MDHHS

Michigan Department of Health & Human Services

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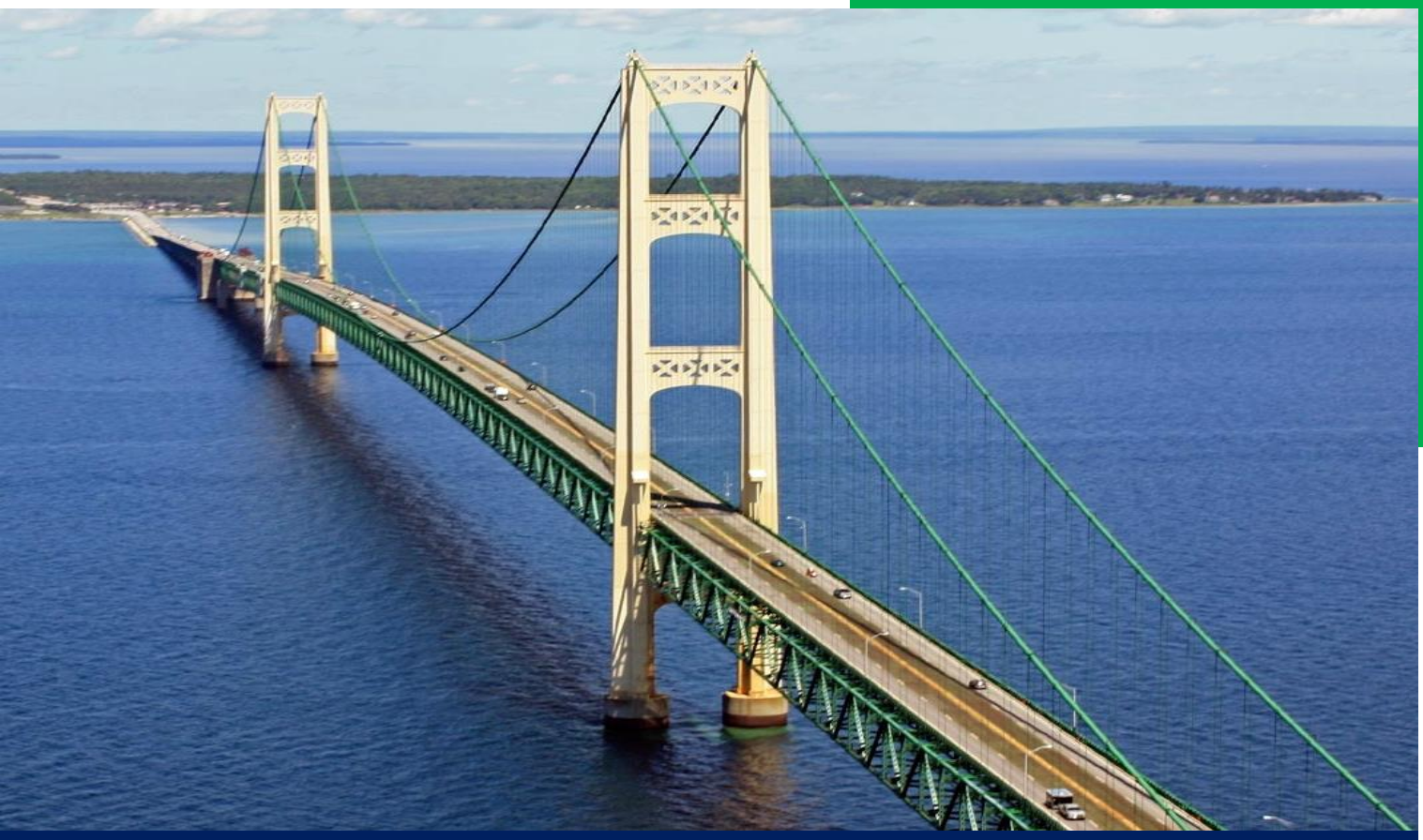

Michigan Title IV-E Prevention Plan

Submission August 2021

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Section I: Introduction

Child Welfare Vision for Transformation and Prevention of Child Abuse and Neglect

Michigan Department of Health and Human Services (MDHHS) in collaboration with youth and parents with lived experience, community organizations, legal and judicial partners, service providers, tribal partners, and other public human-service agencies, have embraced a bold vision for a 21st century children's services system oriented around prevention of abuse or neglect, family well-being and race equity.

MDHHS's goal is to build an equitable and just children's services system that effectively serves and supports children and families by building protective capacities and promoting family stability and well-being. MDHHS aims to create a robust array of preventive services that families facing adversity can access within their communities to meet their needs and maintain safe and loving homes for their children while preventing the occurrence of abuse or neglect. To achieve this goal, MDHHS will develop and sustain collaborative relationships between MDHHS and service providers that are built on a foundation of transparent communication, shared understanding about the roles and capacities of one another, and a joint commitment to positive outcomes for families. MDHHS and its partners will identify, transparently acknowledge, and dismantle the inherent bias, institutional and systemic racism that are present throughout the children's services system. Furthermore, MDHHS and its partners will work together to conceptualize and implement a transformed, anti-racist family-serving system that nurtures and supports all families and communities.

Our work will extend beyond "reasonable" efforts to prevent removal, creating a more adaptive, proactive system that destigmatizes asking for help while promoting and encouraging families to self-identify and easily access concrete supports. MDHHS cannot do this work alone. The family voice is at the center of all work. MDHHS will strive for the development and sustainability of robust, localized service arrays that are representative of the needs and priorities of unique communities and empowering family voice. Creating a continuum of services that is accessible to families in a more seamless, coordinated, and easy-to-navigate manner is critical to the foundation for our enhanced system. Ultimately, our goal is to achieve an innovative systems reform so that most of the funding becomes dedicated to prevention and family preservation services rather than foster care. This redesign of our system and approach will ensure that poverty alone is not a driver of families coming to the attention of children's services or the reason children are separated from their parents. Relatedly, empowering families through increased quality legal representation and advocacy is of critical importance to our successful redesign.

When formal contact with the children's services system is warranted, MDHHS strives to make the first call the last call, resulting in appropriate, culturally responsive, and meaningful assessments and interventions to ensure child safety and address

preconditions for abuse or neglect. MDHHS aims to build and nurture a workforce that operates from a strength-based perspective, innately values the families with whom they engage, and prioritizes keeping families together whenever possible. When removal is necessary, MDHHS prioritizes family and kin caregivers and acknowledges that foster care or kinship placement should be temporary, caregivers should be supported, and appropriate services should be provided to promote timely and sustainable permanency. Above all, MDHHS is committed to creating a children's services system that respects and affirms families of all backgrounds, does not cause further trauma, and ensures that children and families are better off because of the care and services they received.

Overview of System Transformation Efforts

Child safety is the top priority for MDHHS. MDHHS believes the best way to keep children safe is to provide meaningful, timely, and effective services and supports to families experiencing challenges. When such services are provided, fewer children will experience initial or recurrent abuse/neglect and entry into foster care. To achieve this vision, MDHHS intends to significantly change the way our child welfare system responds to suspected abuse/neglect beginning with receipt of the initial intake referral through completion of the CPS investigation. MDHHS is dedicated to ensuring families who encounter the child welfare system experience meaningful supportive services and develop relationships that will help them keep their children safe and improve family well-being. Implementing this Prevention Plan is critical to our ability to achieve these transformation goals.

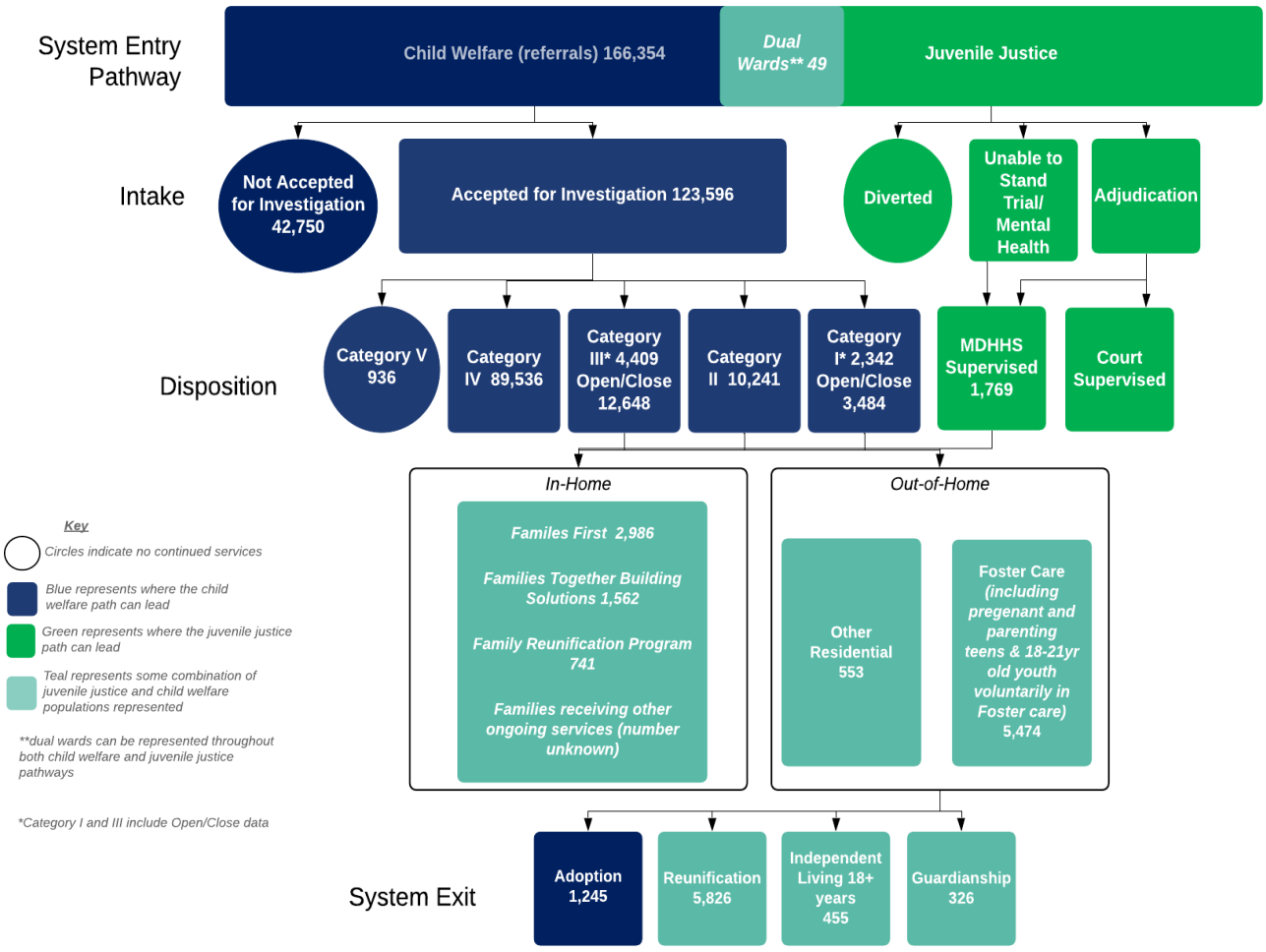
This shift in approach will require increased funds to prevent abuse/neglect and preserve families. Historically, Michigan has spent disproportionately more on removal and placement of children into foster care compared with funds spent on prevention services for families to keep children safe at home. For example, in fiscal year (FY) 2020, Michigan spent over two-hundred million dollars in foster care maintenance and administrative costs from State Ward Board and Care and title IV-E funds and just over twenty-eight million dollars on family preservation and prevention services.

Figure 1 depicts the opportunity that Michigan has to change the trajectory and improve the outcomes for children and families.

Figure 1. Outcome Measures FY2019 and FY2020

	2019	2020
Cases Assigned for Investigation	96,097	70,057
Confirmed Victims of Abuse/neglect	35,725	27,837
Rate of Recurrence	10.83	11.33
Child Removals	5,763	4,425
Percent of Children Discharged to permanency within 12 months (National Performance 42.7%)	27.27%	27.48%

Figure 2. Child Welfare and Juvenile Justice Pathways FY2018



By fiscal year 2022, MDHHS aims to 1) significantly reduce the number of children who experience abuse/neglect and 2) reduce the foster care population to under 10,000. To achieve these targets, Michigan plans to implement strategies to reduce entry into care as well as strategies to speed time to reunification. Strategies implemented will include high quality assessments and service linkages to strengthen families and only leverage foster care when it is necessary. For a comprehensive overview of the department's current initiatives, please see Appendix A. Following are five notable strategies planned or underway.

Please note that throughout the document caseworker refers to individuals working with families in public and private agencies in the areas of prevention, in-home, adoption/guardianship, and foster care.

1. Front End System Redesign

The Children's Services Agency (CSA) will continue making improvements to help keep children and youth safe in their own communities by establishing a system rooted in family well-being, prevention, and equity. Efforts will continue to be made to engage MDHHS staff, caseworkers, community partners, and other key stakeholders in the development and/or utilization of new tools and services to address family needs prior to coming to the attention of Michigan's child welfare system. For circumstances that require further intervention by the department, MDHHS must ensure the response is appropriate, timely, and family-centered. This includes a dedicated focus on addressing implicit bias and disproportionality throughout the continuum of child welfare.

To help ensure that decision making is equitable and consistent, CSA has partnered with Evident Change (formally NCCD, the National Council on Crime & Delinquency and Children's Research Center) and ideas42 to develop a Structured Decision Making (SDM) tool for Michigan's Centralized Intake (CI) staff utilization. MDHHS CI is tasked with receiving, reviewing, and assessing statewide child abuse and neglect complaints in Michigan pursuant to state and federal child protection and welfare laws. The workflow of the assessment will help ensure that caseworkers are making consistent decisions throughout the intake process. The tool will help keep children with their families whenever possible, ensure families are treated fairly, reduce repeat system involvement, reduce racial disproportionality, and reduce the trauma experienced by families who do not require system involvement.

While a final tool is expected in the fall of 2021, full implementation of the tool, including tool automation and training, is expected by March 2022.

In addition to the development of a new SDM tool for Centralized Intake, CSA has partnered with Evident Change to develop new safety and risk assessment tools for Michigan's children's protective services (CPS) program. Safety and risk assessment tools are used by caseworkers to assess child safety and to help determine the likelihood of future system involvement. The development of new tools will help ensure equity, consistency, and accuracy in decision making and service provision. Initial analysis around the current use of the safety and risk assessment is complete, with analysis around the use of the risk reassessment currently underway. Initial recommendations provided to the department and will be explored further over the next several months within the new structure of the MDHHS CSA In-Home Services Bureau.

2. Family First Prevention Services Act to Expand Evidence-Based Prevention Services

Family First Prevention Services Act (Family First) has served as a catalyst for partnership between the MDHHS Public Health Administration and the Michigan Department of Education to expand availability and access to effective home visitation services for families encountering the child welfare system. These services include programs such as Nurse-Family Partnership, Healthy Families America, and Parents as Teachers. MDHHS CSA and Family Preservation caseworkers have joined several home visitation workgroups to further increase agency collaboration to expand home visitation services to meet the needs of the child welfare population. To further support this effort, MDHHS received a significant budget enhancement of two-hundred and twenty-five million dollars for fiscal year 2021 that supports expansion of secondary prevention services and is expected to serve an additional 500 families at imminent risk of having a child enter foster care in this first year. Further expansion of prevention services will be targeted to support families who would have been eligible for ongoing services based on the data analysis completed by Chapin Hall outlined below.

CSA partnered with Chapin Hall at the University of Chicago to better understand the population of families with children at risk for entering foster care, including the prevalence of risk factors that could be addressed through targeted and expanded access to prevention services. The administrative data analysis informed the types of services needed most to prevent entry into foster care, the geographical locations of greatest need, and demographic characteristics of children most at risk for entry.

Descriptive analysis of Michigan data by Chapin Hall indicated that while entries into foster care decreased between January 2016 and December 2019, repeat investigations during the same time period increased, and children experiencing repeat investigations increasingly entered foster care. Children ages six and younger had the highest rates of entry into care, repeated investigations, and subsequent entry after investigations compared to other ages.

Michigan specific data analysis completed by Chapin Hall also indicated the priority target populations to consider for evidence-based prevention programming in Michigan include:

- Families with children under six years old,
- Families with teenagers (particularly 14 – 17-year-old youth), and
- Pregnant and parenting youth.

Known risk factors for child welfare involvement in Michigan for this target population include:

- Parental and youth substance-use,
- Parent and child mental health,
- Domestic violence, and
- Parents in need of supportive parenting skills development.

MDHHS utilizes informal processes to refer families that may benefit from community-based prevention services/support when a report is screened out through Centralized Intake. When a referral does not meet criteria for assignment and the intake worker identifies concerns, a family is connected to a prevention specialist, where available, for further support and connection to community-based services. Community-based services can include but are not limited to services funded by Children's Trust Fund (CTF), Promoting Safe and Stable Families, and Temporary Assistance for Needy Families (TANF). During the front-end redesign efforts, MDHHS plans to build capacity and develop a formal process to provide families with support when the family could benefit from prevention services. In partnership with CTF, MDHHS will utilize data collected from the processes above to ensure that families with challenges can access all types of services along the prevention continuum. The data-informed collaboration will inform which communities need to establish, strengthen, or support programs such as Family Resource Centers.

MDHHS submitted two FY 2022 Proposals for Change Initiative plans to the legislature that will increase evidence-based programming services under the Family First Implementation including a specific appropriation for additional expansion of evidence-based home visiting (EBHV) and service navigation for substance exposed infants and their families.

- EBHV $7,400,000
- Family First Prevention Services Implementation $3,500,000

Evidence-Based Home Visiting (EBHV)

Parental substance abuse is a factor in approximately 1 out of 3 child protective services cases confirmed for child abuse/neglect in Michigan. Infants and young children are at a higher risk of abuse and neglect due to parental substance abuse and enter foster care at the highest rates across age groups.

Home visiting is available but not always utilized by families with multiple risk factors and challenges. In addition to increasing EBHV slots by 1,000, this budgetary allocation will establish 20 Peer Service Navigator positions to facilitate early identification and connection of eligible families to evidence-based home visiting and other services. This coordinated effort will start as pilot programs in urban and rural areas based on need and data analyses with intentional leveraging of existing home-visiting partnerships and the medical community. A MDHHS caseworker position will also be established to make candidacy determinations and support community-based work facilitating access to prevention services without formal engagement with the child protective services system. For more information on specific EBHV program implementation (see Section III).

3. Converting Families First of Michigan to an Evidence-Based Model

In 2019, MDHHS devoted sixteen million and five-hundred thousand dollars (TANF) to its Families First of Michigan (FFM) preservation contracted services, serving approximately 3,000 families at intensive risk of removal in all 83 counties. The program was designed after, but does not fully adhere to, the HOMEBUILDERS model (outlined further in Section III). MDHHS completed a comprehensive comparison of the two models and is working towards converting several of the current FFM contracts to align with the HOMEBUILDERS model. It is anticipated that this change will improve family outcomes, including rate of intact families 12 months following service provision; and it will allow eligibility for title IV-E reimbursement as an evidence-based prevention service.

4. Overhaul Training and Workforce Supports

MDHHS has formed a partnership with approximately 15 Michigan universities to develop and implement a plan to improve child welfare training and workforce recruitment, training, and retention. Recruiting, preparing, and retaining highly skilled caseworkers is critical to consistent practice and excellent decision making needed to assure children are protected and families remain intact, whenever possible.

Three workgroups are currently in place to focus on enhancement of child welfare recruitment, training, and retention. Each workgroup is co-chaired by an MDHHS staff member and a university representative. Participants include MDHHS Children's Services Agency, MDHHS Office of Workforce Development and Training (OWDT), contracted private agencies, the State Court Administrative Office (SCAO), and the Office of Children's Ombudsman. The three workgroups and their areas of focus include:

Pre-Hire/Recruitment. Create a robust internship program giving consideration to stipends; and analyze and enhance child welfare certificate programs.

Pre-Service Institute/New Worker Training. Explore feasibility of university consortium-type model for training by researching what other states have done and what might work best in Michigan.

Post-Training Support/Retention. Explore the role of mentors and structure for provision of post-training support; and explore possibility of tuition reimbursement for master's level programs in child welfare.

5. Incorporating the Use of Evidence-Based Risk Assessment

MDHHS integrated the Michigan Juvenile Justice Assessment System for juvenile justice youth at risk of placement into foster care or returning home from foster care to prevent unnecessary placement into congregate care and to enhance early release from congregate care. The assessment system helps to keep the youth and community members safe. The statewide MDHHS juvenile justice assignment unit assists providers and local office staff with identifying youth who may be serviced within the community in an in-home family setting with additional community-based services and supports.

Partnership with Tribal Representatives

MDHHS respects its government-to-government partnership with Michigan's twelve sovereign tribes. Tribal governments were identified as part of the core Family First Leadership structure. Specific collaborative governance opportunities to learn about Family First and engage in the development of the prevention plan were open to all tribes regardless of workgroup membership. The Tribal Family First Prevention Workgroup instituted to represent tribal interests in the development of the prevention plan and implementation of culturally appropriate prevention services within tribal communities. A Family First overview presentation was provided to tribes exploring implications and providing opportunity for discussion, and engagement in planning of efforts including contributions to iterations of the plan over time. Any modifications to existing agreements between MDHHS and the tribes will be carefully considered in collaboration to fully engage and further support tribal interests in Family First implementation efforts.

Stakeholder Engagement

In active pursuit of the transformational vision of a 21st Century children's services system, Michigan has embarked on Family First implementation in an intentional and collaborative partnership with internal and external stakeholders. A governance structure was developed in partnership with stakeholders to guide the development and implementation of a comprehensive five-year prevention services plan.

At the center of Michigan's governance structure is leadership from tribal governments, the Child Welfare Partnership Council (CWPC), and Michigan's Department of Health and Human Services (MDHHS). The implementation team consists of a Family First steering committee, Tribal Family First Prevention Workgroup, Court Workgroup, and a Prevention Workgroup consisting of four subcommittees of 1) case practice, 2) service array, 3) workforce, and 4) continuous quality improvement (CQI) and evaluation. The process involves participation from tribal representatives, Business Service Center (BSC) leadership, frontline caseworkers, providers, those with lived experience,

and other workgroups. Parent representatives from the Guy Thompson Parent Advisory Council have been integral to the workgroup efforts.

Inclusive to the efforts outlined above, MDHHS has engaged and collaborated with a myriad of statewide entities and national experts to transform Michigan's child welfare system to one that better protects children by effectively serving families prior to involvement in the foster care system. Public Consulting Group (PCG) assisted MDHHS in conducting listening sessions across the state in 2018 to educate critical stakeholders and gather feedback about how Family First could best be leveraged to provide the greatest benefit to children and families across the state. In early 2019, MDHHS in partnership with Casey Family Programs hosted a Legislative Reception to share pertinent information and plans for Family First implementation with Michigan's state legislators.

Town halls and listening circles were held statewide with public and private child welfare stakeholders from June-August 2020. Participants were able to hear from the Children's Services Agency executive director, as well as caseworkers, parents, and youth with system involvement. The vision towards a prevention-based system was shared and widely embraced by stakeholders to promote the best possible outcomes for children and families. Additional public input identifying the need to ease and facilitate access to services, and expand EBHV services, was drawn from the Needs Assessments for the Pritzker Children's Initiative Planning Grant, the Preschool Development Grant Birth through Five, and the Maternal, Infant and Early Childhood Home Visiting grant.

MDHHS also repurposed an existing statewide steering committee called the Child Welfare Partnership Council (CWPC) to specifically guide the work of Family First implementation in Michigan, including development of a shared understanding of Family First and opportunities to further Michigan's child welfare system transformation. This group meets at least every other month to review progress and inform key implementation activities. Membership on the Council includes all relevant stakeholders to successfully implement Family First, including MDHHS, MDHHS Budget, Chapin Hall, Westat, tribal governments, the State Court Administrative Office, the Department of Technology, Management and Budget, MDHHS Children's Trust Fund, legislative staff, and representatives from several of Michigan's contracted private agency providers.

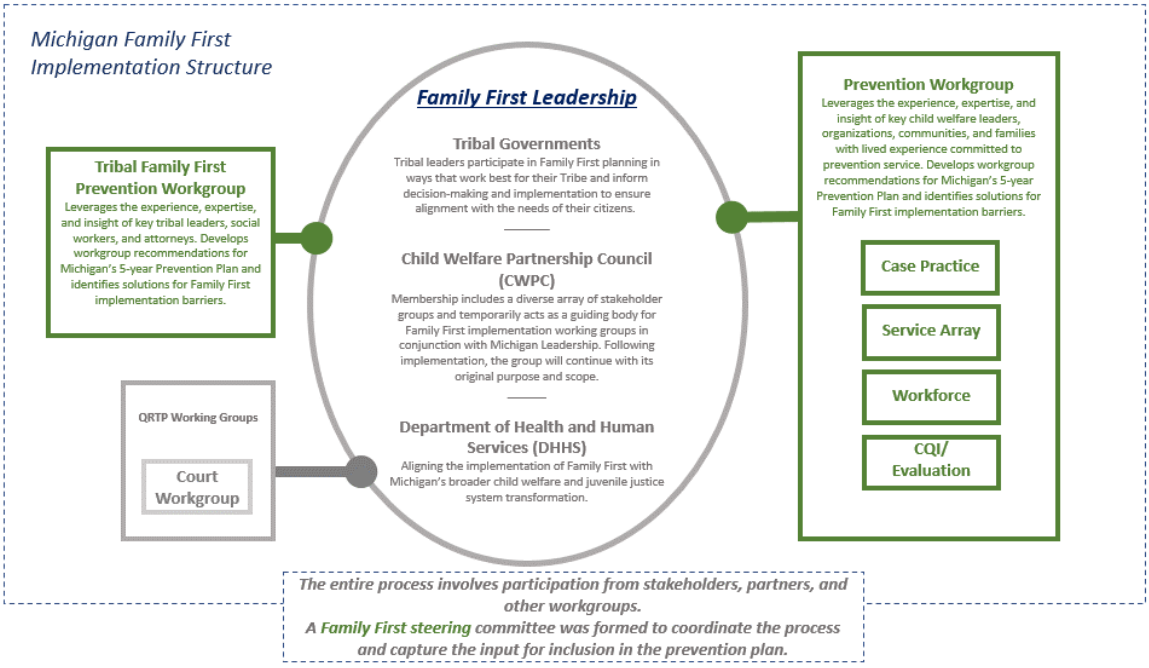
Michigan's commitment to build a system that identifies and connects families to the supports and services to strengthen, and thus prevent unnecessary involvement with the child welfare agency, is evident in its collaboration with valued community stakeholders. This commitment embeds concrete efforts to strengthen and enhance capacity of prevention programs at all levels including primary and secondary (see Appendix B for Michigan's definitions of primary, secondary, and tertiary prevention). This vision is promoted through long standing partnerships with integral stakeholders such as Children's Trust Fund (CTF)/Prevent Child Abuse Michigan, the state lead of Prevent Child Abuse America, to strategically leverage various funding sources such as

Community-Based Child Abuse Prevention (CBCAP) grants, Title IV-B, and title IV-E prevention service dollars to enhance a system infrastructure that builds out a robust prevention services continuum.

Primary and secondary prevention programs supported by CTF across the state reach an array of children and their families through parenting education programs, including but not limited to Strengthening Families Parent Cafés, Infant and Toddler Learning Communities, and various home visiting programs – some with a specific focus on supporting fathers. Each of the primary and secondary prevention programs are embedded in communities across the state to build upon a continuum of support creating a ladder of stability for families. Their strong collaborative efforts, including a strengths-based approach utilizing the Strengthening Families and the Protective Factors Framework, foster a strong foundation of support and guidance for families. CTF funded programs are currently reaching the priority populations determined by the target population data analysis.

CTF prevention programming ranges from personal safety, as well as child sexual abuse prevention curricula for children ages 3 to 18 to support/education, for all families in the community. With this focus on universal services available for all families (primary) as well as those who are at risk for abuse and neglect (secondary), CTF provides a community pathway to success that our families deserve when working with the child well-being system. Together with CSA, CTF will strengthen existing and expand to new service areas to ensure all families in Michigan can be stronger and more resilient, thus enabling the safety and well-being of every child.

Figure 3. Family First Governance Structure



Section II: Eligibility and Candidacy Identification

Pre-print section 9

Family First specifies two populations who may receive title IV-E prevention services:

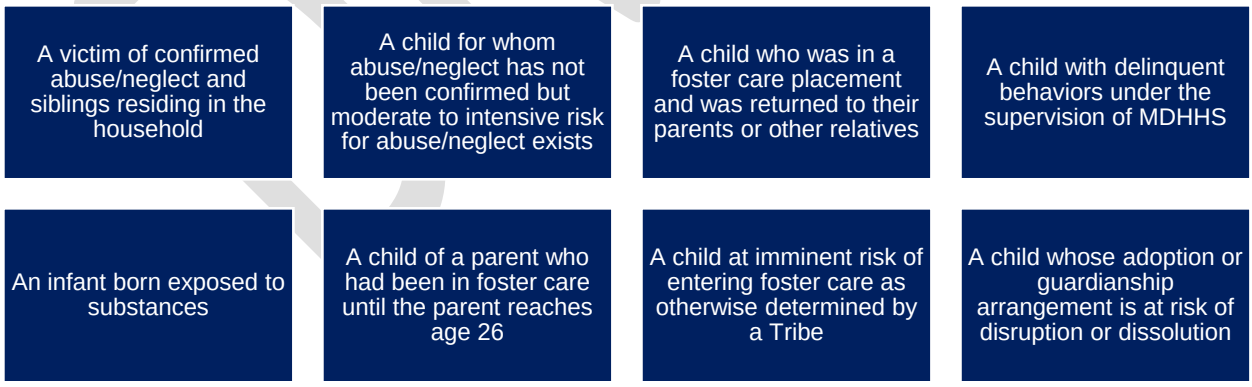
- *A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1).*
- *A child in foster care who is pregnant or parenting.*

Family First also allows for parents or kin caregivers of the above populations to receive title IV-E prevention services.

Prevention Candidate Definition

MDHHS defines 'candidate for foster care' as a child who is identified as being at imminent risk of entering foster care but who can remain safely in the home or with a relative if evidence-based services or programs to prevent the entry of the child into foster care are provided. All candidate definitions include siblings residing in the household or within partial care or custody of a parent to a child determined to be a candidate for foster care. A child-specific prevention plan will be developed for each sibling determined to be a candidate for foster care. Figure 4 shows the populations included in Michigan's Family First candidacy definition.

Figure 4. Family First candidacy populations



Candidacy Eligibility Determination and Documentation

A victim of confirmed abuse/neglect and siblings residing in the household

A caseworker will determine eligibility for a child who is a victim of confirmed abuse/neglect and any siblings residing in the household who meet the criteria of being at imminent risk of entering foster care using the Structured Decision Making (SDM) risk assessment tool. The child is eligible if there is a preponderance of evidence of abuse or neglect, the child remains in the home, and the risk assessment yields a score of moderate to intensive. This eligibility determination will be documented in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) prior to transferring the case to a caseworker who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process).

A strength-based collaborative Family Team Meeting (FTM), or similar meeting, will be held as part of the case transfer process from the investigative to the in-home services caseworker involved in developing the child-specific prevention plan development (meeting inclusive of family members, familial or community supports, representatives from the child's tribe, investigative and in-home services caseworkers. In-home service provision includes formal and informal risk assessments within the first 60 days and every 90 days thereafter utilizing the Family Needs and Strengths Assessment (FANS) and Child Needs and Strengths Assessment (CANS) tools along with SDM safety assessment tools.

A child for whom abuse/neglect has not been confirmed but moderate to intensive risk for abuse/neglect exists

A caseworker will determine eligibility for a child and any siblings residing in the same household, or in the partial care or custody of a parent to a child that is a candidate for foster care, using the SDM risk assessment. The child is eligible if the investigation is denied, and the risk assessment yields a score of moderate to intensive. Although Michigan does not assign a caseworker if abuse/neglect was not confirmed, MDHHS plans to pilot programs to expand involvement with community partners to provide title IV-E prevention services to those families that may need services to prevent the risk of a child entering foster care. The eligibility determination will be documented in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) prior to transferring the case to a caseworker or a contracted agency who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process). These services are voluntary and will be coordinated in partnership with the

family. Potential pilot counties are yet to be determined and will consist of specific target population and programmatic data analysis. Programs and relevant staff under consideration include Brilliant Detroit, Pathways to Potential (P2P) specialist, and prevention caseworkers or prevention monitors.

Infant born exposed to substances

An infant born exposed to substances may come to the attention of MDHHS when exposure to substances and other risk factors exist and may be determined eligible based on the above pathways of confirmed abuse/neglect or at risk of abuse/neglect. However, Michigan intends to expand their prevention services to a broader array of families than just those who come to the attention of the department. MDHHS plans to engage hospitals and community partners in the identification of a child who is at risk of entering foster care due to being born substance exposed without additional risk factors but may not yet meet the requirements to make a report to Centralized Intake. Peer Service Navigators will be established to liaise with the family, hospital or other community partners, and a caseworker determining candidacy eligibility at MDHHS to assess need, determine eligibility, and arrange service delivery. This coordinated effort will start as pilot programs with prioritization given to urban and rural areas based on prevalence of need using data analyses with intentional leveraging of existing home-visiting partnerships and the medical community.

A child who was in a foster care placement and was returned to their parents or other relative

A caseworker will determine eligibility of a child(ren) who was returned to their parents following foster care placement. Prior to recommending reunification to the court of jurisdiction, the caseworker completes the FANS assessment to identify service needs for the family. After the family has made at least partial progress rectifying the issues that led to the child's removal, an SDM safety assessment is completed to determine if the child would be safe, safe with services, or unsafe if returned to the parental home. Upon a safety assessment result of safe or safe with services, the caseworker must recommend that the court of jurisdiction order return of the child to the parent(s). The most recently completed SDM safety assessment will be used by the caseworker to support the identification of imminent risk of return to foster care placement and identify the protective interventions necessary to ensure the child's safety upon return to the parent(s).

A family team meeting (FTM) is held prior to a child's return home to identify necessary supports and coordinate service delivery. FTMs include the family, their identified formal and informal supports, members of the judicial community including parent and child attorneys, tribal community, and agency caseworkers. The FTM participants collaborate in a proactive, strength-based solution-focused approach to develop a thorough reunification plan that supports successful reunification. The caseworker explores service availability utilizing the Evidence-Based Practice (EBP) selection document (to be developed) that would best meet the family's needs. After developing the child-specific prevention plan with the family, the caseworker will document the plan, make any necessary service referrals, and provide ongoing case management to monitor the child's safety and the family's benefit from referred services.

A child with delinquent behaviors under the supervision of MDHHS

A MDHHS juvenile justice specialist will determine eligibility for a youth who came to the attention of MDHHS through the juvenile court. After referral of a youth from the court, MDHHS and the court complete a staffing meeting to determine fit for prevention services with the department. If the youth is eligible or enrolled in a federally recognized tribe and is charged with a status offense, the tribe should be notified and invited to participate in the staffing meeting. Upon assignment of a juvenile justice specialist, a Michigan Juvenile Justice Assessment System (MJJAS) and Juvenile Justice Strengths and Needs assessment are completed with the youth and family to identify strengths, needs, family supports, screen for trauma, and determine whether the child can remain in the community safely with the prevention services in place. At the time of completion of this assessment tool, the juvenile justice specialist will determine if a youth who resides with their family is at imminent risk of entering foster care and continue to develop the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process). The candidacy determination and child-specific prevention plan will be documented in MiSACWIS.

Juvenile Justice youth served in the County of Wayne are served through a unique title IV-E agreement with the State of Michigan. At the time of writing this Prevention Plan, the business processes are not fully developed and as such will not be claimed to title IV-E until its inclusion in our Prevention Plan at a later date.

A child whose adoption or guardianship arrangement is at risk of disruption or dissolution

During the initial years of implementation, MDHHS will focus efforts on serving children who enter adoption from foster care and/or entered a juvenile guardianship arrangement. Additional pathways for children adopted outside of child welfare or entered EPIC guardianships will need to be developed and capacity built within MDHHS. Families with a child adopted or in a guardianship arrangement through MDHHS have four pathways in which they may be determined to be at imminent risk of entering foster care:

1. There may be an open CPS investigation.
2. Determined by an ongoing adoption and guardianship assistance analyst through the Adoption and Guardianship Assistance Office.
3. Through an intensive case management caseworker or caseworker assigned for coordination of services through the Post Adoption Resource Center (PARC).
4. Through a Kinship Care Navigator or MDHHS direct assistance program referral for a kinship care placement as capacity for community pathways is increased.

The first pathway will follow the same eligibility determination as the above criteria through the CPS investigator in coordination with other caseworkers assigned to the case, including a tribal representative if applicable.

As part of the engagement with families in the latter three pathways, a Family-Centered plan is completed within the first two weeks of engagement and will be used as a proxy for determining if the child is at imminent risk of entering foster care without preventive services. If the child is eligible or enrolled in a federally recognized tribe, the tribe will be notified and invited to participate in the meetings with the families. A safety and risk assessment are included as part of the family centered plan. The adoption assistance caseload analyst will work in close collaboration with the caseworker assigned through PARC to determine eligibility and document the candidacy determination in MiSACWIS. Once a candidacy determination is made by the adoption assistance caseload analyst, PARC caseworker will provide assistance for EBP determination, service linkage, and case management. MDHHS is committed to building community pathways including the Kinship Care Navigator program or MDHHS direct assistance worker may refer a family for prevention services assessments and eligibility to help maintain or stabilize kinship placements.

A child of a parent who had been in foster care until the parent reaches age 26 regardless if the parent is in foster care at the time of eligibility determination

This is a new pathway for MDHHS and will phase in this group of candidates in year three and four. This will allow MDHHS sufficient time to build staffing and capacity to

serve this population. Initial planning includes utilizing The Michigan Youth Opportunity Initiative (MYOI) and/or dedicated prevention caseworker, where available. MYOI currently provides support and coordination of service delivery for youth in out-of-home care and young adults that have exited custody of MDHHS. Through their current supportive role to exited care youth and their children, MYOI caseworker will assess need, determine candidacy eligibility, develop the child-specific prevention plan, and refer families to appropriate prevention services. Documentation of candidacy determination, prevention plan, service delivery, and ongoing monitoring will be documented in MiSACWIS by the MYOI caseworker and/or dedicated prevention caseworker, where available. Referrals to the MYOI caseworkers for parents up to age 26 could include Youth in Transition workers or other community organizations such as churches, providers, or others working with these parents within the community. During initial implementation of the prevention plan, MDHHS will evaluate current caseworker activities to assess feasibility of MYOI caseworkers functioning in this capacity.

Child at imminent risk of entering foster care as otherwise determined by a tribe

A representative from the child's tribe will determine eligibility for a child and any siblings residing in the same household or in the partial care or custody of a parent to a child that is a *candidate for foster care* if there is moderate or considerable risk of abuse or neglect, regardless of if there was confirmed abuse/neglect. If a tribe determines that a child is a *candidate for foster care*, they will provide MDHHS with attestation that there is moderate or considerable risk of abuse or neglect to the candidate. This decision will be determined based on the laws and customs of the tribe.

A tribes eligibility determination will be documented in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) prior to transferring the case to a caseworker who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process).

Ongoing Assessments and Redetermination

Ongoing formal and informal risk reassessments are completed during in home service provision every 90 days. For in-home open cases and open foster care serving pregnant or parenting youth in foster care, the caseworkers' monthly contact with the family, prevention service provider reports, and assessment tools including but not limited to the FANS, CANS, and SDM safety and risk assessment tools are incorporated into the ongoing risk and safety monitoring. When a community partner or EBP provider is providing ongoing oversight, program specific assessment tools and timeframes will

be utilized to monitor ongoing risk and safety. If services are expected to exceed the 12-month allotment, a child must be reassessed for candidacy eligibility status at the end of each 12-month prevention episode utilizing the processes and tools outlined above. A new child specific prevention plan is developed to document new candidacy determination and need for continued evidence-based prevention services. For children and families identified by a tribe at the end of the 12-month period, the tribe will submit another attestation for an extension of services if the tribe determines the child to need the prevention services.

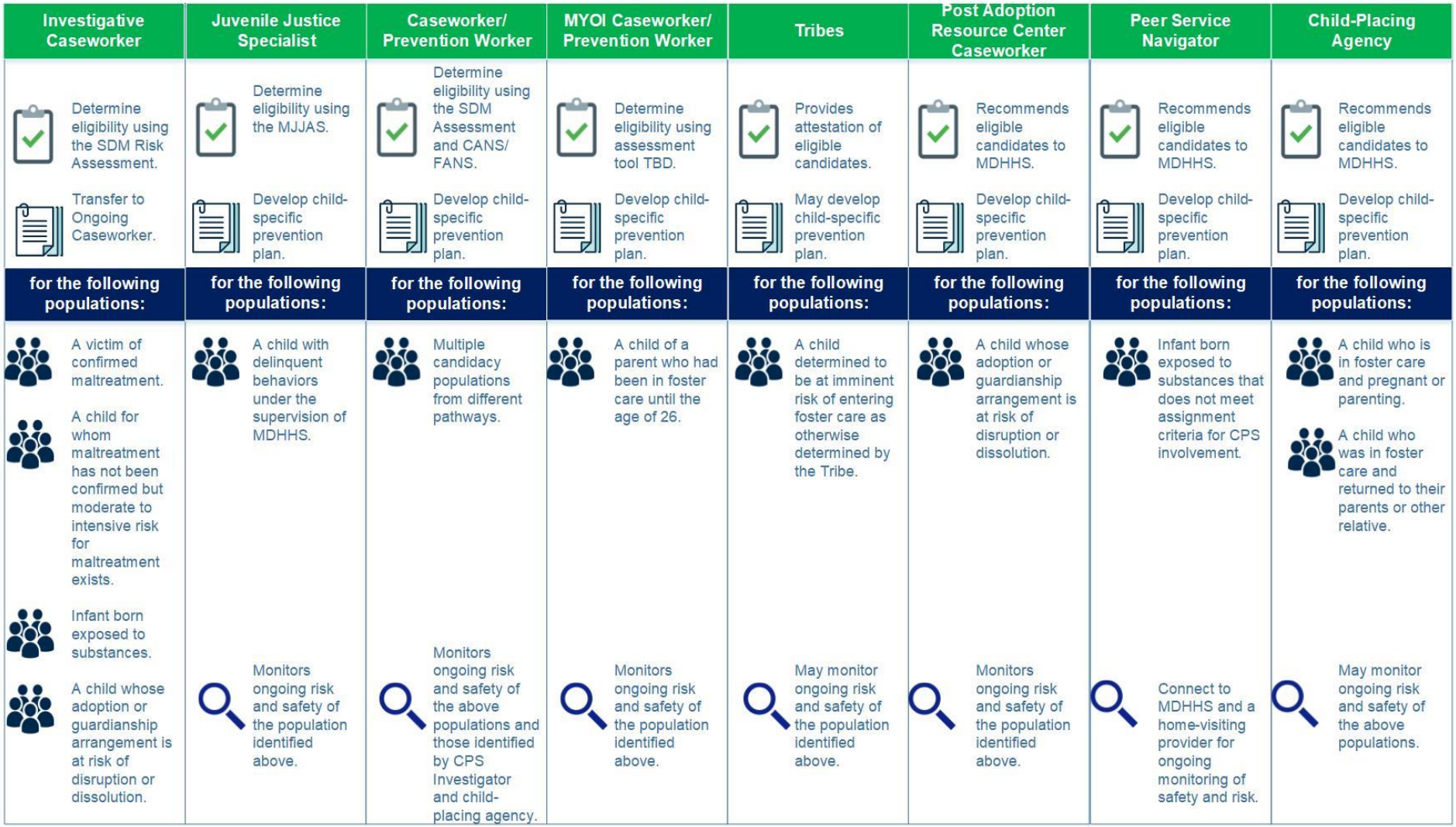
Identifying Pregnant or Parenting Foster Youth

Pregnant and parenting foster care youth represent a unique stand-alone population automatically eligible for prevention services under the Family First legislation. Therefore, candidacy determination is not a pre-requisite in the need's identification and service linkage process for this population.

When caseworkers identify that a youth in foster care is pregnant or parenting, they capture this information in MiSACWIS. A CANS assessment is completed with the youth that includes parenting skills to identify needs and service linkage. This assessment occurs no later than 30 days after placement in out of home care or no later than 30 days after the caseworker learns that the youth is pregnant or parenting. The CANS assessment is completed at 90-day intervals to assess progress and tailor service delivery. The agency is considering the utilization of the FANS to support enhanced service need identification related to parenting skills to ensure the most appropriate service linkage to IV-E prevention services.

An FTM is held in partnership with the pregnant or parenting youth, their family, the youth's tribe, caseworker, service providers, and any additional informal or formal supports for the youth and their child to discuss the strengths, needs, and service planning. The foster care prevention strategy for the youth's child, including referral to specific prevention services to ensure the pregnant or parenting youth is prepared or able to parent, will be clearly documented within the youth's case plan by the caseworker. Partnerships with local housing authorities and placement providers to build capacity for improved placement settings for pregnant and parenting youth is a specific strategy to support this population of youth.

Figure 5. Case Practice Pathways for Family First



Section III: Title IV-E Prevention Services

Pre-print Section 1

To understand the populations of children and families that would benefit most from title IV-E prevention services, MDHHS consulted with Chapin Hall at the University of Chicago to conduct a rigorous analysis of its child welfare data to understand the reasons children were entering care, risk factors for abuse/neglect present in families, and their geographic representation across the state. Needs that could be addressed through preventive programs contained within the three categories of allowable services under Family First were examined, including: 1) In-home, skill-based parenting programs; 2) Substance abuse treatment and prevention; and 3) Mental health treatment. The prevalence of those needs was then geographically mapped across Michigan's counties and discussed with the relevant workgroups and task teams who helped make meaning of those findings.

Based on the data analysis, the priority target populations to consider in Michigan include the following:

Known risk factors for child welfare involvement in Michigan for this target population include the following:

After substantive analysis of Michigan's child welfare population, a Prevention Workgroup formed that included MDHHS leadership, tribal representation, and important community stakeholders including court representatives, experts from evidence-based home visiting programs, experts in the mental health and substance use disorder fields, local county MDHHS caseworkers, leaders within private agency service providers, and parents with lived experience of the child welfare

system. A separate Tribal Family First Prevention Workgroup also formed to identify specific implications of Family First implementation related to the tribes.

The Prevention Workgroup conducted a provider survey and additional outreach to providers to assess the availability of evidence-based interventions across the state and identify additional prevention programs not already listed on the Title IV-E Prevention Services Clearinghouse. Prevention Workgroup representatives reviewed evidence-based programs (EBP) that addressed the target population needs and whether they were currently available in Michigan. Outlined in the table below, Michigan identified 10 programs for which the state is seeking title IV-E reimbursement. All programs identified below have been reviewed and rated by the Title IV-E Prevention Services Clearinghouse and address the needs of families identified in the data analysis.

Sobriety Treatment & Recovery Team

Sobriety Treatment and Recovery Team (START) is not included in Michigan's first prevention plan submission. However, due to START's demonstrated success in other jurisdictions with similar target population characteristics, Michigan will explore a pilot program and identify areas across the state that would benefit from this program which may include near tribal populations. Specific implementation steps for pilot programming along with a rigorous evaluation strategy will be included in a future revision of the five-year prevention plan.

START is an intensive child welfare program for families with co-occurring substance use and child abuse/neglect delivered in an integrated manner with local addiction treatment services. START serves families with at least one child under six years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into START services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each START CPS worker-mentor dyad has a capped caseload of 15 families, allowing the team to work intensively with families, engage them in individualized wrap-around services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity. START is currently rated as *promising* in the Title IV-E Prevention Services Clearinghouse.

Family First Prevention Service Array Overview

Table 1. Manual version for MDHHS Prevention Evidence Based Practices	
Nurse-Family Partnership (NFP)	Consistent with current training and certification for Nurse Family Partnership according to https://www.nursefamilypartnership.org
Parents as Teachers (PAT)	PAT Foundational Curriculum to support families prenatal to 3 AND PAT Foundational 2 Curriculum to support families 3 through Kindergarten.
Healthy Families America (HFA)	Consistent with current required model training and manuals for Healthy Families America in accordance with standards found at https://www.healthyfamiliesamerica.org/
HOMEBUILDERS	Kinney, J., Haapala, D.A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.
SafeCare	Lutzker, J.R. (2016)/ *Provider Manual*, version 4.1.1.
Multi-Systemic Therapy (MST)	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press.
Brief Strategic Family Therapy (BSFT)	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse.
Motivational Interviewing	Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* Guilford Press. Judith A. Cohen, Anthony P. Mannarino, Esther Deblinger (2017) *Treating Trauma and Traumatic Grief in Children and Adolescents (Second Edition)* The Guilford Press, New York, NY 10001
Family Spirit	The Family Spirit® Implementation Guide is implemented in conjunction with the Lesson Plans: *Family Spirit Program: Implementation guide.* (2019). Johns Hopkins Center for American Indian Health. *Family Spirit Program: Lesson plans.* (2019). Johns Hopkins Center for American Indian Health.

 **Parenting**

 **Mental Health**

 **Substance-use Disorder**

Table 2. MDHHS Proposed Evidence Based Practices for Title IV-E Prevention Plan

	Evidence-Based Program	Service Category	Title IV-E Prevention Services Clearinghouse Rating
1	**Nurse-Family Partnership (NFP)**		*well-supported*
2	**Parents as Teachers (PAT)**		*well-supported*
3	**Healthy Families America (HFA)**		*well-supported*
4	**HOMEBUILDERS**		*well-supported*
5	**SafeCare**		*supported*
6	**Multi-Systemic Therapy (MST)**		*well-supported*
7	**Brief Strategic Family Therapy (BSFT)**		*well-supported*
8	**Motivational Interviewing**		*well-supported*
9	**Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**		*promising*
10	**Family Spirit**		*promising*

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
Nurse-Family Partnership (NFP)	Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother. NFP aims for 60 visits that last 60-75 minutes each in the home or a location of the mother's choosing. For the first month after enrollment, visits occur weekly. Then, they are held bi-weekly or on an as-needed basis.	*well-supported* 	Primary goals: • To improve pregnancy outcomes by promoting health-related behaviors • To improve child health, development, and safety by promoting competent caregiving • To enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment Secondary goals: • To enhance families' material support by providing links with needed health and social services − To promote supportive relationships among family and friends	Nurse Family Partnership (NFP) is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members.
Parents as Teachers (PAT)	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child abuse/neglect. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse, and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child	*well-supported* 	Aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse, and neglect, and increase school readiness and success.	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
	health and developmental screenings, and community resource networks.			
Healthy Families America (HFA)	Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for abuse/neglect or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term, and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.	*well-supported* 	Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth • Cultivate and strengthen nurturing parent-child relationships • Promote healthy childhood growth and development • Enhance family functioning by reducing risk and building protective factors	HFA seeks to engage parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence. Individual HFA sites select the specific characteristics of the target population they plan to serve (such as first-time parents, parents on Medicaid, or parents within a specific geographic region); however, the HFA National Office requires that all families complete the parent survey (formerly the Kempe Family Stress Checklist), a comprehensive psychosocial assessment used to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences. The HFA National Office requires that sites enroll families before the child's birth or within three months of the child's birth. After families are enrolled, HFA sites offer them services until the child's third birthday, and preferably until the child's fifth birthday.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
HOMEBUILDERS	HOMEBUILDERS provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. HOMEBUILDERS' practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. HOMEBUILDERS' practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety.	*well-supported*	• Reduce child abuse and neglect • Reduce family conflict • Reduce child behavior problems • Teach families the skills they need to prevent placement or successfully reunify with their children	Families with children (birth to 18) at imminent risk of placement into care, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities
SafeCare	SafeCare is an in-home behavioral parenting program that promotes positive parent-child interactions, informed caregiver response to childhood illness and injury, and a safe home environment. SafeCare is designed for parents and caregivers of children birth through five who are either at-risk for or have a history of child neglect and/or physical abuse. The program aims to reduce child abuse/neglect. The SafeCare curriculum is delivered by trained and certified providers.	*supported*	• Reduce future incidents of child abuse/neglect • Increase positive parent-child interaction • Improve how parents care for their children's health • Enhance home safety and parent supervision	SafeCare is designed for parents and caregivers of children birth through five who are either at-risk for or have a history of child neglect and/or physical abuse. The program aims to reduce child abuse/neglect.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
	The curriculum includes three modules: (1) the home safety module targets risk factors for environmental neglect and unintentional injury by helping parents/caregivers identify and eliminate common household hazards and teaching them about age-appropriate supervision; (2) the health module targets risk factors for medical neglect by teaching parents/caregivers how to identify and address illness, injury, and health generally; (3) the parent-child/parent-infant interaction module targets risk factors associated with neglect and physical abuse by teaching parents/caregivers how to positively interact with their infant/child, and how to structure activities to engage their children and promote positive behavior.			
Multi-Systemic Therapy (MST)	Treatment using MST typically involves multiple weekly visits between the therapist and family, over an average timespan of 3 to 5 months. The intensity of services can vary based on clinical needs. The therapist and family work together to determine how often and when services should be provided throughout the course of treatment.	*well-supported* 	Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) Empower parents with the skills and resources needed to: • Independently address the inevitable difficulties that arise in raising children and adolescents • Empower youth to cope with family, peer, school, and neighborhood problems	This program provides services to youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Brief Strategic Family Therapy (BSFT)	BSFT is typically delivered in 12 to 16 weekly sessions, depending on individual and family needs.	*well-supported* 	For the child/youth: • Reduce behavior problems, while improving self-control • Reduce associations with antisocial peers	BSFT is designed for families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including: drug use and dependency,

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
			• Reduce drug use • Develop prosocial behaviors For the family: • Improvements in maladaptive patterns of family interactions (family functioning) • Improvements in family communication, conflict-resolution, and problem-solving skills • Improvements in family cohesiveness, collaboration, and child/family bonding • Effective parenting, including successful management of children's behavior and positive affect in the parent-child interactions	antisocial peer associations, bullying, or truancy.
Motivational Interviewing	MI is typically delivered over one to three sessions. Each session typically lasts for 30 to 50 minutes. The dosage may vary if MI is delivered in conjunction with other treatment(s).	*well-supported* 	• Enhance internal motivation to change • Increased engagement and retention in services • Increased achievement of plan goals	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas. Michigan will use MI as a strategy to serve adolescents and adults with challenges in the areas of substance abuse and mental health and increase motivation to improve parenting skills.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral	*promising* 	• Improving child PTSD, depressive and anxiety symptoms	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
	problems. Caregivers are included in treatment if they did not perpetrate the trauma and child safety is maintained.		• Improving child externalizing behavior problems (including sexual behavior problems if related to trauma) • Improving parenting skills and parental support of the child, and reducing parental distress • Enhancing parent-child communication, attachment, and ability to maintain safety • Improving child's adaptive functioning • Reducing shame and embarrassment related to the traumatic experiences	feelings or thoughts, or behavioral problems. Caregivers are included in treatment if they did not perpetrate the trauma and child safety is maintained.
Family Spirit	Family Spirit is designed to serve mothers for as long as possible, from 28 weeks gestation until 3 years postpartum. Home visitors teach 63 lessons during 52 home visits. Each visit is 45-90 minutes long. Visit frequency tapers over time. Specifically, mothers receive weekly visits from 28 weeks gestation to 3 months postpartum, biweekly visits between 3 months and 6 months postpartum, monthly visits between 7 months and 22 months postpartum, and bimonthly visits between 23 and 36 months postpartum.	*promising* 	Mothers: • Increase parenting knowledge and skills • Decrease psychosocial risks that could interfere with positive child-rearing (drug and alcohol use; depression; low education and employment; domestic violence problems) • Increase likelihood of taking child to recommended well-child visits and health care • Increase familiarity with and use of community services that address specific needs • Increase life skills and behavioral outcomes across the lifespan Children:	Family Spirit is designed to serve young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy. Other family members can participate in the program lessons alongside mothers.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**EBP Outcomes/Goals that Align with Michigan's Intended Outcomes**	**EBP Eligibility Criteria/Target Population**
			• Increase likelihood of optimal physical, cognitive, and social/emotional development from birth to 3 years • Increase early school success • Increase life skills and behavioral outcomes across the lifespan	

Implementation Plans for Evidence-Based Programs

Each program was carefully selected for the five-year title IV-E prevention plan based on the target populations identified in Michigan that would most benefit from these services to prevent entry into foster care. In addition, considerations were made as to the feasibility of implementation including trauma-informed service delivery models and evaluation considerations. The below table details strategies for implementation of each preventive program and whether a waiver of evaluation will be submitted. See Section VI for fidelity monitoring and oversight activities for each EBP.

Table 4. Family First EBP Implementation Plans and Trauma-Informed Service Delivery	
Nurse Family Partnership	
Strategies for Implementation	The MDHHS Prevention Workgroup provider survey identified multiple locations currently operating Nurse Family Partnership programs across Michigan. MDHHS plans to leverage existing relationships to contract with providers and have considerations for expansion of services to accommodate pregnant and parenting teenagers in foster care for certain locations. Expansion sites will be selected based on a gap analysis of need and availability of providers. If there is not an existing NFP program, local community providers will be brought together to select the agency that will implement the model that best fits the needs identified by the community (NFP, PAT, or HFA). Potential grantees must demonstrate the ability to provide Nurse Family Partnership services with fiscal responsibility and fidelity to the model. MDHHS plans to coordinate with the MDHHS Home-Visiting Unit and with the Nurse Family Partnership National Office in the expansion process as well as the existing service providers. The Nurse Family Partnership National Office and MDHHS will collaborate to structure continuous quality improvement efforts. Additional training and support will be provided through the home visiting unit.
Trauma-Informed Service Delivery	Trauma-informed practice and training are integrated in the program model.
Parents as Teachers	
Strategies for Implementation	The MDHHS Prevention Workgroup provider survey identified 38 locations currently operating Parents as Teachers programs across Michigan. MDHHS plans to leverage these existing relationships to contract with providers and have considerations for expansion of services to accommodate families whose children aged zero to five are at imminent risk of being placed into foster care. Using the existing data analysis of expansion sites will be selected in areas with identified need. If there is not an existing PAT program, local community providers will be brought together to select the agency that will implement the model that best fits the needs identified by the community (NFP, PAT, or HFA). Potential grantees must demonstrate the ability to provide Parents as Teachers services with fiscal responsibility and fidelity to the model. MDHHS plans to coordinate with the MDHHS Home Visiting Unit and with the Parents as Teachers State Office in the expansion process. Grantees will collaborate with the Parents as Teachers National Center and State Office for training and support. Additional training and support will be provided through the home visiting unit.
Trauma-Informed Service Delivery	The PAT program model and training are designed to provide services to families and children affected by trauma and chronic hardship.

Healthy Families America	
Strategies for Implementation	The MDHHS Prevention Workgroup provider survey identified ten (10) provider locations currently operating Healthy Family America programs across Michigan. MDHHS plans to leverage these existing relationships to contract with providers and have considerations for expansion of services to accommodate pregnant and parenting teenagers in foster care and families meeting Family First eligibility criteria for families with children up to age 5. Using the existing data analysis, expansion sites will be selected in areas with identified by expanding existing services, maximizing program reach. In communities identified as having need, and without HFA program, local community partners will meet to select the agency to implement the model that best fits the needs identified by the community (NFP, PAT, or HFA). Potential grantees must demonstrate the ability to provide Healthy Families America services with fiscal responsibility and fidelity to the model. MDHHS plans to consult with the Healthy Families America State Office and the MDHHS Home Visiting Unit in the expansion process. Grantees will collaborate with the National and State Office for training and support. Grantees will also receive support through the Home Visiting Unit.
Trauma-Informed Service Delivery	Service model includes trauma affected youth and training on trauma informed care.
HOMEBUILDERS	
Strategies for Implementation	HOMEBUILDERS is currently operating in seven (7) counties in Michigan as a part of a pilot implementation. The pilot began in January 2021 and includes a contract with the Institute for Family Development (IFD) to ensure program fidelity. IFD provides training and technical assistance and has a level system in place to ensure sites effectively move towards program fidelity. For service delivery, MDHHS has contracted with non-profit child and family service agencies to provide this service. Contracted agencies receive rigorous oversite from the Institute for Family Development to ensure the program is delivered according to the model.
Trauma-Informed Service Delivery	Service model includes trauma affected youth and training on trauma informed care.
SafeCare	
Strategies for Implementation	SafeCare is a new service to be offered by MDHHS. MDHHS data shows that young children, specifically those under age six, are at greatest risk of experiencing child abuse/neglect, recurrence of abuse/neglect, and entry into foster care. Evidence indicates the SafeCare model is effective at reducing and preventing child abuse and neglect. MDHHS will pilot the SafeCare program in two communities with the highest rates of recurrence and entry into foster care. To implement, MDHHS will: • Contract with the developer for training and support to community providers contracted for service delivery. • Establish contracts with community service providers. • Complete full implementation activities such as coaching of in-home providers, certification of in-home providers, and monitoring fidelity.
Trauma-Informed Service Delivery	Service model includes trauma affected youth and training on trauma informed care.
Multisystemic Therapy	
Strategies for Implementation	Multisystemic Therapy (MST) is currently being delivered in 11 separate sites in Michigan. Michigan plans to utilize MST to address problem behaviors in adolescents that are at risk of entering foster care. Considering that youth age 14-17 are one of the target populations for Michigan's prevention efforts, the continued use of MST and its expansion will be an important tool to prevent these children from entering or remaining in foster care;

	preventing youth from entering the juvenile justice system; or from more serious juvenile justice system involvement.
Trauma-Informed Service Delivery	Service model framework includes trauma-informed care for youth affected by trauma.
 **Brief Strategic Family Therapy**	
Strategies for Implementation	Brief Strategic Family Therapy (BSFT) is currently being delivered in five separate sites in Michigan. Michigan plans to utilize BSFT to address problem behaviors in adolescents that are at risk of entering foster care. To maximize title IV-E expansion of prevention services while leveraging a variety of funding sources, BSFT will be phased in based on targeted needs and capacity through a request for proposal (RFP) process.
Trauma-Informed Service Delivery	The BSFT model is a trauma sensitive, culturally competent, and strength based.
 **Motivational Interviewing**	
Strategies for Implementation	Michigan aims to enhance its MiTEAM practice model through the implementation of Motivational Interviewing (MI). Research and evaluation to date have highlighted MI as an effective service delivery strategy with both adult and youth populations to enhance motivation to accomplish a wide range of goals, making it an ideal fit for MDHHS's prevention candidates with service needs in all three Family First service categories--in-home parenting, substance abuse, and mental health. The goal of implementing MI in Michigan is to assure improved engagement and participation of children, youth, and families to achieve the goals set forth in the child-specific prevention plan and to support engagement with and completion of services, including additional EBPs when indicated, being offered. Through increased engagement, we also anticipate better service matching over time to the needs of each child and families and improved prevention and well-being outcomes. MI's client-centered approach will support sustainment of the family's motivation toward progress, so each child and family are able to continue to receive an appropriate dose and level of support and service. MI will be used at each encounter with their families as a core EBP and fully integrated into all casework practice. This will require community-based EBP service providers, caseworkers (public and private), and supervisors to be trained in the use of MI. Supervisors will provide critical support to caseworkers in using MI in the development and monitoring of the child-specific prevention plan.
Trauma-Informed Service Delivery	All child welfare case workers trained in Motivational Interviewing will also be trained in trauma-informed care.
 **Trauma-Focused Cognitive Behavioral Therapy**	
Strategies for Implementation	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most prevalent evidence-based practice in Michigan. Currently there is a trained therapist and supervisor in each community mental health authority in Michigan. In addition, there are numerous private agency and private practice therapists that are certified TF-CBT therapists. TF-CBT may be used for children ages 3-18 and currently is provided to numerous children that are eligible for community mental health services through a severe emotional disturbance (SED) diagnosis.

	To maximize title IVE expansion of prevention services while leveraging a variety of funding sources, TF-CBT will be phased in based on targeted needs and capacity through a request for proposal (RFP) process.
Trauma-Informed Service Delivery	Service model includes trauma affected youth and training on trauma informed care.
Family Spirit	
Strategies for Implementation	Family Spirit is currently being delivered in 12 separate sites within Michigan borders by tribal agencies. Michigan plans to partner with the tribes to determine the locations for Family First implementation and determine supports needed.
Trauma-Informed Service Delivery	Family Spirit as a model supports a trauma informed approach and practice. There are specific elements within the training, quality assurance, on-going affiliate education and support, as well as the strengths-based content within the curriculum that align with trauma informed practice.

Section IV: Child Specific Prevention Plan

Pre-print Section 4

When families come to the attention of the MDHHS-Children's Services, a family can be served through one of three service tracks in the prevention continuum including *Prevention Services for Families*, *Family First Prevention*, and *Family Preservation and Reunification*.

The Prevention Services for Families track is designed to preserve and strengthen family functioning to prevent child abuse and neglect. This track is intended to support families who voluntarily seek assistance from MDHHS or have been identified as at low risk for child abuse/neglect, but where actual abuse/neglect is not presently occurring. MDHHS caseworkers (CPS investigators, Pathways to Potential specialist, Family Independent specialist) or Peer Navigators can offer services through referrals to community agencies. Families accessing services through this pathway do not have an open child protection services case. Services available includes but is not limited to: Families Together Building Solutions, evidence-based home visiting, Wraparound, Brilliant Detroit, Post Adoption Resource Centers, Parent Support Groups, and Family Resource Centers, etc.

Family First Prevention Services is a new pathway and adds new evidence-based programs in key service areas of mental health, substance use disorder and parent skill-based programs. Family First prevention services may be available to families when at least one child has been determined to be a candidate for foster care as outlined in the Candidate for Foster Care section or pregnant or parenting youth in foster care. Families accessing services through this pathway will have an open Family First prevention program and will have an assigned MDHHS CPS ongoing worker, MDHHS Juvenile Justice specialist, MDHHS or contracted private agency foster care worker responsible for ongoing case oversight, a contracted community service provider, and/or a MDHHS prevention or tribal caseworker responsible for ongoing direct or indirect case oversight. Indirect case oversight includes coordination and information gathering from a contracted community service provider responsible for ongoing case management to document eligibility determinations in MiSACWIS.

Family Preservation and Reunification Services focus on families with moderate to intensive risk and where abuse/neglect has occurred and seek to prevent out-of-home placement and prevent recurrence. Families accessing services through this pathway will have an assigned CPS ongoing worker, MDHHS juvenile justice specialist, MDHHS contracted private agency foster care caseworker, MDHHS foster care caseworker, or a tribal caseworker. Family Preservation and Reunification programs available include Families First of Michigan, Family Reunification Program, Parent Partner Program, etc.

Child Specific Prevention Plan

Engaging and assessing families' strengths, needs, and services needed to mitigate risk will occur using existing structures already in practice. Prior to identifying and

referring a child/family to a service within the prevention continuum, the assigned worker will facilitate a Family Team Meeting (FTM) or similar meeting. The FTM represents a child-centered, family-driven, strength-based, team-guided approach, designed to engage families in developing plans for the safety, permanency, and well-being of their children and family. FTMs should include assigned workers, parents, caretakers, children, youth, extended family, friends, neighbors, community-based service providers, community representatives, tribal representatives, or other professionals involved with the family. During the FTM, participants work together to create a child-specific prevention plan for safety, placement stability, well-being and permanency tailored to the individual needs of each child and their parents. This process provides a forum to share ideas and opinions and stresses the importance of the family's perspective and involvement. In addition, this process encourages full participation of all participants, honest communication, and promotes dignity and respect.

Michigan recognizes the power differential that exists between the child welfare system and families who are encountering the system. To alleviate some of the historical connotations of child welfare as having ultimate power over families, the workforce will be trained to understand and recognize how power differentials may be perceived by families and steps to take for the assigned work to engage. This training is included in the MiTEAM module on Engagement. The assigned worker engages with the family and develops a trusting relationship using the evidence-based practice of Motivational Interviewing (MI). One way this will occur is through training of the workforce in MI beginning this calendar year. This strategic strength-based and solution-focused practice of MI will be embedded throughout the caseworker's engagement with families including interviews, thorough assessment of needs and strengths, child-specific prevention planning, and developing a family-driven plan of action that includes goals leading to improved family functioning. The assigned worker will utilize program specific assessment tools to gather and document child and family strengths and needs. Program specific assessment tools include

- SDM risk assessment and safety assessment;
- Family Assessment of Needs and Strengths;
- Child Assessment of Needs and Strengths;
- Juvenile Justice Strength and Needs Assessment;
- Michigan Juvenile Justice Assessment System (MJJAS) risk assessment tool;
- Social Determinants of Health Screening;
- Person-Centered Assessment; and
- other service specific risk assessment tools.

Once a family's needs are identified, the assigned caseworker will engage the family and share service availability utilizing the service array selection document to identify a service that best meets the family's needs. Services identified will be documented in the child-specific prevention plan. All information shared between the MDHHS, and community providers will be shared with appropriate signed consent from the family.

The assigned worker will partner with the family to obtain the information necessary and to make the service referral and connect the family with the service provider. The assigned worker will engage the family and service provider at least monthly to address any barriers identified. The assigned supervisor reviews and approves all prevention plans to ensure appropriate service referral and oversight of prevention candidates. Supervisors meet with their caseworkers a minimum of monthly for ongoing case consultations. In addition, each Business Service Center will have an assigned analyst available to offer support and training on determining candidacy eligibility and understanding services available in the county, including evidence-based programs.

Ongoing needs, strengths, and safety assessments as well as formal and informal risk reassessments are completed on a periodic basis by the assigned worker or EBP service provider. When a family is involved in services, information is regularly gathered from service providers when appropriate consents are in place to update assessment information, risk and safety assessments and the prevention plan.

If there is a continued need for the family to participate in services beyond 12 months, the assigned MDHHS worker will complete a new candidacy determination 12 months from the prevention plan begin date. The assigned MDHHS worker will conduct a safety reassessment and review the prevention plan to assess if the child remains a candidate for foster care. The new candidacy determination will be documented in MiSACWIS.

If a community partner/service provider is providing ongoing support to the family, the assigned MDHHS prevention worker will initiate contact with the community partner within 12 months of the prevention plan start date to initiate a new candidacy determination. The MDHHS prevention worker will gather information necessary to complete the safety assessment to determine if the child remains a candidate for foster care. The new candidacy determination will be documented in MiSACWIS.

Pregnant or Parenting Youth in Foster Care

Upon identification of a pregnant or parenting youth in foster care and an assessment of a need for prevention services to support the youth's ability to safely parent their child(ren), a service referral will be made for prevention services When caseworkers identify that a youth in foster care is pregnant or parenting, they capture this information in MiSACWIS. A CANS assessment is completed with the youth that includes parenting skills to identify needs and service linkage. This assessment occurs no later than 30 days after placement in out of home care or no later than 30 days after the caseworker learns that the youth is pregnant or parenting. The CANS assessment is completed at 90-day intervals to assess progress and tailor service delivery. The agency is considering the utilization of the FANS to support enhanced service need identification related to parenting skills to ensure the most appropriate service linkage to IV-E prevention services.

The prevention plan will be developed in partnership with the pregnant or parenting youth, services providers (including medical, behavioral, and mental health), and other member of the youth's family team during family team meetings.

The foster care prevention plan for any child born to a youth in out-of-home care will be clearly identified within the pregnant or parenting youth's case plan. The services to be provided will be outlined on the pregnant or parenting youth's foster care case plan and treatment plan.

An assigned MDHHS worker will complete eligibility redetermination if the case remains open at 12 months from the prevention plan start date.

Prior to the youth's case closing, the foster care worker will facilitate an FTM to determine ongoing service needs and if the child meets other candidacy types. If the youth's child qualifies as a candidate at imminent risk of entering foster care, the assigned MDHHS worker will facilitate documenting the eligibility in MiSACWIS and outline the case management activities. Ongoing case oversight will be offered by a MDHHS prevention worker or community partner.

Tribal Government Determinations

During the initial eligibility determination, a representative from the child's tribe will determine on a case-by-case basis whether the tribal Caseworker will continue to develop the child-specific prevention plan and document in the attestation. In recognition of the unique strengths, needs, and context of the tribal community, options will be available for individual tribes in determining their role in development of the child specific prevention plan. If the tribe decides to develop the child-specific prevention plan, MDHHS will establish a memorandum of understanding (MOU), Title IV-E agreement, or contract relevant to the tribe for this service and the necessary information shared. If the child's tribe declines to develop the child-specific prevention plan, MDHHS will request representatives designated by the child's tribe with substantial knowledge of the prevailing social and cultural standards and child rearing practices within the tribal community to evaluate the circumstance of the child's family and assist in developing a child-specific prevention plan that uses the available resources of the tribe and community, including traditional and customary support, actions, and services, to address those circumstances.

Integrating the child-specific Prevention Plans within MiSACWIS

All child-specific prevention plans will be documented in MiSACWIS. The child-specific prevention plan will include those children and parents or caregivers who are eligible; will identify the prevention plan begin date; list the services to be provided to or on behalf of the child to ensure the success of the prevention strategy; and include the prevention strategy so the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safety achieved, or live permanently with a kin

caregiver. The child specific prevention plan will be incorporated and part of the existing CPS or foster care case service plans.

Prevention Services and Coordination with IV-B

Title IV-B of the Social Security Act allocates funding to states to support the prevention of out of home placements and keeping families together. Michigan has utilized this funding to support county procured prevention services to meet each of the county's service needs to serve families within the Prevention Services for Families pathway. Counties procure a variety of prevention services, such as the Families Together Building Solutions program through Title IV-B funding that meet the specific needs of their communities. Title IV-B programs will be implemented in conjunction with Family First funded preventative services. Interventions used when programs are funded by IV-B will not be included in the tracking of Michigan's well-supported interventions and will not be claimed to IV-E. Caseworkers will ensure families' case plans and the child-specific prevention plans contain the right constellation of services needed to address risk factors for abuse and neglect and maintain the child safely in their home. This preventive service package in its entirety will be funded by a variety of federal, state, and local funding streams, including Title IV-B and Title IV-E. Caseworkers will ensure that all services for the child and family, regardless of funding stream, are well-coordinated, mutually reinforcing, and appropriate for achieving the case plan goals for the family.

Section V: Monitoring Child Safety

Pre-print Section 3

During the period that services are being offered to eligible children and families MDHHS and/or EBP service providers will monitor the safety of the children and determine any risks present. MDHHS policy requires initial and ongoing assessments of risk and safety of all children receiving services. MDHHS will use existing practices to ensure safety and assess risk for candidates at imminent risk of entering foster care and pregnant and parenting youth in foster care. Additional populations are determined for prevention services as part of the five-year prevention plan that would not traditionally be provided by MDHHS. Safety and risk assessments for these populations will be provided by contracted organizations and monitored by MDHHS on a continual basis. In addition, all providers of services have a responsibility to report any instances of suspected child abuse or neglect as part of the mandated reporting laws.

Assessment and SDM Safety and/or Risk Assessment Tool: Caseworkers will use SDM safety and risk assessment tools, among other strategies, to evaluate safety and risk to children to determine initial eligibility and throughout any open cases to ensure the continued safety and well-being of children and families.

Caseworker Periodic Risk Assessment, Case Plan, and Safety Plan: Once a case is transferred to ongoing services and eligible for prevention services, caseworkers use the SDM risk and safety assessment findings to co-create a case plan that will integrate the child-specific prevention plan in collaboration with the family. Additionally, an initial ongoing assessment occurs within 30 days and ongoing risk assessments occur every 90 days thereafter. These tools and practice judgements will help inform monitoring of safety and risk as well as determine any challenges the family faces warranting adjustment in services.

Family Assessment/Reassessment of Needs and Strengths: A section of the Family Assessment/Reassessment of Needs and Strengths (FANS) tool assesses health, well-being, and parental skills of caregivers. Caseworkers are responsible for administering FANS every 90 days with families receiving in-home services through MDHHS. The 90-day assessment may occur at an earlier interval of 60 days based on risk categories identified through the initial assessment. This tool will aid in monitoring any risk present with families receiving prevention services.

Juvenile Justice Case Services Plan: The juvenile justice specialists must complete a case services plan, initially within 30 days and 90 days thereafter, with the youth to assist in assessing the needs of the youth/family and is the basis for making placement decisions which will determine the type of treatment and services the youth and family will be provided.

Michigan Juvenile Justice Assessment System: The Michigan Juvenile Justice Assessment System (MJJAS) is a research-based, validated assessment instrument developed by the University of Cincinnati Corrections Institute. The MJJAS

was adapted from the Ohio Youth Assessment System and is a structured decision-making assessment tool which identifies the likelihood that a youth will participate in future delinquent behavior and helps inform placement and treatment decisions. When used over time, scores show changes in risk level based upon changes in a youth's behavioral profile and life situation. In addition to regular visits with the child and family, the juvenile justice specialists will use this tool to assess safety and risk of the child receiving prevention services within the first 30 days of contact and ongoing on an as-needed basis with every other service plan.

Juvenile Justice Strengths and Needs Assessment: Juvenile justice specialists complete a JJ Strengths and Needs Assessment with the youth and caregiver during the initial 30 days and every 90 days thereafter with every service plan. This assessment is used for service and treatment planning with the youth and includes domains related to family relationships, emotional stability, substance abuse, and social relations. This tool will aid in monitoring any safety or risk concerns present for youth receiving prevention services.

Contact with the Family: MDHHS requires caseworkers and juvenile justice specialists to regularly meet face-to-face with children and their caregivers. Caseworkers must meet with the child and caregivers at least monthly. Juvenile justice specialists are required to meet with children and their caregivers at least monthly but for higher risk levels, as deemed by the MJJAS, require more frequent contact. Regular and purposeful visiting with the child and family enables the caseworkers to assess safety, risk, and determine other needs of the family and/or caregivers. Contracted agencies that will have oversight of prevention services will be required to assess risk and safety of the children through an array of tools such as the Framework for Risk Assessment, Management and Evaluation (FRAME), protective factors survey, and the Children's Trauma Assessment Center Trauma Screening Checklist.

Family-Centered Plan: As a contracted agency to provide safety and risk assessments, the Post Adoption Resource Centers (PARC) will use their existing family-centered plan to support families whose adoption or guardianship arrangement is at risk of disruption or dissolution. The family-centered plan is developed through careful assessment of social history, present safety and risk issues, safety planning, family strengths and needs, and specific goal setting. This assessment is completed within the first two weeks of engagement and will be used as a proxy for determining if the child is at imminent risk of entering foster care and used to identify the initial safety and risk concerns as well as service linkage needs for the family. The child-specific prevention plan will be purposefully integrated with the family-centered plan. Adoption Assistance Caseload Analysts provide the initial assessment, develop, and document the child-specific prevention plan, and provide follow-up assessments throughout the engagement.

Provider Responsibility: Michigan Child Protection Law requires certain professionals to report their suspicions of child abuse or neglect to Centralized Intake at the MDHHS. Providers delivering prevention services have an obligation to be vigilant to any

suspected child abuse and neglect which provides additional monitoring of child safety during the engagement in services.

Tribal Representative: During the initial eligibility determination, a representative from the child's tribe will determine on a case-by-case basis whether the tribe will continue to monitor the risk and safety of the children receiving prevention services and document in the attestation. If the tribe monitors the risk and safety of the child, MDHHS will establish a memorandum of understanding (MOU), Title IV-E agreement, or contract relevant to the tribe for this service and the necessary information shared. The tribe will continuously monitor the safety and risk of the child throughout service delivery through regular visitation. Tribes may utilize MDHHS's risk and safety tool or may use a tribal specific tools and practices for monitoring risk and safety.

Table 5. Monthly contact standards MDHHS ongoing and juvenile justice

MDHHS Ongoing Monthly Contact Standards						
Opening Month						
Day one = Day following dispositions by caseworker						
7 business day requirement* (Business day 1-7)	• 1 face-to-face contact with each primary caregiver from a participating household • 1 face-to-face contact with each child identified as a victim (can occur in the same contact					
1st calendar month – any risk level	• 1 face-to-face contact with each primary caregiver from a participating household • 1 face-to-face contact with each child identified as a victim (can occur in the same contact) • 2 collateral contacts					
3 or less business days in the opening month	• Only 7 business day requirement (may occur in current month or subsequent calendar month but within 7 business days) • The following calendar month requires standard contact requirements					
2nd/Subsequent Calendar Month Until Closing Month						
Risk Level	Total Contacts	Contracted Agency Allowed Contact	Contact with each victim child/non-victim child	Contact with Each Caregiver per Participating Household	Collateral Contacts	Data Report Contact Requirements per participating household
Intensive	4	3	1	1	4	• 1 face-to-face contact with each primary caregiver • 1 face-to-face contact with each victim child • 1 face-to-face contact with each non-victim child
High	3	2	1	1	3	
Moderate	2	1	1	1	2	
Low	1	0	1	1	1	

Juvenile Justice Community-Based Placements	
Monthly contact standards need to correspond with the calculated risk level of the most recent Michigan Juvenile Justice Assessment System tool.	
Risk Level	Contact Frequency
High	3 face-to-face visits take place with the youth each month.
Moderate	2 face-to-face visits take place with the youth each month.
Low	1 face-to-face visit take place with the youth each month.
At least one contact each calendar month must take place at the youth's placement location. One contact each month must include a private meeting between the youth and the juvenile justice specialist.	

Section VI: Evaluation Strategy and Waiver Request

Pre-print Section 2; Attachment II

Family First requires that each program in the five-year prevention plan have a well-designed and rigorous evaluation strategy unless a state is granted a federal waiver of the requirement. Michigan is seeking a waiver of evaluation for seven of the ten reimbursable programs and intends to contract with the University of Michigan to conduct a rigorous evaluation of the remaining three programs. Michigan will work with the evaluation team and internal Michigan Department of Continuous Quality Improvement (CQI) to ensure integration of evaluation activities and CQI efforts for each evidence-based program in the five-year prevention plan.

Table 6. Family First EBP CQI and Evaluation Strategies

Evidence-Based Program	Evaluation Waiver Request	Formal Contracted Evaluation	State CQI	Claiming FAMILY FIRST
Nurse-Family Partnership (NFP)	✓		✓	✓
Parents as Teachers (PAT)	✓		✓	✓
Healthy Families America (HFA)	✓		✓	✓
HOMEBUILDERS	✓		✓	✓
SafeCare		✓	✓	✓
Multi-Systemic Therapy (MST)	✓		✓	✓
Brief Strategic Family Therapy (BSFT)	✓		✓	✓
Motivational Interviewing	✓		✓	✓
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)		✓	✓	✓
Family Spirit		✓	✓	✓

Family First Logic Model

MDHHS plans to leverage Family First to ensure Michigan families' protective capacities are strengthened and reduce entries or re-entries into foster care through appropriate service matching and supports. MDHHS recognizes that infrastructure, practice supports, collaboration, and services to match families' needs are all important components to successful implementation. Through this process, MDHHS intends to promote more equitable outcomes for Black, Indigenous, children of color, stronger partnerships with the tribal governments, and improved outcomes for all Michigan families receiving prevention services.

Figure 6. MDHHS Family First Logic Model

	Inputs	Outputs	Outcomes	Impact
Infrastructure	• New prevention services' positions (Community Service Analysts) • University partnership for evaluation of SafeCare, TF-CBT, and Family Spirit • Enhanced IT capacity and strong internal department of CQI • Updated policies and procedures to align with Family First • Revised EBP prevention provider contracts	• Capacity to evaluate program outcomes and ensure data quality • Policies and procedures for systematic alignment	• Enhanced capacity to refer and enhance engagement in services • Aligned policies and procedures to implement Family First • Prepared and professional workforce • Increased capacity for data collection and analysis to inform service selection	• Michigan families are strengthened and stabilized • Reduced entries and re-entries into foster care • More equitable system leading to improved outcomes for Black, Indigenous, and children of color • Higher engagement in evidence-based services that meet families' needs • Stronger tribal partnerships and community engagement
Practice Supports	• MDHHS Children Services Agency practice model • Motivational Interviewing complement to the practice model • Assessment tools: Risk, Safety, CANS, FANS, MJJAS • Family First training enhancements, coaching, & mentorship for frontline caseworkers and supervisors	• Effective assessment of child/family needs and appropriate linkages to services • Accurate assessment of risk/safety • Alignment with state best practices		
Collaboration	• Implementation teams • CQI meetings with providers • New or enhanced stakeholder partnerships including those with lived experience • Tribal Family First workgroup	• Partnership on key decisions of Family First implementation • Streamlined referral processes and provider buy-in	• A shared vision and coordination of Family First in Michigan	
Services	• Nurse-Family Partnership • Parents as Teachers • Healthy Families America • SafeCare • HOMEBUILDERS • Multisystemic Therapy • Brief Strategic Family Therapy • Motivational Interviewing • Trauma-Focused Cognitive Behavioral Therapy • Family Spirit	• Evidence-based preventive service array that meets the needs of Michigan children & families • Fidelity in service provision for families • New service pathways for families	• Cultivate and strengthen nurturing parent-child relationships and increase parent knowledge of child development • Enhance internal motivation for positive change • Reduce behavior problems in youth and improve adaptive functioning • Youth and parents gain communication skills and relationship-building • Decrease symptoms of mental health and trauma • Reduce substance-use See section III for specific EBP outcomes	

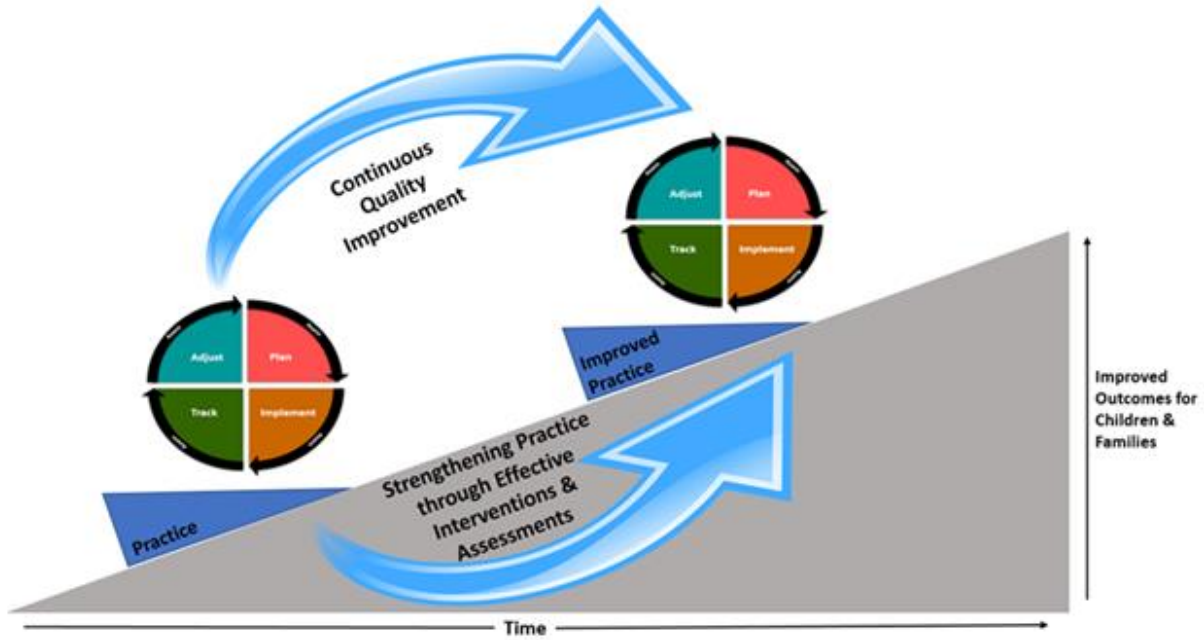
Overview of MDHHS Continuous Quality Improvement Strategy

Michigan is a state administered system implemented in 83 counties which are organized into five distinct Business Service Centers (BSC) geographically aligned by contiguous counties. Michigan's child welfare system operates within state, county (local), and private agencies. Local offices collaborate with BSC QA Analysts on quality improvement strategies and BSC QA Analysts then share local findings with the state-level Division of Continuous Quality Improvement (DCQI). State, local, BSC, and private agency CQI/QA analysts as well as vested stakeholders provide input throughout the CQI process.

The BSC QA analyst is responsible for developing a Continuous Quality Improvement process within a specified BSC to address local barriers and enhance services. They also prepare and coordinate assigned BSC improvement plans aimed to improve client services, program outcomes and quality assurance. The BSC QA Analysts work in collaboration with the BSC Director, the County MDHHS Director, and others who are directly impacted by and interested in the achievement of quality service delivery and outcomes. The BSC QA analyst coordinates and creates mechanisms for the data collection, reporting, and analysis of data for all youth provided services within the BSC.

DCQI currently uses a plan, implement, track, adjust (PITA) CQI cycle to strengthen practice through effective interventions and assessments to improve outcomes for children and families. Figure 7. provides a visual of the current CQI processes. DCQI intends to leverage the PITA CQI cycle in the implementation of Family First and incorporate new pathways for preventive service provider collaboration and tracking of preventive services. Data related to preventive services and case/demographic characteristics of *candidates at imminent risk of entering foster care* will be incorporated into the existing PITA data collection methods, analyzed, and determine if improvements are necessary. See Figure 9. for specific data collection considerations. The integration of Family First prevention services data will occur at the provider, local and state level. Data specific to the fidelity monitoring of evidence-based programming will be collected and shared through reporting to MDHHS CQI teams at the local level. DCQI analysts will collect and analyze this information along with data from the MiSACWIS system to cycle through the CQI processes at the local and state level.

Figure 7. Department of Continuous Quality Improvement CQI Strategy Overview



The existing CQI processes include feedback mechanisms between local offices and regional BSCs and BSCs with the DCQI. Local offices have designated MiTEAM Quality Assurance (MiTEAM QA) Analysts that regularly meet with their regional BSC QA Analyst throughout the PITA cycle. DCQI will leverage the existing CQI meetings to include preventive service providers and action items related to Family First preventive services. MDHHS hired five Community Service Analysts to work closely with the BSC QA Analysts, outlined more in the next section. Figure 8. provides a visual for the revised feedback loop and shows how information will be shared throughout the CQI process following Family First implementation. MDHHS will implement an overall approach to CQI that is comprised of three separate but closely aligned and integrated components: 1) statewide PITA CQI cycle, 2) Family First CQI, and 3) Family First evaluation processes. These components will work in tandem, through the engagement of service providers, state and local MDHHS staff, and key community partners and stakeholders in evidence informed feedback loops and improvement planning processes.

MDHHS will continue to leverage consulting opportunities with Chapin Hall at the University of Chicago during implementation and with partners at the University of Michigan for the evaluation of programs that are not rated as *well-supported* by the Title IV-E Prevention Services Clearinghouse. The following sections outline the details for integrating fidelity monitoring activities for specific EBPs into the overall CQI process and evaluation strategy.

Community Service Analysts

Community Service Analysts will be key to integrating Family First into the current CQI processes. MDHHS hired five Community Service Analysts, one for each BSC, to support statewide CQI activities including contract monitoring and provide additional contributions and oversight to BSC QA Analysts, supervisors, and providers for Family First prevention services. A Community Service Analyst is located in each BSC to facilitate the collection, analysis, and sharing of prevention services data from the local, regional, and state level.

Michigan is institutionalizing CQI expectations through their contracting infrastructure with each EBP prevention provider. Community Service Analysts will receive monthly reports with EBP fidelity monitoring and other measures. They will work closely with model developers, purveyors, or certified trainers and providers to obtain data on the prescribed outcomes of each EBP using the model's prescribed measures. In partnership with existing MiTEAM QA Analysts and BSC QA Analysts, the Community Service Analyst will analyze and incorporate the information into the larger CQI process within MDHHS at the local and state level to refine and improve services. Community Service Analysts will hold quarterly provider meetings and invite additional stakeholders as necessary to share aggregate provider data and facilitate peer sharing.

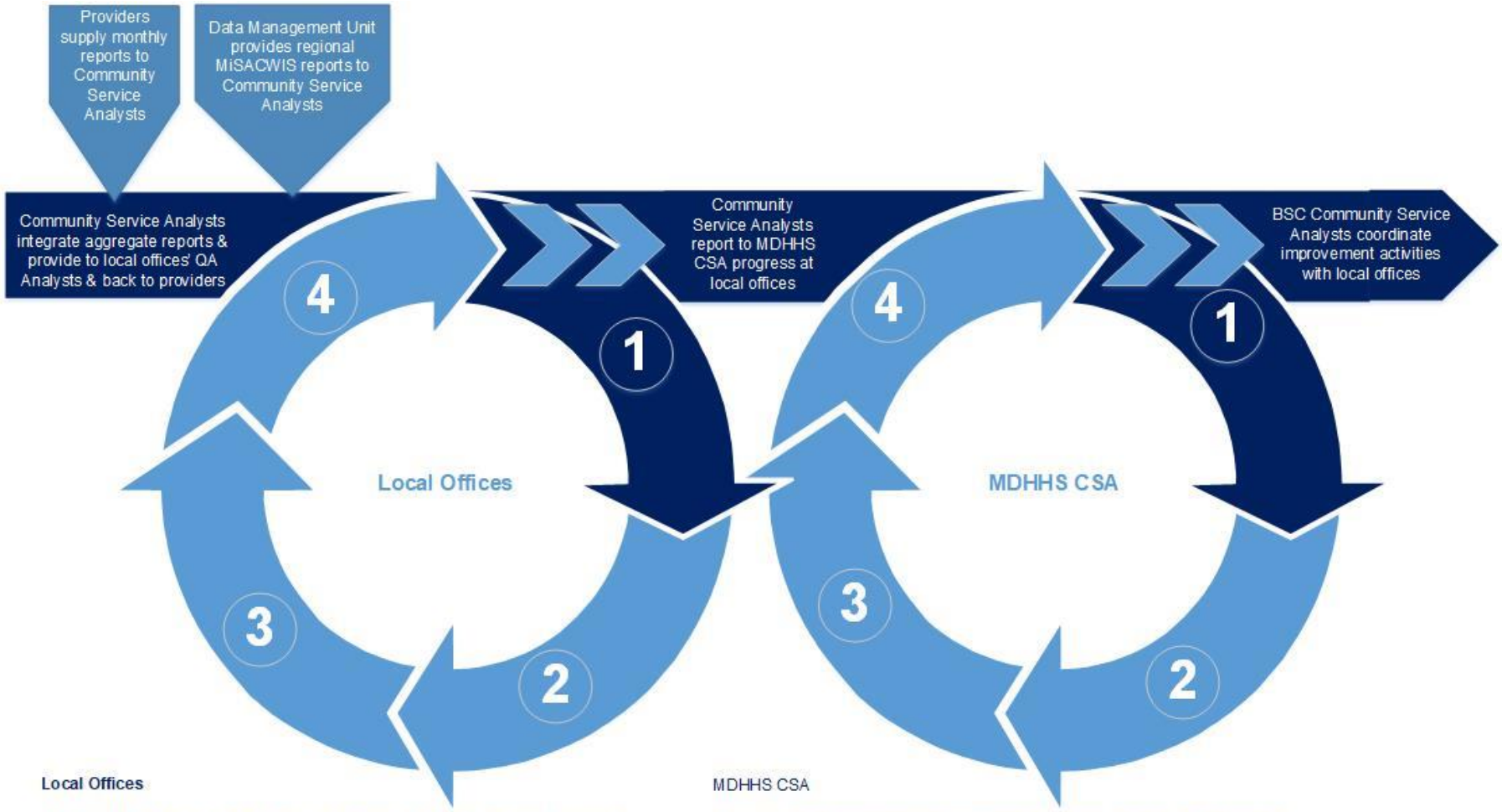
Community Service Analysts will serve as a unique support to the field as well as the prevention provider network to monitor adherence to contract requirements, performance measures, and opportunities for improvement through CQI process. Prevention providers are expected to complete intervention specific fidelity monitoring, as prescribed by each individual implementation manual. Michigan providers were participants in the task groups formed to develop Michigan's CQI process for interventions rated as *well-supported* by the Title IV-E Prevention Services Clearinghouse. They will engage in the development of any new monitoring, case review screening tools or data collection methods developed. This provides additional awareness of state monitoring and fidelity expectations, such as utilizing intervention model specific databases, collaborating with model purveyors to examine client outcomes and ongoing trainings.

Data collected through model specific purveyors, prevention contract reports, evaluators, MiSACWIS, and other CQI mechanisms will be used to assess intervention-specific outcomes by region and provider, as well as statewide aggregated findings on key outcomes, such as rates of entry into foster care and sustained reunification. DCQI will use a measurement framework to intentionally integrate provider level CQI data along with reach and outcome information from MiSACWIS to monitor fidelity to the interventions; whether the interventions are reaching the families they intend to serve; and achievement of intended outcomes (see Figure 9 for reach, fidelity, and outcome measurement framework). CQI processes may also measure additional performance outcomes to the extent possible, like families' experiences and/or satisfaction with the programs or treatment models included in the candidates' child-specific prevention plan.

This data will also be shared with each private provider and local agency office regionally and cycle through the agency CQI feedback loop. Areas identified as needing improvement will reveal systematic and practice issues that need to be addressed to strengthen implementation and ongoing service provisions. Both areas of need and areas of success will be shared at quarterly statewide provider meetings and during BSC stakeholder meetings to further foster a peer learning environment and broader stakeholder collaboration. This feedback will assist in achieving fidelity statewide and identifying areas of growth for agencies, prior to them becoming problematic.

MDHHS and the DCQI will implement a prevention services measurement framework designed to answer research questions related to the reach of prevention services, adherence to EBP model fidelity requirements, and the achievement of key outcomes. The data collected and analyzed to answer the research questions will be used to identify, test, and monitor improvement strategies. Figure 9. presents the measurement framework that will guide implementation of Family First preventive services CQI across EBPs.

Figure 8. Enhanced Family First CQI Strategy Overview



Local Offices

1. MiTEAM QA Analysts receive aggregate reports from their regional Community Service Analyst with provider measures and candidate information to begin analysis with county leadership. In addition, MiTEAM QA Analysts will receive information from their BSC Community Service Analyst results of previous statewide PITA cycle progress.

2. MiTEAM QA Analysts collaborate with BSC QA Analyst to identify any activities to include in their Quality Improvement Activities request form and local CQI plan along with CQI activities outside of Family First.

3. MiTEAM QA Analyst along with the Community Service Analyst and BSC QA Analyst present the aggregate reports and CQI plan at existing local meetings and invite providers to attend. The meetings will be held at a regular cadence that best meets the need of the state and local offices.

4. Results of the discussions will be implemented and incorporated into the local Plan, Implement, Track, Act (PITA) cycle. Community Service Analyst will coordinate and track as well as present at statewide Quality Improvement Council and appropriate workgroup meetings any progress and ensure alignment with MDHHS CSA strategic planning.

MDHHS CSA

1. DCQI Analyst coordinates with Community Service Analysts, in collaboration with BSC QA Analysts, activities related to local Quality Improvement Activities and CQI plans inclusive of Family First related initiatives. DCQI Analyst will identify a sponsor for improvement activities and support implementation.

2. MDHHS CSA leadership will review regional and local plans for improvement during existing meetings. During these meetings leadership will support implementation and ensure alignment with strategic direction.

3. Results of the discussions between Community Service Analysts and QA Analysts will be implemented and incorporated into the statewide Plan, Implement, Track, Act cycle. Community Service Analyst will coordinate and track as well as present at statewide Quality Improvement Council and appropriate workgroup meetings progress and to ensure alignment with MDHHS CSA strategic planning.

4. Community Service Analysts and BSC QA Analysts will provide information back to the local offices information related to the statewide PITA cycle and support implementation of changes.

Figure 9. CQI Measurement Framework

Reach Measures

Measures related to children and families referred to services, outcomes of those referrals, and service uptake and completion.

- Are Family First candidate children/families being identified and referred to EBP services?
- Are referred children and families receiving EBP services?
- What are the demographic and case characteristics of referred children/families receiving EBP services and do they differ from referred children/families not receiving services?
- What is the length of time from referral to the start of services for children/families?
- Are children/families completing services?
- Are there regional variations in EBP referrals, service receipt, and service completion?
- Are there variations in race equity regarding referrals, service receipt, and service completion?

Fidelity Measures

Measures that assess the degree to which the service was carried out with fidelity according to capacity, process, and quality requirements.

- Do the referred children/families meet the eligibility requirements for each specific EBP model?
- Are the EBP services delivered as prescribed by each specific EBP model and guiding manual/curriculum (e.g., fidelity to the model)?
- How many EBP service sessions took place and is this consistent with the EBP model?

Outcome Measures

Measures that assess the impact of the service on child and family outcomes.

Child and family well-being outcomes:

- Do children/families that *receive* an EBP service experience improved outcome in the areas of mental health, substance use, and parenting skills as prescribed by each EBP *(this will be developed based on the EBP-specific program goals)?*
- Do children/families that *complete* an EBP service experience improved outcome in the areas of mental health, substance use, and parenting skills as prescribed by each EBP (*this will be developed based on the EBP-specific program goals*)?

Child safety outcomes:

- Does EBP service *receipt* reduce abuse/neglect? Are children re-referred for suspected child abuse/neglect within 12 months of the child-specific prevention plan start date? Within 24 months?
- Does EBP service *completion* reduce abuse/neglect? Are children re-referred for suspected child abuse/neglect within 12 months of EBP service completion? Within 24 months?

Child permanency outcomes:

- Does EBP service receipt reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
- Does EBP service completion reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?

Family First Preventive Service Array CQI Strategies

Each preventive service will have a unique process for meeting model fidelity requirements and the program-specific data collection will be integrated into the state CQI process. The EBP provider community will provide a standardized report to MDHHS monthly to capture the relevant information. The Community Service Analysts will review the monthly reports and collaborate with providers, QA Analysts, and MiTEAM Analysts in determining if outcomes are being achieved and revise practices to improve as needed. Below are details for each EBP's CQI strategy and incorporation into the statewide CQI process. Also, see Table 7 at the end of the section that includes a summary description of fidelity requirements, processes, and measures for each EBP.

In addition, evaluators will provide stakeholders with quarterly updates using tables and charts based on simple descriptive analyses including penetration/reach of EBPs and outcomes within and across candidate populations: by EBP participation, MDHHS service region, and key demographics (child age, race/ethnicity, and gender). The purposes of these analyses are to provide MDHHS with broad perspective on FFPSA implementation and outcomes, to inform CQI efforts for each EBP, and to provide essential context for the program evaluations.

Evidenced Based Home-Visiting Programs

(Nurse-Family Partnership, Parents as Teachers, Healthy Families America)

MDHHS Children Services Agency (CSA) will partner with the MDHHS Home Visiting Unit (HVU) for Continuous Quality Improvement (CQI) practices that support evidence-based home visiting programs - NFP, HFA, and PAT. The HVU is the recipient of the Maternal, Infant, Early Childhood, Home Visiting Grant (MIECHV). The HVU implements a Health Resources Services Administration (HRSA)-approved CQI state plan for not only home visiting programs funded through the HVU, but programs funded through the Michigan Department of Education as well, creating a strong system of improvement that contributes to program improvement and quality. The HVU monitors all grantees for completion of CQI activities on a quarterly and annual basis. The HVU contracts with the Michigan Public Health Institute to provide additional coaching, support, and data collection for the CQI efforts. Ongoing training and coaching in beginner, intermediate, and advanced CQI methods and tools are provided to grantees.

The HVU utilizes the Plan, Do, Study, Act (PDSA) methodology for all CQI. Michigan convenes a 15-to-18-month CQI Learning Collaborative with topics selected through a comprehensive analysis of statewide data to identify priorities for improvement that will generate system level change.

All grantees participate in local, or individual level, CQI projects to address program-identified areas for improvement to ensure that their evidence-based model is being

implemented with fidelity and quality. Those grantees who are expanded under Family First will have the opportunity to utilize local CQI projects to specifically address improvements they may wish to see to support improvements specific to families served through the five-year prevention plan. All aspects of the HVU CQI work is supported by including parent voice as members of statewide, regional, and local CQI teams. Parent voice and leadership is a hallmark of Michigan's home visiting and larger early childhood systems.

A HVU program analyst and model specific consultants review monthly and quarterly data submissions including enrollment, retention, and caseload capacity. Michigan Public Health Institute is the evaluator for the HVU, collecting all data to ensure grantees are improving on state and federally specified performance measures. Michigan also coordinates with the national model developers to ensure programs are implemented with quality and fidelity to the model. The HVU partners extensively with the HFA Central Office as well as the newly formed PAT State Office for additional support and expertise. Connection with NFP occurs through quarterly check-in calls with regional NFP staff.

The HVU program analysts will provide their regional Community Service Analyst with monthly data submissions that align with the fidelity and outcome measures specified in the five-year prevention plan for each of the EBPs seeking reimbursement under Title IV-E. The reporting requirements will be specified in the contracts and included in contract monitoring activities. If areas for growth are identified, the Community Service Analyst, in collaboration with BSC QA Analysts will determine if existing HVU CQI mechanisms or local CQI mechanisms are most appropriate to champion the improvement strategy.

HOMEBUILDERS

MDHHS CSA will seek formal consultation from HOMEBUILDERS' quality enhancement and training division through the Institute for Family Development. The consultation will include development of quality enhancement plans, measurement approaches, feedback regarding fidelity of service implementation, and delineation of HOMEBUILDERS' standards. The Quality Enhancement System (QUEST) monitors the development and continued improvement of skills needed for program outcomes and fidelity and infrastructure support to integrate into MDHHS CQI processes. Process support will include assistance in hiring staff, workshop training, clinical consultation for therapists and supervisors, technical assistance, client record reviews, review of provider performance on fidelity measures, and review of program outcomes.

Reporting requirements specified in the contract for the HOMEBUILDERS pilot sites will include fidelity and outcome measures. The regional Community Service Analyst will coordinate with a liaison from each of the seven non-profit child and family service agencies for contract monitoring which includes CQI activities. The Community Service

Analyst, in collaboration with the BSC QA Analysts, will determine the best outlets for improvement strategies and the effect on contract monitoring.

Motivational Interviewing

Our goal is to have Motivational Interviewing (MI) used at each encounter with our families. This will require community-based prevention service providers, prevention (CPS-ongoing) caseworkers, and prevention (CPS-ongoing) supervisors to be trained in the use of MI. MDHHS will partner with Motivational Interviewing Network of Trainers (MINT)-certified trainers to provide training to supervisors who will provide critical support to caseworkers in using MI in the development and monitoring of the five-year prevention plan. Community-based EBP service providers will use MI in delivering services. Integrating MI into our current practice model will equip caseworkers with a *well-supported*, evidence-based service to enhance partnering with families to set goals within the child-specific prevention plan, craft strategies and goals, make plans to reach those goals, and boost motivation and internal resolve to follow-through. It will be used seamlessly throughout the life of the family's prevention case to promote uptake of services, ensure completion of services, reduce premature drop-off, and to increase the successful attainment of the child-specific prevention plan including individualized case goals related to improved parenting skills, mental health, and reductions in substance abuse.

Measurement of fidelity is crucial to understanding intervention effects over the short and long-term. The DCQI will gather progress report data from providers and MDHHS supervisors to determine whether family engagement and retention in services following utilization of MI have been achieved. Other metrics will also be considered for measuring family engagement, such as successful completion of case plan services and case closure as well as outcome measures for safety, permanency, and well-being.

MDHHS is studying the available MI fidelity tools to choose the one that will embed within our case practice the most effectively. MDHHS is currently considering:

The *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency (MIA-STEP)* package is a collection of tools for mentoring counselors and other clinicians in the use of MI skills during clinical assessments. *MIA-STEP* was produced by The Addiction Technology Transfer Center (ATTC) Network under a cooperative agreement from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the National Institute on Drug Abuse (NIDA). This document can be found at http://www.motivationalinterviewing.org/sites/default/files/mia-step.pdf.

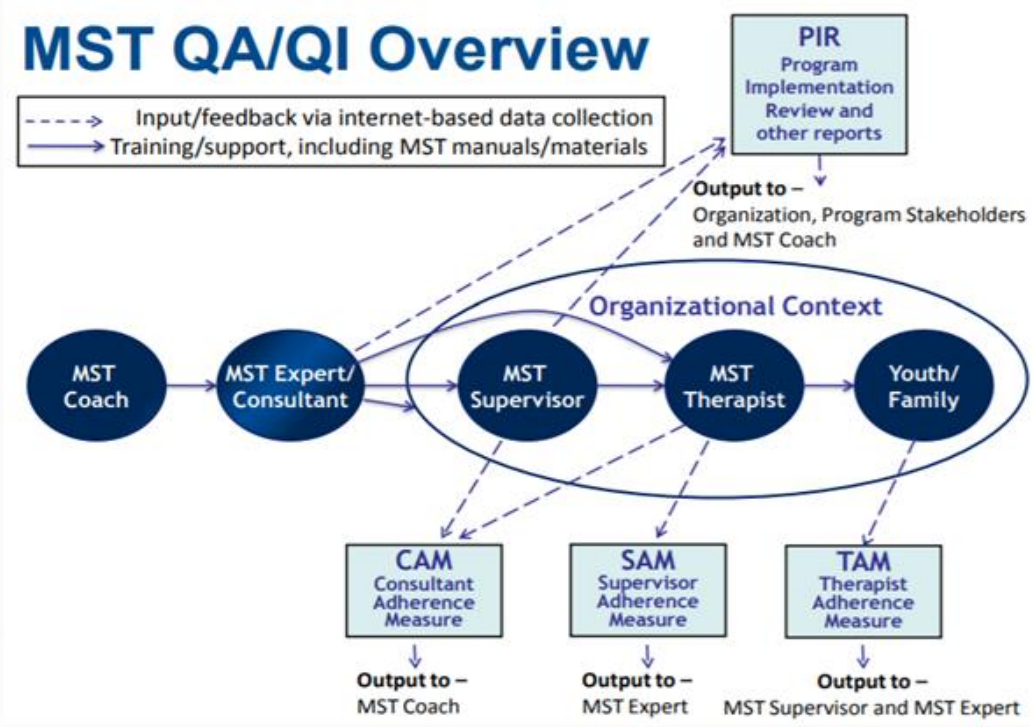
Behavior Change Counseling Index (BECCI) is an instrument designed for trainers to score practitioners' use of Behavior Change Counseling in consultations (either real or simulated). BECCI I is currently being used by prevention providers in Michigan.

Home - Motivational Interview

Multi-Systemic Therapy

Multisystemic Therapy (MST) includes a QA/QI improvement program that provides mechanisms at each level (therapist, supervisor, expert/consultant, and program) for training and support on the elements of the MST treatment model, measuring implementation of MST, and improving delivery of the model as needed. Figure 10 provides a representation of the MST QA/QI system. By providing multiple layers of clinical and programmatic support and ongoing feedback from several sources, the system aims to optimize favorable clinical outcomes through therapist and program level support and adherence. Measurement of the implementation of MST is a function of the MST Institute, and is intended to provide all MST programs around the world with tools to assess the adherence to MST of therapists, supervisors, experts, and organizations.

Figure 10. Multisystemic Therapy QA/QI Overview



A Program Implementation Review (PIR) is compiled by the MST provider, in consultation with the MST Institute, every six months and shared with program stakeholders. The PIR documents both youth outcomes and adherence to the MST model. Program stakeholders review the document with MST providers to identify program strengths and areas to target for improvement.

Model fidelity is embedded in the MST Program. MST is delivered by master's level therapists who work for licensed MST teams and organizations. MST therapists, supervisors, and other staff complete an initial five-day training. Therapists that deliver MST also participate in quarterly clinically focused booster sessions that aim to refresh MST skills and weekly consultations provided by MST experts. MST teams use a structured fidelity assessment approach to ensure clinical service delivery is consistent with the MST model.

The Community Service Analysts will coordinate with MST service providers through contract monitoring, monthly reporting, and quarterly provider meetings. Since most MST providers service the juvenile justice population, the Community Service Analysts will involve the Department of Juvenile Justice and juvenile justice specialists in the CQI process, through individual outreach or inclusion in provider meetings when the juvenile justice population is impacted.

Brief Strategic Family Therapy

Program fidelity and ongoing clinician training are embedded in the Brief Strategic Family Therapy (BSFT) model. BSFT is delivered by therapists with at least a master's degree in social work, marriage and family therapy, psychology, or related field, as well as training in family systems theory and behavioral interventions. Training of clinicians begins following completion of a site readiness process, ensuring the infrastructure exists to support implementation of BSFT with fidelity.

Initial BSFT training consists of didactic exercises, video-recording analysis, and clinical case consultation. Weekly supervision with a BSFT Certified Supervisor occurs weekly for four to six months and consists of review of recorded BSFT family therapy sessions, group feedback and consultation. Once successful mastery of the BSFT principles is demonstrated, fidelity to the model is monitored through progressively less frequent adherence supervision – from monthly to yearly sessions.

Organizations implementing BSFT will be encouraged to use instruments endorsed by the BSFT Institute to gather fidelity, outcome, and any required data. Reporting requirements will be specified in the contract for BSFT which will include fidelity and outcome measures. The regional Community Service Analyst will coordinate directly with providers offering BSFT. The Community Service Analyst, in collaboration with the BSC QA Analysts, will determine the best outlets for improvement strategies and the effect on contract monitoring.

SafeCare

SafeCare is rated as *supported* on the Title IV-E Prevention Services Clearinghouse and will undergo a rigorous evaluation strategy that MDHHS will integrate into the state's CQI processes. A contractual relationship will be developed with model developers to support fidelity monitoring and CQI processes. SafeCare providers will provide standardized reports, to regional Community Service Analysts, monthly and MDHHS will hold a quarterly meeting with evaluation staff to discuss model support and implementation. Community Service Analysts will incorporate data from both pathways into the CQI process to refine and improve practices. Please see Appendix B for more information about the evaluation strategy.

Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy is rated as *promising* on the Title IV-E Prevention Services Clearinghouse and will undergo a rigorous evaluation strategy that MDHHS will integrate into the state's CQI processes. TF-CBT providers will provide standardized reports monthly and MDHHS will hold a quarterly meeting with evaluation staff to discuss model support and implementation. Community Service Analysts will incorporate data from both pathways into the CQI process to refine and improve practices. Please see Appendix B for more information about the evaluation strategy.

Family Spirit

Family Spirit is rated as *promising* on the Title IV-E Prevention Services Clearinghouse and will undergo a rigorous evaluation strategy that MDHHS will integrate into the state's CQI processes. A contractual relationship will be developed with model developers to support fidelity monitoring and CQI processes. MDHHS plans to build an evaluation team inclusive of tribal representation and will contract with an evaluator from the University of Michigan who is a member of a tribe. Family Spirit providers will submit standardized reports monthly and MDHHS will hold a quarterly meeting with evaluation staff to discuss model support and implementation. Community Service Analysts will incorporate data from both pathways into the CQI process to refine and improve practices. Please see Appendix B for more information about the evaluation strategy.

Table 7. Summary description of fidelity requirements, processes, and measures for MDHHS Prevention Evidence Based Practices	
Nurse-Family Partnership (NFP)	Before becoming a NFP Implementing Agency, there must be assurance by the applying agency of its intention to deliver the program with fidelity to the model tested. Such fidelity requires adherence to all the Nurse-Family Partnership Model Elements. The elements can be found at www.nursefamilypartnership.org/communities/model-elements Nurses collect client and home visit data as specified by the Nurse-Family Partnership National Program Office, and all data is sent to the Nurse-Family

Table 7. Summary description of fidelity requirements, processes, and measures for MDHHS Prevention Evidence Based Practices	
	Partnership National Program Office's national database. The Nurse-Family Partnership National Program Office reports out data to agencies to assess and guide program implementation, and agencies use these reports to monitor, identify and improve variances, and assure fidelity to the NFP model.
Parents as Teachers (PAT)	To help achieve fidelity to the PAT model, the PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. In addition, affiliates are expected to participate in the affiliate quality endorsement and improvement process in their fourth year of implementation and every fifth year thereafter.
Healthy Families America (HFA)	HFA requires implementing sites to utilize the HFA Best Practice Standards and to demonstrate fidelity to the standards through periodic accreditation site visits. The HFA Best Practice Standards serve as both the guide to model implementation, as described above, and as the tool used to measure adherence to model requirements. There are 153 standards, and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model. All HFA affiliated sites are required to complete a self-study that illustrates current site policy and practice, and an outside, objective peer review team uses this in conjunction with a multi-day site visit to determine the site's rating (of exceeding, meeting or not yet meeting) for each standard.
HOMEBUILDERS	Each of the 20 Homebuilders Standards has multiple fidelity measures. They are available at http://www.institutefamily.org
SafeCare	There are three fidelity assessment forms that are used for each SafeCare module to assess the Provider's delivery of the program to a family. Each assesses approximately 30 behaviors that should be performed during the SafeCare session (e.g., opens session, observes parent behavior during practice, provides positive and corrective feedback). Each item is rated as "implemented," "not implemented," or "not applicable" to that session. Coaching sessions are also rated for fidelity using a coach fidelity assessment form. The measures can be requested at safecare@gsu.edu.
Multi-Systemic Therapy (MST)	Quality assurance support activities focus on monitoring and enhancing program outcomes through increasing therapist adherence to the MST treatment model. The MST Therapist Adherence Measure (TAM) and the MST Supervisor Adherence Measure (SAM) have been validated in the research on MST with antisocial and delinquent youth and are now being implemented by all licensed MST programs. Both measures are available through the MST Institute at www.mtsi.org. An overview of the Multisystemic Therapy (MST) Quality Assurance Program can be found at https://www.msti.org/mstinstitute/qa_program/. A brief review of the two MST fidelity measures is below: The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a Therapist's adherence to the MST model as reported by the primary caregiver of the family. The adherence scale was originally developed as part of a clinical trial on the effectiveness of MST. The measure proved to have significant value in measuring an MST therapist's adherence to MST and in predicting outcomes for families who received treatment. More information is available at: https://www.msti.org/mstinstitute/qa_program/tam.html. The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists. The measure is based on the principles of MST and the model of supervision presented in the MST Supervisory Manual. More information is available at: https://www.msti.org/mstinstitute/qa_program/sam.html.
Brief Strategic Family Therapy (BSFT)	The program representatives (contact information listed below) administer Standardized Fidelity Rating Instruments for both Competency and Adherence at various intervals of the BSFT® implementation. There is a formal required adherence/fidelity program provided to the BSFT®-competent Therapists via

Table 7. Summary description of fidelity requirements, processes, and measures for MDHHS Prevention Evidence Based Practices	
	periodic adherence supervision sessions. Self-report checklists, trained observations, and video/audio recordings are included in the fidelity rating process. Fidelity Measure Requirements: Clinicians' performance is rated after each session using the BSFT Adherence Certification Checklist and it is based on a rating of the clinician's videotaped session. The rating is initially done by BSFT Institute Faculty until the agency develops its own BSFT Certified Supervisor. The BSFT Adherence Certification Checklist is provided to the agency's staff during training.
Motivational Interviewing	The Motivational Interviewing Treatment Integrity (MITI) is an instrument that yields feedback that can be used to increase clinical skill in the practice of motivational interviewing. The MITI measures how well or how poorly a practitioner is using MI and can be found on casaa.unm.edu/download/miti.pdf. Coding resources to measure fidelity can be found at http://casaa.unm.edu/codinginst.html
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	The TF-CBT Brief Practice Checklist is a self-report form that is available in Appendix 4 of the TF-CBT Implementation Manual. The manual is available from the program representative listed at the end of the entry.
Family Spirit	Family Spirit utilizes a Quality Assurance Form on at least a quarterly basis. A trained supervisor or staff member administers the form in-person during a home visit. They assess the home visitor on specific tasks grouped according to three domains: 1) visit structure; 2) relationship with participant; and 3) adherence, competence, and flexibility. This measure is administered more often if there are concerns with a home visitor's performance. All home-visiting staff members are trained on using this measure during the in-person Family Spirit training. Home visits can also be audio-recorded if the visits cannot be observed. Recording all of them for a period of time and listening to 20% of randomly selected recordings for each home visitor can provide additional quality assurance feedback on home visits. In addition to the Quality Assurance Form, all home visitors are required to complete curriculum knowledge assessments prior to the in-person training and pass with at least 80% on each of the 63 assessments. These knowledge assessments help ensure content mastery leading up to the in-person training session. A copy of these measures can be obtained by emailing Allison Ingalls at aingalls@jhu.edu.

Retrieved from California Evidence-Based Clearinghouse, https://www.cebc4cw.org/

Evaluation Waivers for Well-Supported Interventions

Healthy Families America

The evidence in favor of the use of Healthy Families America (HFA) as a means of promoting positive family dynamics and reducing the risk of foster care placements in Michigan is compelling enough to warrant a waiver. This request for a waiver of the evaluation requirement for Healthy Families America is based on information that families enrolled in HFA:

- Report fewer acts of very serious abuse, minor physical aggression, and psychological aggression and are likely to have a longer period between initial and second reports.
- Enhance positive parenting skills, such as maternal responsivity and cognitive engagement.

Additionally, HFA has demonstrated effectiveness across a variety of geographical regions and across one or more of the target populations identified in Michigan's Family First candidacy definition. Michigan contains a wide geographic diversity including urban, suburban, and rural settings. Currently, HFA programs are being implemented successfully in each of these geographic areas in Michigan, while serving a variety of families whose experience of risk is impacted by the community in which they live.

Nearly half of the participants enrolled in HFA in Michigan are below the federal poverty level. Eighty percent of the families are enrolled in Medicaid, over half have a high school equivalent or less, and 20% are less than 21 years old. HFA serves families in some of the most rural and most urban areas of Michigan (the Upper Peninsula and Wayne County).

Investigations of child maltreatment for families enrolled in HFA in Michigan decreased from 17% to 13%. HFA serves families who have some of the highest risks in the state. Approximately 75% of families enrolled in HFA are provided positive parenting practices including addressing behavioral concerns, early language and literacy activities, and developmental screening.

There is significant research that contributes to the understanding of HFA's efficacy in cultivating and strengthening nurturing parent-child relationships, promoting healthy childhood growth and development, and enhancing family functioning by reducing risk and building protective factors in a variety of geographical locations, including Alaska (Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Cluxton-Keller et al., 2014), Hawai'i (El-Kamary et al., 2004; Bair-Merritt et al., 2010; McFarlane et al., 2013), New York (Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene, 2010; Kirkland & Mitchell-Herzfeld, 2012; Lee, Kirkland, Miranda-Julian, & Greene, 2018), and Oregon (Green, Tarte, Harrison, Nygren, & Sanders, 2014; Green, Sanders, & Tarte, 2017; Green,

Sanders, & Tarte, 2018). HFA's effectiveness in this diverse array of geographic locations indicates the model's wide applicability and suggests that it will also produce positive outcomes in Michigan.

The Title IV-E Prevention Services Clearinghouse and the Home Visiting Evidence of Effectiveness (HOMVEE) websites, both of which promote HFA as a *well-supported* practice, list well-designed research studies that indicate HFA can impact, by partnering with families, additional areas of risk. Blair-Merritt et al.'s (2010) work demonstrates HFA's treatment effect among mothers who reported instances of intimate partner violence, concluding that those who received HFA services reported lower rates of physical assault victimization and significantly lower rates of perpetration relative to the control group. Lee et al. (2009) found HFA to be effective for families across a variety of cultural backgrounds by demonstrating HFA's effectiveness in reducing adverse birth outcomes among socially disadvantaged pregnant women, two-thirds of whom were black or Hispanic.

The HFA model has always supported families in the community including those referred from the child welfare system. Services delivered under the HFA Child Welfare Protocol are no different than the services delivered to other populations or target children in different age ranges. The only distinction under the protocol for families involved in child welfare is the flexible intake window up to 24 months of age for referrals from child welfare. Additionally, because the model was originally designed for families with children ages zero to five, model specific training covers this entire age span, meaning HFA's 3-year minimum length of service ensures children enrolled up to 24 months are served by staff trained to work with families through the age of 5.

References

- Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E., Fuddy, L., & Duggan, A. K. (2010). Reducing maternal intimate partner violence after the birth of a child: A randomized controlled trial of the Hawaii Healthy Start home visitation program. Archives of Pediatrics & Adolescent Medicine, 164(1), 16-23. doi:10.1001/archpediatrics.2009.237
- Cluxton-Keller, F., Burrell, L., Crowne, S. S., McFarlane, E., Tandon, S. D., Leaf, P. J., & Duggan, A. K. (2014). Maternal relationship insecurity and depressive symptoms as moderators of home visiting impacts on child outcomes. Journal of Child and Family Studies, 23(8), 1430-1443. doi: http://dx.doi.org/10.1007/s10826-013-9799-x
- Duggan, A. K., Berlin, L. J., Cassidy, J., Burrell, L., & Tandon, S. D. (2009). Examining maternal depression and attachment insecurity as moderators of the impacts of home visiting for at-risk mothers and infants. Journal of Consulting and Clinical Psychology, 77(4), 788-799. doi: http://dx.doi.org/10.1037/a0015709
- El-Kamary, S. S., Higman, S. M., Fuddy, L., McFarlane, E., Sia, C., & Duggan, A. K. (2004). Hawaii's Healthy Start home visiting program: Determinants and impact of rapid repeat birth. Pediatrics, 114(3), e317-326.

- Green, B. L., Sanders, M. B., & Tarte, J. (2017). Using administrative data to evaluate the effectiveness of the Healthy Families Oregon home visiting program: 2-year impacts on child abuse/neglect & service utilization. Children and Youth Services Review, 75, 77-86. doi: http://dx.doi.org/10.1016/j.childyouth.2017.02.019
- Green, B. L., Tarte, J. M., Harrison, P. M., Nygren, M., & Sanders, M. B. (2014). Results from a randomized trial of the Healthy Families Oregon accredited statewide program: Early program impacts on parenting. Children and Youth Services Review, 44, 288-298. doi: http://dx.doi.org/10.1016/j.childyouth.2014.06.006
- Green, B., Sanders, M. B., & Tarte, J. M. (2018). Effects of home visiting program implementation on preventive health care access and utilization: Results from a randomized trial of Healthy Families Oregon. Prevention Science. https://doi.org/10.1007/s11121-018-0964-8
- Kirkland, K., & Mitchell-Herzfeld, S. (2012). Evaluating the effectiveness of home visiting services in promoting children's adjustment in school. Washington, DC: The Pew Charitable Trusts.
- Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing abuse/neglect recurrence through home visitation: A promising intervention for child welfare involved families. Child Abuse & Neglect, 86, 55-66. doi: http://dx.doi.org/10.1016/j.chiabu.2018.09.004
- McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning. Prevention Science, 14(1), 25-39.
- Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. Child Abuse & Neglect, 34(10), 711-723. doi: http://dx.doi.org/10.1016/j.chiabu.2010.03.004

Parents as Teachers

Michigan is requesting an evaluation waiver for Parents as Teachers (PAT). Parents as Teachers is an evidence-based home visiting model widely implemented in Michigan that promotes optimal early development, learning and health of children by supporting and engaging their parents and caregivers. PAT is a family-centered program that is demonstrated to prevent child abuse/neglect through family support and family strengthening. It is the most widely replicated home visiting model in the United States, serving pregnant women and families with children through kindergarten age. The Parents as Teachers home visiting model meets the criteria for evidence-based and qualifies for the Title IV-E Prevention Services Clearinghouse rated as a *well-supported* practice.

Over 2,300 families were served through Michigan PAT programs in FY20. Of those, 81% had one or more high need characteristics. About 5% of families enrolled in PAT have a high school diploma. Most participants have some college or beyond. PAT ensures they assess family needs. Eighty-seven percent of families received resource connections, 79% received a developmental screening, and 82% received a health review. Approximately 25% of enrolled children had potential developmental or social-emotional delays. 86% of families who enrolled remained with the program, with more than a quarter receiving services for more than 2 years.

Research published in April 2018 in the international, peer-reviewed journal, Child Abuse and Neglect, found that the Parents as Teachers evidence-based home visiting model demonstrates a significant decrease in cases of child abuse/neglect when home visiting services are delivered through a scaled-up, statewide home visiting program. The research represents one of the largest studies in the U.S. conducted to investigate the impact of home visiting on child abuse/neglect, including nearly 8,000 families. Researchers found a 22 percent decreased likelihood of substantiated cases of child abuse/neglect as reported by Child Protective Services data when comparing two groups of children born to first-time mothers (Barbara, H. et al, 2018).

Parents as Teachers home visiting professionals meet families where they are comfortable, typically in their home. Families may have more than one child and can enroll anywhere along the age continuum up to 6. As the ages of children who enter foster care in Michigan are primarily between the ages of zero to five, this model will align well with the families who will be eligible under the candidacy definition, who are at risk of entering the foster care system. The home visitor assesses family needs and partners with parents to set family goals. Each personal visit includes a focus on Parent-Child Interaction, Development-Centered Parenting, and Family Well-Being.

Reference:

- Barbara H. Chaiyachati, Julie R. Gaither, Marcia Hughes, Karen Foley-Schain, John M. Leventhal, *Preventing child abuse/neglect: Examination of an established statewide home-visiting program*. Child Abuse & Neglect: Volume 79, 2018, Pages 476-484, ISS 0145-2134, https://doi.org/10.1016/j.chiabu.2018.02.019.

Nurse-Family Partnership

Considerable evidence exists to support request for an evaluation waiver for the Nurse-Family Partnership (NFP) program which is implemented in Michigan. NFP has evidence of effectiveness the model can impact:

- Reduction of child abuse/neglect
- Enhancement of parental knowledge about child development
- Improvement in long-term economic self-sufficiency of families
- Reduction of injury and hospitalizations
- Improvement in maternal and child health

Nearly 65% of families enrolled in NFP in Michigan are below the federal poverty level. Approximately 75% are enrolled in Medicaid, over half have a high school equivalent or less, and 25% are less than the age of 21 years, with 10% younger than 17 years of age.

Fewer children enrolled in Michigan NFP have been seen in the ED for child injury compared to the national threshold (3.4% vs. 4%). Fewer families (9%) have had an investigated case of child maltreatment. More families enrolled in NFP (44%) are connected to depression services than the national average of families in home visiting (41%). Positive parenting practices including assessing behavioral concerns, developmental screening, and supporting early language and literacy are experienced by an average of 75% of families enrolled in NFP.

NFP has a strong and demonstrated history of success with its target population of first-time pregnant women, and in Michigan, has been effective in supporting pregnant and parenting youth who share characteristics similar to those expected to be eligible as part of Michigan's candidacy definition (including first time pregnant and parenting teens in foster care). NFP is a *well-supported* program on both the Title IV-E Prevention Services Clearinghouse and the HOMVEE websites and has decades of research indicating the model's ability to support families to achieve positive outcomes. Outcomes for families enrolled in NFP are evident through the original studies completed by NFP in New York, Tennessee, and Colorado that included a diverse group of participants. Family outcomes from these randomized control trials include a 48% reduction of child abuse and neglect (Reanalysis Olds et al., 1997), a 56% reduction in ER visits for accidents (Olds DL, et al., 2004), 82% increase in months that parents are employed (Olds DL, et al., 1988), 59% reduction in child arrests at age 15 (Reanalysis Olds et al., 1988), and 67% less behavioral/intellectual concerns at age 6 (Reanalysis Olds et al., 1988).

NFP is built on the premise that visiting nurses can build trust with families, serve as a parenting resource, and provide a support network while engaging a family to develop their own network. NFP only enrolls first time mothers who are less than 28 weeks pregnant. The model will serve families until the child reaches their second birthday. As

a *well-supported* and evidence-based home visiting program, it is an essential part of Michigan's home visiting system.

PAT, HFA, and NFP are all part of the Michigan Home Visiting Initiative, a statewide system of evidence-based home visiting models. Each of these three models are implemented in communities identified as having higher risk through the FAMILY FIRST and MIECHV Statewide Needs Assessments and must meet quality and fidelity requirements of Michigan's home visiting law, Public Act 291 of 2012.

References:

- Olds D.L., Henderson C.R. Jr., Tatelbaum R., Chamberlin R. Improving the life-course development of socially disadvantaged mothers: a randomized trial of nurse home visitation. 1988
- Olds DL, et al. Effects of nurse home visiting on maternal life-course and child development: age-six follow-up of a randomized trial. Pediatrics. 2004
- Reanalysis Olds et al. Long-term effects of home visitation on maternal life course and child abuse and neglect fifteen-year follow-up of a randomized trial. Journal of the American Medical Association. 1997 2. Olds DL, et al. Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics. 1986
- Reanalysis Olds et al. Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-year follow-up of a randomized controlled trial. Journal of the American Medical Association. 1998

HOMEBUILDERS

HOMEBUILDERS is rated as *well-supported* by the Title IV-E Prevention Services Clearinghouse, family-centered program which provides short-term, crisis-oriented services to families in their homes and communities. HOMEBUILDERS is versatile as it can prevent placements of children in foster care, institutions, and juvenile detention. It can also facilitate early returns from those settings and prevent re-removals.

HOMEBUILDERS utilizes a variety of techniques to increase family functioning and reduce risk including Motivational Interviewing, skill building, and parenting support.

HOMEBUILDERS meets the needs of Michigan's target population as the program can work with families with children ages 0-17. HOMEBUILDERS can be applied in rural, urban, and suburban settings and accommodate Michigan's diverse ethnic and racial populations. Finally, HOMEBUILDERS addresses issues that affect Michigan families including substance abuse and mental health.

References:

- Fraser, M. W., Walton, E., Lewis, R. E., Pecora, P. J., & Walton, W. K. (1996). An experiment in family reunification: Correlates of outcomes at one-year follow-up.

Children and Youth Services Review, 18(4-5), 335-361. doi: https://doi.org/10.1016/0190-7409(96)00009-6
- Walton, E. (1996). Family functioning as a measure of success in intensive family preservation services. Journal of Family Social Work, 1(3), 67-82.
- Walton, E. (1998). In-home family-focused reunification: A six-year follow-up of a successful experiment. Social Work Research, 22(4), 205-214. doi:10.1093/swr/22.4.205
- Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. Child Welfare, 72(5), 473-487.
- Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). Evaluation of Family Preservation and Reunification Programs: Final Report. Washington, DC: U.S. Department of Health and Human Services.
- Westat, Chapin Hall Center for Children, & James Bell Associates. Evaluation of family preservation and reunification

Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based, client-centered method 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 the stages of change. 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. MI is a cross-cutting intervention which has demonstrated flexibility and favorable outcomes to promote behavior change with a range of target populations, cultural backgrounds and for a variety of problem areas. It has been shown to be an effective intervention when used by itself or together with a combination of other treatments to reduce risk of abuse/neglect and placement into out of home care.

Numerous studies and evidence support the conclusion of Motivational Interviewing (MI) as a *well-supported* evidence-based service. The usefulness of MI has been demonstrated in outpatient clinic settings, youth programs, correctional institutions, hospitals, schools, and several other environments where child welfare-involved families receive services. On the Title IV-E Prevention Services Clearinghouse, seventy-five studies were reviewed demonstrating a favorable impact to parental or caregiver substance use. The strategies are designed to promote behavioral change through the five stages of change. Increasing motivation reinforces behavioral change that is possible with the setting of behaviorally based goals and is a widely used counseling approach. Based on previous studies and evaluation reports, MDHHS feels that CQI measures will be sufficient.

References:

- Arnaud, N., Diestelkamp, S., Wartberg, L., Sack, P.-M., Daubmann, A., & Thomasius, R. (2017). Short- to midterm effectiveness of a brief motivational intervention to reduce alcohol use and related problems for alcohol intoxicated children and adolescents in pediatric emergency departments: A randomized controlled trial. Academic Emergency Medicine, 24(2), 186-200. doi:10.1111/acem.13126
- Baer, J. S., Kivlahan, D. R., Blume, A. W., McKnight, P., & Marlatt, G. A. (2001). Brief intervention for heavy-drinking college students: 4-year follow-up and natural history. American Journal of Public Health, 91(8), 1310-1316. doi:10.2105/ajph.91.8.1310
- Bernstein, J., Heeren, T., Edward, E., Dorfman, D., Bliss, C., Winter, M., & Bernstein, E. (2010). A brief motivational interview in a pediatric emergency department, plus 10-day telephone follow-up, increases attempts to quit drinking among youth and young adults who screen positive for problematic drinking. Academic Emergency Medicine, 17(8), 890-902. doi:10.1111/j.1553-2712.2010.00818.x
- Carey, K. B., Carey, M. P., Maisto, S. A., & Henson, J. M. (2006). Brief motivational interventions for heavy college drinkers: A randomized control trial. Journal of Consulting and Clinical Psychology, 74(5), 943-954. doi: 10.1037/0022-006X.74.5.943
- 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
- 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
- Diaz Gomez, C., Ngantcha, M., Le Garjean, N., Brouard, N., Lasbleiz, M., Perennes, M., . . . Bellou, A. (2019). Effect of a brief motivational intervention in reducing alcohol consumption in the emergency department: A randomized controlled trial. European Journal of Emergency Medicine, 26(1), 59-64. doi:10.1097/MEJ.0000000000000488
- Diestelkamp, S., Arnaud, N., Sack, P.-M., Wartberg, L., Daubmann, A., & Thomasius, R. (2014). Brief motivational intervention for adolescents treated in emergency departments for acute alcohol intoxication - a randomized-controlled trial. BMC Emergency Medicine, 14, 13. doi:10.1186/1471-227X-14-13
- Fernandez, A. C., Waller, R., Walton, M. A., Bonar, E. E., Ignacio, R. V., Chermack, S. T., . . . Blow, F. C. (2019). Alcohol use severity and age moderate the effects of brief interventions in an emergency department randomized controlled trial. Drug & Alcohol Dependence, 194, 386-394. doi: 10.1016/j.drugalcdep.2018.10.021

- Field, C. A., & Caetano, R. (2010). The effectiveness of brief intervention among injured patients with alcohol dependence: Who benefits from brief interventions? Drug and Alcohol Dependence, 111(1-2), 13-20. doi: http://dx.doi.org/10.1016/j.drugalcdep.2009.11.025
- Field, C. A., Caetano, R., Harris, T. R., Frankowski, R., & Roudsari, B. (2010). Ethnic differences in drinking outcomes following a brief alcohol intervention in the trauma care setting. Addiction, 105(1), 62-73. doi: http://dx.doi.org/10.1111/j.1360-0443.2009.02737.x
- Field, C., & Caetano, R. (2010). The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with Hispanics. Alcoholism, 34(2), 262-271. doi: http://dx.doi.org/10.1111/j.1530-0277.2009.01089.x
- Field, C., Walters, S., Marti, C. N., Jun, J., Foreman, M., & Brown, C. (2014). A multisite randomized controlled trial of brief intervention to reduce drinking in the trauma care setting: How brief is brief? Annals of Surgery, 259(5), 873-880. doi:10.1097/SLA.0000000000000339
- Freyer-Adam, J., Coder, B., Baumeister, S. E., Bischof, G., Riedel, J., Paatsch, K., . . . Hapke, U. (2008). Brief alcohol intervention for general hospital inpatients: A randomized controlled trial. Drug and Alcohol Dependence, 93(3), 233-243. doi: http://dx.doi.org/10.1016/j.drugalcdep.2007.09.016
- 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
- Gaume, J., Gmel, G., Faouzi, M., Bertholet, N., & Daeppen, J. B. (2011). Is brief motivational intervention effective in reducing alcohol use among young men voluntarily receiving it? A randomized controlled trial. Alcoholism, 35(10), 1822-1830. doi: 10.1111/j.1530-0277.2011. 01526.x
- Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., . . . Ries, R. R. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Annals of Surgery, 230(4), 473-480.
- Hansen, A. B. G., Becker, U., Nielsen, A. S., Grønbæk, M., & Tolstrup, J. S. (2012). Brief alcohol intervention by newly trained workers versus leaflets: Comparison of effect in older heavy drinkers identified in a population health examination survey: A randomized controlled trial. Alcohol and Alcoholism, 47(1), 25-32. doi: 10.1093/alcalc/agr140
- Marlatt, G. A., Baer, J. S., Kivlahan, D. R., Dimeff, L. A., Larimer, M. E., Quigley, L. A., . . . Williams, E. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. Journal of Consulting and Clinical Psychology, 66(4), 604-615. doi:10.1037/0022-006X.66.4.604

- Merrill, J. E., Reid, A. E., Carey, M. P., & Carey, K. B. (2014). Gender and depression moderate response to brief motivational intervention for alcohol misuse among college students. Journal of Consulting and Clinical Psychology, 82(6), 984-992. doi: http://dx.doi.org/10.1037/a0037039
- Palm, A., Olofsson, N., Danielsson, I., Skalkidou, A., Wennberg, P., & Högberg, U. (2016). Motivational interviewing does not affect risk drinking among young women: A randomized, controlled intervention study in Swedish youth health centres. Scandinavian Journal of Public Health, 44(6), 611-618. doi: http://dx.doi.org/10.1177/1403494816654047
- 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.
- Roudsari, B., Caetano, R., Frankowski, R., & Field, C. (2009). Do minority or white patients respond to brief alcohol interventions in trauma centers? A randomized trial. Annals of Emergency Medicine, 54(2), 285-293. doi: 10.1016/j.annemergmed.2009.01.033
- Roy-Byrne, P., Bumgardner, K., Krupski, A., Dunn, C., Ries, R., Donovan, D., . . . Zarkin, G. A. (2014). Brief intervention for problem drug use in safety-net primary care settings: A randomized clinical trial. JAMA, 312(5), 492-501. doi: http://dx.doi.org/10.1001/jama.2014.7860
- 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
- Saitz, R., Palfai, T. P., Cheng, D. M., Horton, N. J., Freedner, N., Dukes, K., . . . Samet, J. H. (2007). Brief intervention for medical inpatients with unhealthy alcohol use: A randomized, controlled trial. Annals of Internal Medicine, 146(3), 167-176. doi:10.7326/0003-4819-146-3-200702060-00005
- 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
- Stein, M. D., Herman, D. S., & Anderson, B. J. (2009). A motivational intervention trial to reduce cocaine use. Journal of Substance Abuse Treatment, 36(1), 118-125. doi: http://dx.doi.org/10.1016/j.jsat.2008.05.003

Multi-Systemic Therapy

Considerable evidence exists to support the evaluation waiver request for the Multi-Systemic Therapy (MST) program expansion in Michigan. MST is a *well-supported* intensive, in-home treatment for families with youth ages 12 – 17. Research demonstrates the positive impact of MST on both child and parent domains, including:

- Reducing out of home placement
- Reduced substance use and delinquent behavior
- Improved behavioral and emotional functioning of youth
- Improved positive parenting practices
- Improved caregiver mental and emotional health
- Improved family functioning.

MST is an intensive in-home, community-based treatment program for “troubled” youth age 12-17. Through engagement, continuous assessment of the drivers of behavior and interventions, MST Treatment works to eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) and empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighborhood problems. According to the California Evidenced-Based Clearinghouse for Child Welfare, MST is a *well-supported* program which provides intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.

The selection of MST is advantageous for families with teenagers (one of Michigan’s three priority target populations) to address the Michigan risk factors for child welfare involvement of youth substance use and mental health. MST has been shown to be extremely effective at improving conduct among youth and adolescents with behavior problems, including antisocial and violent behaviors (Henggeler et al., 1997; Jansen et al., 2013), justice system involvement (Schaeffer & Borduin, 2005; Weiss et al., 2013), and substance abuse (Henggeler et al., 1991).

MST has been shown to be efficacious with diverse populations across a wide variety of geographical locations across the Netherlands (Asscher et al., 2014), England (Fonagy et al., 2018), Norway (Ogden & Halliday-Boykins, 2004), and the United States (Johnides, Borduin, Wagner, & Dopp, 2017). MST has also been shown effective in a range of settings, including community mental health (Henggeler, Melton, Brondino,

Scherer, & Hanley, 1997) and juvenile justice systems (Weiss et al., 2013). MST is scalable in Michigan, where eleven licensed teams provide MST through juvenile courts and community mental health in 10 of Michigan's 83 counties.

References:

- Asscher, J. J., Dekovic, M., Manders, W., van der Laan, P. H., Prins, P. J. M., van Arum, S., & Dutch MST Cost-Effectiveness Study Group. (2014). Sustainability of the effects of Multisystemic Therapy for juvenile delinquents in the Netherlands: Effects on delinquency and recidivism. Journal of Experimental Criminology, 10(2), 227-243.
- Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., . . . Goodyer, I. M. (2018). Multisystemic Therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): A pragmatic, randomized controlled, superiority trial. The Lancet. Psychiatry, 5(2), 119-133. doi:10.1016/S2215-0366(18)30001-4
- Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., & Fucci, B. R. (1991). Effects of Multisystemic Therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. Family Dynamics of Addiction Quarterly, 1, 40-51.
- Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65(5), 821-833.
- Henggeler, S. W., Melton, G. B., Brondino, M. J., Scherer, D. G., & Hanley, J. H. (1997). Multisystemic Therapy with violent and chronic juvenile offenders and their families: The role of treatment fidelity in successful dissemination. Journal of Consulting and Clinical Psychology, 65(5), 821-833.
- Jansen, D. E. M. C., Vermeulen, K. M., Schuurman-Luinge, A. H., Knorth, E. J., Buskens, E., & Reijneveld, S. A. (2013). Cost-effectiveness of Multisystemic Therapy for adolescents with antisocial behaviour: Study protocol of a randomized controlled trial. BMC Public Health, 13, 369-369. doi:10.1186/1471-2458-13-369
- Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of Multisystemic Therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. Journal of Consulting and Clinical Psychology, 85(4), 323-334. doi:10.1037/ccp0000199
- Ogden, T., & Halliday-Boykins, C. A. (2004). Multisystemic treatment of antisocial adolescents in Norway: Replication of clinical outcomes outside of the US. Child and Adolescent Mental Health, 9(2), 77-83. doi: doi:10.1111/j.1475-3588.2004.00085.x
- Schaeffer, C. M., & Borduin, C. M. (2005). Long-term follow-up to a randomized clinical trial of Multisystemic Therapy with serious and violent juvenile offenders. Journal of Consulting and Clinical Psychology, 73(3), 445-453.

- Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. Journal of Consulting and Clinical Psychology, 81(6), 1027-1039. doi:10.1037/a0033928

- Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., . . . Guth, C. (2013). An independent randomized clinical trial of Multisystemic Therapy with non-court-referred adolescents with serious conduct problems. Journal of Consulting and Clinical Psychology, 81(6), 1027-1039. doi:10.1037/a0033928

Brief Strategic Family Therapy

Compelling evidence exists to support the evaluation waiver request for Brief Strategic Family Therapy (BSFT). BSFT is rated as a *well-supported* program by the Title IV-E Prevention Services Clearinghouse in three categories: Youth Substance Use Disorders; Youth Mental Health and Parenting Skills. BSFT is an intensive, in-home treatment for families with youth ages 6 – 17 who are at risk for developing problem behaviors including drug use; antisocial peer associations; bullying or truancy. Research demonstrates the positive impact of BSFT on both child and parent domains, including:

- Improved behavioral and emotional functioning of youth
- Reduced delinquent behavior
- Reduced parent/caregiver substance use
- Improved family functioning

BSFT assumes that family-based interactions strongly influence how children behave, and that targeting and improving maladaptive family interactions reduces the likelihood of symptomatic behavior. Therapy progresses in three phases: 1) JOINING –forming therapeutic relationships with all family members; 2) DIAGNOSIS – working with the family to identify interactional patterns that give rise to / encourage / enable problem youth behavior and 3) RESTRUCTURING - addressing behavior, affect and cognition, assists the family in changing the family interactions that are directly related to the problem behavior.

Model fidelity is highly rated with positive outcomes of BSFT. Provider organizations are prepared to integrate BSFT into their organizational framework prior to therapist training to build the infrastructure necessary for fidelity and sustainability. BSFT Therapists then engage in initial training and supervision leading to competency and agency licensing. BSFT Therapists are required to annually maintain their certification through adherence supervision with BSFT Supervisors.

The selection of BSFT for advantageous for families with teenagers (one of Michigan's three priority target populations) to address the Michigan risk factors for child welfare involvement of substance use and mental health. Horigian, V. E., Feaster, D. J.,

Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015) noted the effects of BSFT on parental substance abuse and the connection between parent substance use and adolescent substance use. BSFT significantly reduced alcohol use by parents from baseline to 12 months. In addition, the analysis found that children of parents who reported drug use at baseline had three times as many days of reported substance use at baseline compared with children of parents who did not use or only used alcohol. Adolescents of parents who used drugs at baseline in the BSFT group had a significantly lower trajectory of substance use than adolescents in other treatment programs.

Coatsworth, J., Santisteban, D., McBride, C., & Szapocznik, J. (2001) found families randomized into BSFT were 2.3 times more likely to engage and retain in treatment than comparison families. Study results indicated that the families assigned to BSFT had significantly higher rates of engagement (81% vs. 61%) and retention (71% vs. 42%) than those assigned to a community comparison program. BSFT was also more effective than community comparison programs in retaining more severe cases, specifically cases with high levels of adolescent conduct disorder, and, despite the higher percentage of difficult-to-treat cases, achieved comparable treatment effects on behavior problems.

According to the BSFT Institute, BSFT was originally developed for Hispanic families. Since origination, multiple studies have demonstrated the effectiveness of BSFT with racially diverse populations finding a positive impact on reducing youth problem behaviors (substance use, externalized mental health, delinquency) and improving family functioning.

References:

- Coatsworth, J. D., Santisteban, D. A., McBride, C. K., & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. Family Process, 40(3), 313-332.
- Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. Addictive Behaviors, 42, 44-50. doi: 10.1016/j.addbeh.2014.10.024
- Robbins, M. S., Feaster, D. J., Horigian, V. E., Puccinelli, M. J., Henderson, C., & Szapocznik, J. (2011). Therapist adherence in brief strategic family therapy for adolescent drug abusers. Journal of Consulting and Clinical Psychology, 79(1), 43-53.
- Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., & ... Szapocznik, J. (2011). Brief Strategic Family Therapy versus treatment as usual: Results of a multisite randomized trial for substance using adolescents. Journal of Consulting and Clinical Psychology, 79(6), 713-727.

- Santisteban, D., Perez-Vidal, A., Coatsworth, J., Kurtines, W., Schwartz, S., LaPerriere, A., & Szapocznik, J. (2003). Efficacy of Brief Strategic Family Therapy in modifying Hispanic adolescent behavior problems and substance use. Journal of Family Psychology, 17(1), 121-133.
- Szapocznik, J., Kurtines, W. M., Foote, F. H., Perez-Vidal, A., & Hervis. O. (1983). Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. Journal of Consulting and Clinical Psychology, 51, 889-899.

Section VII: Child Welfare Workforce Training and Support

Pre-print Section 5

Training Plans and Strategies for Child Welfare and Juvenile Justice Workforce

MDHHS is committed to a skilled workforce to assess families' protective factors, areas of need, and strategies to engage in a trauma-informed way. This section outlines the training MDHHS currently provides, and new training needed to ensure effective implementation of Family First. MDHHS currently partners with universities from across the state for ongoing training and plan to expand to include Family First specific training.

Michigan has identified the supervisor role as a critical component to promote appropriate identification of candidates and referrals to prevention services. A robust training and support program for supervisors will be elevated to support Family First implementation. All supervisors receive training through the New Supervisor Institute (NSI). NSI is a four-week program specific curriculum consisting of general child welfare content, program-specific training, a hands-on field week, and leadership topics. Family First specific content will be embedded into week two of NSI during program-specific training. During this week, supervisors will learn about their role in supporting caseworkers in identification of candidates, child specific prevention planning, service linkage, and ongoing safety monitoring. They will also learn of the role of field mentors and community service analysts to serve as another level of support to supervisors, field caseworkers, community providers, and families. Supervisors will receive additional training through the Family First modules outlined below.

Every MDHHS CPS, foster care, MYOI, and adoption caseworker must complete a nine-week Pre-Service Institute (PSI) training that is a combination of classroom, online, and on-the-job training designed to help new caseworkers learn and implement the basic skills necessary to meet the complex needs of the children and families served by the Michigan child welfare system. MDHHS training staff and field supervisors support caseworkers through the step-by-step training process. Juvenile justice specialists often work with children in foster care as well as those under the supervision of MDHHS through the court system and must complete the nine-week PSI training in addition to training specific to youth involved with the juvenile justice system. All services available to youth in foster care and their families are also available to children under the supervision of MDHHS through court order and this will include prevention services related to Family First. As part of this training, caseworkers develop skills to identify child and family needs to refer them to appropriate services. Caseworkers are trained to incorporate a strength-based approach to engaging families in a wholistic assessment process that identifies barriers such as poverty or environmental factors. Additionally, caseworkers learn skills to develop a personal resource guide to understand services available in the area and the program outcomes to support families. The PSI and NSI training currently include instruction on the Structured Decision Making (SDM) tool and

will also undergo enhancements to include specific information about prevention programs and new processes as it relates to determining eligibility and child-specific prevention plan development.

Michigan is made up of 83 counties with five Business Service Centers (BSC) that serve as regional feedback loops between MDHHS and the local departments. As part of the child welfare transformation and focus on prevention, MDHHS intends to hire a Community Service Analyst at each BSC to act as a liaison and mentor in implementation of Family First. The Community Service Analysts will be trained to:

- Educate local department supervisors and caseworkers on the array of preventive services available in their region and ensure appropriate linkages based on family need.
- Provide mentorship and training opportunities on the new processes related to Family First requirements.
- Participate in the continuous quality improvement process and provide necessary requirements from the local departments to MDHHS.
- Ensure availability of services across the state and continuously recommend expansion to meet the changing needs of families.

Additional modules and revisions to existing PSI and ongoing training are planned as part of Family First implementation. MDHHS is committed to enhancing the workforce's knowledge of trauma-informed care and educate families of how existing traumas may be impacting their lives. The enhancements will include the following:

Develop a new Family First training module

MDHHS will develop a new module related to Family First which will include:

1) Family First overview.

2) Caseworker supports and sequencing activities.

3) Videos about EBP prevention services presented by local providers and MDHHS staff that outline the program's target populations, services, and outcomes.

The training module will be available to existing caseworkers, new hires and EBP providers.

Trauma specific assessment tools to ensure a trauma-informed workforce

MDHHS PSI training currently provides trauma training through a module entitled "Trauma and Crisis Management". This module is supplemented with the Children's Trauma Assessment Center (CTAC) Trauma Screening Checklist for parents. In addition to CTAC, caseworkers receive education on Adverse Childhood Experiences (ACEs) to effectively engage parents, assess needs, and appropriately link families to services.

Integration of an equity lens to training

CPS, foster care, juvenile justice specialists and adoption caseworkers will complete an implicit bias assessment and be trained on cultural competence. Cultural Awareness training is also available at the request of MDHHS and Private Agencies on an ongoing basis. Office of Workforce Development and Training (OWDT) is currently working with tribal Partners in building a training curriculum for tribal caseworkers. OWDT is in the beginning phases of development. OWDT will meet with the tribes to discuss training needs and collaborate for training content development and deployment.

Targeted training to identify candidates and service linkage

MDHHS has incorporated family specific training curricula targeted at domestic violence and substance-use safety planning to better support identification and service linkage. Substance abuse and domestic violence were two areas identified through the data analysis of family needs and the programs outlined below will further enhance support to families.

- **"**Safety by Design" curriculum is currently a part of the PSI and promotes skills in caseworkers to be proactive in engaging families in safety planning. The training includes information on how to guide families in identifying safety and protective factors for plan development.
- The "Safe and Together" domestic violence training model also known as the MiTEAM Domestic Violence Enhancement Training, offers an 18-hour course that includes a perpetrator pattern-based, child-centered, and survivor strengths approach. The model includes all members of the family in safety plan development and has been correlated with a reduction in out of home placements.
- Michigan began partnering with the National Center on Substance Abuse and Child Welfare (NCSACW) in 2020 to receive time limited technical assistance. As a result of a caseworker survey, the following project goals were established:

    1. ***GOAL 1:*** Identify and implement substance use training and coaching that includes parent engagement, symptoms, warning signs, identification, treatments, relapse, and recovery planning.

    2. ***GOAL 2:*** Review and assess the current implementation of Plans of Safe Care for infants affected by substance abuse. Determine any current and future system change needs.

    3. ***GOAL 3***: Develop a process that CPS and foster care workers can use to assess parenting capacity, parenting time, permanency planning, and child safety concerns when substance use is a factor.

    4. ***Goal 4:*** Identify changes required to the Comprehensive Child Welfare Information System (CCWIS) to capture data required for Plan of Safe

Care reporting to the National Child Abuse and Neglect Data System (NCANDS) and to inform agency leadership about Plan of Safe Care implementation.

The technical assistance team consists of a core workgroup that meets monthly as well as an executive team that meets quarterly or as needed to assist in decision making.

The recommended substance use training for child welfare caseworkers is summarized below:

Recommended for new hires within a year of hire date

NCSACW Online Tutorial for Child Welfare Training | National Center on Substance Abuse and Child Welfare (NCSACW) (samhsa.gov)

- Self-paced.
- Aligned with cross systems training.
- Certificate of completion and available CEU's.
- Currently available.

Working with Substance Affected Families Webinar Training

Office of Workforce Development &Training Webinar Series

- Designed with stakeholder input.
- Will be available on Learning Management System for current caseworkers to complete as needed.
- Scaffolds onto previous training.

Webinar 1

Reduce the stigma we may unintentionally be displaying towards clients who use substances and help instill a desire to partner with them.

Webinar 2

Discuss the tools and resources available to caseworkers to assist in identifying substance abuse issues. Evaluate the impact of substance use on the Townsend family (case study).

Webinar 3

Discuss the substance use recovery process—what recovery means, caseworker role in the process, and how to assess the person who uses substances to determine family safety and parenting time. Review the Townsend family case study again and look at how we can create a long-term safety plan for them.

Webinar 4

The facilitator will lead a panel of internal and external partners to answer questions related to field practice with families who have substance use issues. The discussion will summarize/reinforce the topics discussed in webinars 1

through 3. Learners will listen to success stories from champions in CPS and foster care. Learners may also share their own experiences.

Mentorship

Experienced caseworkers in the field are assigned to all new employees as part of PSI to provide hands-on support in the field. Mentors assist new hires in progressively building case practice knowledge and shadow the new hire as they complete key activities in a case. The mentor will model and demonstrate key practice skills for engagement with families and linkages to services as part of direct field assessment activities. They serve as a secondary support and liaison between the caseworkers, their supervisor, and the community. Additionally, field mentors will serve as a Family First prevention services expert to assist new caseworkers in engaging with families to identify needs and connect families with appropriate prevention services. This will include support in building out the new caseworkers' resource list. Private foster care caseworkers that will be identifying and linking candidates to services also have access to the mentor training and support.

Tailored in-service training for development of child-specific prevention plans

MDHHS plans to develop Learning Labs for caseworkers to develop skills to identify children and families' service needs for the child-specific prevention plan development related to Family First. These trainings occur in the field as a refresher to content provided in PSI and NSI. They are more individualized and able to be tailored to specific case scenarios as caseworkers gain more field experience. The Learning Labs will support individual capacity building and will be provided after receiving PSI training and a foundational understanding of Family First legislation (candidacy eligibility determination, prevention programming, ongoing safety monitoring). Learning labs offered during PSI currently include report writing, adoption assessment, critical thinking, consent, and subsidy, staying organized, Safety/Risk/FANS/CANS assessment and safety planning.

Training for juvenile justice specialists

Juvenile justice specialists currently receive training to become certified in the Michigan Juvenile Justice Assessment System (MJJAS) course. JJ specialists and supervisors receive the MJJAS and Program Specific Transfer Training (PSTT) to promote high quality assessment of needs and service delivery for youth and their families. Additionally, juvenile justice specialists will receive the Family First specific training along with other MDHHS caseworkers to support proper identification of eligible candidates, service referral process, and ongoing oversight and monitoring.

Motivational Interviewing training for caseworkers
Motivational Interviewing will be phased into Michigan's Family First implementation as a cross cutting evidence-based practice serving candidates and/or their caretakers in the three categories of in-home parent skill based, substance abuse, and mental health within the Clearinghouse. MDHHS will incorporate an intentional and data informed approach to training expansion across the agency. Procurement of a Motivational Interviewing Network of Trainers (MINT) to provide fidelity monitoring support such as coaching calls, training, and the online fidelity review will be secured to support a strong implementation.

Peer Service Navigator training The Peer Service Navigator is a newly developed position to support Michigan's community pathway for candidacy identification and service delivery. Peer Service Navigators must have lived experience with the child welfare system. They will receive the same training courses outlined above available to MDHHS caseworkers related to Family First regarding candidate identification, assessments, and service linkage. Peer Service Navigators will also be engaged to develop training and protocols to outline collaboration with MDHHS caseworkers for requirements for candidacy determination, data collection, and communication.

Training for Tribes
MDHHS commits to co-design ongoing Family First training with tribal representatives and will request input for the development of Family First training enhancements. Tribes will have access to the MDHHS' training, outlined above, to support their knowledge and implementation of Family First prevention services. Tribes will also have the latitude to develop and deploy their own Family First training or culturally specific training to meet their unique strengths and needs. MDHHS will support tribes' capacity to develop tribal specific training.

EBP Provider Workforce Training
All evidence-based programs selected as part of Michigan's title IV-E Prevention Plan will be administered with a trauma-informed framework through external prevention providers. As part of the provider readiness assessment survey outlined earlier in this plan, providers described their compliance with the trauma informed requirements of the Family First legislation in addition to their EBP service availability, capacity, and internal continuous quality improvement systems. Prevention providers will be responsible for their own workforce training to ensure trauma-informed service delivery and EBP fidelity. Contractual relationships with purveyors, developers, or licensed trainers of EBPs will be required to promote proper training, oversight, and adherence to model fidelity. The newly created Community Service Analysist positions will provide oversight and monitoring of these requirements via contract compliance and continuous quality improvement activities.

Any newly developed Request for Proposals (RFP) and contract language will incorporate Family First Prevention Services Act services quality, fidelity monitoring, and data collection requirements. Partnerships with sister agencies and existing provider networks will support an incremental expansion of evidence-based prevention services. Integral to the EBP provider's ability to provide trauma informed service delivery is timely and appropriate sharing of information during the referral process. MDHHS agency caseworkers will share all pertinent information regarding assessment findings and rationale for service needs with prevention providers to support timely and appropriate service delivery.

Section VIII: Prevention Caseloads

Pre-print Section 7

Families served by MDHHS CPS caseworkers, juvenile justice specialist, or a contracted Child Placing Agency have established caseloads as identified in the chart below. Caseloads are monitored by each county and agency director as well as by Business Service Center (BSC) directors and executive leadership.

Currently, MDHHS does not have a set case load ratio for prevention workers serving children that do not have confirmed abuse/neglect but moderate to high risk exists or Post Adoption Resource Center analyst serving families whose adoption or guardianship is at risk of disruption or dissolution. Caseworkers serving families in post adoption instances have mixed caseloads supporting families with various level of needs. The average caseload sizes for families receiving case management services from the Post Adoption Resource Center caseworker is between 1:8 (families) to 1:10 (families). Supervisors monitor caseloads to ensure that sizes are appropriate based on a variety of factors including worker experience and casework requirements. MDHHS will monitor and oversee caseload standards through ongoing CQI practices and will make recommendations for a standard caseload size based on ongoing analysis.

Community-based private prevention providers will maintain caseloads in accordance with the individuals EBP model. Fidelity to the model will be monitored and overseen as part of the contract monitoring by the Community Service analysts within each Business Service Center. Requirements specific to caseload, staffing, trauma-informed model, and training will all be embedded within contractual documents and monitored through site visits, meetings, and report reviews utilizing the contract monitoring tool.

Table 8. Family First Caseloads

Prevention Staff	Caseload standard
MDHHS In-home CPS Ongoing worker	1:17 (families)
Public or Private Foster Care worker or juvenile justice specialist	1:15 (children)
MDHHS Prevention worker	Ranges from 1:10 (families) to 1:17 (families)
Post Adoption Resource Center caseworkers	Varies by provider and service needs
EBP community provider	In accordance with individual EBP caseload standards

Appendices

Appendix A. MDHHS System Transformation Initiatives

MDHHS
Michigan Department of Health and Human Services

It is our mission to ensure safety for Michigan children who come to the Children's Services Agency's attention through timely provision of preventive, early intervention and foster care services that build on the child and family's strengths and lead to timely permanency. Our professional, respectful staff and agency partners will work to address and remediate family trauma, access to services, and strengthen families and their communities.

Vision: All Michigan's children are safe from abuse and neglect and families have the services and supports they need to thrive.

Priority Outcomes

- All CSA initiatives are grounded in anti-racist elements
- Intake and investigations outcomes are consistent and aligned
- Reduction of recurrence through continuous quality improvement
- Children, Youth, and Families are provided trauma-informed services, supports, and interventions

Guiding Principles

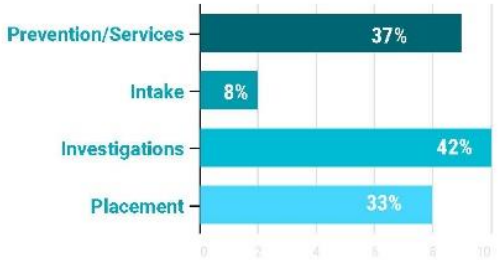
- Prevent of child maltreatment among families that come to the attention of CSA
- Children and youth should be maintained in their own families whenever possible
- All families have an inherent capacity to identify and address the challenges they face
- Children and youth should always be placed in family settings
- Resource families (kin and non-kin) should have the services and supports they need
- Resource families are meant to be a support to birth families
- Family and youth voice should be represented in system and case-level decision-making
- We are committed to achieving racial equity and dismantling bias and institutional racism

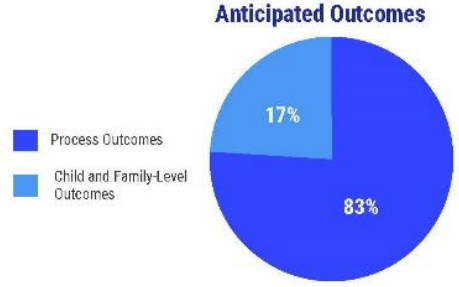
Prevention / Services	Intake	Investigations	Placement
• FFPSA Budget • FFPSA Prevention Plan • QRTP Contracts / Rates • Brilliant Detroit Prevention • **Legislative and Policy Alignment of Maltreatment Types** • **SDM Revalidation** • U of M Families First Assessment • Homebuilders • **CPS Redesign Workshops and Townhalls**	• SDM Tool for Centralized Intake • **CPS Policy Review, Alignment, and Refinement**	• FFPSA / QRTP / CANS • Race Equity - MPHI • Race Equity - U of M • **Legislative and Policy Alignment of Maltreatment Types** • **SDM Revalidation** • **CPS Policy Review, Alignment, and Refinement** • Interview Guidelines - Pending Policy • Central Registry • **CPS Redesign Workshops and Townhalls** • **Reduction of Racial Implications of SDM**	• Congregate Care Reform • Relative Licensure • Safe FTMs • ChildStat • Extension of Emergency CCI Rules • Implement Newly Promulgated CCI Rules • QRTP Implementation • **Reduction of Racial Implications of SDM**

Prevention/Services & Investigations | Intake & Investigations | Investigations and Placement

24 Total number of initiatives

5 Initiatives touch two service areas





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Vision: All Michigan's children are safe from abuse and neglect and families have the services and supports they need to thrive.

Safety Initiatives

Oct - Dec 2020

CPS Redesign Workshops and Townhall
Provided an overview of redesign work through townhalls and subsequent listening sessions to guide workgroup strategy and next steps.
****Completed****

Extension of Emergency CCI Rules
Issuance of a 6-month extension of the Emergency Administrative Rules for Child Caring Institutions.
****Completed****

Jan - March 2021

Central Registry
Proposed modifications to the CR placement requirements

FFPSA Budget
Development of financial structure for implementation of FFPSA

Homebuilders
Implement a well-supported, evidence based program in 7 counties

SDM Tool for Centralized Intake
Development of a valid and reliable tool for intake decisions

Brilliant Detroit Prevention
Prevention program targeted at 2 zip codes in Wayne County to provide parent mentors and benefits navigators - evaluation

Race Equity - MPHI
Research to understand the implications of culturally sensitive removal strategies

FFPSA / QRTP / CANS
CANS development - reporting and data collection as well as field training when applicable

ChildStat
Quality improvement process utilizing data analysis and case dialogue to drive positive outcomes for children and families

Interview Guidelines - Pending Policy
Proposed requirements related to interviews at school without parental permission

Legislative and Policy Alignment of Maltreatment Types
Review and revision of policy to ensure definitions align with legislative mandates (March)

April - June 2021

Congregate Care Reform
Revisions to licensure and oversight of congregate care, improved data systems to track and adjust, enhanced support and training, and reduction of utilization/entry

Race Equity - U of M
Completion of a tableau to reveal trends in 3 system touchpoints as it relates to disparity - intake, case opening, and removal

FFPSA Prevention Plan
Work with internal and external partners to develop statewide prevention plan

QRTP Contracts / Rates
Refine and revise contractual language of current residential contract

CPS Policy Review, Alignment, and Refinement
Revision of policy to reduce requirements and therefore decreasing workload for CPS staff and ensure accurate and timely reports and services

July - Sept 2021

Relative Licensure
Develop an expedited relative licensing process. Pilot January - March with full implementation by July.

QRTP Implementation
Implement revised residential contracts

SAFE FTMs
Provide a structure for more engaging, team-based decision making at removal and placement

Implement Newly Promulgated CCI Rules
Update and promulgate the permanent Administrative Rules for Child Caring Institutions to incorporate the Model Licensing Rules and the recommendations from the CCI Steering Committee

Oct - Dec 2021

U of M Families First Assessment
To understand the effectiveness of the family preservation program options

TBD

SDM Revalidation
An evaluation regarding validity and fidelity to the existing SDM tools for risk and safety assessments

Reduction of Racial Implications of SDM
Evaluation of the implications of decision making through the life of a case related to implicit bias and racially sensitive decision making

Outcome Measures

- Decrease rate of child maltreatment
- Decrease recurrence of maltreatment
- Decrease maltreatment while in care
- Decrease disproportionate representation of minority populations within child welfare
- Decrease rate of children in out-of-home placement
- Increase relative placements

Appendix B. Primary, Secondary, and Tertiary Prevention Definitions

Primary Prevention

Primary prevention activities are directed at the general population and attempt to stop maltreatment before it occurs. All members of the community have access to and may benefit from these services. Primary prevention activities with a universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems associated with child maltreatment. Universal approaches to primary prevention might include:

- Public service announcements that encourage positive parenting.
- Parent education programs and support groups that focus on child development, age-appropriate expectations, and the roles and responsibilities of parenting.
- Family support and family strengthening programs that enhance the ability of families to access existing services, and resources to support positive interactions among family members.
- Public awareness campaigns that provide information on how and where to report suspected child abuse and neglect.

Secondary Prevention

Secondary prevention activities are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, domestic violence, young parental age, parental mental health concerns, and parental or child disabilities. Programs may target services to parents or families that have a high incidence of any or all of these risk factors. Activities are designed to alleviate stress and promote parental competencies and behaviors that will increase the family's ability to successfully nurture their children. Approaches to secondary prevention programs might include:

- Parent education programs for teen parents or substance abuse treatment programs targeted to parents with young children.
- Parent support groups that help at-risk parents deal with their everyday stresses and meet the challenges and responsibilities of parenting.
- Home visiting programs that provide support and assistance to expecting and new mothers in their homes.
- Respite care for families that have children with special needs.
- Family resource centers that offer information and referral services to at-risk families.

Tertiary prevention

Tertiary prevention activities focus on high-risk families and families where maltreatment has occurred (substantiated) and seek to reduce the negative consequences of the maltreatment and to prevent recurrence. These prevention programs may include services such as:

- Intensive family preservation activities designed to strengthen families who are in crisis and protect children who are at risk of harm.
- Individualized service plans that include families in identification of their needs, strengths, and replacement behaviors.
- Parent mentor programs with stable, non-abusive families acting as “role models” and providing support to families in crisis.
- Parent support groups that help parents transform negative practices and beliefs into positive parenting behaviors and attitudes.
- In-home mental health services for children and families affected by maltreatment to improve family communication and functioning.

Appendix C. Evaluation Strategies

Family Spirit Evaluation Plan

Family Spirit Intervention

Michigan Department of Health and Human Services (MDHHS) intends to support the implementation of the Family Spirit evidence-based home visiting program in tribal communities across the state who agree to participate. Michigan seeks to investigate the relationship between the use of Family Spirit with participating tribal communities and the prevention of out-of-home placement for children between 0 and 5 years of age. Michigan's evaluation strategy for the Family Spirit implementation will include evaluation models that focus on process and outcome measures.

Family Spirit is a culturally tailored home-visiting program designed for and by Native American communities to promote optimal health and well-being for parents and their children. The program uses paraprofessionals from the community as home visitors along with a culturally informed, manualized, strengths-based curriculum as a core strategy to support young families. Parents are given information and taught skills designed to promote healthy development and positive lifestyles for themselves and their children. Family Spirit aims to break intergenerational cycles of despair in historically disenfranchised communities by empowering a local workforce as change agents for prompting the best start for young families[1].

Description of Family Spirit Modules and Lessons

The Family Spirit curriculum consists of 6 modules with 63 lessons in total, designed to be taught one-on-one during home visits. However, the modules also can be implemented in a clinic or group session. The modules can be completed sequentially or independently depending on the program structure and participant needs. The *Prenatal Care* module contains lessons that helps expectant mothers prepare for the arrival of their baby and understand what to expect during pregnancy. This module also provides skills to help expectant mothers take care of themselves and their babies after the birth. The *Infant Care* module has lessons that help mothers adapt to life with a new baby, take care of herself, learn basic infant care skills, and learn how to respond to her baby's emotional and developmental needs. Another Family Spirit module is *Your Growing Child*, which contains lessons that help mothers track their child's overall development from 7 months old through 3 years of age and provides skills related to preparing the child for preschool through various activities and play. *Toddler Care* modules and lessons help to build confidence in the mothers parenting skills through daily routines and monitoring, as well as basic skills to help her child form healthy habits to last a lifetime. The *My Family and Me* module contains lessons aim to positively influence the mother, her child, and her family and friends. The last of the six modules is *Healthy Living* where lessons help a mother address and cope with difficult situations, learn goal setting to build self-esteem, be a good role model and learn about substance

[1] *CEBC » Program › Family Spirit*. (n.d.). The California Evidence Based Clearing House for Child Welfare: Information and Resources for Child Welfare Professionals. Retrieved June 6, 2021, from https://www.cebc4cw.org/program/family-spirit/

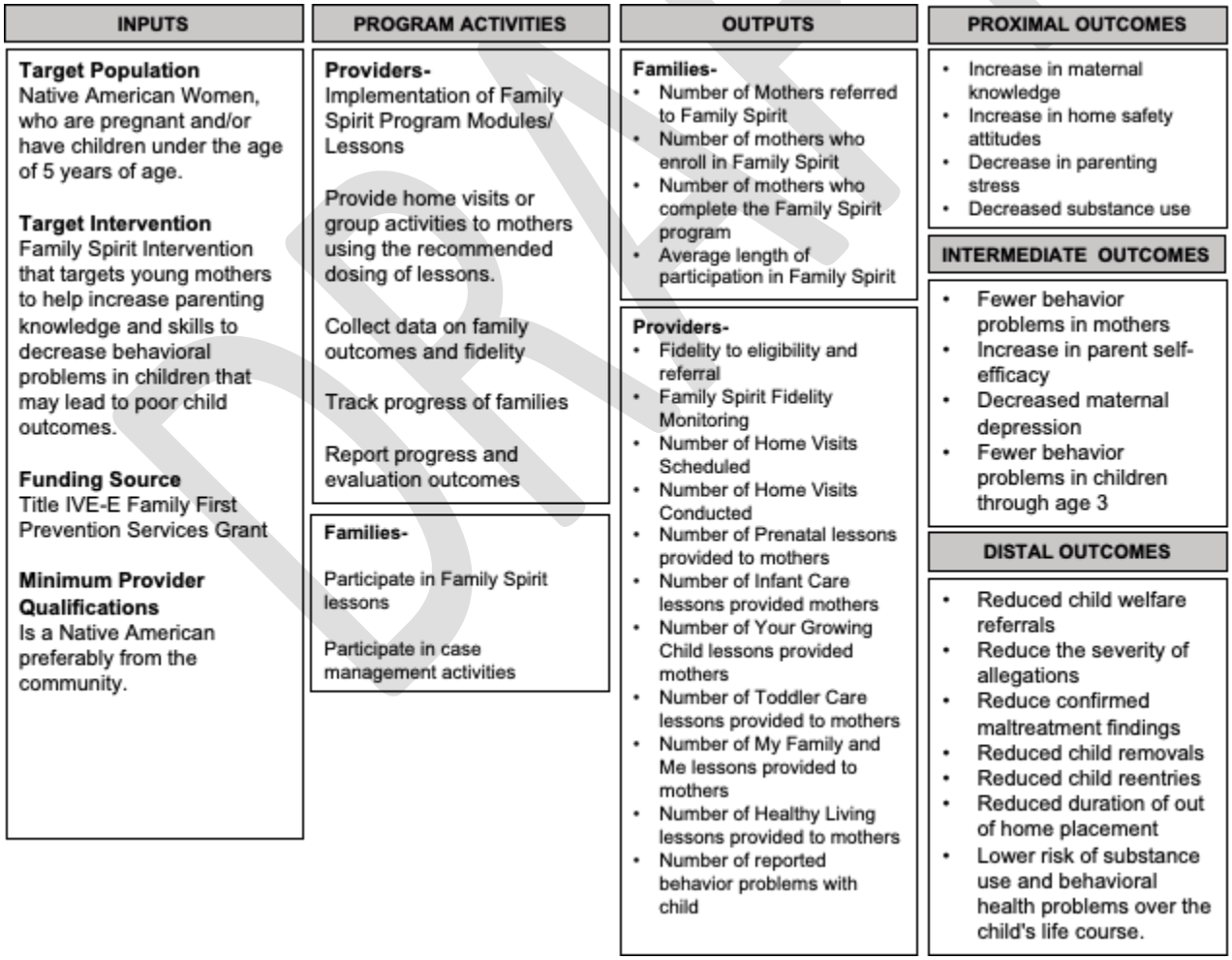
abuse prevention, family planning, prevention of sexually transmitted infections, and where she can go to get help, if needed.

Family Spirit Program Goals and Outcomes

The goal of the Family Spirit program is to reduce out-of-home placements for children by increasing parenting knowledge and childcare skills; decreasing psychosocial parenting and family risks, such as alcohol use or depression; and increasing parents' skills related to the utilization of community resources. The Family Spirit program also seeks to improve child developmental outcomes -- such as increased cognitive and health outcomes -- from birth to 3 years of age.

Working Logic Model and Theory of Change

The following logic model is based on our understanding of the Family Spirit program to date.



Evaluation Design

The evaluation team will conduct a process and outcome evaluation of Family Spirit. We will pay particular attention to fidelity in the implementation of the Family Spirit program within the participating tribal communities. The Family Spirit program is a manualized intervention with clear educational components and quality assurance activities. The evaluation design will be refined after consultation with the tribal communities and MDHHS.

Process Evaluation

The process evaluation will focus on model fidelity and implementation. We will pay particular attention to the eligibility and referral pathway between the tribal community sites and Family Spirit providers, the training, credentialing and certification of Family Spirit facilitators, and the delivery of Family Spirit services. The evaluation team will also assess implementation processes by conducting interviews with case workers and Family Spirit facilitators providers to identify any challenges with the execution of required protocols and practices.

The process evaluation will determine (1) to what degree the Family Spirit program is being implemented as intended at each of the participating tribal communities; (2) what challenges and factors impact implementation; and (3) if the tribal programs are able to reach the target population. Our process evaluation will follow the implementation guidelines provided by the Family Spirit program model.

The Program Evaluation Group will engage in regular contact with MDHHS and the tribal communities implementing the Family Spirit program. We propose a minimum of quarterly meetings to discuss model and implementation support. The Program Evaluation Group will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with the participating tribal programs and MDHHS. The following table outlines the indicators, measures, and data sources for the process evaluation.

Evaluation Question	**Indicators**	**Measures**	**Data Source**
To what degree is the Family Spirit program being implemented as intended?	Number and Percent of program modules/lessons implemented as recommended by Family Spirit Model per tribal site Number and percent of program modules/lesson	Session Summary Form Participant Tracking Log Health Educator Weekly Report to Supervisor	Tribal programs implementing the Family Spirit program

	not implemented as intended The average duration of Family Spirit Session (mins and hours) compared to suggested time		
What challenges and factors impact the implementation of the Family Spirit program?	The number and percent of adaptations made to Family Spirit program implementation The type of adaptations made, e.g., clinic or group setting Identified barriers to Family Spirit program implementation	Site visit interviews	Tribal programs implementing the Family Spirit program
Are tribal Family Spirit programs able to reach the intended target population?	The number of referrals made to the Family Spirit Program The number and percent of mothers enrolled in the Family Spirit Program. The average length of participation for all enrolled participants.	Health Educator Weekly Report to Supervisor	Tribal programs implementing the Family Spirit program

Outcome Evaluation

The outcome evaluation will focus on whether the Family Spirit program achieved its intended results. The results include: (1) increase in maternal parenting knowledge and skills; (2) increase in parental self-efficacy; (3) reduction in parenting stress; (4) decrease in maternal depression; (5) decrease in substance use; (6) increase in cognitive and health outcomes in children through age 3; and (7) child safety and permanency outcomes. The following questions will be used to guide the outcome evaluation.

- To what extent do mothers who participate in the Family Spirit program report an increase in maternal knowledge and self-efficacy?
- To what extent do mothers who participate in the Family Spirit program report a reduction in parenting stress?
- Do mothers who participate in Family Spirit report a decrease in symptoms of maternal depression?
- Do mothers who identify substance use report a decrease in use frequency after participating in the Family Spirit program?
- To what extent do other family members participate in Family Spirit lessons with mothers?
- To what extent do children, whose mothers participate in the Family Spirit program, meet the social, behavioral, and emotional development competence domains?
- Do families who participate in the Family Spirit program have less child welfare referrals and out-of-home placements than families not participating in the Family Spirit program?

The analyses for the evaluation will include descriptive statistics of the families receiving Family Spirit over the course of the study period, as well as a description of service enrollment, service duration, and service referrals. The analyses will also focus on the effects of the intervention associated with Family Spirit. These analyses will look specifically at administrative data related to child safety and child permanency.

Outcome	**Measure**	**Data Source**
Parental Knowledge	Comprehensive Knowledge Assessment (Sequential) Independent Knowledge Assessment (If receiving independent lessons)	Participants receiving Family Spirit either sequentially or independently.
Parent Self-Efficacy and Competence	Parent Locus of Control (PLOC)	Participant

Parenting Stress	Parent Stress Index - Short Form (PSI-SF)	Participant
Maternal Depression	Centers for Epidemiological Studies Depression Scale (CESD-R) or The Edinburgh Postnatal Depression Scale	Participant
Alcohol and Drug Use Questions	Self-report questionnaire adapted from the Voices of Indian Teens (VOIT)	Participant
Child Social and Emotional Development - increase in cognitive and health outcomes in children through age 3	Child Social and Emotional Development Scales Brief Infant Toddler Social Emotional Assessment (BITSEA) or Ages and Stages Questionnaire- Social Emotional (ASQ:SE)	Participant
Child Permanency Reduced child removals Reduced child reentries Sustained reunification Reduced duration of out of home placements	Administrative Data	MISACWIS or BIA
Child Safety Reduced child welfare referrals Reduced the severity of allegations Reduced confirmed maltreatment (finding of preponderance) Fewer prevention needs identified by investigators	Administrative Data	MISACWIS or BIA

Sampling

Currently there are four tribal sites implementing Family Spirit, three located in lower Michigan and one in the Upper Peninsula. It is not certain if additional tribal sites will be implementing the Family Spirit program. Based on the current use of Family Spirit, we propose conducting a multi-site evaluation of the Family Spirit program. Participating program sites will be based on the tribal community locations that select to participate in the program. We will work with each participating site to determine an appropriate sampling frame based on which mothers/ families will be eligible to participate in Family Spirit. According to the Family Spirit model, the program supports young Native parents from pregnancy to 3-years postpartum. While MDHHS does not specify a minimum or maximum age for the mother to participate, they do require the children to be younger than 5 years of age. Thus, we anticipate that the program will reach Native American mothers with children age 5 or younger.

Analytic Approach

Descriptive analyses. All analyses will be supplemented with descriptive statistics of the families receiving Family Spirit over the course of the study period, as well as a description of service enrollment, service duration, and service referrals (implementation variables). Outcome analyses will also focus on the treatment effects associated with Family Spirit. These analyses will look specifically at child and family well-being, safety, and permanency. Ideally, outcomes analyses will compare the Family Spirit families with the families in a comparison group, the exact nature of which is to be determined.

Quasi-experimental comparison group design. One option for this evaluation would be to implement a quasi-experimental comparison group study design, in which outcomes are compared between two groups: tribal sites that implement Family Spirit vs. comparable tribal communities that do not implement Family Spirit. In this study design, we would compare outcomes, especially outcomes that utilize administrative data from MISACWIS, between the two comparable sites.

Modifications of the quasi-experimental study design could include the use of **propensity score matching analysis**. In this model, the tribal communities would serve as many mothers and children as they could in a given period of time, and the evaluation team would use propensity score matching to compare outcomes for the intervention group as compared to similar children that did not receive Family Spirit. The propensity score matching model attempts to match children – one who receives the Family Spirit intervention and one who does not – on key characteristics (age, race, maltreatment history, trauma score, etc.). This approach is considered rigorous, but a limitation of propensity score matching is that it requires some form of initial screening across the two groups (comparison and intervention group) to identify a match on key characteristics. This option could be explored if other design options are limited.

Dosage response analysis. If neither a quasi-experimental study design nor the use of propensity score matching is feasible, another evaluation option is to examine dose response. Because the Family Spirit intervention can be implemented sequentially or independently, we can use process data from the fidelity

and dosage measures to compare outcomes for those who participate in low-, middle- and high dosages of Family Spirit, in other words, compare key outcomes for those mothers/ children who receive very little of the intervention, a moderate amount, or a large amount/ completion of the Family Spirit intervention. This is a relatively weak study design, but it may be practical depending on the sampling and recruitment parameters within the tribal communities. These analyses would provide a sense of the extent to which participation in Family Spirit was associated with positive outcomes for mothers/ children, but it would not allow us to infer that those outcomes were the result of participation in Family Spirit alone.

A related design is a **comparative effectiveness trial**. Since the Family Spirit program modules/lessons can be implemented either sequentially or independently, we could randomize participating tribes to implement the Family Spirit program modules/lessons either sequentially or independently. Using a comparative effectiveness research design would allow the evaluation team to look at the differences and similarities of how the Family Spirit program is implemented at the participating tribes and potential impacts on the target population.

Case study design. Another option is to use a non-experimental case study design. Using this design would allow the evaluation team to understand and compare the process and outcomes of implementing the Family Spirit program across tribal sites. The design would also allow the evaluation team to derive guidance to improve and optimize practice when implementing Family Spirit in participating Michigan tribal communities.

Data Security and Human Subjects for Family Spirit

All data will be maintained and protected on a secure server at the University of Michigan. Access to the data will be limited to users with IRB approval and password protected. The University regularly completes security upgrades and checks to monitor data security and compliance. The focus of data security at the University of Michigan is maintaining strict data access protocols and ensuring and guaranteeing confidentiality.

With regards to human subjects, the evaluation plans will be reviewed by the University of Michigan Institutional Review Board. The eResearch Regulatory Management (eRRM) system provides review and approval processes for the U-M Institutional Review Boards (IRB) and the U-M Institutional Biosafety Committee (IBC). The application types available to research teams include Human Subjects, Repository, and IBC Biosafety. eResearch Regulatory Management helps the university better ensure that it is meeting its obligation to conduct research in an ethical manner in accordance with regulations governing research while reducing the administrative burden. eRRM is developed under the leadership of the U-M Office of Research (UMOR) and Information and Technology Services (ITS), with input from faculty and staff from all three U-M campuses, the institutional review boards, and other review committees.[2]

We anticipate that aspects of the evaluation will require informed consent. The evaluation team will work with IRB staff to develop and gain approval for such consent. We will follow the federal guidelines for

[2] https://its.umich.edu/academics-research/research/eresearch/regulatory-management

informing program participants. The guidelines for informed consent note the following elements.

- A statement that the study involves research
- An explanation of the purposes of the research
- The expected duration of the subject's participation
- A description of the procedures to be followed
- A description of any reasonably foreseeable risks or discomforts to the subject
- A description of any benefits to the subject which may be expected from the research
- A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject
- For research involving more than minimal risk, an explanation as to whether any compensation, and an explanation as to whether any medical treatments are available, if injury occurs and, if so, what they consist of, or where further information may be obtained
- An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights
- A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits, to which the subject is otherwise entitled

Evaluation Roles and Responsibilities

Lead Evaluator

Elizabeth Evans, MSW (50% LOE) will lead the overall project, evaluation planning, and implementation. Elizabeth is a member of the Keweenaw Bay Indian Community in Michigan's Upper Peninsula and worked for tribal communities and their citizens for over 18 years until her transition to the University of Michigan School of Social Work. Elizabeth earned her bachelor's degree in Sociology from the University of Michigan and her MSW from Grand Valley State University. She is currently pursuing her Doctorate in Health Administration from Central Michigan University where her research interest is focused on health equity and improving access to affordable patient driven care for populations facing the highest health disparities. Elizabeth has extensive experience in community based participatory approaches in the development and evaluation of behavioral health programs, primarily working with federally recognized tribes in Michigan. She brings competencies in the areas of survey design, survey data collection, key informant interviewing, focus group facilitation, strategic planning facilitation, and project management.

PEG Faculty Lead

Shawna Lee, PhD, MSW (.75 Summer LOE) is an associate professor at the University of Michigan School of Social Work and Director of the Program Evaluation Group. She has over 15 years of experience conducting and teaching program evaluation. Most recently, Shawna led the design, implementation, and evaluation of a fatherhood-focused home visitation program in collaboration with Healthy Start programs in Michigan. This program was implemented in collaboration with the Intertribal Council of Michigan (ITC)

as well as the Hannahville Indian Community as the participating program site. In other evaluation projects, Dr. Lee conducted a needs assessment of fathers' parenting needs in Detroit and Flint, which involved interviews and focus groups with fathers and social service providers in Flint and Detroit.

Project Administrator

Lisa Greco, LMSW (10% LOE) will be responsible for project management, management of funds, and operational and administrative support. Lisa Greco, LMSW, is an experienced public and private sector human service administrator. Lisa will be responsible for the administrative oversight of the project. She brings competencies in the areas of operational leadership, project management, program development, budget management, staff development, strategic planning, and coalition building.

PEG **graduate students** will provide supporting roles in the project, including assisting with data collection, cleaning, coding, and analysis; documenting project implementation; and preparing dissemination materials.

MICHIGAN'S EVALUATION STRATEGY FOR PROMISING AND SUPPORTED PROGRAMS

Evaluation plans for

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and SafeCare

Submitted
June 2021

Michigan's Evaluation Strategy for Promising and Supported Programs

Pursuant to Section 471(e)(S)(B)(iii)(V), the Family First Prevention Services Act of 2018 requires states to conduct a well-designed and rigorous evaluation of allowable programs or services. Specifically, states are required to identify which programs to implement and how such programs will be rigorously evaluated. The Administration for Children and Families must approve the evaluation plans.

Michigan's Family First Rigorous Evaluation Efforts

The State of Michigan intends to implement and rigorously evaluation *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)* and *Safe Care*. Michigan's evaluation strategy for Family First implementation will include evaluation models that focus on process and outcome measures. The Child and Adolescent Data Lab at the University of Michigan will collaborate with the Michigan Department of Health and Human Services to ensure that there is a rigorous evaluation strategy for each evidence-based practice.

With regards to the interventions of choice, TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. TF-CBT is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.[3] Although the TF-CBT model has been tested mostly with victims of child sexual abuse, this particular intervention has demonstrated positive results for a broader population of children experiencing trauma.[4] TF-CBT is a components-based and hybrid because it is client centered, strengths based, and incorporates a variety of clinical approaches originating from cognitive, behavioral and family therapies. The overarching goal is to significantly reduce a child's negative and maladaptive response to traumatic events. Moreover, TF-CBT seeks to support parents in the development of skills so that they are better equipped to more effectively cope with their own personal trauma histories and support the healthy development of their children.

Safe Care is an in-home parent-training program that targets risk factors for child neglect and physical abuse. Safe Care is a structured behavioral skills training program that focuses on caregiving, household management, and parenting skills. Parents are taught skills in three module areas: (1) how to interact in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviors, (2) to recognize hazards in the home in order to improve the home environment, and (3) to recognize and respond to symptoms of illness and injury, in addition to

[3] https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/#:~:text=TF%2DCBT%20is%20a%20conjoint,related%20to%20traumatic%20life%20events.

[4] https://www.researchgate.net/publication/275400585_Trauma_in_Children_A_Call_to_Action_in_School_Psychology

keeping good health records.[5] The Safe Care model has been used in university-based settings for more than 30 years.[6]

The current document includes the evaluations plans for both *TF-CBT* and *Safe Care*. The evaluation plans mirror the outline suggested by ACF[7] and include the following sections: intervention, theory of change, evaluation design, logic model, data collection, sampling, analytic approach, limitations, dissemination, data security, evaluation roles, timeline, and budget.

[5] https://www.cebc4cw.org/program/safecare/

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3289527/

[7] https://www.acf.hhs.gov/cb/policy-guidance/im-19-04

Trauma-Focused Cognitive Behavioral Therapy Evaluation Plan

INTERVENTION

TF-CBT will be implemented in Michigan with a focus on preventing the use of substitute care placement. TF-CBT is a psychotherapy approach that was developed by Cohen and colleagues to treat children and adolescents experiencing traumatic symptoms. In part, TF-CBT was (and remains) appealing because it is relatively short-term, treating children and adolescents in as few as 12 sessions. Within these sessions, children are taught a variety of cognitive, behavioral, and physiological techniques that they can employ outside of treatment to regulate emotions and more effectively cope. Children learn to develop trauma narratives that gradually tell the story of what occurred during their traumatic experience. Children can write down these narratives or use them in some form of expression (e.g., art, acting, etc.).[8] TF-CBT also builds supports and skill development at the parent and family level. The parent-training component teaches caregivers to manage their own emotional response to the traumatic event to assist the child with emotional regulation. The underlying hypothesis is that if parents can increase their own skills and learn how to effectively support their children, the probability of treatment engagement, completion and success will increase.[9] The empirical evidence supports the use of TF-CBT with children and adolescents between the ages of 3 and 18. The majority of the evidence focuses on treating children with PTSD, anxiety, depression, feelings of distrust and shame. These behaviors are believed to have roots within the child's traumatic history. There is also evidence to suggest that TF-CBT works to improve parenting skills and the parent's ability to support their children.[10] In a recent meta-analysis, TF-CBT was found to be marginally superior as compared with other widely used interventions for children. The authors argue that the gradual exposure to traumatic events, the intensity of that exposure, and the engagement of both children and parents in the treatment were largely responsible for the positive outcomes.[11] Specific to child welfare, TF-CBT has proven effective for symptom reduction in foster care populations and has significantly reduced the placement stability experienced by children in substitute care settings.[12] As part of the current evaluation, we also seek to investigate the relationship between the use of TF-CBT and the prevention of placement for children and adolescents between 3 and 18 years of age.

[8] https://link.springer.com/article/10.1007/s40653-018-0212-1

[9] https://doi.org/10.1016/j.childyouth.2009.08.013.

[10] https://doi.org/10.1002/da.20744

[11] https://doi.org/10.1007/s40653-018-0212-1

[12] https://tfcbt.org/wp-content/uploads/2018/05/FosterCareManual-FINAL.pdf

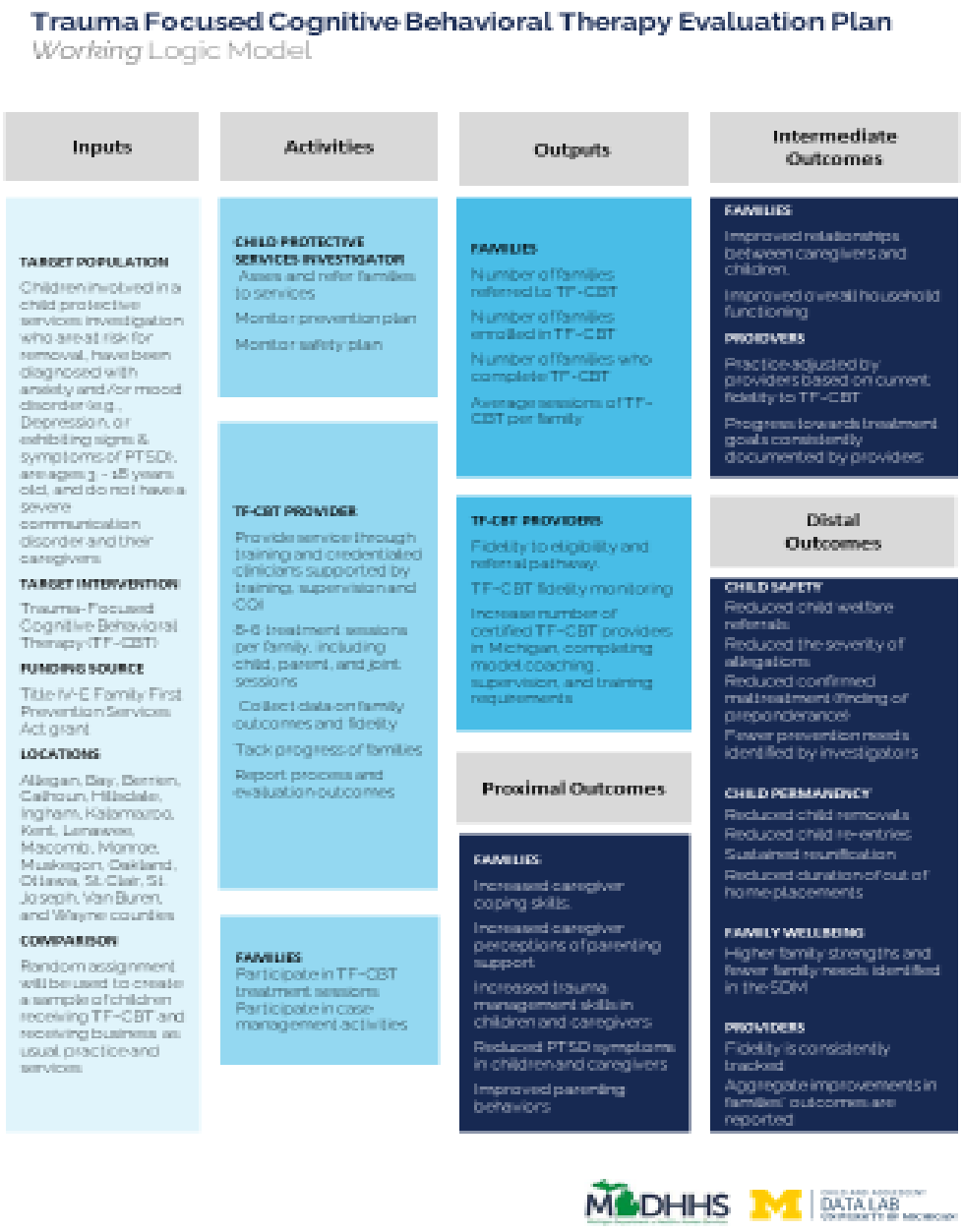
TF-CBT is a manualized treatment approach. A master's degree and training are required of TF-CGT practitioners. TF-CBT is comprised of eight core treatment components.[13] Gradual exposure to these components is viewed as essential. The acronym for the treatment components is PRACTICE.

- P – Psychoeducation and parenting skills
- R – Relaxation techniques: Focused breathing, progressive muscle relaxation, and teaching the child to control their thoughts (thought stopping).
- A – Affective expression and regulation: To help the child and parent learn to control their emotional reaction to reminders by expanding their emotional vocabulary, enhancing their skills in identification and expression of emotions, and encouraging self-soothing activities
- C – Cognitive coping: Through this component, the child learns to understand the relationships between thoughts, feelings and behaviors and think in new and healthier ways.
- T – Trauma narrative and processing: Gradual exposure exercises including verbal, written and/or symbolic recounting (i.e., utilizing dolls, art, puppets, etc.) of traumatic event(s) so the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions. Following the completion of the narrative, clients are supported in identifying, challenging, and correcting cognitive distortions and dysfunctional beliefs.
- I – In vivo exposure: Encourage the gradual exposure to innocuous (harmless) trauma reminders in child's environment (e.g., basement, darkness, school, etc.) so the child learns they can control their emotional reactions to things that remind them of the trauma, starting with non-threatening examples of reminders.
- C – Conjoint parent/child sessions: Held typically toward the end of the treatment, but maybe initiated earlier when children have significant behavior problems so parents can be coached in the use of behavior management skills. Sessions generally deal with psychoeducation, sharing the trauma narrative, anxiety management, and correction of cognitive distortions. The family works to enhance communication and create opportunities for therapeutic discussion regarding the trauma.
- E – Enhancing personal safety and future growth: Provide training and education with respect to personal safety skills and healthy sexuality/ interpersonal relationships; encourage the utilization of skills learned in managing future stressors and/or trauma reminders.

[13] https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/

LOGIC MODEL AND THEORY OF CHANGE

The logic model serves as a visual representation of the program activities and illustrates the theory of change. The clinical activities represent the inputs and largely revolve around the PRACTICE components of the TF-CBT model. The outputs include improved mental health, improved child and parent relationship, improved parenting skills, decreased risk of subsequent maltreatment and decreased risk of substitute care placement.



Theory of Change: Children with a confirmed history of trauma and who demonstrate symptoms associated with trauma (e.g., anxiety, PTSD) complete the PRACTICE components. Through TF-CBT, children develop a variety of new skills to cope with their trauma, process their trauma in a constructive way, and plan for safety moving forward. In addition, the TF-CBT model focuses on improving parenting and improving the parent child relationship. The engagement and involvement of parents is a unique and critical feature of the TF-CBT model. Theoretically, improved parenting

skills and an improved relationship between the parent and the child will serve as a protective factor that reduces the risk of subsequent maltreatment and reduces the need for substitute care placement. There is considerable evidence to support this theory of change.[14]

EVALUATION DESIGN

The evaluation of TF-CBT includes both formative (process) and summative (outcome) measures. A critical component to any rigorous evaluation is to determine if the intervention is implemented as intended. TF-CBT is a manualized treatment, meaning there are clear standards and expectations for what treatment should look like in the field. The process evaluation will determine (1) if the right children and adolescents are targeted as eligible for TF-CBT (2) if the comparison group is indeed similar to the treatment group, (3) if TF-CBT clinicians completed the required training, and (4) if the child and parent services were delivered as intended. The proposed process evaluation will follow the TF-CBT implementation guidelines published by the National Child Traumatic Stress Network.[15] Throughout the life of the evaluation, evaluation staff from the Data Lab will engage in regular contact with MDHHS staff and TF-CBT providers. We propose quarterly meetings to discuss model support and implementation. The Data Lab will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with MDHHS leadership throughout the life of the evaluation. The follow tables outline the indicators, measures, data sources, and timeline for the process evaluation.

ResearchQuestion	Area	Indicators	Measures	Data Source
Are the right children and families identified as eligible and referred for TF-CBT?	Eligibility and referral	Number and percent of children screened for and meeting eligibility. Number and percent of families engaged with services		MISACWIS

[14] DOI: 10.1177/1524838014566718

[15] https://www.nctsn.org/resources/how-implement-trauma-focused-cognitive-behavioral-therapy-tf-cbt-implementation-manual

			Trauma Screening Checklist Version for children 0 to 5 and version for children 6 to 18	
Is the comparison group statistically similar to the treatment group	Implementation and development of comparison group (RCT)	Child and family demographics Child and family risk profiles	Trauma screenings SDM risk profiles Demographic data captured by workers	MiSACWIS
Are TF-CBT clinicians completing the required training	Capacity and qualifications	Number and percent of clinicians completing training Dates of completed trainings	Training certifications	TF-CBT provider
Are the child and parent receiving the services intended?	Fidelity, service delivery and engagement	PRACTICE domains of services, frequency and dates of services delivered.	TF-CBT brief practice checklist	TF-CBT provider

The primary objective of the outcome evaluation is to determine whether TF-CBT achieved the intended results. The results include decreased trauma symptoms, improved family relationships, safety, and permanency. The following research questions serve as the foundation to the outcome's evaluation.

- (*child well-being*) Do the children in the TF-CBT condition experience a reduction in trauma symptomology (pre and post measure)?
- (*family functioning*) Do the families in the TF-CBT condition experience improved family functioning (pre and post measure)?
- (*permanency*) Are children in the TF-CBT condition less likely to be placed in foster care as compared to children that did not receive TF-CBT?
- (*permanency*) If removals occurs, do children in the TF-CBT condition experience significantly shorter length of stay as compared to children that did not receive TF-CBT?
- (*safety*) Are children in the TF-CBT condition less likely to experience a subsequent substantiated report of maltreatment as compared to children that did not receive TF-CBT?

TF-CBT Outcome Measure Table

Outcome	Measure	Data Source
Trauma and trauma symptoms	Trauma Screening Checklist	TF-CBT provider MDHHS worker
Family Functioning	North Carolina Family Assessment Scale	TF-CBT provider MDHHS worker
Placement in foster care	Administrative data	MISACWIS
Length of stay in care	Administrative data	MISACWIS
Subsequent maltreatment reports	Administrative data	MISACWIS

In summary, the process evaluation will focus on model fidelity, the delivery of specific services and implementation challenges. We will pay particular attention to the eligibility, random assignment and referral pathway between CPS and TF-CBT, the training, credentialing and certification of clinicians, and the delivery of TF-CBT services. Fidelity and the receipt of specific services will be assessed by the treatment providers and the completion of the TF-CBT brief practice checklist (included in appendix). This process measure is considered essential in the *TF-CBT Implementation Manual.*[16] Finally, the evaluation team will assess implementation by conducting interviews with CPS caseworkers and TF-CBT providers to identify any challenges with the execution of required protocols and practices. The outcome analyses will focus on permanency, safety, trauma symptoms and family functioning. Some of the analyses will be limited to changes in measurement over time (i.e., pre and post), and other analyses will specifically compare outcomes between the treatment and control conditions.

[16] Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004) and *Treating Trauma and Traumatic Grief in Children and Adolescents* (J.A. Cohen, A.P. Mannarino, and E. Deblinger; NY: Guilford Press, 2006/17

SAMPLING

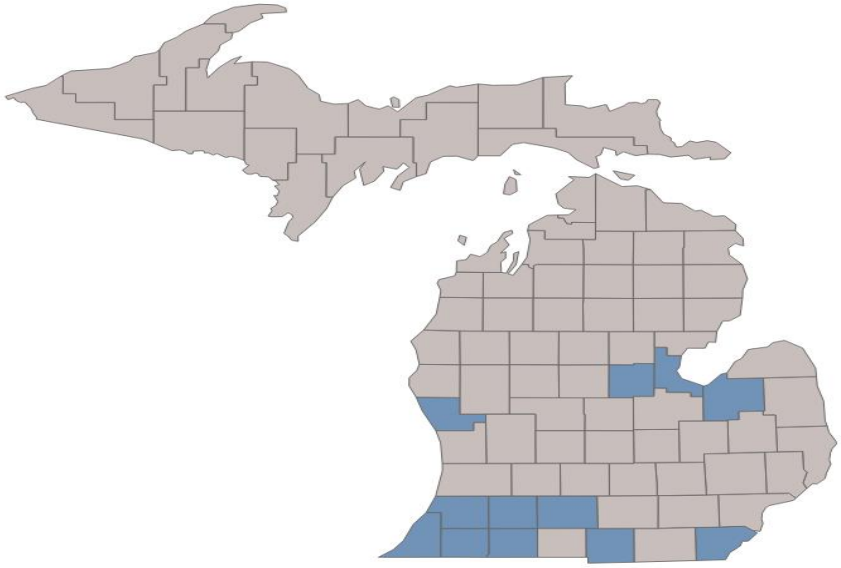
There are two critical questions related to sampling. First, which children will be eligible for TF-CBT? Second, in which geographic area will TF-CBT be offered? The answers to these questions must be data driven. Service providers should not simply treat all children or even treat a random sample of all children with a substantiated allegation of maltreatment. Eligibility should be limited to children with a confirmed trauma history and ones showing signs (symptoms) of trauma-induced anxiety or PTSD. Similarly, State should avoid selecting geographic regions for services based solely on ease of implementation. That is, the criteria for standing up TF-CBT in a particular county should not be based solely on the willingness of a county director to support new programming. The geographic locations should be driving by the potential sample populations (e.g., number of 3- to 18-year-olds in a specific county) and the probability of that potential sample experiencing the primary outcome of interest (e.g., likelihood of removal from the home and placement in foster care).

Which children will be eligible for TF-CBT? TF-CBT will be offered to children and their parents or caregivers who exhibit signs and symptoms of psychological distress that is consistent with trauma. The treatment manual specifies that TF-CBT is intended to benefit children and adolescents between 3 and 18 years of age. Subsequent to a substantiated allegation of maltreatment, parents (with the help of child protection worker) will complete the Trauma Screening Checklist (already in use with MDHHS). The screening checklist focuses on both the exposure to traumatic events and the child's response (i.e., symptoms) likely associated with such events. There are different versions of the checklist based on the child's age.[17] The assessment instruments for each age group are included in the appendices. Children who score in the moderate trauma related distress range (scores 4 or higher) will be eligible for participation in TF-CBT.

In which geographic area will TF-CBT be offered? We identified potential participating counties by analyzing the last five years of Michigan's CPS administrative data. For TF-CBT eligibility, we identified the total possible sample (e.g., number of 3–18-year-olds with a substantiated allegation of maltreatment) and the number of those children/adolescents that were removed from the home and placed in foster care. So that we would have sufficient power to detect program effects, and so that any improvements observed by the intervention group might have the possibility of reducing the overall State placement rate, we selected counties that had at least 200 potentially eligible children removed in the last five years. We also limited site selection to counties in which the overall risk of removal (following substantiation) for this particular age group was at least 9% (rounded up). This approach yielded twelve counties (see Table 1). The proposed counties reflect a fair amount of geographic, racial, and ethnic diversity.

[17] https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_69588_80203-412815--,00.html

Table 1: Potential TF-CBT Participants by County (2015-2021)		
County Name	**Children 3-18 not removed**	**Children 3-18 removed**
Cass	80.7% (1199)	19.3% (286)
Hillsdale	83.9% (1472)	16.1% (282)
St. Joseph	85.0% (1891)	15.0% (334)
Tuscola	87.9% (1591)	12.1% (219)
Berrien	88.8% (5159)	11.2% (648)
Van Buren	89.1% (2488)	10.9% (303)
Monroe	89.4% (2738)	10.6% (323)
Midland	89.3% (2168)	10.7% (260)
Calhoun	90.6% (5434)	9.4% (566)
Bay	90.7% (3397)	9.3% (349)
Muskegon	90.7% (7799)	9.3% (796)
Kalamazoo	90.8% (9677)	9.2% (978)
Ingham	91.1% (10899)	8.9% (1068)



Demographics			
		N = 23194)	**Percent of Sample**
Sex	F	11635	50.2%
	M	11559	49.8%
Race	American Indian	61	0.3%
	Asian	64	0.3%
	Black	6132	26.4%
	Hawaiian/Pacific Islander	4	0.0%
	Latinx	1845	8.0%
	Multiracial	2631	11.3%
	Unknown	20	0.1%
	White	12437	53.6%
Age	Median (9.0)	Mean (9.4)	SD (4.3)

ANALYTIC APPROACH

There are many options for the construction of a comparison group, but first we need to know about capacity. How many children and families will the State be able to serve with TF-CBT?

The ideal approach – that is – the most rigorous approach and the approach that will generate the most confidence with regards to findings is a randomized control trial (RCT), which would be feasible in in several counties where there are more children and adolescents that would qualify (be eligible) for TF-CBT than one could possibly serve. We strongly recommend this approach. In short, the RCT approach is similar to selecting a random sample of eligible cases in each participating county. This is ethical because the selection of participants is not based on personal characteristics; each county is simply making a decision based on capacity. For example, if county X has the capacity to serve 50 children/families in a given year but county X has 400 eligible children/families, we would develop an online random assignment calculator and randomly assign 50 children/families to the TF-CBT condition. This same procedure will be replicated across multiple counties contingent on the capacity within each county. It is both ethical and the most rigorous. It might also be the most economical. It is important to note that this approach is not a "no treatment" control condition. Children assigned to the control group receive services as usual.

An additional benefit of RCT is that the statistical analyses are far more straightforward as compared to a design that relies on propensity score matching or other statistical techniques to control for selection bias. If the random assignment works, (meaning equivalent groups are created), chi-square can be used to estimate differences between the TF-CBT group and the control group on the risks of removal and subsequent substantiated reports of maltreatment. With regards to trauma symptoms and family functioning, we would use a paired sample t-test to investigate change before and after the intervention. Finally, we propose developing an overall fidelity score (from the checklist) and investigating whether fidelity to the treatment model is associated with the identified outcomes. This last approach is similar to a dose response design. Basically – how much of the treatment was received – and is there a threshold at which the likelihood of achieving desirable outcomes observed?

With regards to dissemination, the evaluation team will provide quarterly reports to the State. These reports will cover findings related to both process and outcome measures. The evaluation team will also develop conference presentations and peer reviewed journal articles so that the broader field of child welfare can learn from the experiences in Michigan.

Summary of Evaluation Plan: Trauma – Focused Cognitive Behavioral Therapy (TF-CBT)	
Research Questions	• (*child well-being*) Does TF-CBT reduce trauma symptomology? • (*family functioning*) Does TF-CBT improve family functioning? • (*permanency*) Does TF-CBT reduce the risk of foster care placement? • (*permanency*) If children experience placement in foster care, does TF-CBT decrease overall time in care? • (*safety*) Does TF-CBT reduce the risk of a subsequent substantiated report of maltreatment?
Target Population	• Children and their parents who exhibit signs and symptoms of psychological distress that is consistent with trauma. • Children and adolescents between 3 and 18 years of age. • Children with at least one substantiated allegation of maltreatment. • Children who score in the moderate trauma related distress range. • Counties that had at least 200 potentially eligible children removed in the last five years. • Counties in which the overall risk of removal (following substantiation) for this particular age group was at least 9%.
Measurement	• Trauma Screening Checklist • North Carolina Family Assessment Scale • MISACWIS Administrative data (permanency) • MISACWIS Administrative data (safety)
Evaluation Design	• The most rigorous approach and the approach that will generate the most confidence with regards to findings is a randomized control trial (RCT). • RCT is possible in many counties where there are more children and adolescents that would qualify (be eligible) for TF-CBT than could possibly be served. • This design is ethical because the selection is not based on personal characteristics; each county is simply making a decision based on capacity. • This approach is not a "no treatment" control condition. Children assigned to the control group receive services as usual.
Outcomes of Interest	• Safety • Permanency • Prevent removal • Decrease time in care • Family Functioning • Trauma Symptom Reduction
	• A benefit of RCT is that the statistical analyses are far more

Analysis Plan	straightforward as compared to a design that relies on propensity score matching or other statistical techniques to control for selection bias. • Chi-square can be used to estimate differences between the TF-CBT group and the control group on the risks of removal and subsequent substantiated reports of maltreatment. • Paired sample t-tests will be used to estimate changes in trauma symptoms and family functioning. • The evaluation team will calculate and overall fidelity score (from the checklist). We will investigate whether fidelity to the treatment model is associated with the identified outcomes. • Regression models will be developed to explore subgroup differences and interactions – that is – does the intervention work better for certain sub populations (e.g., younger children, children with short-term placements).
Limitations	• The evaluation team will not know every service received by control group children and families. It is possible that some children in the control group will be exposed to some level of trauma informed clinical work.
Dissemination	• The evaluation team will provide stakeholders with quarterly reports using tables and figures based on descriptive statistics including penetration/reach of TF-CBT participation and outcomes within and across candidate populations. These tables and figures will be split by MDHHS service region and child/family demographics. • The quarterly reports will also cover findings related to both process and outcome measures. • The evaluation team will also develop presentations and peer reviewed journal articles so that the broader field of child welfare can learn from the experiences in Michigan. • The purpose of these analyses and dissemination plan is to provide MDHHS with a broad perspective on FFPSA implementation and outcomes and to help inform CQI efforts.

SafeCare Evaluation Plan

INTERVENTION

SafeCare is an in-home parent training program that targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas: (1) how to interact in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviors, (2) to recognize hazards in the home in order to improve the home environment, and (3) to recognize and respond to symptoms of illness and injury, in addition to keeping good health records. All three modules should be used in the implementation of *SafeCare.*[18]

SafeCare will be implemented in Michigan with a focus on preventing the use of substitute care placement. SafeCare belongs to a class of programs commonly referred to as Behavioral Training Programs. These training programs using modeling, didactics, and practice to improve parents and significantly reduce the risk of child maltreatment.[19] SafeCare is unique because the program is divided into three modules that address household safety, child health, and parent–child interactions. Child health addresses medical neglect risk and is designed to help caregivers detect signs of illness, assess injuries, and intervene effectively. Home safety addresses risk of environmental neglect and is designed to help caregivers identify and remove household safety hazards to create a physically safe home environment. Parent–child interaction addresses emotional neglect risk and focuses on helping caregivers establish positive interactions with their child and engage in sensitive responding.[20]

In a recent randomized trial of SafeCare published in Preventive Medicine, the authors report that SafeCare had small to medium effects for improving parenting outcomes including supporting positive child behaviors, proactive parenting, and two aspects of parenting stress. The authors conclude that parenting programs such as SafeCare offer a promising mode of intervention for child welfare systems as they are likely to improve parenting, improve child outcomes, and potentially reduce maltreatment.[21]

[18] https://www.cebc4cw.org/program/safecare/

[19] https://doi.org/10.1016/S0005-7894(96)80013-X

[20] Guastaferro, K. M., Lutzker, J. R., Graham, M. L., Shanley, J. R., & Whitaker, D. J. (2012). SafeCare®: Historical perspective and dynamic development of an evidence-based scaled-up model for the prevention of child maltreatment. Psychosocial Intervention, 21, 171–180. Guastaferro, K., & Lutzker, J. R. (2017). Getting the most juice for the squeeze: Where SafeCare® and other evidence-based programs need to evolve to better protect children. In D. M. Teti (Ed.), Parenting and family processes in child maltreatment and intervention (pp. 141–163). New York: Springer.

[21] https://doi.org/10.1016/j.ypmed.2020.106167

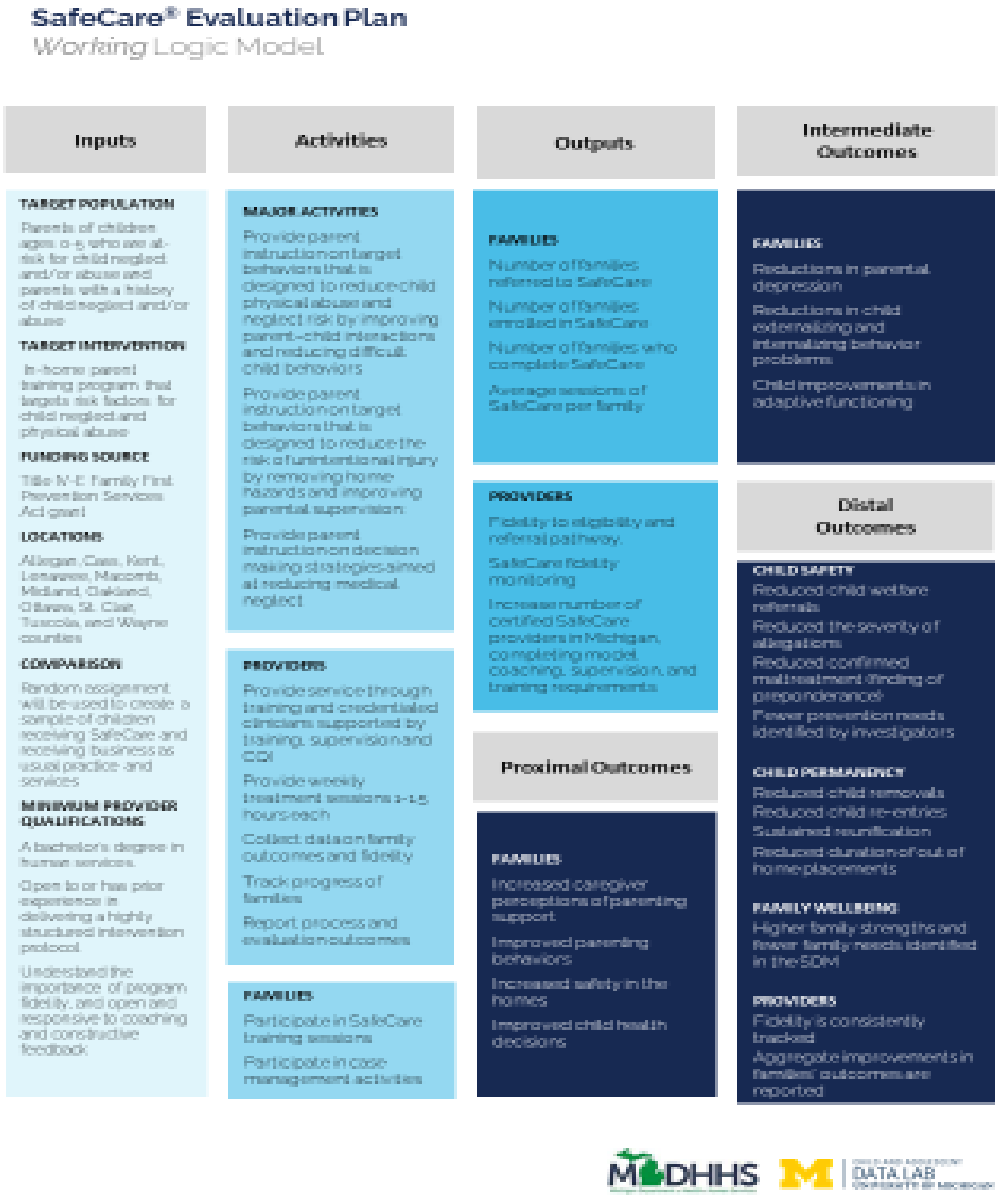
As part of the current evaluation, Michigan seeks to investigate the relationship between the use of SafeCare and the prevention of placement for children between 0 and 5 years of age. SafeCare is a manualized treatment approach.[22] With regards to qualifications and training, SafeCare practitioners are preferred to have at least a bachelor's degree in human services. SafeCare practitioners are required to complete over 30 hours of training followed by nine supervised SafeCare sessions. As noted in the SafeCare treatment manual, the program focuses on the following essential activities:

- Parent-infant/child interaction assessment and training. This provides parent instruction on target behaviors that is designed to reduce child physical abuse and neglect risk by improving parent-child interactions and reducing difficult child behaviors:
- Assess parent's interactions using the *iPAT Assessment Form* (infants 0-18 months) and the *cPAT Assessment Form* (children 18 months-5 years old)
- Teach parent how to organize activities by preparing in advance, establish routines, explain expectations to a child and follow through, use good verbal and physical interactions, and transition between activities
- Home safety assessment and training: This provides parent instruction on target behaviors that is designed to reduce the risk of unintentional injury by removing home hazards and improving parental supervision.
- Assess accessible home hazards with the *Home Accident Prevention Inventory Assessment* form
- Work with parents to remove identified hazards and implement child proofing strategies
- Teach the importance of parent supervision according to the developmental age of the child and what this looks like for the family
- Child health assessment and training: This provides parent instruction on decision making strategies aimed at reducing medical neglect:
- Assess parent skills using the *Sick or Injured Child Checklist Assessment Form*
- Teach use of a decision-making process to determine when to seek emergency services, seek nonemergency medical services, or when to care for a child at home
- Teach parents how to use health reference materials and to keep good health records
- Monitor provider delivery for model fidelity
- Booster training if performance falls below criteria

[22] https://safecare.publichealth.gsu.edu/files/2016/10/Prov.Manual-Preview-v4.1.1.pdf

LOGIC MODEL AND THEORY OF CHANGE

The logic model serves as a visual representation of the program activities and illustrates the theory of change. The major clinical activities include parent instruction that is designed to reduce child physical abuse and neglect risk by improving (1) parent-child interactions and reducing difficult child behaviors, (2) parent instruction that is designed to reduce the risk of unintentional injury by removing home hazards and improving parental supervision and (3) parent instruction aimed at reducing medical neglect



Theory of Change: Neglect is one of the most common forms of child maltreatment. Often, neglected children experience other forms of maltreatment.[23] Research demonstrates the effects of neglect can have more grave ongoing consequences for development as compared to other forms of abuse.[24] Removal from the home and entry into foster care can also contribute to negative mental health outcomes.[25] SafeCare uses home training modules that address child/parent and parent/infant interactions, child health, and home safety to theoretically assist caregivers in creating a safer, supportive home environment ultimately preventing future maltreatment and entry into foster care. In turn, the children of these caregivers experience significant reductions in externalizing and internalizing behavior problems and improvements in adaptive functioning.[26]

[23] U.S. Department of Health & Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau (DHHS). "Child Maltreatment 2018." Child Maltreatment, Child Maltreatment Report, 2018, 21.

[24] Dubowitz, Howard. Neglected Children: Research, Practice, and Policy. SAGE, 1999.

[25] Bederian-Gardner, Daniel, Sue D. Hobbs, Christin M. Ogle, Gail S. Goodman, Ingrid M. Cordón, Sarah Bakanosky, Rachel Narr, Yoojin Chae, and Jia Y. Chong. "Instability in the Lives of Foster and Nonfoster Youth: Mental Health Impediments and Attachment Insecurities." Children and Youth Services Review 84 (January 1, 2018): 159–67. https://doi.org/10.1016/j.childyouth.2017.10.019.

[26] Self-Brown, Shannon, Erin Mcfry, Angela Montesanti, Anna Edwards-Gaura, John Lutzker, Jenelle Shanley, and Daniel Whitaker. "SafeCare: A Prevention and Intervention Program for Child Neglect and Physical Abuse." In Treatment of Child Abuse: Common Ground for Mental Health, Medical, and Legal Practitioners, 50–58. Johns Hopkins University Press, 2014.

EVALUATION DESIGN

The evaluation of SafeCare includes both formative (process) and summative (outcome) measures. A critical component to any rigorous evaluation is to determine if the intervention was implemented as intended. SafeCare is a manualized treatment, meaning there are clear standards and expectations for what treatment should look like in the field. The process evaluation will determine (1) if the right children and families are targeted as eligible for SafeCare (2) if the comparison group is indeed similar to the treatment group, (3) if SafeCare practitioners meet the desired qualifications and (4) if the services were delivered as intended.

Throughout the life of the evaluation, evaluation staff from the Data Lab will engage in regular contact with MDHHS staff and SafeCare providers. The process evaluation will specifically focus on the key implementation and fidelity domains noted in the treatment manual. It is important to note that some of the training activities will be provided by the National SafeCare Training and Research Center (NSTRC).[27] The key area of implementation include:

- Prior to training, NSTRC will work with your agency to prepare for implementation. This process starts with a webinar to introduce your agency staff to the SafeCare program and implementation.

- The providers and NSTRC will discuss implementation logistics. Prior to the Provider workshop, an NSTRC faculty will conduct an in-person orientation at your agency. This includes all agency personnel involved with SafeCare, and any other community supports.

- Initial Implementation: SafeCare is launched by the providers. This phase begins with a 4-day Provider workshop for providers to learn the SafeCare curriculum. After the workshop, Providers are supported by NSTRC Trainers for approximately 6 months as they work towards certification. At the conclusion of this phase, a plan for Full Implementation is developed between the providers and NSTRC.

- Full Implementation: the providers assume responsibility over coaching. Once Coach Trainees achieve Provider certification and are ready to transition to the Coach role, they complete a 2-day Coach Workshop. NSTRC Trainers support coaches for about 6 months as they work towards certification. At the conclusion of this phase, a plan for sustainability is developed between the provider agency and NSTRC.

- Sustainability: The providers work with NSTRC to develop. Once Coaches are certified and the provider wants to take on internal trainings, Coaches may be considered to become a SafeCare Trainer.

[27] https://safecare.publichealth.gsu.edu/

We propose quarterly meetings to discuss model support and implementation. The Data Lab will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with MDHHS leadership throughout the life of the evaluation. The follow tables outline the indicators, measures, data sources, and timeline for the process evaluation. The process and outcome evaluation designs mirror the standards presented in the treatment manuals and reflect the published research on SafeCare.

PROCESS EVALUATION

SafeCare families will be eligible to participate in Michigan if they have at least one child under the age of six and if they have at least three additional risk factors. We propose modifying the SafeCare referral protocol used in Colorado (see attached). Additional risk factors include but are not limited to housing instability, young caregiver (under 20 years of age), child with special needs and single parent. As part of the process evaluation, we will generate quarterly reports to ensure that eligibility criteria are followed.

Services Received and Fidelity: Each of the SafeCare topics is conducted over six 1-1.5-hour sessions that typically occur weekly. All topics use a similar teaching model (an assessment session, followed by four sessions of training, and a final re-assessment session). The program is delivered by parent support providers (PSPs) who receive intensive coaching by the SafeCare program developer and overseen by the National SafeCare Training and Research Center (NSTRC). The process evaluation will capture service participation and service completion. Service participation will focus on the family's involvement with any of the service domains (e.g., health, safety, parent child interactions). Service completion is defined as passing the SafeCare modules. Passing is determined by the assessment scores associated with each SafeCare topic: Safety, Health and Parent-Child Interaction (Interaction). The SafeCare treatment manual establishes the criteria for a passing score on each topic. Families at the beginning and end of each SafeCare topic will complete assessments. For Safety, success includes a plan for removal of all hazards or a plan for increased supervision, with a note that it may be difficult to remove all hazards and one to three remaining is acceptable. For Health, success is defined as a score of 100 percent for emergency room scenarios; a score of 80 percent for doctor's appointment scenarios, and a score of 80 percent for care at home scenarios. Finally, for parent – child interactions, success is defined as demonstrating at least one positive behavior in each of the observed categories being assessed. This approach to the process evaluation will permit the permit the evaluation team to estimate attrition, both the frequency of attrition and the timing of attrition. The SafeCare portal reports will be used to capture service activity and service component completion. The SafeCare portal is available to any State that implements SafeCare. The evaluation team will be responsible for customizing the service reports and training the providers on how best to use the findings noted in the reports.

Certification of Staff: SafeCare requires that providers receive training and certification. This requirement helps ensure consistency across providers and plays a critical role in monitoring program fidelity. The Parent Support Providers (PSPs) can achieve certification as a coach and thus monitor program fidelity by observing recorded home visits. Fidelity will be monitored weekly until providers

are consistently meeting expectations – at which point fidelity monitor will be decreased to monthly. A fidelity and certification report will be generated via the SafeCare Portal.

The evaluation team will link the process data submitted to the SafeCare portal with family demographics and other MISACWIS data elements. These linked data will be analyzed to understand whether certain families (i.e., types of families based on their demographic and social histories) are more likely to engage and complete SafeCare service activities. These data will be run quarterly and provided to MDHHS stakeholders to identify gaps in service delivery (and engagement) and to help inform continuous quality improvement efforts.

OUTCOME EVALUATION

The primary objective of the outcome evaluation is to determine whether SafeCare achieves the intended results. SafeCare is expected to produce the following outcomes:

- Increased caregiver perceptions of parenting support
- Improved parenting behaviors
- Increased safety in the homes
- Improved child health decisions
- Reductions in child externalizing and internalizing behavior problems
- Child improvements in adaptive functioning
- Child Safety
    - Reduced child welfare referrals
    - Reduced the severity of allegations
    - Reduced confirmed maltreatment (finding of preponderance)
    - Fewer prevention needs identified by investigators
- Child Permanency
    - Reduced child removals
    - Reduced child re-entries
    - Sustained reunification
    - Reduced duration of out of home placements
- Family well-being
    - Higher family strengths and fewer family needs identified in the SDM

The analyses associated with the outcome evaluation will focus on the following domains and utilize the following measures. Some of the analyses will be limited to pre and posttest measurement within the SafeCare condition. The analyses utilizing MISACWIS data will offer a direct comparison between the SafeCare condition and the control group.

SafeCare Outcome Measure Table

Outcome	Measure	Data Source
Parenting behaviors, parent child interactions	SafeCare Behavioral Change Checklist	SafeCare portal iPAT Assessment Form (infants 0-18 months) and the cPAT Assessment Form (children 18 months-5 years old)
Home Safety	SafeCare Behavioral Change Checklist	SafeCare portal Home Accident Prevention Inventory Assessment
Parenting Stress	The *Parenting Young Children Scale*	MDHHS Data Lab
Child safety	Administrative data	MISACWIS
Child permanency	Administrative data	MISACWIS
Family well-being	Administrative data	MISACWIS

The evaluation team, in consultation with DHHS leadership will review and identify at least one of the following four measures to capture baseline levels and to estimate change (progress) over time. Although multiple measures would be ideal, we recognize the burden of new data collection and want to balance the needs of the evaluation with the time restrictions on caseworkers. It is important to note that both the treatment (SafeCare) and comparison group families will complete these measures.

The *Parenting Young Children Scale* (PYCS) (McEachern et al., 2012) assesses three dimensions of positive parenting behaviors that are linked to positive parent and child outcomes: *proactive parenting* (e.g., preparing child for challenging situation) is the extent to which a parent takes action to avoid problem behaviors; *support of positive behaviors* (e.g., praising the child) is the extent to which parents use reinforcers for the child and have positive interactions with the child; and *limit setting* (e.g., making sure child follows rules) is the extent to which the parent structures the child's behavior via expectations and rules. Each dimension included seven questions and participants responded on a seven-point scale with higher numbers indicating more positive parenting behaviors.

Alternative Measures to Consider

The *Parenting Stress Inventory-short form* (PSI) (Abidin, 1995) is a 36-item scale designed to measure stressors in parenthood. There are three subscales with 12 items each. The *dysfunctional interactions* subscale (e.g., child smiles less than I expected, child does not like me or want to be close) indicates the extent to which the parent has unmet expectations and does not find interactions with the child reinforcing. The *difficult child* subscale (e.g., child is very mood, child does things to bother me) assesses perception of child's temperament and behavior. The *parental distress* subscale (e.g., having a child has caused problems, feel trapped by responsibilities as a parent) represents perceived child-rearing competence and stresses associated with child parenting. Participants responded on a five-point scale with higher numbers indicating greater parenting stress.

The *Mother-Child Neglect Scale* (MCNS) (Lounds et al., 2004) is a 20-item scale that assesses four domains of neglectful caregiving behaviors: physical (e.g., kept child clean), emotional (e.g., comforted child when upset), cognitive (e.g., read books to child), and supervisory (e.g., knew child's whereabouts). Each domain included five questions, which participants answered on a four-point scale, with higher score indicating behaviors that are more neglectful.

The *Protective Factors Survey* (Counts et al., 2010) assesses five protective factors for child maltreatment. Here we focus on the constructs most relevant to parenting including parenting knowledge (e.g., I do not know what to do as a parent), nurturing behaviors (e.g., my child and I are very close), and family functioning (e.g., family pulls together when things are stressful). Each domain included four or five items and parents responded on a seven-point scale.

SAMPLING

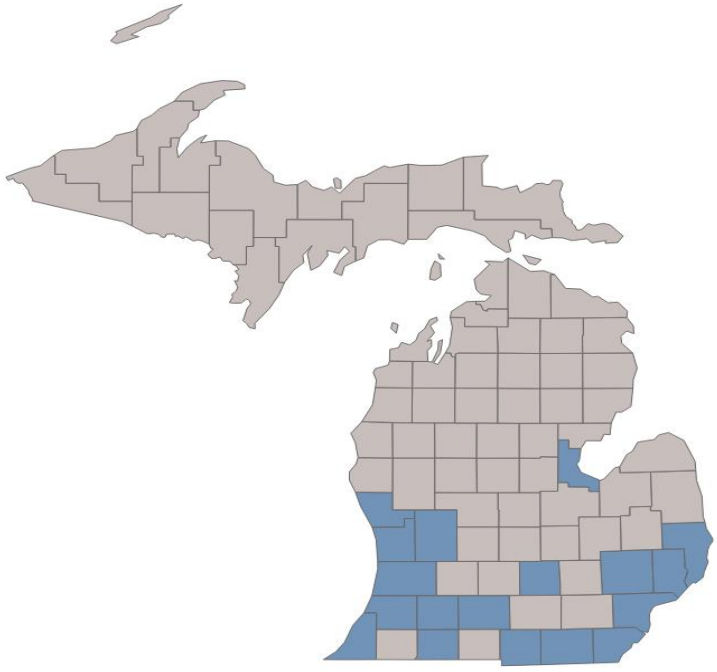
There are two critical questions related to sampling. Which children will be eligible for SafeCare? In which geographic area will SafeCare be offered? The answers to these questions must be data driven. Services providers should not simply treat all children or even treat a random sample of all children with a substantiated allegation of maltreatment. Eligibility should be limited to children with substantiated allegations of physical abuse or neglect. Similarly, MDHHS should avoid selecting geographic regions for services based solely on ease of implementation. That is, the criteria for standing up SafeCare in a particular county should not be based solely on the willingness of a county director to support new programming. The geographic locations should be driving by the potential sample populations (e.g., number of 0- to 5-year-olds in a specific county) and the probability of that potential sample experiencing the primary outcome of interest (e.g., likelihood of removal from the home and placement in foster care).

Which children will be eligible for SafeCare? According to the treatment manual, SafeCare is an in-home program for parents of children under 6 years old who are at-risk for or have been reported for child neglect or physical abuse. SafeCare is not recommended for children associated with substantiated allegations of sexual abuse. Thus, cases involving sexual abuse will be ineligible. Michigan will limit the child population to any child with at least one substantiated allegation of maltreatment (other than sexual abuse).

In which geographic area will SafeCare be offered? The evaluation team identified potential participating counties by analyzing the last five years of administrative data. For SafeCare eligibility, we identified the total possible sample (e.g., number of 0–5-year-olds with a substantiated allegation of neglect or physical abuse) and the number of those children/adolescents that were removed from the home and placed in foster care. So that we would have sufficient power to detect program effects, and so that any improvements observed by the intervention group might have the possibility of reducing the overall State placement rate, we selected counties that had at least 200 potentially eligible children removed in the last five years. We also limited site selection to counties in which the overall risk of removal (following substantiation) for this particular age group was at least 9% (rounded up). This approach yielded eighteen counties (see following Table).

Potential SafeCare Participants by County (2015-2021)		
County Name	**Children 0-5 not removed**	**Children 3-18 removed**
Kent	90.4% (11154)	9.6% (1182)
Wayne	90.0% (31341)	10.0% (3485)
Ottawa	90.0% (2823)	10.0% (313)
Allegan	89.2% (2130)	10.8% (258)
Macomb	89.6% (6183)	10.4% (721)
Oakland	89.2% (7773)	10.8% (945)
Bay	88.6% (1703)	11.4% (220)
St. Clair	87.8% (2377)	12.2% (330)
Kalamazoo	87.8% (6225)	12.2% (867)
Muskegon	87.4% (4207)	12.6% (607)
Calhoun	86.9% (2917)	13.1% (440)
Ingham	86.6% (6085)	13.4% (941)
Lenawee	85.8% (1465)	14.2% (243)
Van Buren	85.5% (1217)	14.5% (207)
Monroe	84.8% (1579)	15.2% (283)
Berrien	84.3% (3001)	15.7% (559)
St. Joseph	79.1% (1012)	20.9% (267)
Hillsdale	78.1% (798)	21.9% (224)

The proposed counties reflect a fair amount of geographic, racial, and ethnic diversity.



Demographic		(N = 14070)	Percent of Sample
	F	6681	47.5%
Sex	M	7389	52.5%
Race	American Indian	51	0.4%
	Asian	20	0.1%
	Black	3693	26.2%
	Hawaiian/Pacific Islander	5	0.0%
	Latinx	992	7.1%
	Multiracial	1967	14.0%
	Unknown	21	0.1%
	White	7321	52.0%
Age	Median (1.2)	Mean (1.4)	SD (1.3)

ANALYTIC APPROACH

The most rigorous approach and the approach that will generate the most confidence with regards to findings is a randomized control trial (RCT), which would be feasible in several counties where there are more children that would qualify (be eligible) for SafeCare than one county could possibly serve. We strongly recommend this approach. In short, the RCT approach is similar to selecting a random sample of eligible cases in each participating county. This is ethical because the selection of participants is not based on personal characteristics; each county is simply making a decision based on capacity. For example, if county X has the capacity to serve 50 children in a given year but county X has 400 eligible children, we would develop an online random assignment calculator (similar to the one developed for the TF-CBT evaluation) and randomly assign 50 children/families to the SafeCare condition. This same procedure will be replicated across multiple counties contingent on the capacity within each county. It is important to note that this approach is not a "no treatment" control condition. Children assigned to the control group receive services as usual.

An additional benefit of RCT is that the statistical analyses are far more straightforward as compared to a design that relies on propensity score matching or other statistical techniques to control for selection bias. Provided that the random assignment works (meaning equivalent groups are created), chi-square can be used to estimate differences between the SafeCare group and the control group on the risks of removal, subsequent substantiated reports of maltreatment and parenting stress. With regards to home safety and parent-child interactions, we would use a paired sample t-test to investigate change before and after the intervention. Finally, we propose developing an overall fidelity score (from the checklist generated by the SafeCare Portal) and investigate whether fidelity to the treatment model is associated with the identified outcomes. This last approach is similar to a dose response design. Basically – how much of the treatment was received as intended – and is there a threshold at which the likelihood of achieving desirable outcomes observed?

With regards to dissemination, the evaluation team will provide quarterly reports to the State. These reports will cover findings related to both process and outcome measures. The evaluation team will also develop conference presentations and peer reviewed journal articles so that the broader field of child welfare can learn from the experiences in Michigan.

Summary of Evaluation Plan: SafeCare	
Research Questions	• Does SafeCare improve parent-child interactions? • Does SafeCare reduce difficult child behaviors? • Does SafeCare remove home hazards (home safety)? • Does SafeCare improve parent supervision? • Does SafeCare improve parent instruction aimed at reducing medical neglect • Does SafeCare decrease the risk of foster care placements? • Does SafeCare decrease the likelihood of a subsequent substantiated report of maltreatment?
Target Population	• SafeCare families will be eligible to participate in Michigan if they have at least one child under the age of six and if they have at least three additional risk factors. • Additional risk factors include but are not limited to housing instability, young caregiver (under 20 years of age), child with special needs and single parent.
Measurement	• Parenting behaviors, SafeCare Behavioral Change Checklist, SafeCare portal • iPAT Assessment Form • Home Accident Prevention Inventory Assessment • Home Safety, SafeCare Behavioral Change Checklist • Parenting Stress The Parenting Young Children Scale • Child safety, Administrative data • Child permanency, Administrative data • Family well-being, Administrative data (FANS)
Evaluation Design	• The most rigorous approach and the approach that will generate the most confidence with regards to findings is a randomized control trial (RCT). • RCT is possible in many counties where there are more children that qualify for SafeCare than could possibly be served. • This design is ethical because the selection is not based on personal characteristics; each county is simply making a decision based on capacity. • This approach is not a “no treatment” control condition. Children assigned to the control group receive services as usual.
Outcomes of Interest	• Increased caregiver perceptions of parenting support • Improved parenting behaviors • Increased safety in the homes • Improved child health decisions

	• Reductions in child externalizing and internalizing behavior problems • Child improvements in adaptive functioning • Reduced confirmed maltreatment (finding of preponderance) • Reduced child removals • Family well-being • Higher family strengths and fewer family needs (SDM)
Analysis Plan	• A benefit of RCT is that the statistical analyses are far more straightforward as compared to a design that relies on propensity score matching or other statistical techniques to control for selection bias. • Chi-square can be used to estimate differences between the SafeCare group and the control group on the risks of removal and subsequent substantiated reports of maltreatment. • Paired sample t-tests will be used to estimate changes in parenting behaviors and home safety. • The evaluation team will calculate and overall fidelity score (from the checklist). We will investigate whether fidelity to the treatment model is associated with the identified outcomes. • Regression models will be developed to explore subgroup differences and interactions – that is – does SafeCare work better sub populations (e.g., first time parents).
Limitations	• The evaluation team will not know every service received by control group children and families. It is possible that some children in the control group will be exposed to some level of parent training program that is similar to SafeCare • Parts of the evaluation are limited to pre and post measurement. The evaluation team will have no information on the changes in these domains associated families in the control group
Dissemination	• The evaluation team will provide stakeholders with quarterly reports using tables and figures based on descriptive statistics including penetration/reach of SafeCare participation and outcomes within and across candidate populations. These tables and figures will be split by MDHHS service region and child/family demographics. • The quarterly reports will also cover findings related to both process and outcome measures. • The evaluation team will also develop presentations and peer reviewed journal articles so that the broader field of child welfare can learn from the experiences in Michigan. • The purpose of these analyses and dissemination plan is to

	provide MDHHS with a broad perspective on FFPSA implementation and outcomes and to help inform CQI efforts.

Data security and human subjects across the two evaluations

All data will be maintained and protected on a secure server at the University of Michigan. Access to the data will be limited to users with IRB approval and password protected. The University regularly completes security upgrades and checks to monitor data security and compliance. The focus of data security at the University of Michigan is maintaining strict data access protocols and ensuring and guaranteeing confidentiality.

With regards to human subjects, the evaluation plans will be reviewed the University of Michigan Institutional Review Board. The eResearch Regulatory Management (eRRM) system provides review and approval processes for the U-M Institutional Review Boards (IRB) and the U-M Institutional Biosafety Committee (IBC). The application types available to research teams include Human Subjects, Repository, and IBC Biosafety. eResearch Regulatory Management helps the university better ensure that it is meeting its obligation to conduct research in an ethical manner in accordance with regulations governing research while reducing the administrative burden. eRRM is developed under the leadership of the U-M Office of Research (UMOR) and Information and Technology Services (ITS), with input from faculty and staff from all three U-M campuses, the institutional review boards, and other review committees.[28]

We anticipate that aspects of the evaluation will require informed consent. Informed consent will occur prior to random assignment. The evaluation team will work with IRB staff to develop and gain approval for such consent. We will follow the federal guidelines for informing program participants. The guidelines for informed consent note the following elements.

- A statement that the study involves research
- An explanation of the purposes of the research
- The expected duration of the subject's participation
- A description of the procedures to be followed
- A description of any reasonably foreseeable risks or discomforts to the subject
- A description of any benefits to the subject which may be expected from the research
- A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject
- For research involving more than minimal risk, an explanation as to whether any compensation, and an explanation as to whether any medical treatments are available, if injury occurs and, if so, what they consist of, or where further information may be obtained
- An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights
- A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits, to which the subject is otherwise

[28] https://its.umich.edu/academics-research/research/eresearch/regulatory-management

entitled

Evaluation roles and responsibilities

The child and adolescent data lab have numerous experts in child welfare, data science, program evaluation and the provision of direct services. Joseph Ryan, Ph.D. will serve as the principal investigator and will lead the evaluations. The primary evaluation team will consist of Dr. Ryan (UM), Dr. Brian Perron (UM), Dr. Bryan Victor (Wayne State University), Dr. Rebecca Sokol (Wayne State University) and Emily Piellusch (UM). Each evaluation will have a lead evaluator (TBD) and a few MSW student interns to help data collection, data cleaning and report writing.

Dr. Ryan is a full professor at the University of Michigan and director of the child and adolescent data lab. His research and teaching build upon his ten years of direct practice experiences with child welfare and juvenile justice populations. Prior to doctoral studies at the University of Chicago, Dr. Ryan worked in direct care for Huron Services for Youth, Boysville and Starr Commonwealth. Prior to joining the faculty at the University of Michigan, Dr. Ryan worked as a research associate at Chapin Hall and was a tenured faculty member and chair of the child welfare curriculum at the University of Illinois' School of Social Work. Dr. Ryan served as the principal investigator on more than 25 studies in child welfare and was the lead evaluator on several Title IV-E waivers demonstrations.

Profile: https://ssw.umich.edu/faculty/profiles/tenure-track/joryan

Dr. Perron is a full professor at the University of Michigan School of Social Work. Dr. Perron directs scientific studies within the child and adolescent data lab. Perron received his Ph.D. in Social Work from Washington University and a certificate in Data Science from Johns Hopkins University. Perron has published over 100 scientific papers that have utilized a broad range of statistical procedures using a variety of data sources. Perron recently published a book on measurement and has taught numerous courses and workshops on data management and analysis. Perron also specializes in data visualization and has expertise creating interactive graphics and dynamic reports for non-technical users.

Profile: https://ssw.umich.edu/faculty/profiles/tenure-track/beperron

Dr. Victor is an assistant professor at the Wayne State University School of Social Work. Bryan G. Victor, MSW, Ph.D., is an Associate Professor at the Indiana University School of Social Work. Dr. Victor's research examines child welfare policy and practice related to domestic violence and substance misuse. He specializes in the use of administrative records to better understand system dynamics and drive data-informed decision-making. Dr. Victor worked for several years with children and families associated with domestic violence.

Dr. Sokol is an assistant professor at the Wayne State University School of Social Work. Dr. Sokol is a behavioral scientist who studies youth exposure to trauma. A developmental lens and public health framework informs her work, whereby she considers trauma prevention at the primary, secondary, and tertiary levels. Dr. Sokol completed her doctorate in Health Behavior at

the Gillings School of Global Public Health at the University of North Carolina-Chapel Hill. Through her graduate studies and predoctoral fellowship with the Carolina Consortium on Human Development, Dr. Sokol developed expertise in longitudinal and latent variable data analysis and developmental science.

Emily Piellusch, MSW is a research associate within the child and adolescent data lab. Emily received her MSW from the University of Michigan and received a BA in women's studies and social work from the University of Michigan. Prior to joining the Data Lab staff, Piellusch completed her MSW field study as an intern at the Data Lab, assisting various research and data analysis projects. She is particularly interested in using analyses of textual data as a means for investigating problematic trends in state, federal, and international systems. Piellusch is passionate about drawing attention to the relevance of data security and privacy within the field of social work, as well as advocating for individual's control over the distribution and use of their personal data. Before beginning the MSW program at U-M, Piellusch was a case manager at a shelter for survivors of intimate partner violence and sexual assault.

TIMELINE AND BUDGET

The evaluations will commence October 1, 2021 and conclude September 30, 2024. The evaluation team will deliver a final report on November 15, 2024. We suggest DHHS enrolls children and their parents for 27 months (starting in fall 2021) and then the evaluation team observe all families through the end of 36 months. This would permit us to observe all families for at least 6 months post random assignment. This is a reasonable window to observe family progress and to understand the relationship between the various interventions, changes in family functioning and the probability of removal. Remember, for the families enrolling in the first year, we will have a two-year observation period.

The overall (TF-CBT, SafeCare and Family Spirit) budget is attached.

TRAUMA SCREENING CHECKLIST (AGES 0-5)

Michigan Department of Health and Human Services

Complete and score the checklist according to instructions on the attached Trauma Screening Checklist Instruction Guide. Reference the attached Trauma Screening Checklist Definitions, if needed. When completed, refer to the Children's Services Agency Trauma Protocol/Trauma Screening Best Practices Guide for further case planning based on results.

Child's Name	Child's Date of Birth	Sex
Person ID (Child)	Case ID	
Parent/Caregiver Name		Date
County/Agency		Completed by ☐ Foster Care ☐ CPS
This checklist completed based on an interview with ☐ Child ☐ Parent/Caregiver		

SECTION 1 – CHECK EACH ITEM WHERE THE TRAUMA IS KNOWN OR SUSPECTED. Note: Endorsing exposure items does not necessarily mean substantiation of the child's experience; it is for screening purposes only.

Are you aware or do you suspect the child has ever experienced or been exposed to any of the following **types of trauma**?

- ☐ Physical abuse
- ☐ Neglectful home environment
- ☐ Emotional abuse
- ☐ Exposure to domestic violence
- ☐ Exposure to other chronic violence
- ☐ Sexual abuse or exposure
- ☐ Parental substance abuse
- ☐ Impaired parenting (mental illness)
- ☐ Exposure to drug activity aside from parental use
- ☐ Prenatal exposure to alcohol/drugs or maternal stress during pregnancy
- ☐ Lengthy or multiple separations from parent
- ☐ Placement outside of home (foster care, kinship care, residential)
- ☐ Loss of significant people, places, etc.
- ☐ Frequent/multiple moves; homelessness
- ☐ Other (indicate) _____

SECTIONS 2 – 4: CHECK EACH BEHAVIOR THAT HAS BEEN OBSERVED IN THE LAST 180 DAYS.

SECTION 2

Does the child show any of the following **behaviors**?

- ☐ Aggression towards self; self-harm
- ☐ Excessive aggression or violence towards others
- ☐ Explosive behavior (going from 0-100 instantly)
- ☐ Hyperactivity, distractibility, inattention
- ☐ Excessively shy
- ☐ Oppositional and/or defiant behavior
- ☐ Difficulty with sleeping, eating, or toileting
- ☐ Social/developmental delays in comparison to peers
- ☐ Repetitive violence and/or sexual play (or maltreatment themes)
- ☐ Unpredictable/sudden changes in behavior (i.e., attention, play)

☐ Sexual behaviors not typical for age ☐ Other (indicate) _____

SECTION 3

Does the child exhibit any of the following **emotions/moods**?

☐ Excessive mood swings
☐ Frequent, intense anger
☐ Chronic sadness, doesn't seem to enjoy any activities, depressed mood
☐ Flat affect, very withdrawn, seems emotionally numb or "zoned out"
☐ Other (indicate) _____

SECTION 4

Does the child have any of the following **relational/attachment difficulties**?

☐ Lack of eye contact, or avoids contact
☐ Sad or empty-eyed appearance
☐ Overly friendly with strangers (lack of appropriate stranger anxiety)
☐ Vacillation between clinginess and disengagement and/or aggression
☐ Doesn't reciprocate when hugged, smiled at, spoken to
☐ Has difficulty in preschool or daycare
☐ Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it
☐ Other (indicate) _____

TOTAL ENDORSEMENTS (add all marked checkboxes)

Henry, Black-Pond & Richardson (2010), rev: 3/16 Western Michigan University
Southwest Michigan Children's Trauma Assessment Center (CTAC)

TRAUMA SCREENING CHECKLIST (AGES 0-5)
TRAUMA SCREENING CHECKLIST INSTRUCTION GUIDE

PURPOSE

Caseworkers who complete the screen should have a basic understanding of trauma, its symptoms, and its potential impact to a child's functioning. A completed Trauma Screening Checklist provides information for workers to recognize trauma, its impact, and assists with case planning and building resiliency. The Trauma Screening Checklist is not intended to be used to make a clinical diagnosis. The Trauma Screening Checklist can be used as a tool to monitor progress and document changes in mood, behavior, attachment and school functioning with each completion of the screen.

ADMINISTRATION AND SCORING

The Trauma Screening Checklist should be administered to the child and the parent/caregiver. An interview of the child should depend on their intellectual, developmental, and emotional capability and their successful completion of a forensic interview. The parent should be interviewed if possible. If the parent is not available, or if the permanency plan is not reunification, the foster parent or caregiver should be interviewed.

1. Prior to interviewing, build rapport with the child and/or parent/caregiver.

2. Conduct separate interviews in a conversational manner with the child and parent/caregiver. For guidance, utilize the Tips for Administration below.

3. Complete the Trauma Screening Checklist based on the completed interview, the review of past records, and any contacts with collateral sources. Traumas identified in Section 1 are known or suspected, and do not have to be substantiated. Consult with your supervisor if you are uncertain about whether to check a particular item. Refer to the Trauma Screening Checklist Definitions for definitions of traumatic events and/or behaviors.

4. Sections 2-4 should be completed based on the **past 180 days**.

5. Determine total score of all sections combined. Each check mark is an endorsement and yields a score of "1."

6. If the score on the child's completed Trauma Screening Checklist differs from the score on the parent/caregiver completed Trauma Screening Checklist, utilize the Trauma Screening Checklist with the higher score for case planning and making referrals.

7. Refer to the Children's Services Agency Trauma Protocol, which includes the Trauma Screening Best Practices Guide, to determine how to proceed.

8. Upload completed Trauma Screening Checklist into the Person Overview section of MiSACWIS. Label Trauma Screening Checklist, followed by the date it was administered.

9. Rescreening is required within 180 days of the initial screening and prior to case closure. Additional screenings are recommended following significant changes within the child's life (placement change, goal change, traumatic event, etc.) and can be completed with supervisory discretion to assist with further assessment or case planning as needed.

TRAUMA SCREENING CHECKLIST (AGES 0-5)
TIPS FOR ADMINISTRATION OF TRAUMA SCREENING CHECKLIST

With a Child/Youth	With a Parent/Caregiver
Build rapport with the child by reminding him/her that he/she knows themselves best, which is why you want to learn all you can directly from him/her.	Build rapport with the parent/caregiver by assuring him/her that you understand he/she knows their child best, which is why you want to learn all you can directly from them.
Utilize MiTEAM competencies and skills, strength-based, solution-focused interviewing strategies to elicit information.	Utilize MiTEAM competencies and skills, strength-based, solution-focused interviewing strategies to elicit information. Recognize and validate the parent/caregiver support for the well-being of the child.
Empower the child by valuing his/her own perceptions of his/her experiences. Educate the child, in an age-appropriate manner, on the impact. Explain that trauma is something that was done to him/her or something he/she experienced (not something he/she caused). Normalize reactions to traumatic events the child has experienced.	To enhance engagement, normalize the parent/caregiver reaction to stress and/or self-blame. Educate the parent/caregiver on reactions to trauma. Explore past traumatic events experienced by the child, potentially linking the child's experiences with the parent/caregiver past trauma to create empathy and understanding for the child. Frame the child's challenging behaviors as the possible impact of traumatic events.
Summarize the results of the Trauma Screening Checklist. Explain that the results will be used to plan for his/her safety and effective services. Generate hopefulness for his/her future.	Summarize the results of the Trauma Screening Checklist. Explain that the results will be used to plan for the child's safety and effective services. Generate hopefulness for the child's future.

TRAUMA SCREENING CHECKLIST DEFINITIONS (AGES 0-5)

SECTION 1: TYPES OF POTENTIALLY TRAUMATIC EVENTS

Type	Working Definition
Physical abuse	The child experienced an actual or attempted infliction of physical pain such as hitting, slapping, burns, and/or bruising by a parent, caregiver or adult.

Suspected neglectful home environment	The child experienced an absence of such things as food, clothing, or shelter, left alone for long periods of time relative to age, or left for extended periods of time to care for siblings; parent/caregiver failure to protect from known or suspected threat of harm, and/or absence of needed medical care.
Emotional abuse	The child experienced verbal abuse (insults, debasement, threats of violence), emotional abuse (bullying, terrorizing, coercive control), belittling and/or humiliating interactions, purposefully shaming the child, or exploitation by the parent/ caregiver.
Exposure to domestic violence	The child experienced exposure (either actually witnessing, hearing, or being in the home) to emotional abuse, actual/ attempted physical or sexual assault, or aggressive control perpetrated between a parent/caregiver and another adult in the child's home environment.
Exposure to other chronic violence	The child experienced or witnessed extreme violence or threats of violence in the community such as neighborhood or gang violence, or the child experienced exposure to school violence or severe bullying.
Sexual abuse or exposure	The child experienced an actual or attempted sexual contact such as fondling, genital contact by a parent/caregiver and/or another adult and/or a much older youth, and/or exposure to age-inappropriate sexual material or environment.
Parental substance abuse	Parental substance use resulting in an inability to care for child's developmental needs on a routine basis; illegal substance use resulting in disruption of response to child's needs being met in a developmentally appropriate manner.
Impaired parenting (mental illness)	As the result of parent/caregiver mental illness, cognitive delays, or their own unresolved trauma, parent/caregiver behavior is erratic and/or unpredictable, or the parent/caregiver does not have the capacity and therefore fails to meet the basic needs of child.

Exposure to drug activity aside from parental use	Parent/Caregiver operating and/or distributing drug growing/ manufacturing operation within the home. May include frequent and chronic traffic in and out of the home secondary to substance abuse and/or criminal drug activity.
Prenatal exposure to alcohol/drugs or maternal stress during pregnancy	Child was prenatally exposed to alcohol/drugs as indicated by the mother's disclosure and/or documented legal action, and/or mother/child testing positive at birth for alcohol/drugs. Mother experienced chronic exposure to domestic violence during pregnancy and/or significant overwhelming relational distress.
Lengthy or multiple separations from parent or primary caregiver	Two or more abrupt, unexplained, and/or indefinite separations from a parent, primary caregiver, or sibling due to circumstances beyond the child's control. These separations may or may not have been related to the child's entry into foster care.
Placement outside of the home (foster care, kinship care, residential, hospitalization)	The child has been involuntarily placed in a hospital (medical/psychiatric) or foster care separating him/her from the care of his/her parents with only supervised access to his/her caregivers. Child has experienced multiple hospitalizations or intrusive medical procedures impacting the child's developmental trajectory.
Loss of significant people, places, etc.	The child experienced an expected loss of someone close to him/her, or witnessed homicide, suicide, motor vehicle accident, drug overdose or experienced significant losses due to natural disaster/events. Significant primary relationship(s) may no longer be available.
Frequent/multiple moves; homelessness	The child experienced homelessness, "couch-surfing" alone or with parents between friends/relatives' residences and/or lived in an emergency shelter for an extended amount of time.

SECTIONS 2 – 4: BEHAVIORS, MOODS, ATTACHMENT ISSUES

The section on behaviors (B), emotions/moods (M), and attachment (A) (under age 6) is written in common terms. Variation in how front-line workers may interpret items is acceptable. If the child is displaying behaviors or concerns not listed, please write them in the "other" field on the checklist.

Behavior/Mood/Attachment	Working Definition
Excessive aggression or violence towards others (B) (Ages 0-18)	Excessive behaviors that cause psychological or physical harm to another individual/or surroundings.
Excessive aggression or violence towards self/self-harm (B) (Ages 0-18)	Child may bite, bang head, pull own hair, hit self, or intentionally put self in harm's way (i.e., running into traffic or other unsafe situations). Includes cutting behaviors.
Explosive behavior (going from 0-100 instantly) (B) (Ages 0-18)	Episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which the reaction is grossly out of proportion to the situation. Also includes excessively prolonged episodes from which it is difficult for child to become calm again.
Hyperactivity, distractibility, inattention (B) (Ages 0-18)	Child may have increased arousal and/or difficulty with concentration and task completion, e.g., child may struggle completing schoolwork or have difficulty forming strong peer relationships.
Excessively shy (B) (Ages 0-18)	Child may cling to parent/caregiver, avoid eye contact, or refuse to speak even after allowed a period of time that is developmentally appropriate to become familiar with a new person or situation.
Oppositional and/or defiant behavior (B) (Ages 0-18)	Child/youth may behave in negative or hostile ways, frequently argue and refuse to comply with rules, become physically or verbally aggressive, destroy property, steal, break the law, start fires or run away.
Sexual behaviors not typical for child's age (B) (Ages 0-18)	Attempts to insert objects in another child's vagina and/or rectum and/or perform oral sex or attempts to insert objects in animals. Simulates sex through humping of stuffed animals, pillows, and/or live animals may also occur. Hypersexualized play is repetitive and may continue without some intervention. Verbalizes sexual acts in a coercive, threating or seductive behavior that is repetitive and does not respond to redirection.

Difficulty sleeping, eating or toileting (B) (Ages 0-18)	May have nightmares, trouble falling asleep, wake up frequently, thrash in sleep, wake easily, be an excessively picky eater, fail to gain weight, hoard or hide food, refuse to eat, only eat certain foods at certain times.
Social/developmental delays in comparison to peers (B) (Ages 0-5)	Inability to read social cues with peers, inability to appropriately engage peers, has difficulty sharing and is prone to regressing into tantrums if he/she does not get way with others.
Repetitive violent and/or sexual play (or maltreatment themes) (B) (Ages 0-5)	Violent or physically intense play that appears repetitive and is not resolved in the play, lack of empathy in violent play, sexual play that involves developmentally inappropriate sexual themes or knowledge, such as intercourse, oral sex, and placing objects into the vaginal and/or rectal openings of dolls or other play characters. Removing clothes from dolls is not in and of itself a concern.
Unpredictable/sudden changes in behavior (i.e., attention, play) (B) (Ages 0-5)	Child seems to have regressed and is now playing or behaving in a much younger fashion than before, seemingly as if the child were much younger in age than he/she is.
Excessive mood swings (M) (Ages 0-18)	Extreme changes from being happy to angry to sad, back to happy within short periods of time with no apparent environmental changes.
Frequent, intense anger (M) (Ages 0-18)	Quick to anger, anger out of proportion to event, extreme anger, may destroy property when in throes of outburst.
Chronic sadness, doesn't seem to enjoy any activities, depressed mood (M) Ages 0-18)	Low energy, lethargic, hard to engage, no joy or enjoyment.
Flat affect, very withdrawn, seems emotionally numb or "zoned out' (M) (Ages 0-18)	Facial expression doesn't change to reflect changes in emotional content of the conversation.
Lack of eye contact, or avoids eye contact (A) (Ages 0-18)	Averts eye contact with interviewer as well as parent/ caregiver. Parent/Caregiver and child do not seem to respond to each other's gaze for purposes of redirection, acknowledgement, permission, etc.

Sad or empty eyed appearance (A) (Ages 0-5)	Lack of spark in eye, facial expression does not change, sullen appearance. Lack of positive affect.
Overly friendly with strangers; lack of appropriate stranger anxiety; lack of appropriate boundaries in relationships (A) (Ages 0-18)	Exhibits over familiarity, will hold hands/touch, sit on lap, ask intrusive questions, and attend to new person rather than observing caregiver's interaction and cues with a new person.
Vacillation between clinginess and disengagement and/or aggression (A) (Ages 0-5)	An insatiable need for relatedness which results in "clinginess" where the child must cling to the parent/caregiver or adult. The child keeps clinging but never feels safe and secure. Child is angry/disappointed because he/she can't have the full attention of the other, he/she may disengage and/or become aggressive. Child may physically lash out, physically retreat, and/or become emotionally flat.
Doesn't reciprocate when hugged, smiled at, spoken to (A) (Ages 0-5)	If other initiates hugs, smiles, etc., the child fails to respond, or child attempts to distance self from the contact.
Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it (A) (Ages 0-18)	When getting hurt, the child seems to either not feel the pain or brushes it off quickly, does not seek adult comfort for pain or fear when it would be age-expected to do so. The child does not allow caregiver or adult to soothe when hurt or sad. Avoids touch, such as rubbing the back or putting on a Band-Aid, avoids being comforted.
Has difficulty in preschool or daycare (A) (Ages 0-5)	Child has extreme difficulty with peer relationships and/or regulation in a semi-structured setting.

TRAUMA SCREENING CHECKLIST (AGES 6-18)

Michigan Department of Health and Human Services

Complete and score the checklist according to instructions on the attached Trauma Screening Checklist Instruction Guide. Reference the attached Trauma Screening Checklist Definitions, if needed. When completed, refer to the Children's Services Agency Trauma Protocol/Trauma Screening Best Practices Guide for further case planning based on results.

Child's Name	Date of Birth	Sex
Person ID (Child)	Case ID	
Parent/Caregiver Name		Date
County/Agency		Completed by ☐ Foster Care ☐ CPS
This checklist completed based on an interview with ☐ Child ☐ Parent/Caregiver		

SECTION 1 – CHECK EACH ITEM WHERE THE TRAUMA IS KNOWN OR SUSPECTED. Note: Endorsing exposure items does not necessarily mean substantiation of the child's experience; it is for screening purposes only.

Are you aware or do you suspect the child has ever experienced or been exposed to any of the following **types of trauma**?

- ☐ Physical abuse
- ☐ Neglectful home environment
- ☐ Emotional abuse
- ☐ Exposure to domestic violence
- ☐ Exposure to other chronic violence
- ☐ Sexual abuse or exposure
- ☐ Parental substance abuse
- ☐ Impaired parenting (mental illness)
- ☐ Exposure to drug activity aside from parental use
- ☐ Prenatal exposure to alcohol/drugs or maternal stress during pregnancy
- ☐ Lengthy or multiple separations from parent
- ☐ Placement outside of home (foster care, kinship care, residential)
- ☐ Loss of significant people, places, etc.
- ☐ Frequent/multiple moves; homelessness
- ☐ Other (indicate) _____

SECTIONS 2 – 5: CHECK EACH BEHAVIOR THAT HAS BEEN OBSERVED IN THE LAST 180 DAYS.

SECTION 2

Does the child show any of the following **behaviors**?

- ☐ Aggression towards self; self-harm
- ☐ Excessive aggression or violence towards others
- ☐ Explosive behavior (going from 0-100 instantly)
- ☐ Hyperactivity, distractibility, inattention
- ☐ Excessively shy
- ☐ Oppositional and/or defiant behavior
- ☐ Sexual behaviors not typical for age
- ☐ Difficulty with sleeping, eating, or toileting
- ☐ Social/developmental delays in comparison to peers
- ☐ Other (indicate) _____

SECTION 3

Does the child exhibit any of the following **emotions/moods**?

- ☐ Excessive mood swings
- ☐ Frequent, intense anger
- ☐ Chronic sadness, doesn't seem to enjoy any activities, depressed mood
- ☐ Flat affect, very withdrawn, seems emotionally numb or "zoned out"
- ☐ Other (indicate) _____

SECTION 4

Does the child have any of the following **difficulties in school?**

- ☐ Low or failing grades
- ☐ Attention and/or memory problems
- ☐ Sudden change in performance
- ☐ Difficulty with authority/frequent behavior referrals
- ☐ Other (indicate) _____

SECTION 5

Does the child have any of the following **relational/attachment difficulties**?

- ☐ Lack of eye contact, or avoids contact
- ☐ Lack of appropriate boundaries in relationships
- ☐ Does not seek adult help when hurt or frightened
- ☐ Other (indicate) _____

TOTAL ENDORSEMENTS (add all marked checkboxes)

Henry, Black-Pond & Richardson (2010), rev: 3/16 Western Michigan University
Southwest Michigan Children's Trauma Assessment Center (CTAC)

TRAUMA SCREENING CHECKLIST (AGES 6-18)
TRAUMA SCREENING CHECKLIST INSTRUCTION GUIDE

PURPOSE

Caseworkers who complete the screen should have a basic understanding of trauma, its symptoms, and its potential impact to a child's functioning. A completed Trauma Screening Checklist provides information for workers to recognize trauma, its impact, and assists with case planning and building resiliency. The Trauma Screening Checklist is not intended to be used to make a clinical diagnosis. The Trauma Screening Checklist can be used as a tool to monitor progress and document changes in mood, behavior, attachment and school functioning with each completion of the screen.

ADMINISTRATION AND SCORING

The Trauma Screening Checklist should be administered to the child and the parent/caregiver. An interview of the child should depend on their intellectual, developmental, and emotional capability and their successful completion of a forensic interview. The parent should be interviewed if possible. If the parent is not available, or if the permanency plan is not reunification, the foster parent or caregiver should be interviewed.

10. Prior to interviewing, build rapport with the child and/or parent/caregiver.

11. Conduct separate interviews in a conversational manner with the child and parent/caregiver. For guidance, utilize the Tips for Administration below.

12. Complete the Trauma Screening Checklist based on the completed interview, the review of past records, and any contacts with collateral sources. Traumas identified in Section 1 are known or suspected, and do not have to be substantiated. Consult with your supervisor if you are uncertain about whether to check a particular item. Refer to the Trauma Screening Checklist Definitions for definitions of traumatic events and/or behaviors.

13. Sections 2-5 should be completed based on the **past 180 days**.

14. Determine total score of all sections combined. Each check mark is an endorsement and yields a score of "1."

15. If the score on the child's completed Trauma Screening Checklist differs from the score on the parent/caregiver completed Trauma Screening Checklist, utilize the Trauma Screening Checklist with the higher score for case planning and making referrals.

16. Refer to the Children's Services Agency Trauma Protocol, which includes the Trauma Screening Best Practices Guide, to determine how to proceed.

17. Upload completed Trauma Screening Checklist into the Person Overview section of MiSACWIS. Label Trauma Screening Checklist, followed by the date it was administered.

18. Rescreening is required within 180 days of the initial screening and prior to case closure. Additional screenings are recommended following significant changes within the child's life (placement change, goal change, traumatic event, etc.) and can be completed with supervisory discretion to assist with further assessment or case planning as needed.

TRAUMA SCREENING CHECKLIST (AGES 6-18)
TIPS FOR ADMINISTRATION OF TRAUMA SCREENING CHECKLIST

With a Child/Youth	With a Parent/Caregiver
Build rapport with the child by reminding him/her that he/she knows themselves best, which is why you want to learn all you can directly from him/her.	Build rapport with the parent/caregiver by assuring him/her that you understand he/she knows their child best, which is why you want to learn all you can directly from them.
Utilize MiTEAM competencies and skills, strength-based, solution-focused interviewing strategies to elicit information.	Utilize MiTEAM competencies and skills, strength-based, solution-focused interviewing strategies to elicit information. Recognize and validate the parent/caregiver's support for the well-being of the child.
Empower the child by valuing their own perceptions of his/her experiences. Educate the child, in an age-appropriate manner, on the impact. Explain that trauma is something that was done to him/her or something he/she experienced (not something he/she caused). Normalize reactions to traumatic events the child has experienced.	To enhance engagement, normalize the parent/caregiver reaction to stress and/or self-blame. Educate the parent/caregiver on reactions to trauma. Explore past traumatic events experienced by the child, potentially linking the child's experiences with the parent/caregiver past trauma to create empathy and understanding for the child. Frame the child's challenging behaviors as the possible impact of traumatic events.
Summarize the results of the Trauma Screening Checklist. Explain that the results will be used to plan for his/her safety and effective services. Generate hopefulness for his/her future.	Summarize the results of the Trauma Screening Checklist. Explain that the results will be used to plan for the child's safety and effective services. Generate hopefulness for the child's future.

TRAUMA SCREENING CHECKLIST DEFINITIONS (AGES 6-18)

SECTION 1: TYPES OF POTENTIALLY TRAUMATIC EVENTS

Type	Working Definition
Physical abuse	The child experienced an actual or attempted infliction of physical pain such as hitting, slapping, burns, and/or bruising by a parent, caregiver or adult.

Suspected neglectful home environment	The child experienced an absence of such things as food, clothing, or shelter, left alone for long periods of time relative to age, or left for extended periods of time to care for siblings; parent/caregiver failure to protect from known or suspected threat of harm, and/or absence of needed medical care.
Emotional abuse	The child experienced verbal abuse (insults, debasement, threats of violence), emotional abuse (bullying, terrorizing, coercive control), belittling and/or humiliating interactions, purposefully shaming the child, or exploitation by the parent/ caregiver.
Exposure to domestic violence	The child experienced exposure (either actually witnessing, hearing, or being in the home) to emotional abuse, actual/ attempted physical or sexual assault, or aggressive control perpetrated between a parent/caregiver and another adult in the child's home environment.
Exposure to other chronic violence	The child experienced or witnessed extreme violence or threats of violence in the community such as neighborhood or gang violence, or the child experienced exposure to school violence or severe bullying.
Sexual abuse or exposure	The child experienced an actual or attempted sexual contact such as fondling, genital contact by a parent/caregiver and/or another adult and/or a much older youth, and/or exposure to age-inappropriate sexual material or environment.
Parental substance abuse	Parental substance use resulting in an inability to care for child's developmental needs on a routine basis; illegal substance use resulting in disruption of response to child's needs being met in a developmentally appropriate manner.
Impaired parenting (mental illness)	As the result of parent/caregiver mental illness, cognitive delays, or their own unresolved trauma, parent/caregiver behavior is erratic and/or unpredictable, or the parent/ caregiver does not have the capacity and therefore fails to meet the basic needs of child.

Exposure to drug activity aside from parental use	Parent/Caregiver operating and/or distributing drug growing/ manufacturing operation within the home. May include frequent and chronic traffic in and out of the home secondary to substance abuse and/or criminal drug activity.
Prenatal exposure to alcohol/drugs or maternal stress during pregnancy	Child was prenatally exposed to alcohol/drugs as indicated by the mother's disclosure and/or documented legal action, and/or mother/child testing positive at birth for alcohol/drugs. Mother experienced chronic exposure to domestic violence during pregnancy and/or significant overwhelming relational distress.
Lengthy or multiple separations from parent or primary caregiver	Two or more abrupt, unexplained, and/or indefinite separations from a parent, primary caregiver, or sibling due to circumstances beyond the child's control. These separations may or may not have been related to the child's entry into foster care.
Placement outside of the home (foster care, kinship care, residential, hospitalization)	The child has been involuntarily placed in a hospital (medical/psychiatric) or foster care separating him/her from the care of his/her parents with only supervised access to his/her caregivers. Child has experienced multiple hospitalizations or intrusive medical procedures impacting the child's developmental trajectory.
Loss of significant people, places, etc.	The child experienced an expected loss of someone close to them, or witnessed homicide, suicide, motor vehicle accident, drug overdose or experienced significant losses due to natural disaster/events. Significant primary relationship(s) may no longer be available.
Frequent/multiple moves; homelessness	The child experienced homelessness, "couch-surfing" alone or with parents between friends/relatives' residences and/or lived in an emergency shelter for an extended amount of time.

SECTIONS 2 – 5: BEHAVIORS, MOODS, ATTACHMENT/SCHOOL ISSUES

The section on behaviors (B), emotions/moods (M), and attachment (A) (under age 6 or school (S) is written in common terms. Variation in how front-line workers may interpret items is acceptable. If the child is displaying behaviors or concerns not listed, please write them in the "other" field on the checklist.

Behavior/Mood/Attachment/School	Working Definition
Excessive aggression or violence towards others (B) (Ages 0-18)	Excessive behaviors that cause psychological or physical harm to another individual/or surroundings.
Excessive aggression or violence towards self/self-harm (B) (Ages 0-18)	Child may bite, bang head, pull own hair, hit self, or intentionally put self in harm's way (i.e., running into traffic or other unsafe situations). Includes cutting behaviors.
Explosive behavior (going from 0-100 instantly) (B) (Ages 0-18)	Episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which the reaction is grossly out of proportion to the situation. Also includes excessively prolonged episodes from which it is difficult for child to become calm again.
Hyperactivity, distractibility, inattention (B) (Ages 0-18)	Child may have increased arousal and/or difficulty with concentration and task completion, e.g., child may struggle completing schoolwork or have difficulty forming strong peer relationships.
Excessively shy (B) (Ages 0-18)	Child may cling to parent/caregiver, avoid eye contact, or refuse to speak even after allowed a period of time that is developmentally appropriate to become familiar with a new person or situation.
Oppositional and/or defiant behavior (B) (Ages 0-18)	Child/youth may behave in negative or hostile ways, frequently argue and refuse to comply with rules, become physically or verbally aggressive, destroy property, steal, break the law, start fires or run away.
Sexual behaviors not typical for child's age (B) (Ages 0-18)	Attempts to insert objects in another child's vagina and/or rectum and/or perform oral sex or attempts to insert objects in animals. Simulates sex through humping of stuffed animals, pillows, and/or live animals may also occur. Hypersexualized play is repetitive and may continue without some intervention. Verbalizes sexual acts in a coercive, threating or seductive behavior that is repetitive and does not respond to redirection.

Difficulty sleeping, eating or toileting (B) (Ages 0-18)	May have nightmares, trouble falling asleep, wake up frequently, thrash in sleep, wake easily, be an excessively picky eater, fail to gain weight, hoard or hide food, refuse to eat, only eat certain foods at certain times.
Excessive mood swings (M) (Ages 0-18)	Extreme changes from being happy to angry to sad, back to happy within short periods of time with no apparent environmental changes.
Frequent, intense anger (M) (Ages 0-18)	Quick to anger, anger out of proportion to event, extreme anger, may destroy property when in throes of outburst.
Chronic sadness, doesn't seem to enjoy any activities, depressed mood (M) Ages 0-18)	Low energy, lethargic, hard to engage, no joy or enjoyment.
Flat affect, very withdrawn, seems emotionally numb or "zoned out' (M) (Ages 0-18)	Facial expression doesn't change to reflect changes in emotional content of the conversation.
Low or failing grades (S) (Ages 6-18)	Consistently low or failing grades, may be because of failure to turn work in, not understanding the material, or excessive absenteeism.
Attention or memory problems (S) (Ages 6-18)	Easily forgets material, difficulty remembering what he/she read or heard in school, difficulty retaining information to process it (e.g., can't remember larger chunks of information when copying from board); inability to focus on task even it that task is interesting to the child, easily distracted by things in the environment.
Sudden changes in performance (S) (Ages 6-18)	Child is able to be successful in completing assignments, understanding material but then regresses and is unable to complete assignments and/or understand material within very short time.
Difficulty with authority (S) (Ages 6-18)	Difficulty following rules, accepting limits and boundaries.
Lack of eye contact, or avoids eye contact (A) (Ages 0-18)	Averts eye contact with interviewer as well as parent/ caregiver. Parent/Caregiver and child do not seem to respond to each other's gaze for purposes of redirection, acknowledgement, permission, etc.

Overly friendly with strangers; lack of appropriate stranger anxiety; lack of appropriate boundaries in relationships (A) (Ages 0-18)	Exhibits over familiarity, will hold hands/touch, sit on lap, ask intrusive questions, and attend to new person rather than observing parent/caregiver interaction and cues with a new person.
Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it (A) (Ages 0-18)	When getting hurt, the child seems to either not feel the pain or brushes it off quickly, does not seek adult comfort for pain or fear when it would be age-expected to do so. The child does not allow parent/caregiver or adult to soothe when hurt or sad. Avoids touch, such as rubbing the back or putting on a Band-Aid, avoids being comforted.

Which PRACTICE component did you implement today? Mark only ONE component for each session.

Therapist Identifier:_____ (May also check caregiver participation for any session)

TF-CBT Treatment Component	Session #:	1	2	3	4	5	6	7	8	9	10
	Date:	/	/	/	/	/	/	/	/	/	/
Caregiver participation: Meet with caregiver > 15 minutes											
P: Provide psychoeducation about traumatic experiences, trauma reactions, youth's symptoms and trauma reminders **GE:** identify trauma triggers; use proper words for traumas and body parts											
P: Provide parenting skills (praise, selective attention, time out, contingency reinforcement) **GE:** connect parental response and youth's behavior problems to trauma											
R: Provide individualized relaxation skills **GE:** Connect use of relaxation skills to youth's trauma reminders											
A: Provide affect identification and modulation skills **GE:** Connect use of skills to youth's trauma reminders											
C: Introduce cognitive triangle; encourage more accurate/helpful thoughts **GE**: Help PARENT use cognitive coping for trauma related maladaptive thoughts											

T: Develop youth's trauma narrative in calibrated increments with thoughts, feelings and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed **GE:** Re-read the TN at the beginning of *each* session										
I: **GE**: Develop in-vivo desensitization plan for generalized avoidant behaviors										
C: Conjoint youth-parent sessions: share youth's TN ; youth and parent Q&A; improve communication **GE**: Share TN with parent or address other trauma related issues conjointly										
E: Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills **GE:** Address safety skills related to youth's trauma										
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TF-CBT Treatment Component	Session #:	11	12	13	14	15	16	17	18	19	20
	Date:	/	/	/	/	/	/	/	/	/	/
Caregiver participation: Meet with caregiver > 15 minutes											
P: Provide psychoeducation about traumatic experiences, trauma reactions, youth's symptoms and trauma reminders **GE:** identify trauma triggers, use proper words for traumas and body parts											
P: Provide parenting skills (praise, selective attention, time out, contingency Reinforcement) **GE:** connect parental response and youth's behavior problems to trauma											
R: Provide individualized relaxation skills **GE:** Connect use of relaxation skills to youth's trauma reminders											
A: Provide affect identification and modulation skills **GE:** Connect use of skills to youth's trauma reminders											
C: Introduce cognitive triangle; encourage more accurate/helpful thoughts **GE**: Help PARENT use cognitive coping for trauma related maladaptive thoughts											
T: Develop youth's trauma narrative in calibrated increments with thoughts, feelings and worst moments. Cognitively process maladaptive cognitions. Share with parent as TN is developed											

GE: Re-read the TN at the beginning of *each* session										
I: **GE**: Develop in-vivo desensitization plan for generalized avoidant behaviors										
C: Conjoint youth-parent sessions: share youth's TN ; youth and parent Q&A; improve communication **GE**: Share TN with parent or address other trauma related issues conjointly										
E: Address personal safety skills and assertive communication; increase awareness of problem-solving skills and/or social skills **GE:** Address safety skills related to youth's trauma										
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Appendix D. Evaluation Waiver Requests

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Appendix E. State Prevention Plan Pre-Print

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Appendix F. Signed Assurance for Trauma-Informed Service

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Appendix G. State Title IV-E Reporting Assurance

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Appendix H. Maintenance of Effort

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Appendix I. Family First Policy

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