IV-E Prevention Program)

Family First allows for two types of populations to be eligible for the Title IV-E Prevention Program: 1) children who are determined by the state to be candidates for foster care; and, 2) pregnant and parenting youth who are in foster care. Vermont's Prevention Workgroup gathered and assessed data from various sources within its child welfare system to develop its definition of candidacy, including responses from surveys of those with lived experience (youth and families), DCF employees, stakeholders, and community providers, as well as data analysis of the most common risk factors identified within families and youth who are in DCF custody or served by DCF.

The following visual shows the target populations that Vermont has identified as meeting its candidacy definition:



Vermont recognizes and values the overarching vision of Family First, which includes increased, evidence-based prevention to decrease the need for children to enter foster care and for families to require DCF intervention at any level. As this vision comes to fruition, Vermont's candidacy definition will be revisited regularly, with the long-term goal of supporting families in communities and reducing the need for DCF intervention.

Why did Vermont choose a broad candidacy definition?

Vermont's current statutes and policies assign DCF as the primary intervening agency for several types of issues, including child safety, juvenile justice (juvenile probation), Youthful Offender probation, children beyond the control of their parents, and truancy. Throughout the process of developing the Prevention Plan, Vermont has reflected on the fact that the current default of most agencies and organizations within the state is to refer children and families who need support to DCF. This means that a transformative shift in the mindset of the Department and the community will be necessary, along with building and strengthening a system of community providers that can effectively support children and families

without the need for DCF intervention, except for those cases that are exceptionally high risk. This shift will require increased and consistent high-level collaboration with agencies and providers to achieve Vermont's vision. Due to the large array of issues that Vermont's child welfare system is currently tasked with addressing, Vermont felt that its candidacy definition should broadly reflect those populations, at least at the start of implementing Family First, with the intention to revise the definition as needed throughout implementation. Vermont's vision is that, over the long-term, prevention services through Family First will reduce the number of children and families needing to be referred to DCF, significantly reducing the number of candidates in all target populations within the candidacy definition, with the exception of the Community Pathways population. The goal is that in the future more, and one day all, candidates will be supported without DCF involvement through the Community Pathways.

Vermont intends to begin implementation of Family First with children and families involved with Family Services, including open family support cases, Conditional Custody cases, and families involved in an assessment or investigation with a "moderate" risk rating on the SDM Risk Assessment (for children under 2 years old), or a "very high" risk rating (for children ages 6-11), as well as children under 6 with a safety plan in place. These populations are already easily identified within Family Services, allowing opportunity for Vermont to successfully implement Family First requirements and ensure policies and protocols are in place to implement additional candidate populations. After the initial stage, Vermont will expand to include the remaining target populations, except for Community Pathways, which will be deferred for implementation after all other populations.

Vermont hopes that over time, as more EBPs are selected and other agencies become familiar with Family First requirements, community providers will be in a better position to identify candidates within the Community Pathways population and the implementation of that population can then happen.

After the initial implementation during Year 1 (explained above), Vermont plans to incrementally expand to the other populations within its candidacy definition in a phased approach over the course of the 5-Year IV-E Prevention Plan. FSD recognizes that implementing new legislation within Vermont will require a number of changes and updates to its policies, data collection system and case management technology. It will also entail focused and planful collaboration with service providers and stakeholders. While Vermont is enthusiastic about rejuvenating its approach to prevention services, it also recognizes that we will need to work through and fine-tune various processes throughout multiple layers of implementation. This will take time and will be impacted by other factors as well, such as the ongoing COVID-19 pandemic, issues with staffing FSD and mental health agencies, etc., which are issues seen across the nation. Vermont is committed to making Family First a success; however, we would like to be transparent that the plan for implementation of the various candidacy populations may change as Vermont navigates the changes and issues described above.

Vermont's legislature, service providers, community and DCF-FSD recognize the importance of implementing the Community Pathways population in a timely manner, therefore, our goal is to begin implementation of this population by Year 3 of our IV-E Prevention Plan (as outlined below). With this approach, we hope to see a reduction in need for the populations that are more reliant on DCF-FSD as we approach Years 4 and 5, while continuing to improve our prevention services upstream from DCF-FSD.

For purposes of this initial submission of Vermont's IV-E Prevention Plan, we are seeking approval for the candidacy populations described in Year 1 (below). The following years outlined below describe Vermont's vision for the subsequent years of this 5-year plan. We plan to submit amendments for additional candidacy populations as we gather more information and develop our processes, both internally and with providers

The phased approach described below outlines Vermont's goal of implementation over the course of its 5-Year IV-E Prevention Plan and Vermont will submit amendments to the plan as needed:

- Year 1:
    - Children and Families Served by FSD In Home (non-court involved cases)
    - Court-involved Families (Conditional Custody Orders)
- Year 2:
    - Children Served by FSD In Home with a Sibling in Care
    - FSD In-Home Juvenile Probation Youth
    - Children and Families Who have Exited Foster Care (post-permanency)
    - Children in Established Adoptions or Guardianships at Risk of Disruption, including Kin Caregivers
- Year 3:
    - Community Pathways without DCF Involvement
- Year 4:
    - Continued implementation of above populations
- Year 5:
    - Continued implementation of above populations

Vermont's candidacy definition is informed by data and has identified consistent patterns among the target populations related to their risk of a child entering foster care. Some highlights of the research and data that Vermont considered in developing its candidacy definition are:

- Of all Child Safety Interventions, investigations are most represented. Risk of harm and sexual abuse are the most represented allegations.[1]

- Of all the safety assessments completed, a child under the age of 6 was involved in: 52% of safety assessments in 2019 and 55% of safety assessments in 2020.[2]

- Of all risk assessments completed, a child under the age of 2 was involved in: 27% of risk assessments in 2019 and 31% of risk assessments in 2020.[3]

- Of all risk assessments completed, a moderate risk score on the SDM Risk Assessment occurs at the highest percentage (45% for both 2019 and 2020), followed by a high-risk score (39% for 2019 and 2020).[4]

- Of all risk assessments completed in 2019 and 2020, the most common parent/caretaker characteristic was substance abuse within the last 12 months. For children, the most common characteristic was mental health or behavioral issue.[5]

- Children ages 6-11 are the most represented age group within Vermont's FSD in-home, non-court-involved cases.[6]

[1] Data source: AHS Report Catalog CSI Timeliness Report. Note: Data is at the allegation level.
[2] Data source: SDM Data Collection System (DCS) Safety Assessments. Note: Safety tool outcome data includes initial, change of circumstance, and closing case types. Data is a duplicated count of families.
[3] Data source: DCS for SDM tools. Note: Risk tool outcome data includes initial and change of circumstance case types. Data is captured at family level and is a duplicated count. Child age based on the household containing at least one child within category R6.
[4] Data source: DCS for SDM tools. Note: Risk tool outcome data includes initial and change of circumstance case types. Data is captured at family level and is a duplicated count.
[5] Data source: DCS for SDM tools. Note: Risk tool outcome data includes initial and change of circumstance case types. Data is captured at family level and is a duplicated count. Child characteristics corresponds to risk tool item R7. Total n=6786.
[6] Data source: AHS Report Catalog RaceEthnicityAllOpenCasesChildLevel. Note: CF case data is point-in-time as of 5/25/2021. Due to limitations of our system, the number of children in the CF population may not be exact. Our system only captures CF information at the family level and we are not able to always positively identify current children in a household if there has been prior involvement.

- Conditional Custody Orders (CCO) to parents are the most common type of orders issued by Vermont's family courts. Of all age groups, 0-5 is the most represented in these CCO's.[7]
- Across both 2019 and 2020, the numbers of new adjudicated youth and new truancy referrals remained consistent.[8]
- In 2019 and 2020, the vast majority of children exiting foster care through reunification returned to a parent (83.8% in 2019 and 84% in 2020); a much smaller percentage returned to kin or fictive kin (16.2% in 2019 and 16% in 2020).[9]
- 86% of current adoption or guardianship subsidies involve children aged 6-17.[10]
- Of all Case Review Committee (CRC) referrals in 2019 and 2020 (Vermont's inter-agency committee that reviews referrals to residential programs), children ages 12-15 were most represented. DCF made the most referrals to CRC.[11]
- Of all CRC referrals in 2019 and 2020, conduct disorder was the most common child characteristic, followed by self-harm and suicidal ideation.[12]

The candidacy definition was also informed by results and findings from surveys, focus groups, and extensive discussion amongst stakeholders, agencies, and community providers.

Candidacy Target Populations

The target populations within Vermont's candidacy definition are described as follows:

- Children and Families Served by FSD In-Home (non-court involved cases)
    - Children and youth within this target population will be identified through open family support cases, as well as during an investigation or assessment when the following criteria are met:
        - Families involved in an assessment or investigation with a "moderate" risk rating, or higher, on the SDM Risk Assessment (for children under 2 years old), or a "very high" risk rating (for children ages 6-11), as well as children under 6 with a safety plan in place (with any risk rating).
        - Families involved in a CHINS B assessment with a "moderate" or higher risk rating.
        - Families experiencing parental substance use disorders and/or children experiencing mental health or behavioral health concerns.

[7] Data source: AHS Report Catalog- Conditional Custody Report. Note: Parents include custodial and non-custodial parent. Data does not include children in custody.
[8] Data source: BARJ 2020-2021 spreadsheet. Note: Data is based on state fiscal year 7/1/2020-6/30/2021.
[9] Data source: Quarterly Custody Management TREND Report. Note: Data does not include exits to adoption or subsidized guardianship with kin/fictive kin.
[10] Data source: AHS Report Catalog Adoption Subsidy Payee Report. Note: Data is point-in-time as of 5/25/2021 and reflects all children ages 0-17 who are in a subsidized adoption or guardianship. N=2418.
[11] Data source: CRC Referral Spreadsheet. Note: Data reflects all referrals made regardless of decision.
[12] Data source: CRC Referral Spreadsheet. Note: Data reflects all referrals made regardless of decision.

- Candidacy within this population will be documented in the child-specific prevention plan and intake documents (such as the Determination).

- Children Served by FSD In-Home with Sibling in Care
    - Children and youth within this target population will be identified through DCF's involvement with a sibling in foster care. Vermont policy requires the Family Services Worker to work with the family as a whole, even if there is only one child in foster care, with regular contact and assessment of the family. The tools used for these assessments are the SDM Safety Assessment and SDM Risk Assessment.
    - Candidacy within this population will be documented in the child-specific prevention plan.
- Community Pathways Without DCF Involvement
    - Vermont has chosen to defer implementation of this target population once Family Services and community providers have had experience with Family First, additional EBPs are selected, and effective policies and protocols are in place. Further, Vermont is currently working on strengthening its data collection tools within Family Services and among community providers, which will more accurately identify candidates for prevention services within this target population.
- Court-Involved Families
    - Children and youth within this target population will be identified through the relevant court involvement, including children in a Conditional Custody Order with a finding of "safe" on the SDM Safety Assessment.
    - Candidacy within this population will be documented in the child-specific prevention plan.
- Children and Families Who Have Exited Foster Care (post-permanency)
    - Children and youth within this target population will be identified through discharge planning and case closure when a child exits foster care, either to reunification, guardianship, adoption, or another planned living arrangement. Family Services can continue to serve these children and youth on a voluntary basis, as well as offer post-permanency services delivered by community providers. Children within this target population may also be identified through a report made to DCF.
    - Candidacy within this population will be documented in the child-specific prevention plan, as well as in case closure documents.
- FSD In-Home Juvenile Probation Youth
    - Youth within this target population will be identified through the Youth Assessment Screening Instrument (YASI), which is administered by DCF and providers through Balanced and Restorative Justice (BARJ). The YASI is required for all youth with a pending delinquency charge to determine risk factors, protective factors, and identifying appropriate services to support the youth. Vermont will identify candidates as youth with a "high" or "very high" risk rating on the YASI, or "moderate" risk with "low" protective factors.
    - Candidacy within this population will be documented in the child-specific prevention plan.
- Children in Established Adoptions or Guardianships at Risk of Disruption, including Kin Caregivers
    - Children and youth within this target population will be identified through various ways, such as caregivers contacting Vermont's Kinship Navigation resource (Vermont Kin as Parents and/or accessing 2-1-1),

making a request for assistance through a contracted post-permanency provider, contacting the Vermont Adoption Consortium, or through a request for assistance or report made to DCF. Vermont has several resources for caregivers that can help identify candidates within this population, such as through caregiver support groups across the state, Adoption Consortium social media pages, an adoption library and a monthly newsletter. It is important to note that Vermont considers any family formed by adoption or guardianship as eligible for post-permanency services. The family does not have to receive Medicaid and the child does not have to be adopted from foster care to be eligible for post-permanency services.

- Candidacy within this population will be documented in the child-specific prevention plan.

Pregnant and Parenting Youth in Care

In addition to the above target populations, pregnant and parenting youth in foster care are categorically eligible for Family First prevention services. When a youth becomes pregnant while in foster care or enters foster care as a pregnant or parenting youth, Family Services Workers are required to follow Vermont Family Services Policy 74: Pregnant and Parenting Teens in Custody. In summary, the policy requires the Family Services Worker to report the situation to their supervisor, who convenes a staffing (including the intake supervisors), to assess the youth's ability to safely parent a newborn, the supportive services they will need, role of the father in the infant's life, and any steps the intake supervisor should take (such as commencing an investigation, filing a petition or opening a family support case). All pregnant youth are promptly referred to an appropriate medical practitioner; the Vermont Department of Health for Healthy Babies program, WIC, any other appropriate benefit programs, and the local parent-child center. Further, all parenting youth in state custody are referred to appropriate supportive family services for themselves and their children, such as services for education, financial assistance, childcare, peer support groups, mentoring, etc.

In addition to the steps outlined above, supervisors are required to document steps and reasoning behind decisions made by Family Services Workers and youth within the case management system and candidacy will be documented in the child-specific prevention plan for that youth's child. Child-specific prevention plans will also document that pregnant and parenting youth in care are eligible for Family First prevention services, including relevant assessments of safety, risk, strengths, and efforts to connect youth to appropriate prevention services.

Aligning Family First Candidacy with Vermont's Current Process of Assessment and Case Planning

As will be discussed in Section 7, Vermont's training curriculum for new and current employees will be leveraged to ensure workers are trained and knowledgeable in how to assess children and families to determine if they meet the definition of candidacy. Vermont only recently began identifying and claiming for our work with "traditional" candidates for foster care. Staff has been trained in that process and our Random Moment Timer System and other processes have been updated to support and document our work with traditional candidates. In the Prevention Plan, our traditional candidates are now included in the definition of prevention candidates, albeit a small subset of the total prevention candidate population. In the initial implementation of prevention candidacy, we will build on the processes already in place to determine traditional candidates and apply those to the initial prevention population. That means that our workforce will be trained in completing a child-specific prevention plan with the candidate family and, in that plan, indicate that the child is a prevention candidate. Currently, and in the implementation of prevention candidacy, the requirement is that the workforce document the family's involvement in the creation of the plan. The date that the plan is discussed/created with the family, is the date the child is considered a traditional candidate. For preventions candidates, the date on which a child is identified in a prevention plan as a candidate or pregnant/parenting foster youth in need of services is the date

that begins the 12-month period, as the legislation dictates. If the child requires services after 12 months from the time that the child was first deemed eligible for Prevention Candidacy, the state will exercise the option to extend their prevention candidacy for the duration needed to complete the prevention service by documenting the child's continued eligibility under Sec. 471(e)(4)(A). Should the child continue to be eligible, a new Prevention Plan will be established for the subsequent 12 months. If a child completes the prevention service, but still has an open, eligible case with Family Services, they will be considered traditional candidates. Family Services will comply with all relevant regulations related to each type of candidacy to ensure proper claiming.

Vermont intends to use the same method to track the other target populations of the candidacy definition, as a child-specific prevention plan will need to be created for each child and family. In addition, the current training on case documentation will be modified to include information on the specific documentation requirements of Family First.

Current Vermont policy outlines the various ways a child and family may be assessed to determine their risks and needs, depending on the information received and the type of case (such as child safety or juvenile justice). This current practice can be leveraged to also assess if the child or family meets any component of the prevention candidacy definition. For child safety interventions, workers utilize Structured Decision Making (SDM) tools to assess risk, safety, and needs. Specifically, workers conduct the SDM Safety Assessment to assess child safety and the possibility of safety planning with the family. Workers conduct the Risk Assessment and Risk Reassessment to assess a family's risk level at the beginning of the Department's intervention and then at regular intervals over the life of the case. For juvenile justice cases, workers utilize the Youth Assessment Screening Instrument (YASI), a validated tool created by Orbis, that determines a level of overall risk to engage in further delinquent behavior, a level of overall protective factors that mitigate the overall risk, as well as specific domains (such as mental health, substance use, family dynamics, school, etc.) that include domain-specific risk and protective factors. For all case types, workers are required to develop the child-specific case plan with the family, child (when age-appropriate), and any providers working with the child and family. Vermont's case plan includes a section on the family and youth's perspective of the case, including what they think their strengths and needs are, as well as what they would like to achieve through their work with FSD and other community providers.

Workers have the tools needed to assess safety and risk (such as SDM, YASI and assessments produced by community providers), including to identify children and families who meet the Vermont prevention candidacy definition. The extra step of identifying specific prevention candidates and appropriately documenting them as such will be a relatively simple addition to what Vermont workers are already doing. The specific training around Vermont's prevention candidacy definition, how to identify a child or family as a prevention candidate, and the documentation specifically required by Family First will be provided to new and current workers and will be added to existing Vermont policy regarding safety monitoring, risk assessment, and case planning.

Workers have the tools needed to assess safety and risk (such as SDM, YASI and assessments produced by community providers), including to identify children and families who meet the Vermont prevention candidacy definition. Consequentially, the extra step of identifying specific prevention candidates and appropriately documenting them as such will be a relatively simple addition to what Vermont workers are already doing. The specific training around Vermont's prevention candidacy definition, how to identify a child or family as a prevention candidate, and the documentation specifically required by Family First will be provided to new and current workers and will be added to existing Vermont policy regarding safety monitoring, risk assessment, and case planning.

Title IV-E Prevention Services (Service Description and Oversight)

A. Describe the proposed services selected for inclusion

Vermont has chosen two practices to implement in year 1 of the 5-Year Prevention Plan. Vermont will start with a small number of EBP's in the first year to support a successful implementation and reliable CQI processes. These practices were selected for two main reasons. First, each of these practices have at least a small foothold in Vermont. Because these practices are already known and have been adopted as beneficial interventions by our greater system, there was a lot of support from our stakeholders for these practices. Additionally, these practices have high efficacy ratings, which also enhanced support for them.

Practices Selected:

Child Parent Interactive Therapy (PCIT)

Vermont will implement PCIT in accordance with the model as offered by PCIT International. The Clearinghouse summary of PCIT is as follows: 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 (e.g., defiance, aggression), increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach 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 or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families can 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 caregivers.

Vermont will adopt and implement with consistency the model that has been approved by the Title IVE Clearinghouse and will utilize the following book/manual in implementation: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011.* PCIT International, Inc.

The target population for this service will be families with children between 2 and 7 years who experience emotional and behavior problems that are intense and frequent.

Level of evidence: Well-Supported

The intended outcome from this service is to increase the percent of youth living at home at 12 and 24 months. The parent will feel more confidence in their parenting abilities and as a result, the behavior of the child will improve. Additional outcomes include increased parental well-being with an improvement in their mental and emotional health, and family functioning.

Because of sustained staffing issues across Vermont and the shortage of qualified mental health clinicians, this intervention will be offered in a regional model, instead of in each of the 13 DCF districts. Vermont understands that this is not ideal and will cause hardships to families living more distant from the location of the service. To help address those hardships, Vermont will consider funding transportation to the service and exploring the possibility of conducting sessions remotely.

Motivational Interviewing (MI)

Vermont has invested in implementation of MI at several points over a number of years. This practice is highly valued in Vermont. In the early 2000's Vermont trained all front-line staff in the use of MI as part of the implementation of the then new practice model. Since that time, Vermont has supported consultation by MI professionals for our front-line staff and also supported some training and implementation of this practice by community providers who have contracts with Vermont DCF. By adopting the practice as part of the Prevention Plan, Vermont is once again asserting our belief in this intervention; a position that was supported by our stakeholders. Through this implementation, Vermont will be able to expand this service to a population that has not been able to benefit from it in the past.

The Clearinghouse summary of MI is as follows: 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 those 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. The Prevention Services Clearinghouse reviewed studies of MI focused on illicit substance and alcohol use or abuse among youth and adults, and nicotine or tobacco use among youth under the age of 18. MI is typically delivered over one to three sessions with each session lasting about 30 to 50 minutes. Sessions are often used prior to or in conjunction with other therapies or programs. They are usually conducted in community agencies, clinical office settings, care facilities, or hospitals. While there are no required qualifications for individuals to deliver MI, training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers.

Vermont will adopt and implement with consistency the model that has been approved by the Title IVE Clearinghouse and will utilize the following book/manual in implementation: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.

Initially, motivational interviewing is going to be incorporated into three existing services offered to children and families served by Vermont DCF. The first population served are families receiving Intensive Family Based Services (IFBS). Those served by IFBS are families with children ages birth to 17 who are at risk of entering foster care, those who have been reunified after foster care, or those who would benefit from parenting skill development. Families served by IFBS may also be struggling with substance use disorder and/or may have needs related to mental health, but neither is a requirement for inclusion in the program. The intended outcome for MI as part of the IFBS program is to increase the percent of parents/caregivers with increased parenting skills.

Vermont will incorporate MI into a program called Balanced and Restorative Justice (BARJ). This is a program that works with youth ages 10-22 who have committed or are at risk of committing a delinquent act and sometimes their families. Many of the youth who participate in BARJ have substance use disorder and/or needs related to mental health, but neither is a requirement for inclusion of the program. Generally, BARJ serves adolescents. The intended outcome of MI as implemented in the BARJ contract is to increase the percent of youth with decreased recidivism and increase the percent of youth exhibiting an increase in pro-social decisions This will yield greater youth well-being and decrease or avoid further systems involvement, including the juvenile justice system.

Vermont will also incorporate MI into our contract for Substance Abuse Case Managers. The work of these case managers is to assist families with children ages birth to 17 when they come to the attention of DCF to conduct a substance abuse assessment and refer to treatment when indicated. The case manager maintains a connection with families to support the referral to treatment and other services in order to facilitate a "warm hand off" to treatment. This very human centered and connected assessment and referral process has increased the number of people who enter treatment. The

intended outcome from incorporating MI into this service is to increase the percent of parents/caregivers with reduced substance abuse.

Level of evidence: Well-Supported

B. Describe the rationale for selecting this service

The process undertaken by the Prevention workgroup to identify all prevention candidates, then the candidates that will be the target of year one, and finally the corresponding EBP's to serve that population, was thorough and methodical. The Prevention Workgroup with 80+ members, representing both internal and external stakeholders, developed the recommendations to the Core Team for approval of Vermont's definition of Candidacy. From there, the workgroup's purpose shifted to form recommendations about which EBP services Vermont should offer under Family First. This process began with a discussion about the characteristics of the population to be served and their needs. This was accomplished through a series of questions about the characteristics of Vermont's children and families at greatest risk, as well as prevalent services need for that same subset. Three pieces of data shared by DCF drove the conversation:

- Of all risk assessments completed in 2019 and 2020, the second most common parent/caretaker characteristic was the presence of mental health issues in the last 12 months. For children, the most common characteristic was mental health or behavioral issue.[13]

- Of all the safety assessments completed in 2019 and 2020, a child under the age of 6 was involved: 52% in 2019 and 55% in 2020.[14]

- Of all risk assessments completed in 2019 and 2020, the most common parent/caretaker characteristic was substance abuse in the last 12 months.[15]

As a result of this data, the group was committed to finding EBPs that are effective in the realms of substance abuse and mental health. The group also wanted to find interventions that are effective with the under 6 population because the data shows their presence in the majority of safety assessments, but also because of the acknowledged vulnerability of the youngest, pre-school population of Vermonters. However, even though the under 6 age group makes up the majority of children in safety assessments, there was a desire to address the needs of all children in Vermont that are also living in homes where substance abuse or mental health challenges are present.

The group explored programs that fit the identified needs of the initial target populations, noting their rating level on the Clearinghouse, along with the capacity within the current structure and service array to implement the various programs. The group decided to give priority to those rated at well-supported on the Clearinghouse.

[13] Data source: DCS for SDM tools. Note: Risk tool outcome data includes initial and change of circumstance case types. Data is captured at family level and is a duplicated count. Child characteristics corresponds to risk tool item R7. Total n=6786.
[14] Data source: SDM Data Collection System (DCS) Safety Assessments. Note: Safety tool outcome data includes initial, change of circumstance, and closing case types. Data is a duplicated count of families.
[15] Data source: DCS for SDM tools. Note: Risk tool outcome data includes initial and change of circumstance case types. Data is captured at family level and is a duplicated count. Child characteristics corresponds to risk tool item R7. Total n=6786.

The group reviewed a handful of programs that fit the agreed-upon and discussed their respective fit with Vermont's children and families, along with the feasibility of implementation. The group identified the top three areas of need before ultimately matching EBP's to all those constellations.

The group chose to prioritize EBPs for children ages 0-5, followed by 6-11 year old's, then 12-17 year old's. They identified that the top essential needs for families relate to:

1. Substance use combined with parenting skills
2. Mental health combined with parenting skills
3. Child and youth mental health needs

Out of that discussion, the following EBP's were put forward to the Core Team for consideration:

Strengthening Families

Parent-Child Interaction Therapy (PCIT)

Motivational Interviewing

Parents as Teachers

Trauma-Focused Cognitive Behavioral Therapy

The Core Team decided to go forward with two EBP's in our first year, choosing:

1. PCIT because it exists in pockets of Vermont already and has a high rate of success. PCIT is a good fit for Vermont because it is designed for families who have a child between the ages of 2-7, so it fits the year 1 priority population. Also, PCIT is a mental health program, which is responsive to the data showing mental health issues being a key factor in families involved in a safety assessment.
2. MI because it is already a service provided throughout Vermont and we felt confident in our ability to expand the service within the existing structure. Additionally, MI has been shown to work across a spectrum of age groups, which is important as we are committed to reaching as many families in need as possible. This program will be available across a range of services that target families with children from birth to adulthood. MI has shown success as a substance abuse intervention. The data indicate that parental substance abuse is a driving factor in family involvement with DCF, so this intervention is responsive to that need.

One of the existing services into which MI will be incorporated primarily serves families with young children working on parenting skills, which is one of the priority areas identified by the workgroup. MI is also being incorporated into a program for adolescents who are at risk of system involvement through delinquent behavior. In Vermont, there is little or no substance abuse treatment for adolescents. MI will address this unmet need for the adolescent population participating in the BARJ program. DCF works with a community provider, Lund, who co-locates substance abuse case managers in our district offices to provide consultation to our workforce on substance abuse issues, but also to meet with families as they come to the attention of DCF to assess for substance abuse issues and then provide support and resources for treatment, when indicated. Embedding MI into the work of the case managers will reach families with children at all ages and will address the needs of parents with substance abuse issues.

C. Plan to ensure that each EBP is being delivered within a trauma-informed framework

Vermont aims to deliver services within a trauma-informed framework throughout all aspects of child welfare and youth justice. Vermont has recently increased its commitment to this principle by ensuring trainings provided to new and existing

staff are taught with a trauma-informed lens. Vermont expects these same values to extend to its provider workforce, including the delivery of EBPs. One of the determining factors in selecting the initial EBPs was whether they are delivered within a trauma-informed framework. Vermont will ensure that each EBP is being delivered within a trauma-informed framework by ongoing collaboration with providers, data collection, CQI and reviewing data to ensure providers are delivering the model to fidelity.

D. Implementation Plan

a. Vermont will begin executing the implementation of these practices upon approval of the 5-Year Prevention Plan by the Children's Bureau. Vermont is exploring two paths to implementing PCIT. The first is to release a Request for Proposals RFP seeking proposals for interested and qualified clinicians. The state would then enter a contract with those clinicians to perform the service and to abide by requirements of FFPSA. The second path is to work with the Department of Mental Health (DMH) to incorporate this practice into the work of community mental health agencies around the state. In this scenario, Vermont DCF would incorporate the FFPSA requirements into the existing grant agreements between the mental health agencies and DMH. The expected start date of these services is July 1, 2022. Regardless of which path Vermont takes to implement PCIT, Vermont DCF will continue to partner with the Vermont Department of Health Access, Medicaid Policy Unit and the DMH to ensure compliance with all Federal guidelines for claiming of these services with Title IVE Prevention funds versus Medicaid funds.

   To implement MI with the existing practices, Vermont DCF will include the requirements of implementing MI within their existing service structure into request for proposals (RFP) for those services. The RFP will include training, documentation, and data collection requirements, and requirements that the program operates with fidelity to the model. By explaining the requirements as part of the RFP, current providers can decide if they want to commit to implementing MI into their service structure and allows for additional providers to submit proposals. There may be a shift in the service providers based on this addition, but Vermont is enthusiastic about the adoption of EBPs into the existing services and welcomes working with those providers who share that enthusiasm.

b. Strategies to Support Implementation:

   Vermont chose its selected EBPs with a focus on feasibility of implementation. Since Vermont is aware that implementing Family First will require a substantial shift in its process of data collection, CQI and monitoring, we wanted to begin with EBPs that are most feasible to implement as these key components are continuing to be developed.

   A key aspect of PCIT and MI is that they are services that are already being delivered in many areas within in Vermont, either by local designated mental health agencies or contracted community providers. Agencies and providers are familiar with PCIT and MI and are supportive of their implementation. This will allow for greater opportunity to collaborate with other agencies and organizations, to monitor outcomes and continue to fine-tune and improve the service delivery.

   Vermont is continuing to develop its overall monitoring strategy for data collection and CQI, and is considering a quarterly meeting among providers, the Prevention Workgroup and CQI/Data Collection Workgroup to ensure there is open communication and an effective and efficient process is developed. As described above, we will explore modifying existing contracts and grants to expand PCIT and MI as a prevention service in Vermont.

c. Activities to ensure fidelity and outcomes monitoring:

Vermont is considering the best way to approach fidelity and outcomes monitoring. Because of the outdated IT system, creating a vigorous plan for fidelity and outcomes monitoring is essential. Currently, the plan is for Vermont DCF take on this work internally with existing workforce. In this case, all data collection and monitoring will be manual in nature and will rely only minimally on the existing IT system. The activities that will be included begin with making the expectation of the providers of the EBPs very clear through contract/grant language. The contracts will make clear the expectation that the model be delivered to fidelity, that all training requirements are met, that any associated credentials are obtained and in a specific timeframe, and the reporting requirements. The contract will also dictate the requirements for data collection, including the expected outcomes and how those will be monitored. Fidelity and outcome monitoring will be conducted in close connection with the providers, DCF leadership, the FFPSA Core Team, and the Prevention Workgroup. Staff will receive and analyze data from the providers, conduct desk reviews and site reviews of the programs, as needed, and will enter in improvement plans if there are concerns about if/how a provider is meeting the contract expectations. Parallel to this process will be the beginning of the creation of a CCWIS system in Vermont. Funding has been allocated to begin this process. Vermont is committed to having a data collection system that is able to effectively demonstrate our outcomes in an efficient way.

For MI as part of the IFBS program, outcomes will be identified and monitored using data collected by IFBS providers and existing data in Vermont's data collection system. The intended outcome for MI as part of the IFBS program is to increase the percent of parents/caregivers with increased parenting skills. Vermont DCF staff will use data specific to custody entries and reports to the child abuse hotline to monitor the success of the intended outcome. Fewer reports accepted due to unsafe parental behavior as well as fewer children entering custody due to unsafe parental behavior would support the successful implementation of MI in IFBS programs.

For MI as part of the BARJ program, outcomes will be identified and monitored using data collected by BARJ providers, Court data, and existing data in Vermont's data collection system. The intended outcome for BARJ is to increase the percent of youth with decreased recidivism and increase the percent of youth exhibiting an increase in pro-social decisions. Vermont DCF staff will use data specific to recidivism and agency involvement due to "delinquency" (as reflected in delinquency case types DY, DP, and DC) to monitor the success of the intended outcome. Fewer youth involved with Vermont DCF as a "delinquent" and shorter case involvement for "delinquent" youth would support the successful implementation of MI in BARJ programs.

For MI as part of the Substance Abuse Case Managers program, outcomes will be identified and monitored using data collected by Substance Abuse Case Managers, data collected by other substance use providers, and existing data in Vermont's data collection system. The intended outcome for using MI in this service is to increase the percent of parents/caregivers with reduced substance abuse. Vermont staff will use data specific to children entering custody due to parental substance as well as reports made to the child protection hotline regarding parental substance use to monitor success of the intended outcome. Fewer children entering custody due to parental substance use and fewer accepted intakes regarding parental substance use on families already involved with Vermont DCF would support the successful implementation of MI in the Substance Abuse Case Managers program.

Providers delivering MI will be using the Motivational Interviewing Treatment Integrity (MITI 4.2.1) instrument for fidelity assessment and monitoring. This tool has substantial research supporting it and it focuses on capturing information to improve practice.

For PCIT, outcomes will be identified and monitored using data collected by PCIT providers and existing data in Vermont's data collection system. The intended outcome for PCIT is to increase the percent of youth living at home at 12 and 24 months. Vermont staff will use data specific to children ages 2-7 entering custody as well as reports made to the child abuse hotline regarding child behavior to monitor the success of the intended outcome. Fewer children ages 2-7 entering custody due to child behavior and fewer intakes accepted regarding child behavior would support the successful implementation of PCIT.

Vermont intends to continue utilizing the fidelity instruments currently being administered by providers of PCIT, who are within four designated agencies of the Department of Mental Health. These providers use the Eyberg Child Behavior Inventory (ECBI) per PCIT protocols. They also have an RBA scorecard that encompasses Child Behavior Checklists (CBCLs) and Parent Stress Index (PSI) measures. Since the providers are at a Level One trainer status, there are measures around clinician competency.

d. How information learned from monitoring activities will be used to refine and improve service delivery:

By providing children and families at risk of entering foster care with an expanded array of well-implemented evidence-based preventive services, coupled with evidence-based, trauma-informed case management using motivational interviewing techniques to support service uptake and participation, Vermont envisions outcomes for families will be significantly improved in accordance with the intended outcomes of each program. For example, parents enrolled in substance abuse treatment EBPs will experience reductions in problematic patterns of use; parents and children enrolled in dyadic therapy will experience improved attachment; and a teen enrolled in an EBP focused on improving mental and behavioral health will experience increased pro-social behaviors and reduced acting out. These improvements in individual and family functioning will in turn lead to reduced child maltreatment and, ultimately, reduced demand for foster care as the preventive services expand. DCF's Theory of Change (see the Evaluation section) depicts the sequence of causal events and mechanisms by which outcomes for children, families, and communities are expected to improve due to Family First.

Child Specific Prevention Plan

A. Process for developing child-specific prevention plans for candidates and prevention plans for pregnant and parenting youth

Child-Specific Prevention Plans for Candidates

Vermont's traditional candidates for foster care include family support cases (CF case type) and conditional custody orders (CCOs) to parents. Family support cases are open voluntarily for ongoing services following a child safety intervention (investigation or assessment) and a high or very high-risk score on the SDM Risk Assessment tool. CCOs to parents are court involved cases with court-ordered conditions in place which the parent must abide by. FSD is currently in the process of expanding its traditional candidates for foster care to also include CCOs to kin/relatives, family friends, and other non-parents. FSD's prevention candidates are defined and addressed in Section 2.

Currently, FSD has two case plan templates that will be modified to serve as the child specific prevention plan and document the candidacy determination, assessment for needed prevention services, and identification of specific prevention services for referral and linkage. Vermont is also considering future development of a universal prevention plan template for the community pathway candidacy group that would be used by contracted partners if the case does not open with FSD.

FSD's case planning obligations increase once a Child in Need of Supervision (CHINS) proceeding is initiated or once there is court involvement in some capacity. Once the case is court-involved, case plans are written with multiple audiences in mind (families as well as the parties to the court case). However, preventative work still occurs with candidates for foster care who have a case with court oversight. An overarching value of our case planning process is the importance of family and youth voice.

Each child-specific prevention plan includes the following sections:

- Case plan goal
- Summary of current DCF-FSD involvement
- Relevant history
- Family and youth perspectives
- Connections and supports to the family
- Assessment of the child/youth's strengths and needs
- Assessment of the parents' strengths and needs
- Action plan (with action steps and timeframes)
- Signature page

Optional sections based on the child-specific need and relevancy to the reason for case opening/support:

- Living situation information (if in the conditional custody of a relative)
- Physical, developmental, mental, and dental health
- Education information

Generally, for prevention plans for candidates, the case plan goal should be speaking to why remaining in the home with the parents is in the child's best interests. If one child has more significant needs compared to their siblings, the case plan cannot be written exclusively about the one child. If we are not intentional about speaking to every child in each section, it can paint a false picture that the other children do not have needs or issues to be addressed. Each applicable section of the case plan template must address all children and their needs/information.

Instruction and training to FSD staff regarding child-specific assessment includes the following:

- When assessing each child's strengths and needs, the intent is to state where the child is having trouble and explain how that translates into a need for support. Children's needs are addressed in this section because children should not typically have action plans (unless their behaviors, truancy, or delinquency are factors) because it is their parent's behaviors, actions, or inactions, or need for support that prompted division involvement.
- Every child has basic needs that need to be met; every child also has specialized needs. This plan should include the child's basic needs and needs associated with what is developmentally appropriate based on the age of the child. Needs that should be assessed in this narrative include those related to social and emotional development. These may include permanency needs, social competencies, attachment, caregiver relationships, social relationships and connections, social skills, self-esteem, and coping skills. This section can describe the child or youth's personality, temperament, behaviors, and emotional presentation.
- Describe the process used to assess the child's needs and determine strengths and protective/promotive factors (and risk factors if applicable). The assessment process may include a formal evaluation conducted by service providers, or assessment may include informal methods such as interviews, observations, and conversations with the child/youth, family, safety network, or service providers. Include service recommendations to address the child/youth's needs, risk factors, and the status of such services.
- For delinquency or youthful offender cases, in addition to the narrative described above, include YASI information in this section about the youth's strengths and needs. Indicate proposed conditions of probation (which may include a recommendation regarding the term of probation) to address the identified risks and protective factors. Include an assessment of the impact of the delinquent act on the victim and the community, including, whenever possible, a statement from the victim. Indicate what is needed to repair the harm to victims and the community.

In addition, Vermont has recently developed a Risk of Human Trafficking Screening Tool that will soon be shared with Family Services staff to utilize in instances where human trafficking is suspected, or certain criteria are met and further assessment is needed (explained further below), to further assist in case planning and making appropriate service referrals. This tool was developed with the support of Vermont's Human Trafficking Workgroup and is currently under peer review. The following is a description of the tool's intended use, taken from the instructions of the tool:

This tool should be utilized by staff for children of all genders ages 12 and older when referring for or developing a Coordinated Services Plan (CSP) OR when considering a higher level of care that does not require a CSP or Case Review Committee (CRC) approval AND following significant events (i.e., return from a run or a new accepted report). Recommended/Best Practice Use: If a child comes to DCF-FSD's attention through an accepted report of trafficking, this tool may be useful when assessing their risk factors during the investigation. If a CHINS proceeding is initiated for children ages 12 and up, this tool should be utilized to assess risk factors and inform case planning and service referrals (i.e., most risk factors should have a corresponding service provision to help mitigate the risk.) This tool should be revisited/updated every time a subsequent case plan is completed.

Prevention Plans for Pregnant and Parenting Youth

FSD does not have consistent statewide data on the number of young people who are pregnant or parenting while being served by the division. However, the Youth Development Program (YDP) uses a federal data element from The National Youth in Transition Database (NYTD), which prompts: "Have you given birth to or fathered any children that were born?" Generally, about 15% of YDP youth have children based on this definition. This amounts to approximately 75 youth per year of 500 youth served; however, we assume that a vast majority are 18+. Please note this does not capture youth who are not working with YDP.

FSD strives to begin planning as soon as we become aware that a client (youth or adult) is expecting a new baby. The open case and existing relationship present a unique opportunity for preventative planning with the family as early as the first or second trimester of pregnancy. We advise staff to be supportive of parents and jointly engaged in safety planning for their new baby. Family services workers must assess if expectant parents can safely care for their infant and what service referrals parents will need to support them in providing for the safety and well-being of the newborn.

FSD has two policies and a checklist that guide its work with the pregnant and parenting population. The checklist is meant to be a mental map and supervision tool to help division staff consider all relevant factors related to safety and planning for newborns. The use of the checklist is intended to support continuous assessment throughout a pregnancy and post-birth. Additionally, the checklist should assist in determining whether a higher level of intervention or additional supports are needed throughout the assessment. The checklist and policy were originally developed with clients with open cases in mind (both candidates for foster care with open cases and those who have children in foster care); however, revisions are currently underway to better address the pregnant and parenting youth population.

Areas of assessment include prior child protection involvement (within Vermont or in other states), criminal activity by caregivers or household members, substance use, domestic violence/intimate partner violence, residency/housing, and physical and mental health. Each area should be evaluated initially and throughout pregnancy, at the time of birth, and upon discharge from the hospital. Within each of these categories, there are opportunities for supports, service referrals, and the enhancement of protective factors for the expectant parents. The division's assessment takes place through observation, interviews with expectant parents and collateral contacts, and through any new reports received. FSD assesses the circumstances of both parents and does not limit the focus to only the mother.

In summary, the checklist includes the following overarching considerations:

- How will a newborn impact the identified dangers or safety concerns that currently exist for other children?
- Do the parents have the ability and willingness to protect the newborn, as well as the other children in the home?
- Is there anyone in the home or any household circumstances that would pose a different or additional threat to a newborn?
- Are the current circumstances different than the known history? Can the differences be articulated?
- If older children are not able to safely live with the parents, have circumstances changed that make it safe for a newborn to remain in this parent's care?
- Does the family have a safety network comprised of family, friends, or community members who care about the newborn and older children, and are willing to take action to support the family and keep the children safe?
- Is a safety plan needed?
- What has the family done to prepare for the newborn?
- What is the family's plan for the new baby?
- Has there been prenatal care? Has prenatal care been accessed consistently?
- What community referrals are needed, and has the family accessed them?
- When there are concerns of substance exposure during pregnancy, has the plan of safe care (POSC) been developed?

A visit in the hospital is only required if medical providers express concerns about the newborn's safety or a parent's behaviors and interactions. Family services workers are required to visit the home within three business days of the newborn's discharge from the hospital and will conduct a second subsequent home visit within two weeks of discharge. During the home visits, family services workers are having conversations and making observations related to bonding and attachment, feeding, sleep environment, and general presentation of the caregivers and home. FSD

strives to maintain ongoing communication with the pediatrician, visiting home nurse, and/or other medical provider to confirm infant is being seen for all medical appointments and is gaining weight.

If a family support case (no court involvement) is opened or court oversight is sought due to safety concerns, a case plan will be developed with the family that will build upon the work done with the family during the assessment described above.

Additional resources:

- Family Services Policy 74: Pregnant and Parenting Teens in Custody
- Family Services Policy 78: Assessing Expectant Parents and the Safety of Newborns on Open Cases
- FS-78 (Checklist for Assessing Expectant Parents & the Safety of Newborns on Open Cases):

FS-78-Checklist-Assessing-Expectant-Pa

B. Process for assessing service need

Service recommendations and referrals are meant to address the parent's needs, risk factors, and supports. The assessment of the parent's needs and service needs refers to FSD's determination of what the parent needs to provide safe and appropriate care and supervision and to ensure the safety and well-being of the child(ren). Areas of assessment typically include mental health, physical health, substance use, housing and resource management, criminal activity, domestic violence/intimate partner violence, parenting practices, safety networks and natural support systems, and any other areas of identified risk that need to be addressed.

FSD is currently exploring the *SDM Family Strengths and Needs Assessment* as a possible addition to Vermont's safety and assessment tool package. A small committee is reviewing items from Vermont's CFSR and QCR data to consider how this tool could potentially improve certain areas of practice with families. Limited funding, the lack of a CCWIS system, and staff/district office capacity are areas of concern that are being considered.

C. Description of processes to ensure appropriate service referral, linkage, and oversight for prevention candidates, including redeterminations of candidacy and revisions to the prevention plan

Across FSD's 12 district offices, there is both overlap and variation within available services. FSD strives to ensure referrals are made for services and supports families could benefit from; however, specific programming and referrals may not always match the exact need. As additional EBPs become available and service capacity is built within communities, we hope families' needs will closely align with the services available to them.

A formal review of candidacy and continued eligibility occurs every six months. Currently, the screen in SSMIS is built to send out redetermination reminders at 4 and 5 months so that the family services workers have ample time to review the case plan with the family and enter the date of that interaction with the family.

Once a child and family are selected for an EBP, they will continue to be assessed both formally and informally – through the use of our structured decision-making tools (discussed in Section 5), use of the CANS in some districts depending on the designated mental health agency (DA), during monthly visits and contact, during team meetings, collateral contacts and updates provided by team members and service providers, collaboration during team meetings, and other assessments and evaluations from providers.

Family Services Workers, in consultation with Family Services Supervisors, will monitor and oversee the safety of children receiving services during the 12-month child-specific prevention plan period by administering an SDM Risk Assessment during the initial 60 days, and then an SDM Risk Reassessment every 90 days thereafter. Vermont

endorses best practice of assessing whether a service continues to be effective for a child or family at the time of each assessment or reassessment. Therefore, the reexamination of the child-specific prevention plan will occur at multiple points throughout the 12-month period, especially when the risk of the child entering foster care remains high. These reexaminations will focus on assessing whether the service continues to be an appropriate fit for the child and/or family and if it is being delivered at an effective level. The reexamination of services will be informed by data and professional recommendations provided by the service provider. Family Services Workers will work with service providers to modify the delivery of services and/or refer to a different service, if needed.

D. Integrating the child-specific prevention plans within the CCWIS system

Vermont has significant limitations when it comes to our data and IT systems. Vermont does not have a SACWIS system nor a CCWIS system. There has been some thought of exploring whether Results Oriented Management (ROM) could be utilized to pre-populate certain pieces of prevention plans and case plans. If the option were available to us, FSD would be in full support of integrating child-specific prevention plans within a CCWIS system. Vermont recently dedicated funding to the creation of at least one module of a CCWIS system and we will be moving in this direction over the next few years, recognizing the urgent need of this as it relates to effective data collection and planning.

E. How prevention services will be coordinated with other services provided to the child/family under the IV-B plan (pre-print section 4)

Vermont's funding from Title IV-B part 1 is spent through the Child Development Division, supporting childcare. Vermont recognizes that childcare, in and of itself, is a prevention service for families and we will continue to support the use of those funds in this way. Vermont's funding from Title IV-B part 2, is used to stabilize families with more tangible resources, often focusing on the lower end of Maslow's Hierarchy of Needs (food, water, shelter, etc.). These funds are used to stabilize families in various ways, and we will continue to use these funds to support families receiving prevention services. We know that families who are receiving prevention services may have other life factors that are causing instability, which limits their capacity to engage in the meaningful work of the prevention service. For instance, when a parent is worried that their child doesn't have winter boots and a coat, they are unlikely to be able to fully engage in a prevention service that is focused on their interactions with their child. These funds will continue to be used to address those additional stressors to further stabilize the family and make it more likely that they can fully engage with the prevention service.

Title IV-B part 2 is a very flexible funding source for Vermont that funds some of our programs, such as Project Family, which also offers post-adoption services (which is a population that falls under Vermont's candidacy definition for prevention services). We also use it to support families who have non-custody cases in various ways. For example, we may purchase furniture or items to make their home safer or better able to care for their child; we may purchase other items to support the family (one example includes buying a car so a mother could get to work). We have also used it to pay various types of bills for a family, such as an electric bill to turn their power back on.

Overall, Vermont intends to braid the funding of both Title IV-B and Title IV-E prevention services to support the child and family from a holistic lens. The funds and resources through Title IV-B support a child and family with the more tangible needs, whereas the funds and resources through Title IV-E prevention services support a child and family through a skill-based approach. Having both of these supports allows the opportunity for a well-coordinated and complementary blend of services and aid for a family that will enable them to be successful in the long-term.

Monitoring Child Safety (pre-print section 3)

A. Description of state's approach to monitoring and overseeing the safety of children receiving title IV-E preventive services throughout the service delivery period

Intake and Screening

Vermont has a centralized child protection hotline which receives reports of abuse and neglect from mandated reporters and community members. This hotline is open and operating 24 hours a day, 7 days per week. In addition to reports of abuse and/or neglect, the hotline receives calls regarding youth currently in foster care who may be in need of support, or a facilitated emergency placement change.

Vermont's policies on intake acceptance, definitions of abuse and neglect, and child safety interventions are found here:

- Family Services Policy 50: Child Abuse and Neglect Definitions
- Family Services Policy 51: Screening Reports of Child Abuse and Neglect
- Family Services Policy 52: Child Safety Interventions – Investigations and Assessments

Vermont statutory definitions used within child welfares services are available here: https://legislature.vermont.gov/statutes/section/33/049/04912

Vermont rules pertaining to responding to child abuse and neglect are available here: https://dcf.vermont.gov/sites/dcf/files/FSD/Rules/2000.pdf

Vermont utilizes a differential response system. At the point of acceptance, a report is assigned either to an investigative or assessment track. The investigation route will result in a determination of whether to substantiate the allegation of abuse and/ or neglect. When an individual is substantiated for abusing or neglecting a child, their name is placed on the Vermont Child Protection Registry. The assessment track does not result in a determination yet does aim to assess the overall risk to children in the household, and to connect families with services where appropriate. Vermont targets prevention efforts towards families who are at high or very high risk of future involvement with the child welfare system. To determine which families fall into this category, Vermont partners with Evident Change (formally known as Children's Research Center), a nonprofit social research organization and a center of the National Council on Crime and Delinquency. Vermont is currently using the following Structured Decision Making® (SDM®) assessment tools.

B. Staff roles and responsibilities for assessing and monitoring risk throughout service delivery

Methods of assessing and monitoring risk and safety (both formally and informally) on an ongoing basis include:

- Home visits and contact with parents and children/youth (both quality and quantity of visits)
- Private discussions with children/youth about their needs and experiences
- Use of safety and support networks
- Collaboration with community partners, service providers, and collateral contacts
- Behavioral indicators and observations made by staff across settings

In addition to physical safety, the division also assesses and considers psychological safety and young people's mental health. Safety planning for children and youth include interventions that allow the child to be both physically and emotionally safe. Additional resources include:

- Family Services Policy 76: Supporting and Affirming LGBTQ Children & Youth
- Family Services Policy 154: Children and Youth in DCF Custody Requiring Mental Health Screening, Mental Health Placement, or Psychiatric Hospitalization

Vermont's current practice of monitoring child safety requires Family Services workers to conduct the SDM Risk Assessment and SDM Risk Reassessment at regular intervals throughout an open case (see chart on next page). For the purposes of monitoring cases within Vermont's prevention candidacy populations, Family Services Workers, in consultation with Family Services Supervisors, will monitor and oversee the safety of children receiving services during the 12-month child-specific prevention plan period by administering an SDM Risk Assessment during the initial 60 days, and then an SDM Risk Reassessment every 90 days thereafter. Vermont endorses best practice of assessing whether a service continues to be effective for a child or family at the time of each assessment or reassessment. Therefore, the reexamination of the child-specific prevention plan will occur at multiple points throughout the 12-month period, especially when the risk of the child entering foster care remains high. These reexaminations will focus on assessing whether the service continues to be an appropriate fit for the child and/or family and if it is being delivered at an effective level. The reexamination of services will be informed by data and professional recommendations provided by the service provider. Family Services Workers will work with service providers to modify the delivery of services and/or refer to a different service, if needed.

C. Description of what tools will be used and protocols and timeframes for administering them

See next page.

VERMONT SDM® OVERVIEW

Please see policy and procedures section of the SDM Procedures Manual for each tool and complete details.

Decision	SDM® Tool	Which Cases & Households	Who	When	DCF-FSD Policy
Can the child safely remain at home?	Initial SDM Safety Assessment	• All new Chapter 49 investigations and assessments • All new CHINS (B) assessments *** If there are allegations in two households within a single CSI, there may be two initial SDM Safety Assessments. ***	FSW assigned to the investigation/ assessment	ALWAYS completed within 24 hours of the first in-person interview with the family	Policy 52: Child Safety Interventions – Investigations and Assessments
Should an ongoing case be opened for voluntary Family Support Case (CF) services?	SDM Risk Assessment	• Chapter 49 investigations and assessments • CHINS (B) assessments *** The SDM Risk Assessment is always completed on the household of a caretaker who is an alleged perpetrator, regardless of whether the household is the child's primary residence. If the alleged perpetrator is not a caregiver nor a member of the child's household, the SDM Risk Assessment is not required. ***	FSW assigned to the investigation/ assessment	Completed once during investigation/assessment period before making decision about ongoing (CF) services. Specifically: • For investigations, as soon as the FSW has sufficient information to accurately assess risk, but no later than 60 days from acceptance • For assessments, as soon as the FSW has sufficient information to accurately assess risk, but no later than 45 days from acceptance	Policy 52: Child Safety Interventions – Investigations and Assessments
Has the risk level been reduced so that the Family Support Case (CF) can be closed?	SDM Risk Reassessment	Family Support Cases (CF) as long as there is not an unresolved danger.	Ongoing FSW assigned to the case	Completed every 90 days, followed by the SDM Safety Assessment prior to case closure if the risk has lowered.	Policy 69: Family Support Cases – Case Planning, Reassessment, Case Plan Updates, and Closure
Can the child be returned home? Should reunification efforts continue? Should the permanency	SDM Reunification Reassessment	Cases where a child has been determined to be a *Child in Need of Care or Supervision*, specifically CHINS (A) or (B), and is placed out-of-home (either through DCF custody or a conditional custody order to others) with a case plan goal of reunification.	Ongoing FSW assigned to the case	Completed: • Within 30 calendar days prior to completing each case plan • When recommending reunification or a change in the permanency planning goal	Policy 98: Reunification of Abused or Neglected Children and Youth

goal be changed?					
Does a change in circumstances affect the child's safety?	SDM Safety Assessment	Cases open due to a child protection matter; not applicable to juvenile justice cases.	Ongoing FSW assigned to the case	When there is a change in family circumstances and/or a change in the ability of safety interventions to mitigate dangers. Examples include the birth of a baby, a change in household composition or make-up, a move, a new criminal charge, a significant change in health, or a new report of child abuse or neglect during the open case.	Policy 55: Unaccepted Reports on Open Cases

SDM Safety Assessment®

The SDM® safety assessment guides decisions about whether or not a child requires placement or a safety plan in order to remain safely at home. The safety assessment assesses the child's immediate danger or risk of harm and the interventions currently needed to protect the child.

Safety assessments are completed on all investigations and assessments, as well as any open cases in which changing circumstances require safety assessment due to a change in family circumstances, including (change in household composition, a new baby, a move to a different household, new criminal charge, a significant change in health, or a new non-accepted report). Safety assessments are also completed when it is brought to the division's attention that there has been a change in the ability of safety interventions to mitigate dangers. The safety assessment is completed by the assigned family services worker within 24 hours of the first contact with the family.

SDM Risk Assessment®

The risk assessment estimates the probability of future involvement with the child welfare system. The higher the risk, the more important it is to engage the family in services to prevent future harm. Risk assessments are conducted on all new chapter 49 investigations and assessments and CHINS (B) assessments, regardless of determination. The risk assessment is completed by the assigned family services worker once during the investigation/assessment, before deciding about ongoing services. Responses to each item on the risk assessment tool led to a risk classification of low, moderate, high, or very high. High- and very high-risk cases are typically opened for ongoing services.

Family engagement strategies such as circles of support and network building are utilized by the family services worker to increase safety and reduce risk. Families are connected to services in the community as needed. Families who score low or moderate on the risk assessment tool are also connected with services and the case is closed if there are no unmitigated dangers.

SDM Risk Reassessment®

The risk reassessment uses a selection of some of the strongest actuarial risk items plus progress toward case plan goals to arrive at an estimate of the likelihood of future harm after services have been provided for a period of time. It is used to guide decisions about whether to continue ongoing services or to close the case. It is conducted every 90 days by the assigned family services worker on all ongoing cases where all children are in the home.

Cases that are reassessed as low or moderate risk are closed unless there are unresolved dangers. A safety reassessment is completed to determine safety status. When a case is closed, case, referrals to community services are made as appropriate to address continuing service needs. Cases that are reassessed as high or very high risk remain open for services.

SDM Reunification Assessment®

The purpose of the reunification assessment is to structure critical case management decisions for children in placement who have a reunification goal by:

1. Routinely monitoring critical case factors that affect goal achievement;
2. Helping to structure the case review process; and
3. Expediting permanency for children in substitute care.

The reunification assessment is completed by the assigned family services worker, on all ongoing cases in which at least one child is in out-of-home placement with a goal of return home. If more than one household is receiving ongoing services for reunification, complete one assessment on each household.

Family Services Policy 122 requires a case plan review at least every six months. Each review process should begin with a Structured Decision Making® (SDM) reunification assessment to inform the recommendations made. It should be completed:

- No more than 30 calendar days prior to completing each case plan or recommending reunification or a change in the permanency planning goal; or
- Sooner, if there are new circumstances or new information that would affect safety status and/or risk level.

The reunification assessment guides the decision of whether to:

1. Return a child to the removal household or to another household with a legal right to placement (non-removal household) where there are historical or current concerns about the household regarding safety and risk;
2. Maintain out-of-home placement; or
3. Change the case plan goal and implement a permanency alternative.

The following chart outlines when each SDM assessment will be used within Vermont's candidacy populations:

		SDM Safety Assessment	SDM Risk Assessment	SDM Risk Reassessment
Children and Families Served by FSD In-Home (non-court involved cases)	Families involved in an assessment or investigation with a "moderate" risk rating, or higher, on the SDM Risk Assessment	Yes	Yes	No
	Children under 6 with a safety plan in place (with any risk rating)	Yes	Yes	Yes, if family support case is opened.
	Families involved in a CHINS B assessment with a "moderate" or higher risk rating	Yes	Yes	Yes, if family support case is opened.
	Families experiencing parental substance use disorders and/or children experiencing mental health or behavioral health concerns	Yes	Yes	Yes, if family support case is opened.
Other Populations within VT's Candidacy Definition	Children served in-home with sibling in care	Yes	Sometimes	Sometimes
	Community pathways without DCF involvement	No	No	No
	Court-Involved Families	Yes	Yes	Sometimes

The periodic assessment process for youth within Vermont's juvenile justice candidacy population will consist of the same assessment process that is currently in practice. The Youth Assessment Screening Instrument (YASI) is administered by workers and/or restorative justice staff who are trained and certified to conduct YASI. The periodic assessment process includes an initial assessment within 30 days of opening a case and YASI reassessments every 6 months thereafter to regularly assess risk.

While the YASI assesses level of risk to re-engage in high-risk and delinquent behavior, the SDM is also utilized for juvenile justice-involved youth (including those who are served by the BARJ contract) to monitor ongoing child safety and risk. These youth are assessed using the SDM tools following the same policy and procedures that are required for the other case types outlined in the chart above. Since Vermont is a state that blends child welfare and juvenile justice work into one department and is served by the same staff of Family Services Workers, the monitoring of child safety and risk for juvenile justice-involved youth is assessed the same as a case involving a child or youth who is not involved in the juvenile justice system.

Evaluation Strategy and Waiver Request (pre-print section 2; Attachment II)

A. Vermont's Overall Approach to Evaluation and Continuous Quality Improvement (CQI) of Prevention Programs

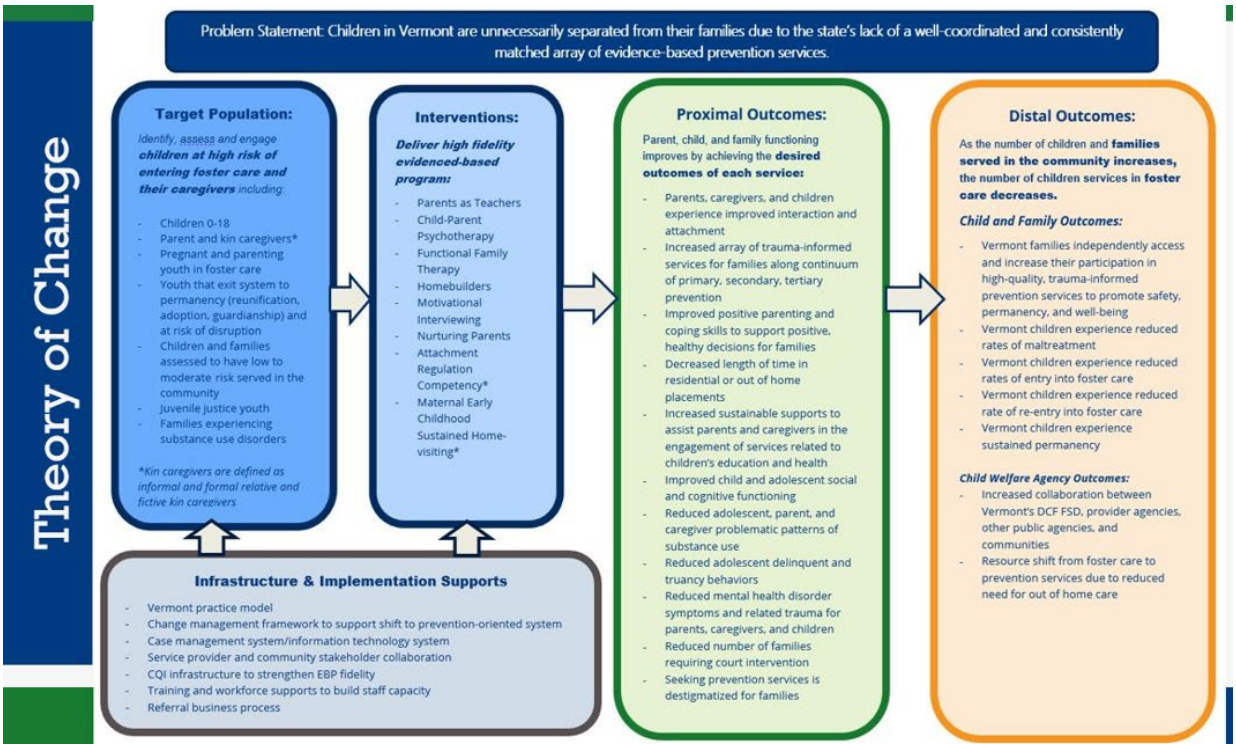
Family First requires each EBP service submitted in a state's Prevention Plan to include a well-designed and rigorous evaluation strategy. The Children's Bureau may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI requirements. Vermont has reviewed and is requesting a waiver for the following well-supported programs for initial phase of implementation: PCIT and MI. Please refer to section C below for waiver request justification for these programs. FSD will also need to maintain strong CQI systems to monitor model fidelity and identified outcomes for well supported programs.

Continuous quality improvement activities will be performed under the direction of the Quality Assurance (QA) Unit in partnership with the FFPSA Manager and FFPSA Policy Specialist within FSD. Please see Section D for more information. CQI and evaluation activities will follow established procedures to monitor, compile, assess and report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions.

B. Theory of Change

Vermont's problem statement is our children are unnecessarily separated from their families due to the state's lack of a well-coordinated and consistently matched array of evidence-based prevention services. FSD plans to utilize Family First funding to improve stability and preservation of families, including minimizing the need for removal and entry into foster care. Vermont's theory of change (see next page) acknowledges that substance misuse, lack of parenting skills and mental health conditions contribute to parental capacity to ensure child safety, permanency, and well-being. Vermont's child welfare agency is currently under study by the UVM-CWTP Research team regarding our high foster care entry rate. We await further information from this thorough analysis which is to be completed this fall. Additionally, in reviewing our risk assessment data from 2019 and 2020, the most common parent/caretaker factor was substance abuse in the last 12 months. For children, the most common risk factor was mental health or behavioral issue.

By providing children and families at risk of entering foster care with an expanded array of well-implemented evidence-based preventive services, coupled with evidence-based, trauma-informed case management using motivational interviewing techniques to support service uptake and participation, Vermont envisions outcomes for families will be significantly improved in accordance with the intended outcomes of each program. These improvements in individual and family functioning will in turn lead to reduced child maltreatment and, ultimately, reduced demand for foster care as the preventive services expand.



C. Evaluation Waiver Request Justification

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

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

Attachment II, Request for Waiver of Evaluation Requirement for a Well-Supported Practice is submitted for the following well-supported services on the Title IV-E Prevention Services Clearinghouse: Parent Child Interaction Therapy (PCIT) and Motivational Interviewing (MI). See Appendix for the signed waiver requests.

Compelling Evidence of Effectiveness of the Practice

The chart below details the EBP's selected along with a description of how that service would impact outcomes for our state's population.

Candidacy Population(s)	Prevention Service Needs Identified Need(s)	Proposed Intervention(s)	Outcome(s)
Of all risk assessments completed in 2019 and 2020, the 2nd most common parent/caretaker factor was the presence of mental health issues in the last 12 months. For children, the most common factor was mental health or behavioral issue. Of all the safety assessments completed in 2019 and 2020, a child under the age of 6 was involved: 52% in 2019 and 55% in 2020.	Mental Health	Parent-Child Interaction Therapy (PCIT), targeted for children ages 2-7 years, and their parents or caregivers.	• Decreasing externalizing child behavior problems • Increasing child social skills and cooperation • improving the parent-child attachment relationship • reducing children becoming involved with DCF
Of all risk assessments completed in 2019 and 2020, the most common parent/caretaker factor was substance abuse in the last 12 months. Of 3500 youths assessed in that same time period, 56% indicated substance use was a risk factor.	Substance Use Disorder	Motivational Interviewing (MI), a method of counseling clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes	• Substance misuse reduction • Increase parent and child well-being • Reduction of risk to the child • Reduction of children becoming involved with DCF

The following are descriptions of the proposed selected well supported EBP's strength of evidence for their effectiveness.

Parent Child Interaction Therapy

The Title IV-E Prevention Services Clearinghouse has studied and reviewed Parent Child Interaction Therapy (PCIT) concluding it to be a well-supported service. The Clearinghouse summary of PCIT is as follows: 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 (e.g., defiance, aggression), increase positive parenting behaviors, and improve the quality of the parent-child

relationship. During weekly sessions, therapists coach 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 or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or 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 caregivers. Parent-Child Interaction Therapy is rated as a well-supported practice because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.[16] [17]

Also from the Clearinghouse, the extent of evidence to support PCIT includes:

Results of Search and Review	Number of Studies Identified and Reviewed for Parent-Child Interaction Therapy
Identified in Search	36
Eligible for Review	21
Rated High	5
Rated Moderate	6
Rated Low	4
Reviewed Only for Risk of Harm	6

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

[17] McCabe, K., Yeh, M., Lau, A., Argote, C. B., McCabe, K., Yeh, M., . . . Argote, C. B. (2012). Parent-Child Interaction Therapy for Mexican Americans: results of a pilot randomized clinical trial at follow-up. Behavior Therapy, 43(3), 606-618. doi:10.1016/j.beth.2011.11.001

Following is a summary of findings from the 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: 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	0.57 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

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.

Parent Child Interaction Therapy (PCIT) has been demonstrated as effective through numerous studies and inclusion as evidence-based in multiple clearinghouses and reports, leading FSD to determine that the program's effectiveness is compelling for Vermont's child welfare and juvenile justice populations. 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. The review by the Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable and statistically significant impacts on child behavioral and emotional functioning[18] [19] [20], positive parenting practices[21] [22], and parent/caregiver mental or emotional health[23] [24], which are among FSD's proximal outcomes noted in our theory of change. There were no unfavorable effects. These findings are summarized in the tables above.

[18] Bjorseth, A., & Wichstrom, L. (2016). Effectiveness of Parent-Child Interaction Therapy (PCIT) in the treatment of young children's behavior problems. A randomized controlled study. PLoS ONE, 11(9), e0159845. doi:10.1371/journal.pone.0159845.

[19] Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008). The effectiveness of Parent-Child Interaction Therapy for families of children on the autism spectrum. Journal of Autism and Developmental Disorders, 38(9), 1767-1776. doi:10.1007/s10803-008-0567-5.

[20] Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial. Research on Social Work Practice, 25(1), 117-128.

[21] Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for Parent-Child Interaction Therapy in the prevention of child maltreatment. Child Development, 82(1), 177-192.

[22] Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial. Research on Social Work Practice, 25(1), 117-128.

[23] Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of Parent-Child Interaction Therapy: Interim report of a randomized trial with short-term maintenance. Journal of Clinical Child Psychology, 27(1), 34-45.

[24] Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008). The effectiveness of Parent-Child Interaction Therapy for families of children on the autism spectrum. Journal of Autism and Developmental Disorders, 38(9), 1767-1776. doi:10.1007/s10803-008-0567-5.

Vermont has selected PCIT because we have found that parent/caregiver mental health and a child's behavioral issue are the most common factors leading to child welfare involvement in our state. PCIT has shown to be effective in the above cited studies to improve 2-7 year old children's responsiveness to their parent's/caretaker's directions, cross-culturally and in children with disabilities displaying challenging behavior related to the disability. This is important to Vermont as over half of Vermont's safety assessments consider a child under the age of 6. Many studies on the Clearinghouse, including those cited above, indicate that the positive parenting and interactions stemming from PCIT reduces parent/caregiver stress and improves parent/caregiver mental health, which are the two key factors that impact children/families in Vermont and we have chosen to be targeted through the use of PCIT.

Motivational Interviewing

The Title IV-E Prevention Services Clearinghouse has studied and reviewed Motivational Interviewing (MI) concluding it to be a well-supported service. The Clearinghouse summary of MI is as follows: 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 those 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.

The Prevention Services Clearinghouse reviewed studies of MI focused on illicit substance and alcohol use or abuse among youth and adults, and nicotine or tobacco use among youth under the age of 18. MI is typically delivered over one to three sessions with each session lasting about 30 to 50 minutes. Sessions are often used prior to or in conjunction with other therapies or programs. They are usually conducted in community agencies, clinical office settings, care facilities, or hospitals. While there are no required qualifications for individuals to deliver MI, training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers.

MI is rated as a well-supported practice because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain.[25] At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome. In accordance with the *Handbook of Standards and Procedures*, if after review of 15 studies a program or service has not achieved a rating of well-supported, additional studies are reviewed until the program or service has achieved a rating of well-supported or all eligible studies have been reviewed. For Motivational Interviewing, 30 studies were reviewed in depth, in order of prioritization.

Also from the Clearinghouse, the extent of evidence to support MI includes:

See chart on next page.

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

Results of Search and Review	Number of Studies Identified and Reviewed for Motivational Interviewing
Identified in Search	206
Eligible for Review	75
Rated High	13
Rated Moderate	8
Rated Low	9
Reviewed Only for Risk of Harm	45

Following is a summary of findings from the 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	-0.01 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	0.16 6	15 (109)	6066	Favorable: 16 No Effect: 91 Unfavorable: 2
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	0.00 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 effectiveness of Motivational Interviewing (MI) has been demonstrated through multiple studies and inclusion as effective in multiple clearinghouses and reports, leading FSD to determine that the program's effectiveness is compelling for Vermont's child welfare and juvenile justice populations[26] [27]. 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 studies cited found MI to be effective in treating

[26] Cunningham, R. M., Chermack, S. T., Ehrlich, P. F., Carter, P. M., Booth, B. M., Blow, F. C., . . . Walton, M. A. (2015). Alcohol interventions among underage drinkers in the ED: A randomized controlled trial. Pediatrics, 136(4), e783-e793. doi:10.1542/peds.2015-1260

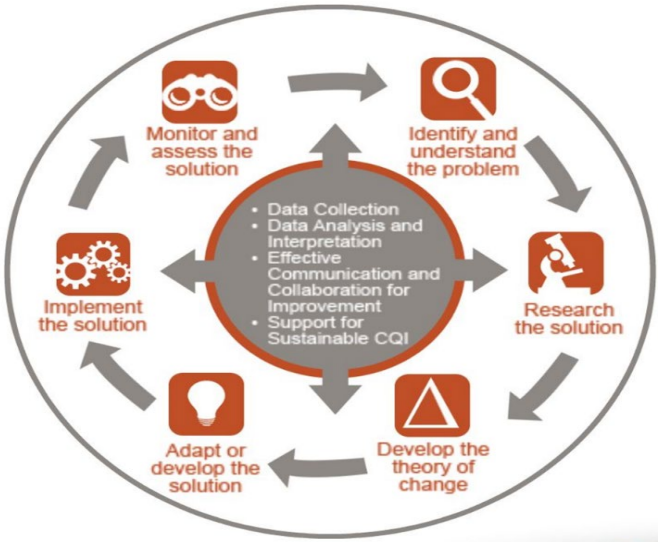
[27] D'Amico, E. J., Parast, L., Shadel, W. G., Meredith, L. S., Seelam, R., & Stein, B. D. (2018). Brief motivational interviewing intervention to reduce alcohol and marijuana use for at-risk adolescents in primary care. Journal of Consulting and Clinical Psychology, 86(9), 775-786. doi:http://dx.doi.org/10.1037/ccp0000332

substance use disorder in parents and young adults[28][29], which is why the EBP was selected to respond to Vermont's most urgent child welfare concern- substance use disorder in parents of young children under the age of 6, as well as youth are justice-involved. MI was selected for the justice-involved population given the efficacy showed by the cited studies in youth aged 12-17 because of the significant concern Vermont also has with substance use disorder in youth. Substance use disorder is a leading factor in many juvenile justice cases, with YASI screening indicating that substance use was a major risk factor in 56% of juvenile justice-involved youth. Vermont intends to help address this issue within the target population using MI.

The review by the Title IV-E Prevention Services Clearinghouse resulted in a rating of well supported and shows that MI had favorable impact on adult well-being specific to parent/caregiver substance use[30][31], which is identified as a proximal outcome in FSD's theory of change. The review identified two unfavorable effects. These findings are summarized in the table above.

D. Continuous Quality Improvement (CQI) Overall Strategy

Vermont's continuous quality improvement and quality assurance program is administered by the Quality Assurance (QA) team. This team provides qualitative and quantitative outcome data to senior managers for consideration in decision making related to practice and services to improve outcomes for children and families. The QA team utilizes the following approach to our CQI practices:



[28] Saitz, R., Palfai, T. P. A., Cheng, D. M., Alford, D. P., Bernstein, J. A., Lloyd-Travaglini, C. A., . . . Samet, J. H. (2014). Screening and brief intervention for drug use in primary care: The ASPIRE randomized clinical trial. JAMA, 312(5), 502-513. doi:http://dx.doi.org/10.1001/jama.2014.7862

[29] Fuster, D., Cheng, D. M., Wang, N., Bernstein, J. A., Palfai, T. P., Alford, D. P., . . . Saitz, R. (2016). Brief intervention for daily marijuana users identified by screening in primary care: A subgroup analysis of the aspire randomized clinical trial. Substance Abuse, 37(2), 336-342. doi:http://dx.doi.org/10.1080/08897077.2015.1075932

[30] Rendall-Mkosi, K., Morojele, N., London, L., Moodley, S., Singh, C., & Girdler-Brown, B. (2013). A randomized controlled trial of motivational interviewing to prevent risk for an alcohol-exposed pregnancy in the Western Cape, South Africa. Addiction, 108(4), 725-732. doi:http://dx.doi.org/10.1111/add.12081

[31] Stein, M. D., Hagerty, C. E., Herman, D. S., Phipps, M. G., & Anderson, B. J. (2011). A brief marijuana intervention for non-treatment-seeking young adult women. Journal of Substance Abuse Treatment, 40(2), 189-198. doi:http://dx.doi.org/10.1016/j.jsat.2010.11.001

Vermont's CQI/QA system is guided by the 5 key components of a CQI system outlined by ACF ACYF-CB-IM-12-07 issued on August 27, 2012.

I. Foundational administrative structure

The Family Services' Quality Assurance (QA) Team consists of 3 Quality Assurance Specialists, a supervisor, and an administrative support staff. The entire team continues to join the regional New England CQI meetings that have been held virtually over the last year to share different CQI practices and learn from one another. The QA team also received technical assistance from the Capacity Building Center to support their data analytics skills which they applied to several areas of work related to FSD's focused indicators and the analysis of our residential utilization and FFPSA work. The QA team is also part of the Change Management workgroup who was charged with the development of an FSD framework and will be involved in the implementation of this framework over the upcoming year.

As part of our CQI framework, FSD Leadership continues to utilize the district annual roadshows (renamed to Listening Sessions) to evaluate how the division is doing related to the goals, strategies, and activities outlined in our strategic plan. Staff share the themes they are seeing in their district which helps informs where we are successful and where need to revisit our approach.

The CQI Steering Committee is comprised of staff from each district office and in different roles, along with central office staff, and meets regularly to review different areas of our strategic plan and identifies ways to keep the district staff informed and connected to this work. Also, our Child Welfare Training Partnership (CWTP) staff is represented in this group. With CWTP, we jointly implemented Collaborative Learning Agreements (CLAs) to provide technical assistance directly to the districts to support new practices, leadership development, and onboarding new employees. CLAs are written agreements between the districts and the Child Welfare Training Partnership that identify and align district goals, outcome data, and training needs. This allows the division to make sure our finite resources through the CWTP are targeting what leadership has identified as priorities within the districts and makes sure each district is getting equal support.

II. Quality data collection

Currently, FSD is engaging our IT partners around data collection necessary to implement FFPSA. For QRTP implementation, we have been working with IT staff to develop data collection capacity and this work is scheduled to be implemented for 4/1/22. For the prevention side of FFPSA, FSD is in the process of identifying the best path forward for data collection. FSD has planned for two potential mechanisms for those providers that do not submit to a national purveyor. Initially FSD believes EBP providers will send data to FSD based on a template we develop specific for that EBP to ensure uniformity and compliance with the essential data elements for CQI and fidelity. FSD's longer term plan is to develop a provider portal in our data system.

At the same time, FSD has been collaborating with the new IT Director around a road map for moving forward with CCWIS implementation. Our current discussions involve building out a 5+ year plan for module implementation and funding. Funding of a new system is the greatest barrier for CCWIS implementation. Our goal for CCWIS is to reduce duplicative work (data entry into multiple systems), increase data collection capabilities, taking advantage of technology to enhance the efficiency and effectiveness of staff time and create robust reporting that allows real-time information around outcomes for children and families.

Quality data collection processes for each of the well supported EBP's will include one or more of the following:

- Each EBP service provider will submit their data to the National Purveyors and the state agency will work with the national organization to receive this information for evaluation by the state agency.
- Each EBP service provider will send data to FSD based on a template we develop specific for that EBP to ensure uniformity and compliance with the essential data elements for CQI and fidelity.
- Each EBP service provider will submit data through a future portal provider in our data system.
- The Department's data collection from the providers will include data on race, ethnicity, age, gender, language preference and geographic region to allow the Department to observe any disproportionalities associated with those factors

FSD will develop a data collection and report plan in partnership with EBP providers during October and December, 2021. Please see Tables 6.1 and 6.2 for the ongoing CQI monitoring timelines for the well supported EBP's.

III. Case review data and process

Our Qualitative Case Reviews is another important way the division measures progress. During our PIP, FSD successfully implemented a case review system which replicates the CFSR process by teaming up FSD staff and community partners who are responsible for reviewing 2 cases over 3 consecutive days. The division has adopted the use of the federal Onsite Review Instrument (OSRI) as part of the case review process. At the end of each review, the QA team provides each district with a summary of their performance and will meet with their staff or leadership team to discuss. The QA team provides trainings to new reviewers by using a mock case Vermont created and applying the OSRI. Prior to COVID, the division planned on regular bi-annual in-person spring and fall QCRs, measuring all 18 items, reviewing approximately 150 cases annually. With the outbreak of COVID, the division cancelled the spring 2020 QCR. In the fall of 2020, after learning about the PIP extension, the division conducted a virtual item 3 only review in an effort to pass our PIP. In the Spring 2021, the division conducted a virtual QCR measuring the following items: 1, 4, 6, 13, 14, and 15. These items were selected because they focus on areas of practice that we need to continue to shine a light on and it felt manageable given the impact of our QCR reviewer resources during the pandemic and hiring freeze. The division is committed to getting our QCR back on track by training more reviewers now that the hiring freeze has been lifted in preparation for Round 4 of the CFSR. Our goal is to do an 18 item in-person review the spring and fall of 2022.

In addition to our QCRs, several years ago the division developed a review tool to review our Centralized Intake and Emergency Services intakes. The goal is to continue to imbed this into our CQI framework therefore we are conducting our second review this summer. Lastly, Evident Change (formerly the Children's Research Center) continues to provide TA around our use of case reads to support the

implementation of our revised and new SDM tools in districts. We are engaging in discussions with Evident Change to perform a risk calibration study for our SDM tools in the coming year.

IV. Analysis and dissemination of quality data

The QA team provides routine reporting to all levels of staff relating to our indicators and outcomes on a weekly, monthly, quarterly and annual basis. This indicator data is also shared at our senior management level, at least quarterly and provides further opportunity to discuss our outcomes and successful strategies that have been implemented. Central office committed to using our monthly division management team meetings to review the data together, the directors then follow up in their districts and identify strategies, and then we review the data again at a future monthly division management team meeting. The goal is to repeat this process for the 3 indicators each year for 3 years (we are currently beginning year 3). Currently, FSD's reporting includes analysis by gender, age and geographical disproportionality but does not yet have consistent reporting based on race and ethnicity. FSD is close to implementation of our Results Oriented Management (ROM) reporting tool which contains several reports focused on racial disparity and disproportionality. FSD is eager to begin analyzing this data, including helping to inform the ongoing work of our Racial Equity workgroup. In addition to reporting around race and ethnicity, the ROM reporting tool will allow users to access indicators and outcomes reporting in real-time instead of our current reporting which ranges from weekly, monthly, quarterly and annually.

After each round of the QCRs, the QA team prepares a summary of the districts results and themes that emerged from the review, which includes feedback from parents and youth during the interviews. The QA team will generally meet with the districts leadership team to review results, answer questions, and help strategize ways to improve priority items. In addition, the QA team also pulls together quarterly management reports for directors to review and help inform what is going well and areas that need more attention.

Both the indicator data and the QCR data help to inform the Collaborative Learning Agreements between the districts and the Child Welfare Training Partnership.

Analysis and dissemination of quality data processes for each of the well supported EBP's will include one or more of the following:

Like analysis and dissemination of quality data noted above, each of the well supported EBP's will include one or more of the following:

- EBP service provider data will be analyzed quarterly (if agreeable by the National Purveyors) by the state agency.
- EBP fidelity tools will be developed/utilized to monitor by the state agency.
- State agency outcomes data will continue to be analyzed quarterly by the state agency.

The EBP CQI monitoring will occur by the state agency and will include quarterly dissemination of data to key stakeholders to the FFPSA implementation as well as the EBP providers themselves. As mentioned in Section 3, staff will receive and analyze data from EBP providers, conduct desk reviews and site reviews of the programs, as needed, and will enter in improvement plans if there are concerns about if/how a provider is meeting the contract expectations.

As mentioned previously, the following timelines will guide our CQI monitoring processes for the well supported EBPs. As noted below, the state will engage in these CQI monitoring activities during the first year of the EBP implementation. This work will occur in collaboration with the EBP providers to best understand their current practices and align with FFPSA data collection, fidelity and performance monitoring.

Table 6.1 Motivational Interviewing (MI) Evaluation/CQI Monitoring Estimated Timeline

Month/Year	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Ongoing
Activity													
Create Data Collection and Report Plan	X	X	X	X									
Create Evaluation Dissemination Plan	X	X	X	X									
Establish Fidelity Monitoring	X	X	X	X	X	X							
Plan for Performance Monitoring	X	X	X	X	X	X							
Plan for Data Analysis				X	X	X	X						
Conduct Data Analysis										X	X	X	X
Implement Key Performance Metrics Data Display											X	X	X
Dissemination of Evaluation													X

Table 6.2 Parent-Child Interactive Therapy (PCIT) Evaluation/CQI Monitoring Estimated Timeline

Month/Year	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Ongoing
Activity													
Create Data Collection and Report Plan	X	X	X	X									
Create Evaluation Dissemination Plan	X	X	X	X									
Establish Fidelity Monitoring	X	X	X	X	X	X							
Plan for Performance Monitoring	X	X	X	X	X	X							
Plan for Data Analysis				X	X	X	X						
Conduct Data Analysis										X	X	X	X
Implement Key Performance Metrics Data Display											X	X	X
Dissemination of Evaluation													X

FSD has formed a subgroup consisting of Family First designated FSD staff and quality assurance staff, with additional input from our Family First Prevention consultant from the Center for States. This group will conduct a developmental evaluation of each service provider and EBP to assess their ability to collect data, reporting capacity, and determine fidelity instruments that are either already in use or that may need to be amended where appropriate. FSD plans to create an ongoing partnership with service providers to include ongoing monitoring of fidelity to the practice model and outcomes achievement. After the developmental evaluation is completed, fidelity tools implemented and data collection established, the subgroup and service provider will meet quarterly to review data and discuss improvement of practices as necessary.

Development and summative evaluation components will consist of:

1. Agency Capacity: Number of staff and clients able to be served?
    a. Number of clinicians and clinical supervisors
    b. Average caseload per clinician
    c. Average duration of intervention
    d. Total cases served per reporting period (quarter)

    e. Number of training staff or funding for outside trainers
    f. Funding source
2. Reach: To what extent is the intervention being provided to each of the following candidacy subgroups?
    a. Children and families served by FSD, In-Home, ages 2-7
    b. FSD In-Home Juvenile Probation Youth
3. Fidelity: What measures are being used and data being captured to measure fidelity?
    a. Training certification
    b. Qualification of clinician
    c. Supervisor/clinician ratio
    d. Clinician/client ratio
    e. Target population
    f. Language of client
    g. Age of client
    h. Number referred
    i. Number enrolled
    j. Name of assessment
    k. Rate of timely submission of assessment driving plan
    l. Number enrolled who completed 1 session
    m. Avg # of days from referral to first session
    n. Avg # of sessions to completion
    o. Number enrolled who completed services
    p. Fidelity monitoring assessment tool used
    q. Frequency of monitoring tool use
4. Program-Specific Outcomes. Outcomes monitored?
    a. What EBP specific outcomes are being monitored
        i. For MI in use with IFBS families: Percent of parents/caregivers with increased parenting skills
        ii. For MI in use with BARJ providers: Percent of youth with decreased recidivism; percent of youth exhibiting an increase in pro-social decisions
        iii. For MI in use with Substance Abuse Case Managers: Percent of parents/caregivers with reduced substance abuse
        iv. For PCIT in use with children ages 2-7 who experience emotional and behavior problems that are intense and frequent: Increase percent of youth living at home at 12 and 24 months
    b. How are outcomes communicated to clinicians/agencies, how often
5. Foster Care. To what extent are programs preventing foster care entry or re-entry?
    a. Number of children entering care within 12 months
    b. Number of children entering care within 24 months
6. In-Home Involvement. To what extent are programs preventing future systems involvement?
    a. Number of children entering an in-home episode without court involvement, within 12 months and within 24 months
    b. Number of children entering an in-home episode with court involvement, within 12 months and within 24 months

V. Feedback to stakeholders and decision makers and adjustment of program and process

FSD will utilize the current CQI feedback system to integrate EBP data in our ongoing data collection, analysis and reporting process. This will inform FSD around EBP fidelity, process and impact on outcomes.

DCF central office regularly meets with contract providers to review data and discuss practice related issues. These meetings often involve the district directors which is helpful to address issues together and ideally come to agreement on contract changes when needed to be more effective and achieve desired outcomes.

FSD has quarterly stakeholder meetings, which has representation from the Court Improvement Project, Vermont Kin as Parents, Vermont Family Network, VT Federation for Families, and the Youth Development Program. This has been a venue to share practice related updates and data, answer questions, and hear feedback. Prior to COVID, the division began hosting these meetings virtually which proved to be successful as our participation numbers have risen from an average of 10 to over 100 stakeholders. The family and youth agencies bring back information to the parents and youth to solicit additional thoughts, comments, and questions. Every year, the Division Management team meets with the Youth Advisory Board who prepares a summary of what they feel are priorities for the division. The division then identifies opportunities and strategies to move their priorities forward.

These processes will ensure effective ongoing monitoring for our selected EBP's.

E. Evaluation Strategy for Proposed Interventions

Vermont FSD intends to implement only well-supported interventions during the initial phase of FFPSA implementation. It is anticipated in the future that FSD will pursue EBP's that may not be well-supported and when that occurs, an evaluation strategy will be noted in an updated plan.

Child Welfare Workforce Training and Support

As mentioned earlier in the Prevention Plan, Vermont's child welfare system serves families and youth through both child safety interventions and juvenile justice work. The Department holds a contract with the University of Vermont (UVM) called the Child Welfare Training Partnership (CWTP), which is responsible for creating and delivering trainings to new employees, current employees, foster parents and community providers. The trainings offered through the CWTP focus on trauma-informed practices and supporting workers and providers through regular training opportunities on various topics related to trauma, monitoring safety and working with youth, advanced practicums, as well as consistent opportunities for coaching and micro-learnings for all district workers (including all employees across DCF, such as workers, supervisors, directors and operations). Vermont's current training curriculum provides the foundation of what Family First seeks to instill in the workforce, allowing for opportunity for Vermont to enhance its training offerings to embed Family First content.

Vermont's current training for new employees includes:

1. **Integrated Foundations Learning Program for Child Protection & Youth Justice Practice**
   This 8-week, 12 module curriculum will be offered 2-4 times/year, dependent on the number of new employees hired over a period of three months. Each module consists of integrated online learning and remote interactive learning opportunities. Brief outlines of each module include:
   - Module 1:
     - Overview of child welfare and juvenile justice in Vermont, including key federal and state laws that govern child welfare practice.
     - Justice, Equity, Diversity and Inclusion (JEDI): understanding the impacts on our values, practice and approaches to child welfare assessment, case planning and family meetings.
   - Module 2:
     - Engagement skills with families, case planning and assessment
     - Motivational interviewing
     - Phases of casework process
   - Module 3:
     - Recognizing and assessing different types of child abuse
     - Understanding child and adolescent development with a focus on the impacts of trauma
   - Module 4:
     - Overview of Safety Organized Practice, SDM and safety planning
     - SDM course to improve assessments of family situations and increase frequency and accuracy of assessments, identifying and involving family networks
   - Module 5:
     - SDM Risk Assessment, Risk Reassessment tools
     - Developing risk statements
     - Family Safety Planning meetings
     - Additional SDM course

- Module 6:
    - Case planning, CSI intervention, adapting case plan throughout the life of a case, SMART goals, behaviorally descriptive language
    - Documentation of face-to-face contacts, case notes, case plan goals, family meetings
    - Timelines for CSI documentation
    - Case plan template
- Module 7:
    - Working with the court system: writing affidavits, testifying, understanding the worker's role within court, state and national statutes
    - Types of hearings and typical trajectories
- Module 8:
    - Permanency: Family Finding, working with kin, Family Time Coaching
    - Permanency course: review relevant research and understand policy framework around achieving permanency and utilizing best practice
- Module 9:
    - Youth development, resources for youth (such as Youth Development Program)
    - Engagement skills for working with youth
- Module 10:
    - Substance use: review different substances, effects on families, strategies to overcome barriers to engagement
    - Domestic violence: identify behaviors that can contribute to impede child safety, DV team and LUND resources, safe parenting and accountability.
    - Safe and Together Model
    - Substance Abuse for Child Welfare Professionals tutorial
- Module 11:
    - Professional self: safety culture, staff safety, self-care, professional development
    - Secondary traumatic stress
- Module 12:
    - Simulated lab: commencement of a case, initial home visit, interviewing a child, removing a child from their home completing Suitability Assessments, completing family finding tools.

In addition to the 12 topically focused modules, we have identified 5 core tenets of learning that will be threaded throughout all 12 modules.

The 5 core tenets are:

- Safety Culture & Safety Organized Practice
- JEDI: Justice, Equity, Diversity & Inclusion
- Trauma Informed Practice
- Engagement
- Permanency

2. **Foundations Field – Based Practice**
   The purpose of the field-based practice category is to provide opportunities for new Family Services Workers to transfer their learning from the classroom and computer to the field and test their understanding of the connection between knowledge and practice. Through methods such as job shadowing, observation, peer mentoring, coaching, document review and documentation practice Family Services Workers gain insight into the role and responsibilities of a child welfare and/or youth justice Family Services Worker.

New employees are trained in child safety monitoring and risk assessment using Structured Decision Making (SDM) tools through Evident Change. Family Services Workers are initially trained to use SDM during their Foundations training and with trainings offered by Evident Change. Existing Family Services Workers participate in additional SDM trainings as they are offered, such as when updates are added to SDM guidance or when districts or operations indicate that a "refresher" training would be beneficial.

Vermont plans to continue to use the SDM model and add additional training around child safety monitoring required by Family First. In addition, Vermont will modify its current training on documentation for new employees to include documentation requirements specific to Family First. While Vermont does not currently have a tool to support workers in matching families to the most appropriate services or EBP's, the current case planning document requires workers to assess the strengths, risks and needs of each family and child, which, in conjunction with the SDM risk and safety assessment tools, enables the worker to identify what areas of risk and need should be prioritized in matching the most appropriate service or EBP. Vermont is considering adding the case planning tool (Family Strengths and Needs Assessment) provided by SDM to its current suite of SDM tools in the future.

Vermont's current case planning training occurs within Foundations and through ongoing support from direct supervisors, district directors, staff mentors and coaching (if needed). Workers who are assigned youth justice cases (including youth who have been found delinquent, on juvenile probation or youth ages 10-17 involved with Family Services through a Family Support case, a CCO or in DCF custody) are certified in administering the Youth Assessment Screening Instrument (YASI), which is a validated tool provided by Orbis. Training to be certified in administering the YASI includes an initial, comprehensive training with a simulation, as well as "refresher" trainings offered throughout the year. Family Services Workers assigned youth justice cases have the opportunity to "shadow" the process of administering the YASI and assessing the results by pairing up with a more experienced Family Services Worker and partnering with Balanced and Restorative Justice (BARJ), a service through contracted community providers, who specialize in youth justice work, administering the YASI and supporting high-risk youth.

While modifying the existing training curriculum for new employees will be relatively easy to accomplish to meet the requirements of Family First, Vermont also recognizes that ensuring existing employees receive the appropriate training will require a more targeted approach. To accomplish this goal, Vermont created a Workforce Preparation Workgroup. This workgroup was initially comprised of operations staff, policy managers and central office staff, but will increase to include district staff, supervisors, and directors to allow for continued collaboration to ensure current employees are receiving effective training on the requirements for Family First.

The Workforce Preparation Workgroup also serves as a conduit for operations staff and district directors to discuss training needs throughout each district and to ensure consistent messaging around Family First

and best practice is shared with each district. Vermont's structure of operations managers, district directors and supervisors allows for a top-down commitment to Family First and best practice. Through the operations managers and district directors within the Workforce Preparation Workgroup, they will ensure that staff are receiving the appropriate training and coaching around the requirements and vision of Family First.

Vermont's current system of training for current employees allows for various avenues to train the workforce on the requirements of Family First, such as coaching with a UVM-CWTP training specialist offered to workers, supervisors and directors within each district, as well as one-hour micro-learnings offered regularly through an interactive video platform that focus on one topic (for example, a topic would be "Matching Family Needs to Appropriate EBP's"). Vermont intends to utilize coaching and micro-learnings to consistently train and communicate with the FSD workforce around Family First requirements and how it fits within best practice.

In addition to the consistent, focused support through coaching and micro-learnings, Vermont is currently exploring various ways to effectively train existing child welfare staff around the requirements and expectations of Family First on a larger scale. The Workforce Preparation Workgroup is having discussions with operations staff, Family Services Workers and the UVM-CWTP training staff to create a training structure to ensure that all current staff will be trained around identifying candidates for prevention services, creating child-specific prevention plans, conducting safety and risk assessments for child candidates receiving prevention services, engaging families to assess their strengths and needs and matching them with appropriate prevention services, as well as ongoing evaluation of the appropriateness of the prevention services the child and family are receiving.

In addition to the existing training approaches that Vermont currently offers, there are also plans to create new ways of sharing information with the workforce, such as identifying workers within each district office to be the "champions of Family First," which will allow each district office to have one or two workers who will be involved in the Workforce Preparation Workgroup and will act as a conduit to help bring information about Family First to their respective district. They will also be available to support other workers within the district and model the requirements and practices outlined by Family First through opportunities such as mentoring and through regular meetings among casework teams. Operations managers, district directors and supervisors will help to identify Family Services Workers who would be best suited to serve as "champions of Family First."

Further, Vermont plans to create videos specific to each district that will inform staff and providers about EBP's within their community and how they can access more information about Family First in their region. The videos will include an overview of the EBP's available in their respective districts, the referral process to link a child and family to a prevention service, as well as contact information for providers in the districts.

Some Family Services Workers have voiced a desire to access more advanced, clinical trainings. Vermont would like to explore the possibility of more reciprocity with providers in terms of mutual access to trainings offered by Family Services and providers. This will allow for all service providers working with a family to be well-rounded and informed, offering the most effective intervention possible. Vermont will need to explore how this reciprocity in training will be achieved from a budgetary perspective and thus may be implemented later within the 5-year plan.

While community providers are welcome to attend trainings provided by the UVM-CWTP, it is presently only at a first come, first serve basis, with priority placed on FSD staff. Vermont recognizes that this is a gap within its training system that will need to be addressed to comply with Family First and is essential to achieving its vision of working openly and collaboratively with providers to prevent children from entering foster care.

Vermont is working with the Workforce Preparation Workgroup and Prevention Workgroup to develop a training plan for the EBP provider workforce to ensure the provider workforce is trauma-informed, will be able to monitor safety and assess risk (to allow for a collaborative approach throughout the delivery of the EBP, with shared monitoring between Family Services and the provider, or in instances when Family Services is not involved) and to ensure the providers have the skills and capacities to deliver the selected EBPs. Vermont is planning to outline specific training requirements for each EBP within each EBP contract. The organization or agency holding the contract for each EBP will be expected to ensure appropriate trainings are delivered to their respective EBP providers (these responsibilities will be included in each contract). After the initial, foundational training for the EBP, further training will be needed to ensure providers are delivering the EBP and collecting the required data in a manner that is true to the model and to fidelity. The structure of this ongoing training is still being discussed, but a tentative plan includes contracting with UVM to assist with data collection and support.

Prevention Caseloads

Caseload size is an important factor in ensuring effective case management for families and children receiving prevention services, as well as to ensure that those who come into the system exit in a timely manner. Managing caseload size was a clear priority in the Vermont DCF FSD Strategic Plan from 2019 – 2021. Three of the seven overarching goals included specific action items and highlighted the impact FFPSA implementation could have on statewide caseload sizes. Vermont has determined that the prevention caseload sizes can be maintained at their current rates given that candidates for prevention services will be limited to children who receive a Child Safety Intervention (CSI), and youth in Foster Care who are pregnant and parenting. Vermont has historically shined a brighter light on the caseloads of those on the Front End (meaning Child Safety Interventions), structuring an allocation system within the districts based on appropriately staffing the Child Safety Interventions (CSI) caseloads. Recently, Vermont reduced its standard from 100 CSIs per year per worker to 80 CSI's per year per worker. This was to better align with the best practice around timely closures. The table below outlines the Department's caseload standards. However, one of the ongoing challenges, faced nationally at present time, is Worker recruitment and retention. The below table illustrates that as well.

Child Welfare Caseload Standards

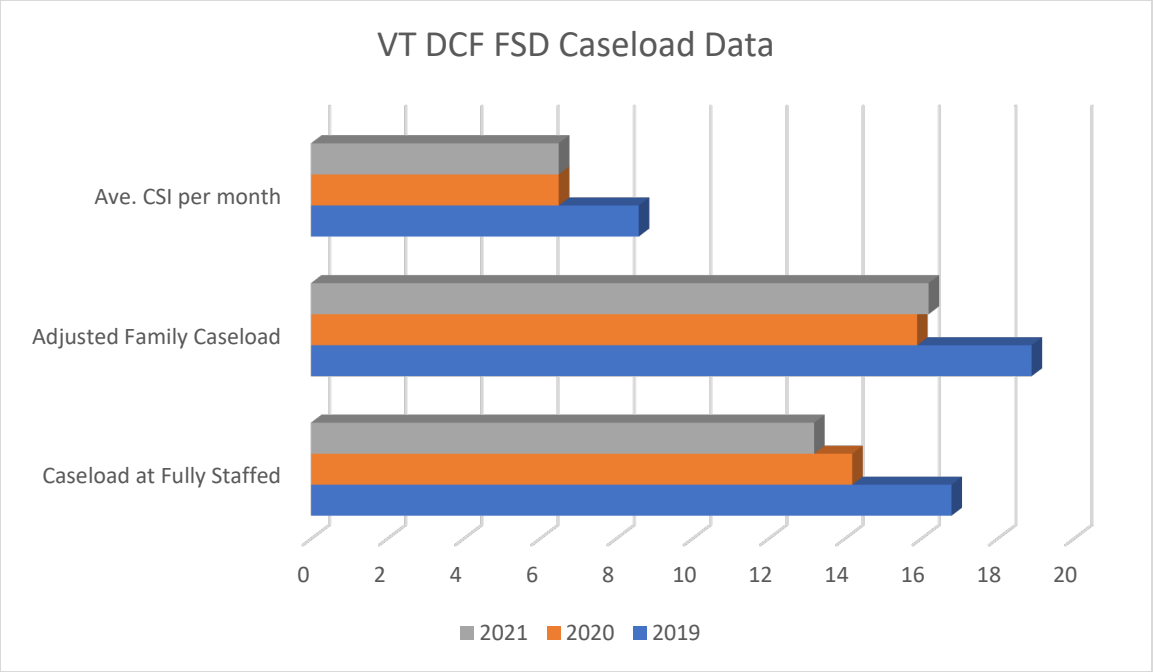
Table Key:

Ave. CSI per month – this refers to the average investigations and assessments accepted for intervention

Adjusted Family Caseload – this accounts for staff vacancies or newer workers not fully trained and therefore not able to hold full caseloads.

Fully Staffed Caseload – this refers to what caseloads would look like if offices were fully staffed and trained for those same points in time

Table on next page.



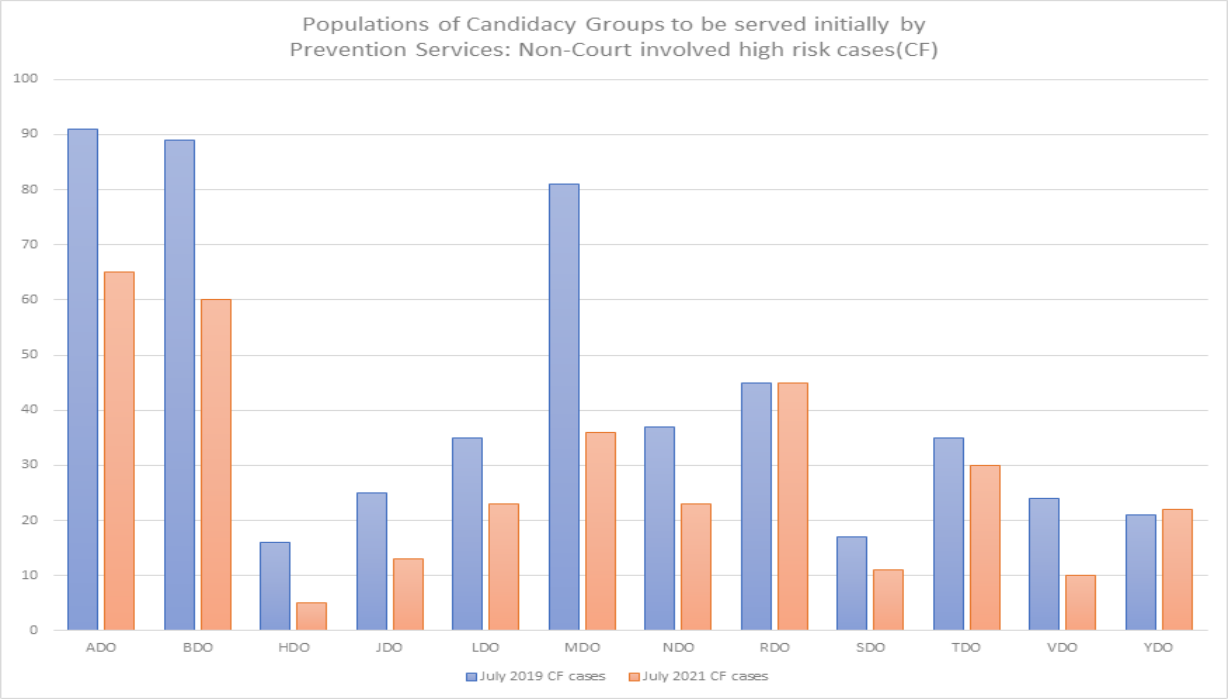
Prevention caseloads will be managed in Vermont with the goal of maintaining 12-16 cases per worker. Caseload sizes are overseen regularly by frontline supervisors, District Directors, Vermont DCF-FSD Operations, and ultimately, the Director of Operations. They regularly oversee and monitor caseload standards through ongoing CQI practices and regular agency-wide performance monitoring. Per policy and best practice standards set forth in Vermont FSD policy, these cases will be monitored and overseen on a consistent basis through SDM tool oversight and case planning (which is explained in more detail in sections 4 and 5). Supervision meetings between Family Services Workers and their Supervisor ensures that Risk Reassessments happen at the intervals they should, as well as the process of matching appropriate prevention services to the needs of the child and/or family, including subsequent monitoring. Additionally, Vermont DCF FSD will expect all EBP providers to uphold the staffing and caseload requirements specified by each intervention and in accordance with the intervention fidelity.

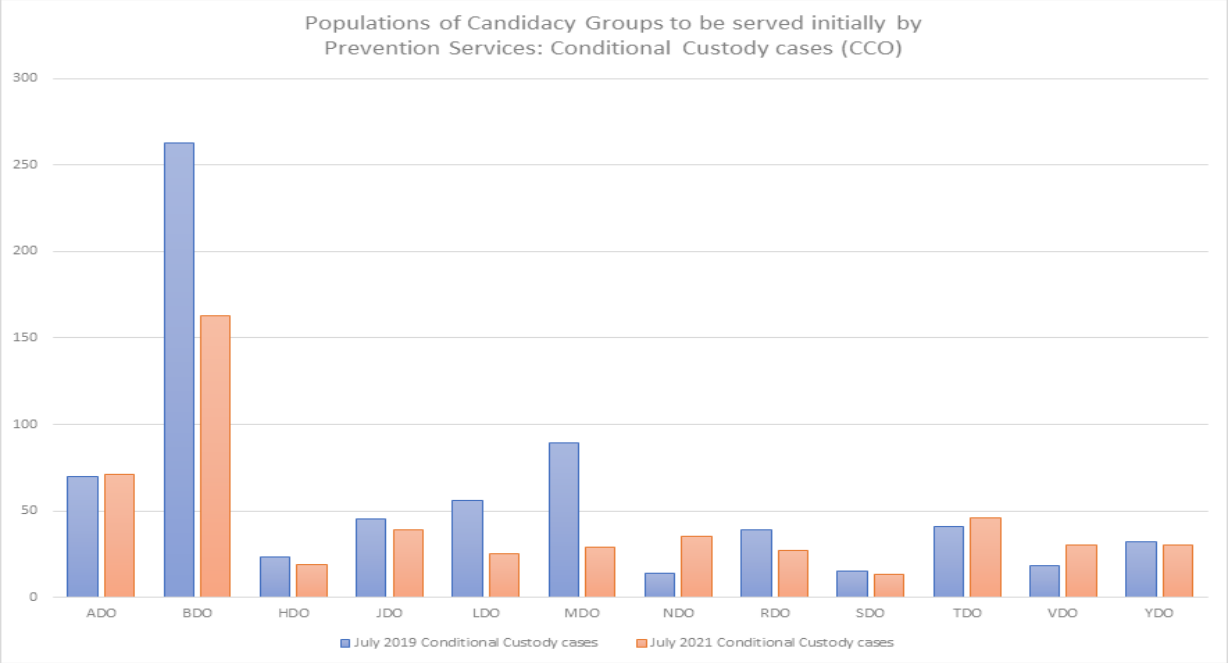
For the first chosen EBP, Parent-Child Interaction Therapy, the average caseload size is 4-6 for approximately a 6-month period. Due to the training and supervision costs of implementing PCIT, Vermont expects to start with a regional approach, issuing approximately 4 contracts statewide. With three clinicians per site, this would mean that approximately 36 children/families could be served per site, per year. Selection would be chosen through the SDM risk assessments and braiding those with eligible children in the ages 2-5 range. Because of the high rating for success with this EBP, along with some proven track record in Vermont with this service, this EBP was chosen.

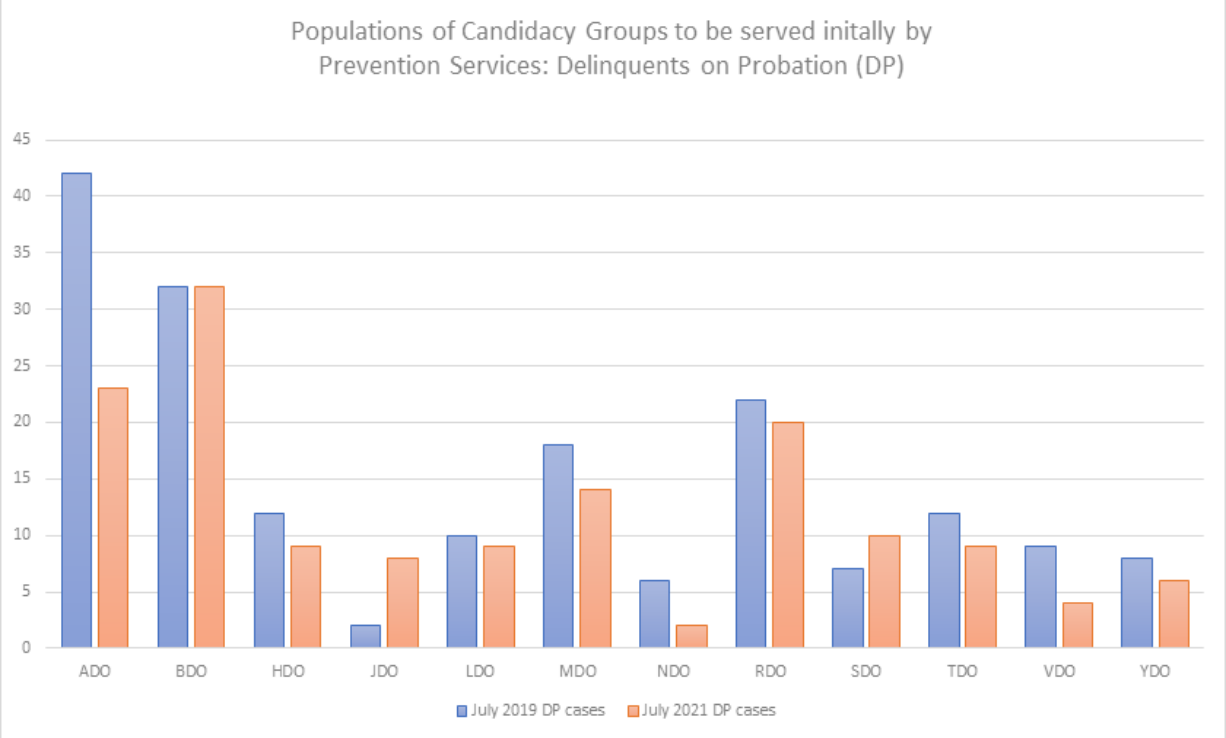
For the next EBP in Vermont's first year plan, Motivational Interviewing, will be an embedded service within existing program in Vermont's service array. It will allow for children and youth to be served within a variety of age groups and providers. It is the plan to expand MI to be included in services such as our Balanced and Restorative Justice contracts, Lund Substance Abuse Screener contracts, and Intensive Family Based Services contracts and we have identified possible other areas to grow the practice in Vermont. This would allow for the 15-20 cases per worker in every catchment area of the State to be served based on the risk level as identified by Structured Decision Making or by the Youth Assessment

and Screening Instrument tools implemented by the DCF caseworker. Because this will likely create the greatest capacity, DCF would focus this on the children ages 6+ population and corresponding parents/caregivers, especially given that PCIT is focused on a younger population, and this will serve to round out our overall service array. Additionally, this service also most closely matches the need based on the huge influx that Vermont has experienced over the past several years with substance use related cases.

In Vermont, we are easily able to begin identifying candidates in three main areas: those families who are high or very high risk as defined by SDM, resulting in an open family support case but no court or custody involvement; cases where young children are in the Conditional Custody of a parent or other relative but could result in custody without adequate resources; and Justice involved youth on probation (DP's). Vermont has 12 district offices. Below are charts depicting the numbers of those cases in each district, with comparison data pre-COVID and current.







Vermont will begin with the Candidacy groups identified above as those are mostly easily identified by DCF. Candidates through Community Pathways and other "external" populations will be weaved in over the following year or two, as we develop tools to identify those Candidates in the most objective way. We further recognize that Candidates that touch the child welfare system are most likely to become involved and often entrenched, so the decision to begin with those candidates appears to be the most beneficial as well.