

PUTTING FAMILY FIRST

developing an evidence-based
child welfare preventive practice model



Acknowledgments

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About the Annie E. Casey Foundation

The Annie E. Casey Foundation is a private philanthropy that creates a brighter future for the nation's children by developing solutions to strengthen families, build paths to economic opportunity and transform struggling communities into safer and healthier places to live, work and grow. For more information, visit the Foundation's website at www.aecf.org.

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Introduction and Purpose

The Family First Prevention Services Act (Family First) creates exciting new opportunities for child welfare practitioners to help keep children safely with their families. The law redirects federal funds to provide preventive services and, when foster care is needed, allows federal reimbursement for care in family settings and certain residential treatment programs for children with emotional and behavioral needs that require special treatment. When foster care is needed, the law allows federal reimbursement for care in family settings and certain residential treatment programs for children with emotional and behavioral needs that require special treatment. To reduce foster care entry or reentry, Family First emphasizes three strategies: (1) evidence-informed preventive services for families and children at risk of foster care placement, (2) kin navigation services to increase the likelihood of alternate placement within the kin network and (3) continuous child safety monitoring.

This paper provides guidance for state child welfare agencies on what to consider when developing a preventive practice model that aligns with the requirements of Family First, addresses the unique needs of families within local communities and ensures that selected programs and practices can be implemented with quality. It is designed to help child welfare agencies use evidence and targeted strategies to advance equitable results and focus on the culture, history, assets, needs and values of communities. Specifically, this paper will guide states through a process that begins with considering the role of case management as foundational to a preventive practice model. Case management should be an evidence-based intervention and serve as the anchor for an effective approach to

preventive services in child welfare. The paper explains how evidence-based case management can ensure families receive targeted support and services through comprehensive needs assessment and goal planning driven by family voice and choice. Readers will learn how careful consideration of therapeutic and research-driven approaches can be used to match evidence-based models with the specific needs of families and communities. In addition to detailing the three key elements of a preventive practice model, the paper outlines how jurisdictions might leverage the opportunity to better serve families through Family First by carefully thinking through program candidacy, financing and reimbursement; systems alignment; the inclusion of family voice at the earliest stages of decision making; and strategies to support effective practices. These concepts are further examined in the Leveraging Family First section.

While it is important to note the critical role of primary prevention in supporting children and families and reducing child abuse and neglect, this paper is focused on a preventive practice model for families who have already come to the attention of child welfare agencies, in accordance with Family First. Therefore, prevention is discussed in the context of preventing out-of-home placements for child welfare–involved children and youth, rather than primary prevention efforts aimed at stopping child abuse and neglect before it occurs.

The paper concludes with three case examples from state and local jurisdictions that are implementing key aspects of a preventive practice model.

We have defined several key terms used throughout this paper to ensure a shared understanding of proposed concepts.

KEY TERM	DEFINITION
Preventive practice model	A framework for serving families with children at risk of placement with the goal of preventing placement. A practice model should be aligned with the agency’s guiding principles or values and include three core elements: evidence-based case management, targeted services to address risk and protective factors and evidence-based treatment models.
Evidence-based case management	A consistent approach, supported by research evidence, to working with families to understand their situation, including their strengths and needs, and develop a plan to reduce risk factors, enhance protective factors and facilitate behavior change
Targeted services	Services and support for families that address their unique needs and meet the specific goals of their case to prevent placement in care
Evidence-based model	Programs focused on mental health, substance abuse prevention and treatment, building parent skills at home or kinship navigation that have available evidence to support their use in practice. More information on the rating of evidence for Family First can be found in the Title IV-E Prevention Services Clearinghouse.

Methodology

An iterative team-based approach was used to develop and refine this paper, including its guidance on how jurisdictions might establish a preventive practice model and leverage Family First to benefit children and families at risk of placement. An initial paper was developed with the goal of identifying effective elements of a preventive practice model that strengthen direct practices with children and families at risk of out-of-home placement and are reimbursable under Family First. Then, in May 2019, the Annie E. Casey Foundation brought together a small group of experts to review the resulting model, undergirded by evidence-based practices and programs, and provide feedback on the relevance, fit and feasibility of its components, as well as the necessary infrastructure and funding strategies for implementation. Participants included child welfare leaders, purveyors of evidence-based programs and experts on policy development, public systems, research and equity and inclusion.

During the first gathering, a number of broader issues were discussed, such as equity, financing, systems alignment

and approaches to determining which children are candidates for foster care. It became clear that the complexity of leveraging Family First and articulating these concepts in a paper would require additional feedback and development beyond the initial convening. As a result, participants committed to serving as members of a design team that would support refinement of the paper. The paper was revised following the initial convening, and the design team met again in September 2019 to review and discuss the changes. In advance of the meeting, design team members provided individual feedback through a survey on the paper's clarity, relevance and next steps. The results of the survey were shared with the design team, and the group participated in a facilitated exercise to identify and prioritize additional revisions. It is the group's hope that the iterative development of the paper has enhanced its overall relevance and usefulness for state agencies. Planning is underway for a series of focus groups with youth and families in 2020 to gather feedback on the preventive practice model; findings from those focus groups will be used to further refine this paper.

Introduction to Preventive Practice Model

Family First provides an opportunity for states to develop a coordinated preventive practice model to support families in their communities, promote family stability and well-being and reduce the need for placement in foster care. As states seek to expand the use of evidence-based and evidence-informed preventive services, they will need to develop an overall approach that includes goals and objectives, specific programs and practices and resources for ensuring the delivery and continuous improvement of high-quality services.

A practice model is “a conceptual map and organizational ideology of how agency employees, families and stakeholders should unite in creating a physical and emotional environment that focuses on the safety, permanency and well-being of children and their families.”¹ In other words, a practice model provides a framework for an agency’s overall approach to child welfare work, or in this case, its overall approach to preventive services for children at

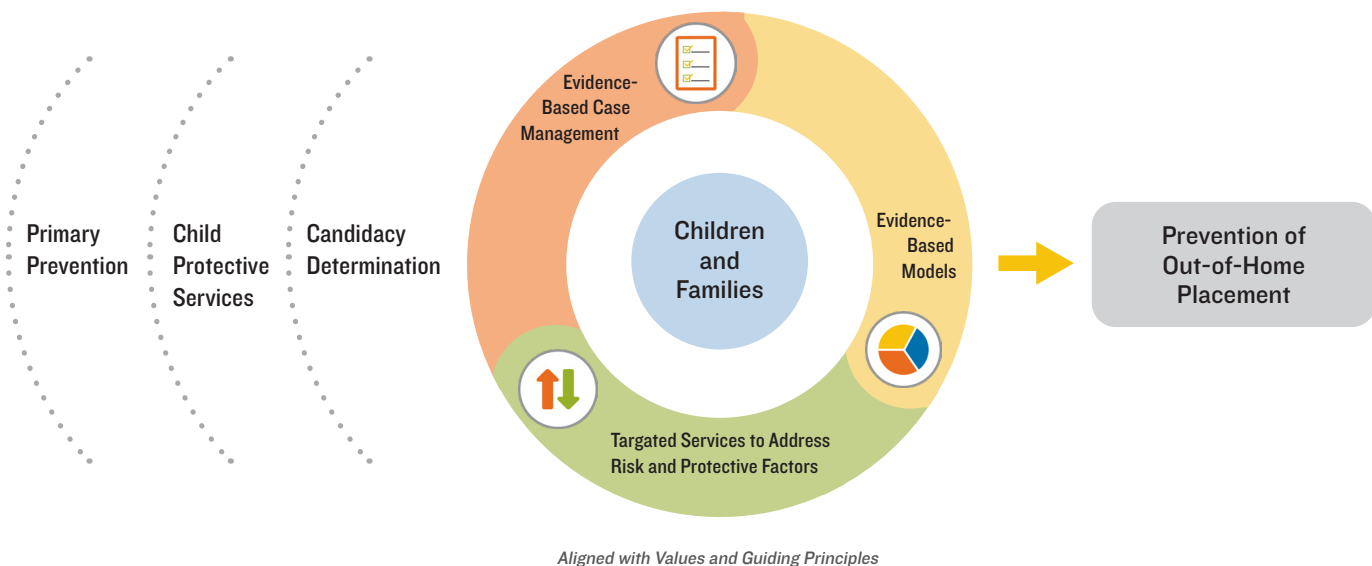
risk of placement and their families. Using a well-defined practice model has resulted in improved professional and organizational collaboration; increased collaboration with families receiving services; a shift to more child-centered, holistic and inclusive practices; opportunities for reflection and assessment of practices and outcomes; and adoption of evidence-based interventions.² Practice models should define the practice at the level of daily interactions and provide detailed descriptions of the types of behaviors, activities and strategies caseworkers use with families, as well as community partners and systems stakeholders.³

A well-defined preventive practice model aligns all preventive efforts for families. Specifically, it connects evidence-based case management, targeted services to enhance protective factors and mitigate risk factors and evidence-based models based on families’ specific goals and needs (figure 1). Before selecting their preventive services array, states will want

to describe their underlying values and principles, their goals and objectives for preventive services, their approach to providing a continuum of services and their commitment to seamless service delivery for children and families at risk of entering or reentering foster care. They should also outline their plans for equitable implementation of services, throughout which strong equity components (including explicit attention to the culture, history, values and needs of the community) will be integrated into service selection and implementation.

The proposed preventive practice model includes three core elements, described in greater detail below. Developing a preventive practice model with these components allows for an opportunity to shift from compliance-driven case monitoring and provision of available services to evidence-driven case management that includes a comprehensive understanding of a family’s situation and provision of the

FIGURE 1. CORE ELEMENTS OF A PREVENTIVE PRACTICE MODEL



right services to meet their unique needs. Each component provides a foundation for the next. Evidence-based case management can promote stable and trusting relationships between caseworkers and families. Through these relationships, caseworkers can partner with families to begin to understand what changes in behavior may be needed to strengthen the family and prevent placement. Caseworkers can then support families in meeting their immediate and concrete needs through targeted services to reduce risk factors and enhance strengths and assets, or protective factors. Once a family's immediate and basic needs have been addressed, caseworkers can work with them to determine whether the family is able to successfully engage in and benefit from an evidence-based service or program, if needed.



Evidence-Based Case Management

Evidence-based case management serves as an anchor for family support in a preventive practice model. State child welfare agencies are often incentivized to integrate evidence-based programs into their service array without the time, resources or support to consider how these programs are coordinated with and connected to an evidence-based case management approach. Establishing evidence-based case management elevates and standardizes core casework practice and ensures that families receive both consistent preventive case management services and customized services based on their needs and goals. Case management

needs to be driven by evidence and guided by the same values, principles and underlying assumptions for change.

A focus on evidence-based case management also creates an opportunity to consider the types of strategies used with families, the evidence available to support those strategies and the contextual fit of strategies with the communities and families within the state or jurisdiction. Evidence-based case management practices can provide opportunities for authentic inclusion of families in decision making, which, in turn, enhances support and commitment to case planning implementation.⁴ Such practices also foster stable relationships between caseworkers and families and a context in which evidence-based programs and models can achieve their intended results. Additionally, embedding an evidence-based approach into frontline case management practice can elevate workers' capacity and sense of efficacy, thereby limiting staff turnover.⁵ Another important benefit of foundational evidence-based case management is that it can advance equity and inclusion by allowing jurisdictions to link families to relevant programming and interventions based on the culture and communities in which they live.

States can consider two approaches to selecting evidence-based case management. One option is to use an established model — for example, Family Connections or Solutions-Based Casework — that encompasses fundamental case management and preventive practices that have demonstrated evidence.

Alternatively, states can establish a suite of foundational evidence-based and evidence-informed practices using a common elements approach. For example, if specific assessment or engagement practices are commonly included as building blocks of evidence-based programs, these elements can be packaged by a state child welfare agency to inform a case management model built on the best available evidence. This approach should ensure that evidence-based treatment and support programs align with day-to-day practices case planners use when engaging with families and ensuring the ongoing coordination and delivery of prevention services. Core components of case management might include needs and strengths assessment, safety planning and monitoring, goal setting, ongoing support and coaching, family engagement, coordination of services and termination.⁶ Aligning evidence-based practices with day-to-day case planner activities creates an opportunity for general preventive case management services to be reimbursable under Family First. Evidence-based case management models must provide tailored and universal support to all families participating in preventive services.

Identifying case management as an evidence-based intervention has both service and fiscal implications. States will need to establish expectations for case management similar to those set for evidence-based programs (e.g., that they are supported by evidence, are well operationalized, have a fidelity assessment and support in place to ensure high-quality delivery, etc.). They must also consider how this conceptual shift may affect reimbursement.



Targeted Services to Address Risk and Protective Factors

As states seek to build protective factors, reduce risk factors and prevent adverse childhood experiences, they will need to support a targeted service array that ensures specific programs and practices are available to address different levels of risk factors, enhances protective factors and builds resilience for all families served through child welfare preventive services. States should also build the capacity of caseworkers to collaborate with families and effectively respond to family needs through more appropriate referrals that mitigate relevant risk and promote protective factors. Building a targeted services array — and the staff capacity to effectively use it — requires readiness and support at an organizational level.

The identification of targeted services to address the needs of children and families takes place at the family level and the agency level. Caseworkers must partner with families to engage in a thorough assessment to understand their needs, risk factors and protective factors. Developing this understanding empowers child welfare state agencies to 1) identify appropriate services already available in the system and ensure caseworkers and families can identify and access these services; 2) select and procure evidence-based and evidence-informed programs matched to specific needs that are not currently met through the current service array; and 3) form effective partnerships with other agencies and providers who are receiving referrals and delivering direct services to families. States

should disaggregate data and conduct analyses based on inquiry and research-driven questions to more precisely understand the risk and protective factors for specific subpopulations — and more effectively select, procure and implement evidence-based treatment models and evidence-based support services that align with those factors.

As an initial step in the development of a preventive practice model, states can consider whether and to what extent their services (case management, concrete support and clinical treatment) address varied levels of risk (low, moderate, high). The more likely services are to directly target risk factors for a family, the more likely they are to achieve positive change and enhance protective factors.^{7,8} This targeted focus assumes states have an adequate assessment and reassessment process in place to ascertain a family's hierarchy of needs and risk factors and match and sequence services and solutions accordingly. An evidence-based case management model can ensure that risk and protective factors are addressed through case management practices, concrete support (e.g., housing resources, economic support models, etc.) or coordinated evidence-based treatment models. In cases where state child welfare agencies need to add clinical treatment models or choose enhanced clinical services to address child and parent trauma, they may decide to train all clinicians in cognitive behavioral therapy (CBT, the basis for many treatment programs), or all case planners in motivational interviewing.



Evidence-Based Models

Once states have selected an approach to evidence-based case management and have a clear understanding of how services might be coordinated to target risk factors and enhance protective factors, they should establish an array of therapeutic and clinical treatment and support services that address the unique needs — and the geographical, cultural and linguistic characteristics — of their population.⁹ States need to consider choices that address a broad range of needs (behavioral health, trauma, mental health, substance abuse and parenting and parent well-being) and are also feasible to implement. With the preventive practice model as the structure in which all preventive services are coordinated, Family First provides an opportunity for states to develop a continuum of services and programs to support the safety, permanence and well-being of children and families. States must build capacity to access and use disaggregated data to examine the service needs of subgroups, with thoughtful consideration given to equity and risk factors. The continuum of services should be developed with these data in mind to effectively address the diverse needs of families and ensure both improved and equitable outcomes.

Similar to evidence-based case management, states have options in how they can organize their continuum of treatment and support services. One option is to select services based on the level of risk they address, ensuring the continuum includes services that address needs at all risk levels. Another option is to organize the continuum by

service type. More specifically, states can assess whether family support services and clinical treatments are offered across the four types of Family First services described in federal guidance: mental health programs; in-home, skill-based programs; substance abuse programs; and kinship navigator programs. While it is unlikely that there will be well-supported interventions that cover all of these areas, states can consider both evidence-based programs that are a good fit and community-defined evidence-based programs and practices not yet included in federal guidance. As an example of existing services and programs, states may select SafeCare[®] (in-home, parent skills based), Multisystemic Therapy (substance abuse), Trauma Systems Therapy (mental health) and/or the Children's Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (kinship navigator). In addition, states may use Team Decision Making to ensure families and their support networks are engaged in all decision-making processes,^{10,11} including those related to out-of-home placement and placement moves. States will also want to consider whether their continuum includes services for children, parents and families. For example, additional services may be needed to treat parental depression (such as interpersonal therapy), distinct from other family treatments.

Selection of services should include a fit and feasibility assessment to better understand 1) the level of evidence for the program or practice; 2) the extent to which the program or practice meets diverse population

needs; 3) the extent to which the program or practice is well defined; 4) the level of support and resources provided for the program or practice to be implemented with fidelity; 5) the capacity needed for the agency to sustain the model, including ongoing costs, partnerships with community service providers and workforce development; 6) family perception of need and the relevance of the intervention; and 7) the fit of the model with other services the agency is delivering and with the community's values, priorities, history and culture.

The use of a fit and feasibility assessment is even more critical in the context of a limited number of culturally relevant, evidence-informed programs available for selection. As state child welfare agencies assess the fit and feasibility of available services, they may decide that some child and family needs can be met through expanding culturally relevant and community-based services that may not currently be identified as evidence-based programs. In these cases, states should assess current levels of evidence for the selected services and develop plans to build evidence and further operationalize them to be scalable and sustainable. States will be given the opportunity to make a case for reimbursement for services that are a strong match for community needs and have documented available practice and research evidence. States may want to form research–practice partnerships with local universities to formally assess, build upon and improve community-defined evidence.

Leveraging Family First Through the Use of a Preventive Practice Model

The development and use of a preventive practice model is not a one-size-fits-all approach.¹² It requires states to thoroughly assess and think critically about leveraging Family First provisions to reinvent their preventive services to promote improved and equitable outcomes for children and families. The following sections outline additional considerations for states using Family First to reimagine and develop a system of care for children at risk of placement.

Determining Candidacy

Family First provides a new opportunity for states to claim federal reimbursement for services to prevent foster care, keeping children in their homes whenever safe and possible. To claim

federal reimbursement, states must deem a child to be a “candidate for foster care ... but for these services.”¹³ It is critically important that states define “candidacy” within the parameters of the law,¹⁴ which provides the foundation for expanding federally funded prevention services in a way that will best serve children and families.

Functionally defining candidacy is a challenging task. Given the historic lack of funding for meaningful primary prevention services and the desire to maximize federal funding as much as possible, states have often defined the term broadly in an effort to serve more families — but this can have unintended consequences, including expanding the number of families

coming into contact with the child welfare system and furthering structural and institutional racism.

In many communities, particularly low-income communities of color, policy and historic disinvestment have undermined family economic security and well-being.¹⁵ However, it is important not to deem children “candidates for foster care” based on broad community factors (e.g., zip code). Research demonstrates that the majority of children and families living in poverty never come to the attention of child welfare agencies and that designating children from certain communities as candidates would only widen racial disparities, including disparities in child welfare

TABLE 1. FUNDING SOURCES FOR CHILD WELFARE PREVENTION SERVICES

FUNDING SOURCE	PREVENTION SERVICES FUNDING CAN SUPPORT
Title IV-B Funding	Child welfare prevention; family preservation/reunification
Medicaid	Clinical and therapeutic models that support behavioral and mental health
Temporary Assistance for Needy Families (TANF)	Services that meet at least one of the main purposes of the TANF program, including helping children to be cared for in their own homes or with relatives
Social Services Block Grant (SSBG)	Commonly used by child welfare systems to fill gaps in other funding streams
Community-Based Child Abuse Prevention Grants (CBCAP)	Community-based child abuse and neglect prevention efforts
Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)	Evidence-based home-visiting models

system involvement.¹⁶ For example, an expansive definition of candidacy would increase the number of families on a prevention plan, and research findings show that surveillance and monitoring can push children and families involved with the child welfare system deeper into the system.¹⁷ To address gaps in prevention while not exacerbating structural and institutional racism, states should 1) responsibly define candidacy to prevent children at imminent risk of placement from entering foster care and 2) leverage the opportunity provided by Family First to develop a comprehensive prevention continuum.¹⁸

To responsibly serve “candidates for foster care” and their families, states must define candidates as those children who are at imminent risk of entering foster care but who can safely be served in their homes and communities. State agencies should identify appropriate populations by evaluating state and local data to understand the needs of children and families who are known to the child welfare system. This includes using data to understand the characteristics and trends of children currently entering foster care, including those who are short stayers (exiting foster care within 90 days of entering) and those who experience a subsequent

substantiated or indicated report of abuse or neglect after a previous referral was closed. States can then make informed and responsible decisions, defining candidacy and developing implementation of prevention services targeted to meet their needs.

Defining candidacy also has an important effect on a state’s ability to finance a comprehensive prevention continuum. Family First requires states to provide a state match to finance prevention services. As states expand their definition of candidacy, they will have to make decisions about where in their budget to reduce spending on other programs or activities. To avoid compounding or recreating historic disinvestment in low-income communities and communities of color, states must invest in a broader prevention continuum to promote primary prevention while also providing prevention services to families to avoid the need for foster care. This is a difficult balance and one that will look different in states across the country. Defining candidacy and understanding the context of historic disinvestment and structural racism will enable states to create a prevention continuum that promotes well-being for children and families of color.

Strategic Financing to Support a Preventive Practice Model

Although Family First gives states the option to support prevention services with Title IV-E funding, there are a number of requirements in Family First that limit how funds can be used.¹⁹ Making the most of this opportunity requires leaders to begin with a clear vision of their practice model and then develop a strategic financing plan for how Title IV-E and other prevention funding streams can be coordinated to support it. Without a clear vision of the practice model, the funding opportunity may drive development of services that are not well targeted to the needs of families, nor effective in reducing out-of-home placements.

Prevention services in child welfare have historically been supported by both dedicated funding streams administered by child welfare agencies and more general social service funding streams (see table 1). States and counties vary widely in whether they allocate more flexible federal funding streams toward prevention services as well as how much they invest state and local dollars.²⁰

FIGURE 2. COMPONENTS OF TITLE IV-E FUNDING

ADMINISTRATIVE	PREVENTION SERVICES	TRAINING
Proper and efficient administration of IV-E plan	Approved evidence-based services for “candidates” for foster care	Training necessary for proper and efficient administration of IV-E plan
Case management Referrals Assessment Data collection Quality assurance	Mental health Substance abuse Parent training	Eligibility determination Appropriate referrals Appropriate services provision Evaluation of appropriateness of services
50% federal match	2020–2026: 50% federal match 2027: Federal Medical Assistance Percentages (FMAP)	50% federal match

Family First’s addition of Title IV-E funding to the landscape is particularly significant because IV-E is an open-ended entitlement funding stream. This means that the federal funding is uncapped; the federal government will reimburse for all state and local spending on services that meet the requirements of the law. There are three main components of the IV-E funding program (see figure 2) that provide federal reimbursement for evidence-based prevention models, case management and the infrastructure to support quality implementation. While the appropriate financing strategy for a prevention practice model will be unique to the practice model and to the state and local policy and funding context, states should follow a general rule of first identifying which components of the practice model can be supported by more restricted funding streams (Title IV-E, Medicaid, MIECHV) and then filling in gaps with more flexible funding streams (IV-B, TANF, SSBG; see table 2).

The following are considerations relevant across states:

- Family First guidance specifies that Family First is the “payer of last resort”; if a prevention program is eligible for Medicaid funding under the state plan, Medicaid has to pay first. States should begin by identifying whether Medicaid will reimburse for any of the targeted services or evidence-based models included in their plan. If Medicaid can support a program and the program model is approved on the Title IV-E Prevention Services Clearinghouse, Title IV-E can fill in gaps for what Medicaid does not cover. For example, Title IV-E could support the program for families who are not eligible for Medicaid.
- Both Medicaid and Title IV-E are programs for which state and federal governments share responsibility for funding. States can only draw down federal Medicaid and IV-E dollars if they are willing to commit state and local funds to services. States that are unwilling or unable to allocate state or local dollars to prevention services will miss out on the opportunity to

leverage federal IV-E funds and will likely continue to rely on limited funding from federal block grants for services.

- Much of the focus on the opportunity in Family First has been on the ability to fund the IV-E prevention program models. Title IV-E administrative claiming and training funds also can offer critical support for fidelity monitoring, data collection and evaluation, training, assessment and referral systems, and the program administration and policy work needed to make program implementation successful. State agencies were able to make IV-E administrative claims to support case management for candidates for foster care prior to Family First; however, these claims were subject to a narrower definition of candidacy in federal policy and to IV-E foster care income eligibility requirements. Under Family First, states have greater flexibility in defining candidacy, and there is no income requirement for IV-E eligibility for prevention services. This means

TABLE 2. POTENTIAL FUNDING SOURCES FOR A PREVENTIVE PRACTICE MODEL

PRACTICE MODEL COMPONENT	POTENTIAL FUNDING
Evidence-based case management	State and local funds IV-E prevention services claiming if case management model on IV-E Clearinghouse IV-E administrative claiming if not approved model IV-E training claiming for training for case managers
Targeted services to address risk and protective factors	State and local funds Medicaid if service is eligible for Medicaid claiming under state plan IV-E prevention services claiming if service on IV-E Clearinghouse IV-B, SSBG, TANF (fill gaps)
Evidence-based models	State and local funds Medicaid if service is eligible for Medicaid claiming under state plan IV-E prevention services claiming if model on IV-E Clearinghouse IV-E training claiming to support training infrastructure for models MIECHV (coordination with public health on capacity building, infrastructure, referrals) IV-B, SSBG, TANF (fill gaps)

that a larger proportion of families and children receiving preventive services will be eligible for federal IV-E claiming and the relative share of federal versus state dollars supporting administrative functions should increase. In addition, federal guidance clarified that IV-E administrative funds can be used to support the evaluations of programs as the law requires, offering important new support for quality data collection and evaluation.

Developing an Aligned System

Development of a preventive practice model should be aligned with the vision, values and processes of the state child welfare agency, and child welfare leadership plays a critical role in ensuring such alignment. More specifically, distributed leadership throughout the state is essential to promoting buy-in and clarity about the vision and functions of a preventive services practice model. Developing a cohesive

preventive practice model requires explicit identification of core values and principles to guide the state child welfare agency's approach to working with families, partners and communities and intentional alignment of those guiding values and principles with services and support. For example, if a state identifies family voice and a focus on strengths as core values for their prevention approach, all services within their practice model should explicitly attend to family voice and employ a strengths-based approach.

In line with Family First, a preventive practice model and related services should be trauma informed, which involves understanding, recognizing and responding to the effects of trauma. It's also important for leadership to consider how and with whom evidence was developed, and whether demonstrated outcomes have been disaggregated to better understand the program's effectiveness for specific groups of

children and families, such as by race and ethnicity. These nuances are critical to understanding how well interventions fit the context in which they will operate and how well they are positioned to eliminate disparities and achieve positive and equitable outcomes for all children and families.

Leaders can also ensure their preventive practice model is aligned with other services and activities. For example, state child welfare agencies should consider the possibility of leveraging investigative services as enhancements to the preventive practice model. Bridging these services and connecting investigative services to preventive efforts can support the development of a strong case plan and ensure families experience a cohesive system with seamless transitions. For example, Signs of Safety® incorporates child voice into the assessment process to support development of a comprehensive and inclusive case plan. Motivational

interviewing and Team Decision Making are also examples of services that span from the investigative stage to the preventive casework with families. Motivational interviewing can help address a family's ambivalence toward treatment, and Team Decision Making can support family voice and inclusion in decision making.

Ensuring Family Voice

Family First is based on the premise that keeping children safe with their families avoids the trauma of family separation and involvement in foster care. The legislation also promotes family care for children who can no longer safely remain in their homes. Prioritizing family voice is central to the work of strengthening and promoting stability in families. This includes incorporating the perspectives of children, youth, caregivers and extended family in decision making at both the individual case level and the leadership and systems levels.

The development of a preventive service practice model must authentically include family voice. States should not only examine their child welfare data to identify universal and population-specific needs and potential services and models, but also incorporate the perspectives of children, families and foster parents in understanding and interpreting needs as well as exploring and selecting potential services and models. In accordance with equitable practices, parents and foster parents should be compensated for their time and effort to support the redesign of preventive services based on Family First. Additionally, at the direct services level, child and family voice should drive the development of a case plan and the provision of supportive services and evidence-based models. Family

voice should be included at the earliest stages of decision making and at critical junctures such as potential out-of-home placements for high-risk children and youth. Evidence-based practices such as Team Decision Making can be used to ensure the inclusion of family voice in all decisions.

Supporting Effective Practice

The development of a preventive practice model that is focused on behavioral change improves a caseworker's ability to engage with a family because the focus of work with a family is centered on change, stability and support. The caseworker's behavior toward a family can significantly increase the likelihood of developing a positive relationship.²¹ Ensuring that family goals and case activities are driven by the family builds rapport, promotes the effectiveness of practice and will build better outcomes for families beyond their involvement with child welfare.

Supporting effective practice requires the visible infrastructure to develop and ensure staff competency. Available implementation infrastructure for established evidence-based models can vary. States should consider a service or model's fit with their local context; their availability to develop the competency and capacity of their child welfare workforce to meet the demands of evidence-based practice and facilitate data use, communication and stakeholder engagement; and the service or model's alignment with policy and fiscal environments. Jurisdictions also will need capacity to support continuous learning and improvement as well as authentic stakeholder engagement to appropriately adapt models to address disparities.

Conclusion

The Family First Act offers an opportunity for states to reimagine their approach to child welfare. As states move forward with implementing the law, this brief provides guidance for developing an effective and aligned approach to preventive services that benefits families and children at risk of placement. Preventing children from entering foster care requires a systemic approach: expanding, sustaining and continuously improving practices; carefully considering candidacy for foster care; and aligning financing, infrastructure and family engagement. By involving families in decisions about their own lives and using what works, states can create lasting mechanisms that strengthen families and communities and improve their young citizens' ability to thrive.

Appendix: Case Examples

The following examples are intended to illustrate how jurisdictions can integrate core concepts outlined in this paper into their child welfare practice to improve outcomes for children and families. Each example is based on experiences of child welfare agencies and highlights at least one of the three elements of the preventive practice model: evidence-based case management, targeted services to address risk and protective factors and evidence-based models.

Evidence-Based Case Management

This example highlights how a state can invest in an evidence-based case management model and shift from a compliance-focused approach to one focused on behavioral change and protective capacities.

This small state identified an opportunity to re-envision its continuum of prevention services to better meet the needs of children and families. An assessment of its system also highlighted the need to better serve specific groups such as teens with behavioral challenges and parents with substance abuse issues, as well as a need for improved case management practices that defined roles, responsibilities and workload. The state defined case management to include:

1. working with the family to develop a family service plan (family team meetings);
2. helping the family connect to needed services (referrals, assistance at appointments);

3. aiding the family in accessing services (transportation planning and support);
4. assessing the parents' protective capacities and behavior changes over time; and
5. monitoring the child's safety and addressing any new safety or risk concerns.

In this state, caseworkers from both the public state child welfare agency and nonprofit contractors were responsible for several of these tasks. With a belief that high-quality case management should be considered a prevention service that contributes to better outcomes for families, the state agency set out to clearly define the roles and responsibilities of each of these workers, shift to a more proactive, supportive approach in working with families and ensure caseworkers used effective and consistent strategies to help families achieve service goals.

The state identified Solution-Based Casework™ (SBC) as a statewide evidence-based model of case management to help caseworkers partner with the family to identify their strengths and build the skills necessary to support the safety and well-being of their children. All children receiving in-home prevention services through the state would be assigned a caseworker trained in SBC's evidence-based case management approach. In addition, when needed, children and families would also be referred to other specialized services, including evidence-based interventions like SafeCare.

Targeted Services to Address Risk and Protective Factors

This example highlights how a small state strengthened its screening and assessment process and established a targeted service array and approach to meet the goals and needs of a particular subgroup of children and families.

To reduce the number of older youth entering foster care for the first time due to escalating conflict with parents, this state designed a differential response approach to include a two-tiered investigative track for teens referred to its hotline. Reports that did meet statutory requirements continued through the traditional investigative track. Reports that did not meet the statutory requirements instead received a family assessment to connect families to targeted community-based services.

Family assessment consists of a rapid response to reports of issues with teens, with families being contacted by phone within 24 hours. All families are assessed for safety and risk, and a variety of other tools are used to assess the youth's and the family's needs. Families who do not have outstanding safety threats or risk factors may have their cases closed while others are assigned to one of two levels for ongoing prevention services:

- Level I: Crisis intervention. Children and families are assigned to a community-based program, which provides short-term crisis intervention, conflict resolution assistance and referrals to other services.

- Level II: Functional Family Therapy. About 20% of families are referred to this evidence-based program, which provides a three-stage, intensive counseling approach.

The program provides a rapid, flexible response aimed at de-escalating family conflict and then building therapeutic wraparound services. A return-on-investment analysis concluded that within the first two years of implementation, the focus on assessment and intervention saved more than the program cost.

Evidence-Based Models

This example highlights the work of a large urban child welfare system to conduct a thorough needs assessment; consider the fit, feasibility and context of potential programs; and develop a core set of evidence-informed prevention programs.

This agency identified the need to develop a continuum of evidence-based preventive services better tailored to families' needs to reduce the likelihood of children coming into care. At the time, the child welfare system was serving approximately 20,000 families each year in preventive services. In identifying evidence-based and evidence-informed models, the following goals were established to improve outcomes:

- improving family functioning and well-being;
- reducing repeat maltreatment; and
- preventing placement in foster care.

The agency developed a strong teaming structure to build its internal capacity and the external capacity of providers to support this work. Through an in-depth needs assessment that considered need, fit, context and feasibility, the agency identified more than 10 evidence-based and evidence-informed practice models to integrate into a continuum of preventive services. The selected models offered a diverse array of services that allowed the agency to categorize models by the level of risk and the specialized service needs they addressed.

The agency then created a tool to help workers responsible for making referrals to prevention services determine which type of program best fit the family's needs and level of risk. The tool used the worker's assessment findings and family characteristics such as child age to match the family to a specific evidence-based model that fit with the family's needs and was located in their community. Once the referral was made, the provider had the opportunity to accept or refuse the referral, based on the provider's determination of whether the referral met the criteria for their evidence-based program.

The agency continued to deliver preventive case management services alongside or within the evidence-based interventions being provided to families. The agency and its providers partnered closely to integrate and align case management tasks with evidence-based interventions and developed logic models for each model to help communicate how each of the interventions addressed safety and risk.

Endnotes

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- 13 The Family First Prevention Services Act of 2018, Pub. L. No. 115–123. Retrieved from <https://cssp.org/wp-content/uploads/2018/10/Family-First-Prevention-Services-Act-of-2018.pdf>
- 14 Pregnant and parenting youth in foster care are eligible to receive these prevention services without their children needing to be deemed candidates for foster care.
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- 19 A detailed description of the fiscal requirements and considerations for Family First is beyond the scope of this paper. For additional information, please refer to the following webinar delivered as part of the Annie E. Casey Foundation’s Leading With Evidence series: *Planning for Family First Prevention Services: Three Key Fiscal Elements to Consider*. The webinar provides additional background information as well as handouts focused on fiscal considerations.
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