Attachment 1: Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024

Revised January 2021

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PART A – CHILD WELFARE

The information provided in this part of *Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024* (Prevention Plan) pertains to Iowa's child welfare system. Part B addresses Iowa's juvenile justice system, with whom the Iowa Department of Human Services (DHS) has an IV-E Agreement. Part C provides assurances and attachments applicable to the overall Prevention Plan.

Introduction

In calendar year (CY) 2019, Iowa's population of children ages 0 – 17 was 730,767[1]. During that same year, DHS assessed 33,004 reports of suspected child abuse and neglect. Of those assessed reports, DHS staff conducted:

- 6,543 (20%) family assessments, which involved 8,560 children; and
- 26,461 (80%) child abuse assessments, with assessment dispositions of:
  - 17,947 (68%) of child abuse assessments resulted in a finding of "not confirmed" (aka not substantiated), which involved 18,113 children;
  - 6,891 (26%) of child abuse assessments resulted in a finding of "founded" (aka substantiated) abuse, which involved 9,532 children; and
  - 1,623 (6%) of child abuse assessments resulted in a finding of "confirmed" (aka substantiated) abuse, which involved 1,936 children. "Confirmed" abuse means that the abuse was minor, isolated, and not likely to re-occur; and the perpetrator was not placed on the child abuse registry.[2]

Of the total number of abused or neglected children, 5,323 (46%) were 5 years of age or younger, 3,055 (27%) were between 6-10 years, and the remaining 3,085 (27%) were older than 11 years. Of all substantiated child abuse or neglect:

- 54% was neglect (denial of critical care);
- 27% was dangerous substance;
- 7% was physical abuse;
- 7% was presence of illegal drugs in a child's body;
- 4% was sexual abuse; and
- the categories of allows access by a registered sex offender, allows access to obscene materials, mental injury, child sex trafficking, prostitution of a child, and bestiality in the presence of a minor each made up less than 1% of the total substantiated child abuse or neglect.[3]

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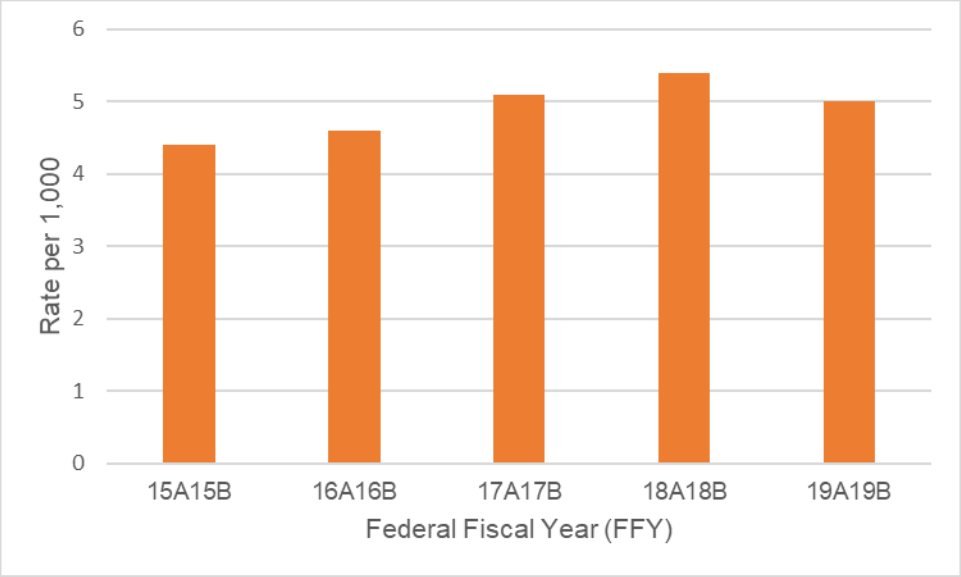
[1] Iowa, Child and Family Service Review (CFSR 3) Data Profile, Context Data, dated February 2020; population estimate 2018 utilized for 2019
[2] DHS, 2019 Child Welfare By The Numbers, available at https://dhs.iowa.gov/sites/default/files/childwelfarebythenumbers2019.pdf?060920201749
[3] Ibid.

Chart A1 below shows increases of foster care entries for Iowa's abused or neglected children from federal fiscal year (FFY) 2015 through 2018, but a decline from FFY 2018 to FFY 2019.

Chart A1: Iowa Foster Care Entry Rates per 1,000 (FFY 2015-2019)



Source: Child and Family Service Review (CFSR 3) Data Profile (Context Data), February 2020

The Family First Prevention Services Act (Family First) (Public Law 115-123) provides an opportunity for Iowa to utilize title IV-E funding to improve its service to children abused or neglected and their families. Family First authorizes funding for time-limited mental health and substance abuse prevention and treatment services and for in-home parent skills-based services. Children, who are candidates for foster care or pregnant or parenting youth in foster care, and their parents or kin caregivers, may receive these evidence-based prevention services. The goal of the title IV-E Prevention Services and Programs is to prevent the need for foster care placement and the resultant trauma of unnecessary parent-child separation. Iowa's Family First, Blueprint for Iowa's Future Child Welfare System, "Family Connections are Always Strengthened and Preserved" (Attachment A1), reinforces Iowa's commitment to prevent foster care entry.

DHS decided to implement the title IV-E Prevention Services and Programs as authorized by Family First. In accordance with ACYF-CB-PI-18-09, herein is Iowa's Prevention Plan. DHS may expand the services and applicable population in this Prevention Plan, through plan amendments, as additional evidence-based services receive approval through the Title IV-E Prevention Services Clearinghouse or through additional independent systematic reviews as part of the transitional payment review process authorized by the Children's Bureau through ACYF-CB-PI-19-06.

Acronyms and Abbreviations

Table A1: Acronyms and Abbreviations	
AMP	Achieving Maximum Potential
CWSG	Annie E. Casey Foundation's Child Welfare Strategy Group
CY	Calendar Year
IECMHC	Center of Excellence for Infant and Early Childhood Mental Health Consultation
CAA	Child Abuse Assessment
CINA	Child in Need of Assistance
CPW	Child protection worker
CWIS	Child welfare information system
CWPC	Child Welfare Partners Committee
CWG	Child Welfare Policy and Practice Group
Children's Board	Children's Behavioral Health System State Board
Children's System	Children's Mental Health System
CA	CINA Assessment
CAPP	Community Adolescent Pregnancy Prevention
CCWIS	Comprehensive child welfare information system
CQI	Continuous quality improvement
CHEA	Council for Higher Education Accreditation
COA	Council on Accreditation
CARF	Council on Accreditation for Rehabilitation Services
DAS	Department of Administrative Services
DoE	Department of Education
ECI	Early Childhood Mental Health Consultation
FCS	Family Centered Services
Family First	Family First Prevention Services Act (Public Law 115-123)
ECI	Family Support Leadership Group
FSS	Family support specialist
FTDM	Family Team Decision-Making
FFY	Federal Fiscal Year
IS	Intervention specialist
CJ	Iowa Children's Justice
IDPH	Iowa Department of Health
DHS	Iowa Department of Human Services
IME	Iowa Medicaid Enterprise
Prevention Plan	Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024
MIECHV	Maternal Infant Early Childhood Home Visitation
NSTRC	National SafeCare® Training and Research

Table A1: Acronyms and Abbreviations	
	Center
PIP	Program improvement plan
QA	Quality assurance
RFP	Request for proposal
SWCM	Social work case manager
SBC	Solution Based Casework®
SFY	State Fiscal Year
STY-I	State Youth Treatment Implementation Grant
SW	Support Worker
YTDM	Youth Transition Decision-Making

Section I: Title IV-E Prevention Services and Programs

Assessment of Child and Family Eligibility for the Title IV-E Prevention Program

The state must describe how it will assess children and their parents or kin caregivers to determine eligibility for title IV-E prevention services. (471(e)(5)(B)(v)))

DHS will utilize its child abuse and child in need of assistance (CINA) assessment processes to determine eligibility for Iowa's title IV-E prevention services. The process begins with Iowa's child abuse hotline, which receives reports of suspected child abuse. When the allegation meets the three criteria for abuse or neglect in Iowa (i.e., the victim is under the age of 18; the allegation involves a caretaker for most abuse types; and the allegation meets the Code of Iowa definition for child abuse), staff accept the report for a child protective assessment. Staff assigns accepted reports to one of two pathways for assessment, a Family Assessment or a Child Abuse Assessment. If a report of suspected child abuse does not meet the criteria for acceptance, staff rejects the report. Staff screen rejected reports to determine if the report meets the criteria for the child to be adjudicated a CINA in accordance with Iowa Code § 232.2(6). If rejected reports meet CINA criteria, staff assigns the report for a CINA Assessment.

- Child Abuse Assessment (CAA): The CAA is Iowa's traditional path of assessing reports of suspected child abuse. During the course of a CAA, the DHS child protection worker (CPW):
  - Visits the home and speaks with individual family members to gather an understanding of the concerns reported, what the family is experiencing, and engages collateral contacts in order to get a holistic view;
  - Evaluates safety and risk for the child(ren), including completion of *Form 470-4132, Safety Assessment* and *Form 470-4133, Family Risk Assessment* (Attachments A2 and A3 respectively);
  - Engages the family to assess family strengths and needs through a full family functioning assessment; and
  - Connects the family to any needed voluntary services.

  By the end of 20 business days, the CPW must:
  - make a finding of whether abuse occurred,

- consider whether a perpetrator's name meets criteria to be placed on the Iowa Central Abuse Registry, and
- determine whether to request court intervention.

Findings include:
- "Founded" means that a preponderance (more than half) of credible evidence supports that child abuse occurred and the circumstances meet the criteria for placement on the Iowa Central Abuse Registry.
- "Confirmed" means that a preponderance (more than half) of credible evidence supports that child abuse occurred, but the circumstances did not meet the criteria for placement on the Iowa Central Abuse Registry because the incident was minor, isolated, and unlikely to reoccur. (Only the abuse types, physical abuse and denial of critical care, lack of supervision or lack of clothing, can be confirmed).
- "Not Confirmed" means there was not a preponderance (more than half) of credible evidence to support that child abuse occurred.

The finding and risk level determine whether the family will receive services and at what level.
- "Not Confirmed" and "Confirmed" low risk – The CPW makes recommendations to the family for services available in the community.
- "Confirmed" moderate risk and "Founded" low risk – The CPW offers the family voluntary, state-purchased family-centered services.
- "Confirmed" high risk and "Founded" moderate and high risk – The CPW transfers the case to an ongoing social work case manager (SWCM) for formal DHS family-centered services.

- Child in Need of Assistance (CINA) Assessment (CA): CPWs conduct CA to examine the family's strengths and needs in order to support the families' efforts to provide a safe and stable home environment for their children and to determine the necessity of juvenile court intervention. During CAs, the CPW also utilizes *Form 470-4132, Safety Assessment* and *Form 470-4133, Family Risk Assessment*, to determine the child's safety and risk level for abuse and neglect.

  At the conclusion of the CA, the CPW determines the disposition of the case:
  - If CINA criteria are met, the CPW may refer the case for a CINA petition according to local protocols. The CPW refers the case to the SWCM or supervisor and provides transfer information.
  - If during the course of the CINA Assessment the circumstances constitute an abuse allegation on any child in the house, the CPW refers the child for child protective intake.
  - If the CINA criteria are not met and there are no circumstances that constitute an abuse allegation, the CPW may provide information on services available to the family in the community.

  The CA risk level determines service availability to the family:

- low risk – The CPW makes recommendations to the family for community services.
- moderate risk – The CPW offers the family voluntary, state-purchased family-centered services.
- high risk – The CPW works with their supervisor and a SWCM to provide formal DHS family-centered services to the family.

For purposes of the title IV-E prevention services program, a child is:
1. 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) of 471(e).
2. A child in foster care who is a pregnant or parenting foster youth.

DHS considers a child or youth to be "…either a person less than eighteen years of age or a person eighteen or nineteen years of age who meets any of the following conditions:
(1) Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma.
(2) Is attending an instructional program leading to a high school equivalency diploma.
(3) Has been identified by the director of special education of the area education agency as a child requiring special education as defined in Iowa Code section § 256B.2, subsection 1…" (Iowa Code § 234.1(2)(a)).

Furthermore, a child in foster care, who turns 18 and meets the conditions above, may sign a Voluntary Placement Agreement with DHS to continue their foster care placement.

1. Candidate for Foster Care: As mentioned above, the CPW utilizes *Form 470-4133, Family Risk Assessment*, which comprises two scales that measure the level of risk regarding abuse and neglect in CAA and CAs. The outcomes of high risk for CAA ("Confirmed") and moderate and high risk ("Founded") as well as high risk for CA indicates the child is at "imminent risk" of entering foster care. At the conclusion of the assessment process, the CPW's *Child Protective Services Child Abuse Assessment Summary, Form 470-3240*, or *CINA Services Assessment Summary, Form 470-4135*, (Attachments A4 and A5 respectively) reflects the CPW's work with the family to develop a plan of action moving forward, which comprises the child's prevention plan. The prevention plan will include the following plan requirements, prior to the provision of any prevention services:
   - Identify the child as "a candidate for foster care", which means the child is at "imminent risk" of entering foster care, but who can remain safely at home or in a kinship placement while receiving Iowa's prevention services; and
   - Identify the:
     - strategy to prevent the child's entry into foster care so that the child may safely: remain at home, live temporarily with a kin caregiver, or live permanently with a kin caregiver; and

- services to be provided to the child, the parents, and the kin caregiver (if applicable) that will ensure success of the identified foster care prevention strategy.

The process is the same for adoption or guardianship cases where there is a risk of a disruption or a dissolution, i.e. they have to come through the assessment process, either CAA or CA.

2. Pregnant or Parenting Youth in Foster Care: While DHS' child welfare information system (CWIS) tracks a parenting youth in foster care who has their child with them in the foster care placement, the system does not currently include a data field to track youth in foster care who are pregnant. DHS will add a data field to track this population as part of implementing a comprehensive child welfare information system (CCWIS). Therefore, at this time, DHS will not be drawing down IV-E prevention funding for the pregnant or parenting youth population. However, the pregnant or parenting youth's SWCMs will ensure the youth in foster care receives the appropriate services to meet the child's prenatal and/or parenting needs, which may include a prevention service. Supervisors will oversee this practice through their clinical consultations with the SWCM.

Please see Section III, Monitoring Child Safety, for information on processes utilized during the life of a case, which reflect the re-determination of eligibility for title IV-E prevention services.

Services Description and Oversight

Describe the HHS approved services the state will provide, including:

- *whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the title IV-E Prevention Services Clearinghouse*
- *the target population for the services or programs*
- *an assurance that each HHS approved title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III)*
- *how providing the services is expected to improve specific outcomes for children and families*

The Iowa Department of Human Services (DHS) will provide services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregivers' needs for the services or programs directly relate to the child's safety, permanence, or well-being to prevent the child from entering foster care. Effective October 1, 2020, child protection workers (CPWs) will utilize *Form 470-4133, Family Risk Assessment*, to determine the child and caregivers' eligibility for DHS' title IV-E prevention services, as outlined above under *Assessment of Child and Family Eligibility for the Title IV-E Prevention Program*.

The categories of prevention services and programs include:

- Mental Health and Substance Abuse Prevention and Treatment Services: Children and caregivers receive evidence-based mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period. The 12-month period begins on the date that staff identify the child as a "child who is a candidate for foster care" or a pregnant or parenting youth in foster care in the child's prevention plan.
  - Children and caregivers usually receive these services through community providers of mental health and substance abuse treatment in Iowa. Health insurance, both public and private, typically covers these services. Therefore, DHS did not include these services in its Prevention Plan.
  - Central office staff is currently working with:
    - contractors to ascertain the specific evidence-based mental health and substance abuse prevention and treatment services they provide, and
    - DHS' Iowa Medicaid Enterprise (IME) to identify a coding structure that will work with Medicaid for payment and provide specific data points for these services for child welfare involved families.
  - DHS is also collaborating with the Iowa Department of Public Health (IDPH) to map out available substance abuse prevention and treatment programs in order to identify any service gaps.
- In-Home Parent Skill-Based Programs: Children and caregivers receive evidence-based in-home parent skill-based programs for not more than a 12-month period. The 12-month period begins on the date that staff identify the child as a "child who is a candidate for foster care" or a pregnant or parenting youth in foster care in the child's prevention plan. These programs include parenting skills training, parent education, and individual and family counseling.

  As reflected in Table A2, DHS will implement two evidence-based in-home parent-skill based programs. DHS has an opportunity to continue and expand an existing in-home parent skill-based program, SafeCare®. There is also an opportunity to implement a new evidence-informed service, Solution Based Casework® (SBC). DHS identified that these services meet or will meet the needs of our children and families. DHS' family-centered services (FCS) contractors will implement SafeCare and SBC statewide, which will be part of our new FCS, effective July 1, 2020.

Table A2: Iowa's In-Home Parent Skill-Based Programs		
Evidence-Based Program Name, Description, including Manual, Target Population & Requested Funding	**Targeted Outcomes/Program Goals**	**Evidence Rating & Source**
SafeCare is a trauma-informed[4], supported behavioral parenting model shown to prevent and reduce child maltreatment and improve health, development, and welfare of children ages 0-5 in at-risk families. It is a home visitation-based parent-training program conducted over 18 sessions, with each session one to one-and-a-half hours in length. Parents whose children, ages 0-5, are at-risk for neglect or physical abuse receive instruction in three modules. These modules address three risk factors that can lead to child abuse and neglect: 1) the parent-child relationship, 2) home safety, and 3) caring for the health of young children. Each module includes a baseline assessment, intervention (training sessions), and a follow-up assessment to monitor progress over the course of the program. *Manual:* Provider Manual, version 4.1.1.[5] *Title IV-E Prevention Services Funding*	• Reduce future incidents of child maltreatment. • Reduce entries and re-entries into foster care. • Increase positive parent-child interaction. • Improve how parents care for their children's health. • Enhance home safety and parent supervision.	Supported, Title IV-E Prevention Services Clearinghouse
Solution Based Casework® (SBC) is an evidence-based case management approach to assessment, case planning, and ongoing casework. The approach helps the caseworker focus on the family in order to support the safety and well-being of the family's children, ages 0-17. The goal is to work in partnership with the family, through at least weekly 45 minute sessions, to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them. This approach targets specific everyday events in the life of a family that have caused the family difficulty and represent a situation in which at least one family member cannot reliably maintain the behavior that the family needs to accomplish its goals. The model combines the best of the problem-focused relapse prevention approaches that evolved from work with addiction, violence, and helplessness, with	• Reduce incidents and future incidents of child maltreatment. • Reduce entries and re-entries into foster care. • Increase positive parent-child interaction. • Improve how parents care for their children.	Does not meet eligibility criteria, Title IV-E Prevention Services Clearinghouse

[4] Please see Attachment III (a) for assurance that SafeCare® meets the trauma-informed service-delivery requirements.
[5] Lutzker, J. R. (2016). SafeCare provider manual (version 4.1.1)

Table A2: Iowa's In-Home Parent Skill-Based Programs		
Evidence-Based Program Name, Description, including Manual, Target Population & Requested Funding	**Targeted Outcomes/Program Goals**	**Evidence Rating & Source**
solution-focused models that evolved from family systems casework and therapy. By integrating the two approaches, partnerships between the family, DHS worker, FCS contractor, and other service providers can be developed that account for basic needs and restore the family's pride in their own competence. The assumptions of SBC include (1) full partnership with the family is a critical and vital goal for each and every family, (2) partnership for protection should focus on patterns of everyday life of the family, and (3) solutions should target the prevention skills needed to reduce the risk in those everyday life situations.		

How the state selected the services (471(e)(5)(B)(iii)(III))

In 2016, DHS began implementing SafeCare as part of the SafeCare research project conducted by Georgia State/National SafeCare Training and Research Center (NSTRC). Five of DHS' contracted child welfare, service organizations implemented SafeCare through their existing contracts. In order to provide SafeCare to parents, one must be a certified home visitor. Each of these five organizations have certified home visitors, coaches, and trainers. Some of the contractors also have "train the trainers", who provide training within their own respective organizations. Contractors are also SafeCare accredited, renewable on an annual basis, through the NSTRC.

As part of the research project, recruitment of families continued through September 30, 2017 within the specific counties identified and selected by Georgia State. Due to the research component of the project, not all of Iowa's counties implemented SafeCare. Once the research project ended, which included expectations of the contractors, DHS staff explored and decided to expand SafeCare statewide. DHS reviewed the SafeCare research, which included family survey results. Survey results showed that caregivers had a high rate of satisfaction, as did the providers delivering the model, which was a specific area of evaluation by NSTRC.

In the fall of 2018, DHS enlisted the assistance of Annie E. Casey Foundation's Child Welfare Strategy Group (CWSG) to assess Iowa's current child welfare practice, to make recommendations, and to assist Iowa in strategically prioritizing Iowa's improvement strategies[6]. Specifically, the CWSG:

[6] The Annie E. Casey Foundation (AECF) Iowa Needs Assessment 2019, (March 26, 2019), Available at https://dhs.iowa.gov/sites/default/files/IA_Assessment_Deck-Provider_Meeting.pdf?040320201510

- Assessed the needs of children and families served by Iowa's child welfare system and Iowa's child welfare, service array to see if services provided met identified needs.
  - Analyzed data:
    - Analyzed both state and regional/county level data to understand priority issues (i.e. prior victimization, in-home services, and out of home care)
    - Review of prior analyses completed by state data personnel
  - Reviewed policies, documents, and contracts, such as:
    - Internal policies
    - Key legislation including task force reports, DHS' and Children's Bureau visions
    - Communications materials
    - Provider request for proposal (RFP)
    - Achieving Maximum Potential's (AMP's) Youth Voice Project
  - Conducted focus groups with:
    - DHS Social Worker IIs (social work case managers (SWCMs)) and IIIs (child protective workers (CPWs)) (34)
    - DHS Supervisors (26)
    - Parent Partners[7] (30)
    - Parents (28)
    - Youth (25)
  - Conducted interviews with:
    - DHS' Family First Oversight Team
    - DHS Regional Managers
    - External stakeholder interviews: Judges, Legal Aid Attorney
    - IT and QA staff
- Recommended service models for foster care prevention services.
- Assisted DHS in planning to support Family First implementation, including fiscal analysis, foster care prevention model selection, and implementation strategies.

CWSG's assessment noted some key challenges in Iowa's child welfare system, such as unnecessary placements in foster care, teenagers with challenging behaviors, and parents with substance abuse issues. CWSG noted systemic issues that undergird these challenges are lack of individualization of services, lack of role clarity between DHS and contracted service providers, lack of experienced workforce capacity, and lack of efficacious accountability. In response, CWSG recommended the following:

- Implement a clear case management model with defined roles, e.g. SBC. "Case management can be a prevention service that requires skilled workers, reasonable caseloads and clearly defined activities.

[7] Parent Partners are parents who previously had their children removed by DHS but achieved and maintained reunification for at least one year. Parent Partners provide peer-to-peer mentoring support to parents whose children have been removed from their care.

  - Working with the family to develop a family service plan (family team meetings)
  - Helping the family connect to needed services (referrals, assistance at appointments)
  - Aiding the family in accessing services (transportation planning or support)
  - Assessing the parents' protective capacities and behavior changes over time
  - Monitoring the child's safety and addressing any new safety or risk concerns"[8]
- Establish an array of evidence-based interventions, e.g. SafeCare
- Institute stronger accountability for DHS and child welfare services' contractors

Iowa will continue working with CWSG to guide Family First implementation efforts.

In June 2019, the Child Welfare Policy and Practice Group facilitated 10 Provider Partnership Forums[9] across the state, which was a way for DHS to collect service providers' voices regarding the future of child welfare in Iowa. These forums included open conversation in a safe space designated for providers. These small group conversations provided an opportunity to share cross-area perspectives with the guidance of a neutral facilitator, sharing of success and themes of concern, and an initial discussion of Family First. The topics included but were not limited to the following:

- Implementation of evidence-based services
- Financing services, including incentives
- Caseload size
- Workforce (turnover, compensation, and staff retention strategies)
- Transportation

How the state plans to implement the services or programs (471(e)(5)(B)(iii)(II))

Utilizing information gleaned from the service selection processes, in August 2019, DHS issued a RFP to solicit proposals from qualified eligible bidders to deliver FCS, inclusive of SafeCare and SBC, which align with Family First. In December 2019, DHS received bid proposals. In March 2020, DHS announced the apparent successful bidders. There will be a contract transition period during the month of June 2020, with the new statewide provision of services beginning July 1, 2020. DHS does not anticipate a delay in implementing SafeCare across the state. Currently, there is a least one FCS contractor certified to provide SafeCare in all five DHS Service Areas. Of the seven FCS contractors, only two will need training and will work toward certification under the FCS contracts. However, contractors have until

[8] The Annie E. Casey Foundation (AECF). Iowa Needs Assessment 2019. (March 26, 2019). Slide 12. Available at https://dhs.iowa.gov/sites/default/files/IA_Assessment_Deck-Provider_Meeting.pdf?040320201510.

[9] The Child Welfare Policy and Practice Group. (June 11, 2019). Iowa Department of Human Services Provider Forums Report. Available at https://dhs.iowa.gov/sites/default/files/IA_Provider_Forum_Final_Rpt.pdf?041020201749.

December 1, 2020 to have their staff trained in SBC, which may delay SBC implementation until the individual contractor staff complete training.

DHS awarded 10 contracts to child welfare, service organizations for our child welfare FCS, with two contracts in each of the five DHS Service Areas. FCS includes, but is not limited to, SafeCare and SBC, and the following services, which are not part of the Prevention Plan:

- Family Team Decision-Making (FTDM) Meeting and Youth Transition Decision-Making (YTDM) Meeting Facilitation
- Family Preservation Services, Child Safety Conference Facilitation, and Motivational Interviewing

Contracts will have an initial two-year contract term with the ability to extend the contract for four additional one-year terms. Contractor requirements include, but are not limited to, the following:

- Accreditation:
  - Accredited by the Council on Accreditation (COA) for one or more of services including child protective services, family preservation and stabilization services, foster care services, or kinship care services and affirms their commitment to maintain that accreditation during the contract period; or
  - Accredited by the Joint Commission for Behavioral Health Care Services and affirms their commitment to maintain that accreditation during the contract period; or
  - Accredited by the Council on Accreditation for Rehabilitation Services (CARF) for child and youth services and affirms their commitment to maintain that accreditation during the contract period; or
  - Committed to apply for accreditation with any of these three organizations, if not currently accredited, within three months of executing a contract with DHS, receive accreditation within 21 months of the contract execution date, and maintain accreditation for the remainder of the contract period.
- SafeCare:
  - Accredited by the NSTRC
  - If not accredited, apply for accreditation within 3 months of contract execution, receive accreditation within two years of contract execution date, and maintain accreditation during contract period.

Both SafeCare and SBC will be available to families with children in the home, families with children placed with kin caregivers, and families with children placed in foster care. FCS contractors will provide SafeCare and SBC with fidelity to the applicable model, with services provided for no more than 6 months for SafeCare and 12 months for SBC. FCS contractors also may provide SBC with children and families for up to 3 months in non-DHS involved (voluntary) cases. In non-DHS involved (voluntary) cases, FCS contractors have case management and decision responsibility but must still adhere to minimum casework contacts for SBC.

Table A3: SafeCare® and Solution Based Casework® (SBC) Implementation Requirements		
Evidence-Based Intervention	**DHS' Service Delivery Requirements**	**DHS' Documentation Requirements**
SafeCare	The contractor's Intervention Specialist (IS) provides weekly sessions of SafeCare® in accordance to model fidelity. The IS, at a minimum, makes four face-to-face casework contacts, 60 minutes in length, within each full calendar month delivering SafeCare, with additional casework contacts occurring based upon family need. • At a minimum, if the children reside in the parental home, two of the four casework contacts take place in the parental home. • If one or more children resides out of the home, at least one of the four casework contacts must occur in the home where the children currently reside.	The IS completes and submits the following original and updated documentation, at a minimum, to the DHS worker: • Casework Contact Note - The IS completes the DHS-developed casework contact note after each SafeCare casework contact with the family. The IS submits the contact note to the DHS worker within 10 calendar days from the date of the contact. • Service Termination Summary - The IS completes a DHS-developed service termination summary within 10 business days from closure of SafeCare and sends it both to the DHS worker and the parents, unless termination of parental rights occurred.
Solution Based Casework® (SBC)	The contractor's Family Support Specialist (FSS), at a minimum, makes four face-to-face casework contacts within each full calendar month of SBC service delivery, with additional casework contacts occurring based upon family need. However, if the family also receives SafeCare in addition to SBC, the FSS makes two face-to-face casework contacts rather than the four. The casework contacts will be at least 45 minutes in length and include interventions and assessment of parent/child interactions for safety and risk. • At a minimum, three of the four casework contacts occur in the parental home. • If one or more children resides out of the home, at least one of the four casework contacts must occur in the home where the children currently reside.	The FSS completes and submits the following original and updated documentation, at a minimum, to the DHS worker (or DHS designee for non-DHS cases): • Casework Contact Note - The FSS completes the DHS-developed casework contact note after each contact with the family. The FSS submits the contact note to the DHS worker or DHS designee for non-DHS cases within 10 calendar days from the date of the contact. • Service Plan – The FSS completes and submits a DHS-developed service plan that aligns with the current DHS family case plan, within 45 calendar days (DHS cases) or 30 calendar days (non-DHS cases) of the initial referral for services, with a copy sent within 5 business days of submission to DHS and to the parents, unless termination of parental rights occurred. • Case Progress Report - The FSS completes and submits a DHS-developed quarterly case progress report for only DHS cases within 5 business days from the end of the service provision quarter, with a copy sent to the parents, unless termination of parental rights occurred. • Service Termination Summary - The FSS completes a DHS-developed service termination summary within 10 business days

Table A3: SafeCare® and Solution Based Casework® (SBC) Implementation Requirements		
Evidence-Based Intervention	**DHS' Service Delivery Requirements**	**DHS' Documentation Requirements**
		from case closure and sends it both to the DHS worker and the parents, unless termination of parental rights occurred.

How implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved (471(e)(5)(B)(iii)(II))

DHS' Family-Centered Services (FCS) contractors providing SafeCare must receive certification by the National SafeCare Training and Research Center (NSTRC). The NSTRC provides training, observation, and guidance to DHS contractors to ensure their certification attainment, ongoing fidelity monitoring, and annual recertification. To become a SafeCare provider, individuals must first attend the four-day workshop conducted by certified SafeCare trainers from the NSTRC. The workshop uses a combination of instructional presentations, skills observation, and role-play sessions with training specialists to teach service providers about implementation of the three core modules, i.e. Health Module, Home Safety Module, and Parent-Child/-Infant Interactions Module, as well as communication and structured problem solving skills. After attending the workshop, certified SafeCare coaches must observe and rate the individual's fidelity in at least nine sessions until staff obtain sufficient proficiency in SafeCare skills (measured by at least 85% or greater on the fidelity assessment) to attain certification. Fidelity monitoring for providers includes a review of session audio by coaches, who use standardized fidelity checklists to evaluate provider's competency and accuracy in conducting each session. Coaches give session feedback to providers to support their SafeCare practice. During provider certification, this occurs as often as needed until the provider is certified. After certification, providers continue fidelity monitoring once a month for two years, at which point they move to quarterly fidelity monitoring. NSTRC requires fidelity to consistently be at 85% or greater for continued SafeCare implementation.

FCS contractor SafeCare coaches periodically conduct recordings or observations of SafeCare sessions for quality assurance purposes. SafeCare Trainers and NSTRC Specialists check coaches' quality assurance. Each year, FCS contractor SafeCare trainers demonstrate their accuracy in assessing fidelity of provider and coach support sessions and workshop training skills.

Once certified, individuals can receive additional training to become a SafeCare coach or trainer. The NSTRC requires onsite SafeCare coaching. To become a SafeCare coach, certified individuals participate in a two-day workshop to learn the role of a coach, including how to coach and provide constructive feedback to the SafeCare provider. After attending the workshop, a SafeCare trainer observes and rates the coach on demonstration of coaching skills and mastery in fidelity monitoring for certification as a coach.

After individuals complete the required trainings and receive certification as a SafeCare provider and SafeCare coach, individuals may attend a two-day workshop that teaches SafeCare training methods, how to teach adult learners, how to set up role-play, how to provide feedback to trainees, and how to support SafeCare coaches. Becoming a SafeCare trainer is a commitment to the NSTRC to adhere to their requirements regarding distribution of materials, supporting SafeCare coaches and providers, and reporting data to NSTRC through the SafeCare Implementation Data Network (SIDN), https://safecareportal.nstrc.org/SafeCare/WebApp/Account/Login. After the workshop, the NSTRC observes SafeCare trainer trainees during their first provider workshop to ensure fidelity to the training model. To become fully certified, the NSTRC Trainer must rate the SafeCare trainer trainee as having achieved mastery in the delivery of a provider workshop. All but two of DHS' FCS contractors currently have internal SafeCare trainers.

The NSTRC requires DHS' FCS contractors to obtain annual recertification to ensure model fidelity of SafeCare. The NSTRC conducts annual accreditation, in which organizations accredited in SafeCare, provide documentation of compliance with the SafeCare Implementation Standards. Accreditation standards are on the core program criteria that promotes a high quality service delivery to maximize the effectiveness of SafeCare for families. These standards require that organizations: (1) implement the SafeCare model as prescribed to maintain fundamental structural, measurement, and mastery criteria; (2) conduct ongoing quality assurance of worker's SafeCare responsibilities; and (3) have a minimum number of providers actively delivering SafeCare at the time of accreditation. NSTRC will also consider details pulled from the SafeCare Portal such as frequency of SafeCare visits, module and program completion, and program satisfaction. The contractor organizations submit information about their SafeCare implementation through an online accreditation survey. The NSTRC Accreditation Manager schedules a phone interview to ensure organizations maintain high quality implementation and fidelity to the model. If an implementation has not met SafeCare standards, that organization has a corrective action plan. In addition to this once a year check in, organizations can reach out to NSTRC at any time and the NSTRC will provide local sites technical assistance with implementation and quality assurance. The NSTRC's accreditation process also provides opportunities to obtain SafeCare program and technology updates, the latest research findings regarding SafeCare and its implementation, as well as an opportunity to highlight the strengths of an organization's implementations and to obtain consultation about challenges or concerns. NSTRC requires ongoing coaching to keep the contractors' certifications active.

Through its contracts with FCS contractors, DHS provides funding for contractors not already certified in SafeCare to attain their certification. There are two FCS contractors currently pursuing SafeCare certification, with expected certification by July 1, 2021. DHS contractual expectations are that FCS contractors will attain and maintain SafeCare certification throughout the contract period.

Similar to the NSTRC, the SBC developer provides SBC training (pre-training reading groups, management training, initial training, supervisor training, learning transfer, and

eLearning for new employees), implementation support through follow-up coach calls, and SBC certification at several levels (caseworker, supervisor, coach, and trainer). SBC contractors will enter their data into the SBC developer's implementation website for fidelity monitoring.

Plans to determine outcomes achieved: DHS plans to contract with an evaluator to complete an evaluation of SafeCare. Attachment A: Iowa SafeCare Evaluation Plan provides detailed information about Iowa's plans to determine SafeCare outcomes, and their achievement, through the evaluation. Additionally, DHS has the following SafeCare contract performance measures in contracts with the FCS contractors:

- Performance Measure 1: 65% of parents in contractor's cases receiving SafeCare will complete and graduate from all three modules.
- Performance Measure 2: 85% of parents in contractor's cases receiving SafeCare will complete the parent-child/parent-infant interactions module.

DHS coordination and collaboration with contractors in SafeCare CQI activities: Once direct support from NSTRC ends and a FCS contractor is at full implementation, the CQI activities that DHS coordinates and collaborates with the contractors primarily relates to the fidelity monitoring and accreditation as listed above. However, there will be coordination and collaboration in evaluation activities as mentioned in Attachment A. Additionally, the below discussion regarding feedback loops also provides opportunities for CQI discussions between DHS and FCS contractors.

How information learned from the monitoring will assist in refining and improving practices

As part of DHS' activities for SafeCare, DHS' feedback loop utilizes stakeholder group processes and contract monitoring to refine and improve practices. Stakeholder group processes, which usually occur at a local level but roll-up to a state level, include but are not limited to:

- Service Area Contractor Meeting – Held in each Service Area, contractor leadership, i.e. director level of organizations that hold contracts with DHS and DHS leadership, attend these meetings. This group comes together quarterly to share agency updates, performance data, as well as the current focus of the state resulting from upcoming policy and/or contract changes. This allows everyone to have a voice and provide feedback regarding upcoming changes. Often this is a time for stakeholders to communicate regarding any barriers that they are experiencing and begin problem-solving issues.
- Joint Supervisor Meetings – These will occur quarterly between DHS, FCS contractors, and foster care supervisors. This is time to partner and problem solve regarding service-related issues that staff are experiencing. The supervisors also receive information derived from other contractor meetings. Supervisors often jointly develop topics for staff meetings, as needed, for field staff.
- Joint Quality Assurance (QA) Meetings – These occur in some Service Areas quarterly between DHS QA staff and QA staff from the contractors in the Service Areas. This is an opportunity for QA staff to share what they have been focusing on

and offer any assistance. This is a partner and learner opportunity to share across organizations for continuous quality improvement (CQI).

Twice a year, via phone call, teleconference, or webinar, the DHS' family-centered services (FCS) program manager and assigned service contract specialist plans to meet with the FCS contractors to discuss a set agenda shared with the contractors prior to the call. At the conclusion of the meeting/call, the FCS program manager will create a one-page document summarizing the key points and overview of the discussion and will share the one page document with contractor representatives, DHS service area managers, service contract specialists, child welfare bureau chief, and division administrator.

The FCS program manager also regularly attends the local in-person meetings (Service Area Contractor Meetings) scheduled in each of the Service Areas in an effort to increase understanding of the challenges contractors face and support program development, performance, and improvement. By attending the local service area meetings, the FCS program manager gains understanding regarding the systemic challenges between contractors and field operations. In addition, the information discussed during the local service area meetings build upon the information discussed during the semi-annual meetings/calls. The in-person meetings also help facilitate discussion about training, program development and improvement, and best practices.

The FCS program manager (aka contract manager), in collaboration with the assigned service contract specialists, oversees the contracts for FCS, which includes SafeCare and SBC. The contract manager determines compliance with general contract terms, conditions, and requirements and assesses compliance with the contract deliverables, performance measures, or other associated requirements based on information received from the service contract specialist for the contract. Service contract specialist activities include but are not limited to:

- Responding to day-to-day questions from the contractor.
- Resolving contract issues and disputes between DHS and the contractor to the extent possible.
- Monitoring data on a monthly basis regarding any incentive payments the contractor is eligible to obtain.
- Conducting onsite reviews of contractor records, including the records of subcontractors as necessary, to validate the contractor's monthly service reporting and compliance with the service requirements. DHS reserves the right to set the frequency of onsite reviews.
    - For SBC, the service contract specialist will read a minimum of 10 randomly selected records on open DHS child welfare service cases and a minimum of three randomly selected records on non-DHS cases for a total of 13 records quarterly. Selection of the records will occur through a random sampling methodology reviewed as part of the contractor's quality assurance review. If there is a significant error rate observed of more than 10%, DHS reserves the right to increase the sample.
        - If the randomly selected SBC records also include provision of SafeCare, the service contract specialist will read for these service requirements as well.

- Monitoring program improvement plans (PIP) that the contractor is required to develop to improve their performance in meeting the service requirements.
- Conduct onsite reviews of the contractor's overall quality assurance system to validate that the contractor is implementing a quality assurance system as described in their proposal. Quality assurance reviews by the service contract specialist will occur periodically throughout the contract period. The first review will take place within the first nine months of the contract. Further review, as needed, will ensure that the service contract specialist maintains an understanding of the contractor's quality assurance processes. During the subsequent reviews, the service contract specialist will review 10 staff files including newly hired staff and on-going staff, and five subcontractor staff if there are any subcontractors, to check on the compliance with records checks and qualifications. Based on service contract specialist's or contractor's preference, these reviews may be scheduled prior to or concurrent with the contract compliance review.

How each service or program provided will be evaluated. – See Evaluation Strategy and Waiver Request below.

Evaluation Strategy and Waiver Request

Evaluation Strategy: The state must include a well-designed and rigorous evaluation strategy for each service, which may include a cross-site evaluation approved by ACF.

Family First requires that each approvable service listed in Iowa's Prevention Plan have a well-designed and rigorous evaluation strategy, unless granted a waiver from HHS for a well-supported intervention. DHS' evaluation strategy for SafeCare is to contract with an evaluator to conduct the well-designed and rigorous evaluation (please see Attachment A: Iowa SafeCare Evaluation Plan).

Evaluation Waiver Request: Consistent with section 471(e)(5)(C)(ii) of the Act, the Children's Bureau may waive this requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state may request this waiver using Attachment II to the five-year plan and must demonstrate the effectiveness of the practice.

Not Applicable

Monitoring Child Safety

The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.

Both DHS and child welfare services' contractors will monitor and oversee the safety of children who receive prevention services under DHS' Prevention Plan.

1. Periodic Risk Assessments:

   Safety Assessment: DHS staff utilize safety and risk assessments, including risk reassessments, to oversee the safety of children receiving child welfare services, including prevention services. The safety assessment is a decision-making and documentation process that evaluates safety threats, present danger, child vulnerability, and family protective capacities to determine the safety response. Specifically, the assessment looks at child safety using three constructs:
   - The threats of maltreatment that are present at this time (i.e., aggravating factors that combine to produce a potential dangerous situation).
   - The child's vulnerability to maltreatment (i.e., the degree that a child cannot on the child's own avoid, negate, or minimize the impact of present or impending danger).
   - The caretaker's protective capacities (i.e., the family strengths, or resources that reduce, control or prevent threats of maltreatment from arising as well as factors and deficiencies that have a negative impact on child safety).

   Since safety assessment is an ongoing process, DHS staff, child protective workers (CPWs) and social work case managers (SWCMs), conduct a safety assessment, utilizing *Form 470-4132, Safety Assessment*, with supervisory consultation, at the following critical junctures throughout the course of the family's involvement with DHS:
   - Within 24 hours of first contact with the child during a child protective assessment (CPW)
   - At completion of the child protective assessment (CPW)
   - Whenever circumstances suggest the child is in an unsafe situation (SWCM)
   - Before the decision to recommend unsupervised visitation (SWCM)
   - Before the decision to recommend reunification (SWCM)
   - Before the decision to recommend closure of protective services (SWCM)

   If the child is conditionally safe, DHS staff initiate controlling safety interventions, which may include the parent arranging informal temporary care of the child, through a safety plan. If the child is unsafe, DHS staff pursue removal of the child from the parental home, sanctioned by a court order or voluntary agreement, for foster care placement.

   Risk Assessment: Risk refers to the probability or likelihood that a child will suffer maltreatment in the future. The identification of risk looks at the conditions within a family that may put the child at risk of maltreatment. Risk is not static; it changes and needs re-evaluated throughout the life of the case. Risk factors indicate child welfare threats that if left unattended could result in a safety concern. Some risk

factors identify what needs to change within the family so that the child will remain safe.

DHS intake staff assess risk during intake in terms of the type and severity of the risk with respect to the allegations. Risk factors exist on a continuum from low to high that indicate the likelihood that any form of maltreatment will occur or reoccur.

DHS' CPW completes *Form 470-4133, Family Risk Assessment*, before the completion of the child protective assessment. This tool in combination with clinical judgment helps to focus on the needs of the family. The Family Risk Assessment:

- Evaluates personal, physical, and environmental factors in families that are associated with repeat maltreatment,
- Documents risks related to abuse and neglect, and
- Assigns a score of low, moderate, or high risk for the family within each category. The family risk score is a factor in determining case referral for services. As mentioned under Assessment of Child and Family Eligibility for the Title IV-E Prevention Program above, family risk scores of moderate or high indicate a child is a "candidate for foster care".

CPWs record the results of the risk assessment in the *Child Protective Services Assessment Summary, Form 470-3240*, or in the *CINA Services Assessment Summary, Form 470-4135*, in the section entitled, "Summary and Analysis of Safety/Risk Assessments." The information gathered from the risk assessment becomes part of the case information given to the SWCM for an ongoing services case. The SWCM uses this information when conducting case planning activities with the family.

DHS' SWCMs reassess risk formally and informally periodically throughout the life of the case. The results of the risk reassessments and the assessment of the family's functioning gauge progress and determine appropriate services. Staff conduct formal risk reassessments by using *Form 470-4134, Risk Reassessment* (Attachment A6), during case and prevention plan reviews (discussed under 2. below) and before case closure. SWCMs conduct informal risk reassessments, without the use of a tool, at the following points during the life of a case:

- At family decision-making team (FTDM) meetings,
- In unsafe situations,
- During any contact with child, caregiver, or future caregiver,
- After review of reports,
- In clinical case consultations with the supervisor and other professionals,
- Before unsupervised family interactions or visits,
- Before reunification, and
- Whenever circumstances suggest.

Client Contacts: DHS' SWCMs conduct face-to-face visits with each child receiving services in the home and those in out-of-home placements. At a minimum, face-to-face visits occur once every calendar month but can be more frequent based upon

the needs of the child. The majority of the visits take place in the child's place of residence, with the visit being of sufficient length to focus on the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan's goals. Documentation of the visits occurs in DHS' child welfare information system (CWIS), contact note.

Family-centered services (FCS) contractors' workers assess child safety throughout provision of SafeCare and Solution Based Casework® (SBC) by identifying, documenting, and reporting the three elements of safety constructs: threats of maltreatment, child vulnerability, and caretaker's protective capacities, during client contacts. This occurs regardless if the case is a DHS case or a non-DHS (voluntary) case.

- SafeCare: The Intervention Specialist (IS) provides weekly sessions of SafeCare in accordance to model fidelity, which includes, at a minimum, four face-to-face casework contacts, 60 minutes in length, within each full calendar month. Additional casework contacts occur based upon family need. At a minimum, when the children reside in the parental home, two of the four casework contacts must occur in the parental home. If one or more children resides out of the home, at least one of the four casework contacts must occur in the home where the children currently reside. The IS completes a DHS-developed casework contact note after each SafeCare casework contact with the family, which is due to the DHS worker within 10 calendar days from the date of the contact.
- SBC: The Family Support Specialist (FSS), at a minimum, makes four face-to-face casework contacts within each full calendar month of service delivery, with each casework contact at least 45 minutes in length and includes interventions and assessment of parent/child interactions for safety and risk. Additional casework contacts occur based upon family need. If the family receives SafeCare in addition to SBC, the FSS conducts two face-to-face casework contacts rather than the four. At a minimum, three of the four casework contacts occur in the parental home. However, if one or more children resides out of the home, at least one of the four casework contacts occurs in the home where the children currently resides. The FSS completes a DHS-developed casework contact note after each casework contact with the family, which is due to the DHS worker within 10 calendar days from the date of the contact.

2. Prevention Plan Review

DHS: As described earlier in this section, CPWs will document the prevention plan in their child protective services child abuse and CINA services assessment summaries. DHS requires SWCMs to develop an initial case permanency plan on all DHS cases, in-home and out-of-home, in partnership with the child and family, within 25 days of the date the DHS opens a service case or the child's entry into foster care, whichever occurs first. SWCMs will incorporate the prevention plan created by the CPW into the child's initial case plan.

DHS staff will utilize FTDM meetings, with the child (if age appropriate), the family, the family's supports, professionals, etc. to review the initial case permanency plan,

inclusive of the prevention plan, and develop a more robust plan. Facilitation of these meetings occur through the FCS contractors. Subsequent case and prevention plan reviews occur as part of FTDM meetings according to the following schedule:

- Initial (within 45 calendar days from the date of referral),
- Six months from the date of referral to services,
- 12 months from the date of referral to services and every six months the case remains open, and
- Prior to case closure if referred by the DHS SWCM.

DHS staff also utilize youth transition decision-making (YTDM) meetings to review the case permanency plan, inclusive of the youth's transition plan, for youth in foster care who are 16 years of age and older. DHS staff may utilize these meetings for pregnant or parenting youth in foster care in addition to any applicable FTDM meetings. YTDM meetings occur on or after the youth's 16th birthday and within 90 days prior to the youth's 18th birthday, if applicable. FCS contractors also facilitate these meetings.

FCS Contractors: To comply with accreditation standards and DHS contract requirements, the FSS completes a DHS-developed service plan and submits the service plan to DHS within 45 days of the initial referral for DHS cases and within 30 calendar days for non-DHS (voluntary) cases. Staff also provide the parents a copy of the plan within 5 days of submission to DHS, unless termination of parental rights occurred. For DHS cases, the FSS utilizes individualized case needs and results of the FTDM and YTDM meetings, as well as other meetings such as a Child Safety Conference, to direct the blend of services and supports provided to address the safety, risk, and permanency issues, reflected in updates to the service plan.

Section II: Consultation and Coordination

The state must: Engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers

The Iowa Department of Human Services (DHS) consults with other state agencies responsible for administering mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, to foster a continuum of care for children and their caregivers.

Mental Health and Substance Abuse Prevention and Treatment Services

Iowa struggles with a fragmented mental health system and a shortage of psychiatrists. Iowa often ranks as one of the lowest states in the nation when it comes to mental health treatment services and accessibility. This is, at least in part, due to our geography and the increasing decline in population in many of our rural areas. Understanding what we know now about mental health and the correlation between childhood trauma and chronic disease, we know that perhaps the best way to prevent mental illness in adults is to screen for and treat mental health concerns in early childhood. However, as noted, providers and services are sometimes scarce in certain parts of the state. One way Iowa addresses this is through the promotion and development of Early Childhood Mental Health Consultation (ECMHC) services as part of a continuum of services related to children's mental health.

DHS staff continue to participate in the ECMHC workgroup formed under the direction of the Iowa Department of Public Health (IDPH) to assess the needs of the state in this area and to develop a plan to increase capacity. The DHS prevention program manager is a member of this state level group of leaders currently working with a TA Specialist from the Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC) to improve access to ECMHC in Iowa for professionals in the early childhood fields (i.e., childcare, early learning, family support, home visitation, etc.).

To further address children's mental health, in 2019, Iowa's Governor Reynolds signed into law House File 690, which established requirements for the Children's Behavioral Health System after receiving the Strategic Plan for the Children's System State Board as ordered by Executive Order No. 2 signed April 23, 2018. The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need. The Children's Board comprises 17 voting members appointed by the Governor. The DHS and DoE director's co-chair the Children's Board. The basis for the selection of the members of the Children's Board were their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.[10]

As mentioned earlier, DHS' child welfare staff are currently working with:

- FCS contractors to ascertain the specific evidence-based mental and substance abuse prevention and treatment services they provide, and

[10] For more information about the Children's Behavioral Health System State Board, please go to https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board.

- DHS' Iowa Medicaid Enterprise (IME) to identify a coding structure that will work with Medicaid for payment and provide specific data points for these services for child welfare involved families.

IDPH and DHS also collaborate on the State Youth Treatment Implementation Grant (STY-I). The purpose of this partnership is to expand and enhance evidence-based treatment and recovery support services for substance use disorders and/or co-occurring disorders among adolescents and transitional aged youth and their families. Specifically, the DHS routinely participates in the Adolescent Steering Committee meeting, which takes place on a quarterly basis. In addition, the DHS agreed to participate in the Youth and Family Subcommittee, which focuses on developing strategies to increase adolescents and family involvement in treatment services.

After the passage of Family First, DHS worked with IDPH and its substance use disorder providers to explore implementation of the placement of children with parents in a licensed residential family-based treatment facility for substance abuse. At this time, DHS decided not to move forward but may reconsider this in the future. In addition, DHS staff are working currently with IDPH staff to map services available for families, reflecting both services that IDPH and DHS child welfare provide.

Family Support

Adolescent Health Advisory Committee: With a number of changes that occurred with the Community Adolescent Pregnancy Prevention (CAPP) program, DHS initiated an interagency Advisory Committee of relevant stakeholders at the statewide level. This committee currently includes representatives from the following agencies or disciplines:

- DHS, including the DHS program manager;
- IDPH, including the Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) program managers;
- Iowa Department of Human Rights, Division of Criminal and Juvenile Justice Planning (CJJP); and
- DoE.

The committee heavily participated in some of the decision-making processes around the most recent CAPP grantee request for proposal (RFP). In addition, it was critical for DHS and IDPH to be in communication as both agencies released RFPs for similar services over the past 6 months, which helped to reduce the potential for duplication or gaps in services. The committee also will play a role in the review of the statewide needs assessment and strategic plan underway to look at the issue of adolescent pregnancy in Iowa. An individual risk factor for child abuse is being a young parent.

Iowa Family Support Program: The State of Iowa has worked towards state infrastructure building in the area of family support for many years. However, as a recipient of federal MIECHV (Maternal Infant Early Childhood Home Visitation) funding, Iowa had an opportunity to advance significantly this work. The Iowa Family Support

Program is in the IDPH, Bureau of Family Health and serves as a hub for numerous programs, services, and initiatives including:

- Institute for the Advancement of Family Support Professionals – an online learning environment built upon core competencies necessary for success in the field of family support
- The Iowa Family Support Network website – an information and resource referral source for various support programs in the state
- Parentivity – a web-based community for parents
- The Iowa Family Support Credentialing Program – an accreditation program for family support programs in Iowa
- Family Support Leadership Group (ECI) – a multidisciplinary group of stakeholders from various public/private organizations who lead various state family support and/or home visitation programs
- Family Support Programming:
    - HOPES/HFI – Healthy Opportunities for Parents to Experience Success - Healthy Families Iowa (HOPES-HFI) follows the national Healthy Families America evidence-based program model.
    - MIECHV –federal funding for various evidence based home visitation models being used in a number of "high risk" communities in Iowa

The DHS, Bureau of Child Welfare and Community Services staff participates on the Family Support Leadership Group (ECI) and serves on the MIECHV State Advisory Committee. In addition, Iowa's child abuse prevention providers now utilize Iowa's Family Support Statewide Database (FSSD) and on June 6, 2019 participated with other state teams from across Regions V and VII to provide input on data exchange standards under MIECHV.

Family First Implementation

DHS staff engaged stakeholders to develop the Family First, Blueprint for Iowa's Future Child Welfare System (Attachment A1). After finalization of the Blueprint, DHS staff discussed the Blueprint with a multitude of stakeholders, which included Achieving Maximum Potential (AMP) (foster care youth councils in Iowa), Parent Partners, child welfare services contractors, courts, tribes, etc. DHS posted the Blueprint on its website at: https://dhs.iowa.gov/sites/default/files/Comm534%20FF%20Blueprint%20for%20Iowa's%20Future%20Child%20Welfare%20System%20(Abbreviated%20Version).pdf?062120191912.

Child Welfare Policy and Practice Group (CWG): CWG, a nonprofit technical assistance organization, has extensive experience in conducting evaluations in more than two dozen states. CWG focuses on system evaluation, constructing effective implementation strategies, and strengthening the quality of front-line practice through training and coaching. In 2019, the CWG elicited feedback from the provider community regarding current processes and practices, including recommendations for improved outcomes for children and families; greater fiscal efficiency and, any questions

or concerns about Iowa's vision for practice and technical implementation of Family First. CWG facilitated 10 provider forums throughout the state, which included provider directors and administrators, Family Safety Risk and Permanency (FSRP) Care Coordinators and supervisors, other child welfare service providers, and court appointed special advocates (CASAs). While DHS central office staff managed the venues, invitations, and scheduling, there were no DHS employees present at any of the forums.

Annual DHS/Child Welfare Services Contractors Meetings: Each year DHS conducts a statewide meeting that includes representation from current child welfare service contractors, DHS field and central office staff, and other external partners. The purpose of the statewide meeting is to bring DHS and current child welfare services contractors together to continue strengthening relationships and identifying ways to work together across the entire service array to improve our child welfare outcomes. A small number of public and private Child Welfare Partners Committee (CWPC) members volunteer to participate in a planning committee to prepare and plan for the statewide meeting. Meetings in 2018 and 2019 included but were not limited to:

- a presentation on Family First;
- a keynote presentation that focused on inspiration, transformation, and strategic planning;
- a presentation by Kerri Smith with the Annie E. Casey Foundation (AECF) regarding their assessment findings and recommendations on steps DHS needs to take to improve services in Iowa11; and
- pre-implementation activities associated with Family First.

Child Welfare Partners Committee (CWPC): The Child Welfare Partners Committee (CWPC) exists because both public and private organizations recognize the need for a strong partnership. It sets the tone for the collaborative public/private workgroups and ensures coordination of messages, activities, and products with those of other stakeholder groups. This committee acts on workgroup recommendations, tests new practices/strategies, and continually evaluates and refines its approaches as needed. The CWPC promotes, practices, and models the way for continued collaboration and quality improvement. The vision of the CWPC is the combined experience and perspective of public and private organizations provide the best opportunity to reach our mutual goals: child safety, permanency, and well-being for Iowa's children and families. Collaboration and shared accountability keeps the focus on child welfare outcomes. The CWPC unites individuals from Iowa DHS and private organizations to create better outcomes for Iowa's children and families.

Through collaborative public-private efforts, a more accountable, results-driven, high quality, integrated system of contracted services is created that achieves results

[11] AECF PowerPoint Presentation regarding assessment is available at https://dhs.iowa.gov/sites/default/files/IA_Assessment_Deck-Provider_Meeting.pdf?030520201600

consistent with federal and state mandates and the Child and Family Services Review (CFSR) outcomes and performance indicators.

The committee serves as the State's primary vehicle for discussion of current and future policy/practice and fiscal issues related to contracted services. Specifically, using a continuous quality improvement framework, the committee proposes, implements, evaluates, and revises new collaborative policies and/or practices to address issues identified in workgroup discussions. Both the public and private child welfare organizations have critical roles to play in meeting the needs of Iowa's children and families. A stronger public-private partnership is essential to achieve positive results. The committee meets on a regular basis throughout the year.

With completion of their three-year strategic plan, the primary focus of the CWPC shifted to support DHS with implementation of Family First.

As membership terms expire on the CWPC, selection of new members occurs to maintain the balance of public and private representation. All new members receive orientation to the CWPC including membership roles/responsibilities/expectations, history of the CWPC, active workgroups, and products developed out of the workgroups. More information on the CWPC is available at https://dhs.iowa.gov/about/advisory-groups/childwelfare/partner-committee

Oversight and Implementation Workgroups (Attachment A7): DHS developed a Family First Oversight Group that oversees five workgroups, comprising internal and external stakeholders, including social service organizations, to implement Family First. The five workgroups include:

- Communication and Marketing
- Training
- Information and Technology/Systems
- Practice and Forms
- Data

Dr. Amelia Frank Meyer, LISW, APSW: In September and October 2019, Dr. Frank Meyer presented six trainings on the "Human Need for Belonging" throughout the state (one training in each service area) for DHS staff. External stakeholders, such as judges and attorneys, also attended. The trainings explored the life-long impact of out-of-home placement on children and the importance of safely connecting children to their family. These trainings occurred to prepare the DHS workforce and stakeholders for Family First implementation and necessary shifts in practice. One of the sessions was recorded and available at https://www.youtube.com/watch?v=i0y4yvkpAI8&feature=youtu.be.

Children's Justice: DHS staff also remains active in the Children's Justice State Council, as well as Children's Justice (CJ) Advisory Committee, and other taskforces and workgroups. The CJ State Council and CJ Advisory Committee meet quarterly, with members representing all state level child welfare partners. Council and committee

members discuss policy issues, changes in practice, updates of child welfare relevance, and legislative issues. For example, within the last couple of years, Iowa's Supreme Court directed establishment of a taskforce to consider what actions the judiciary needs to take in light of Family First implementation. The group reviewed a variety of materials, discussed practice in Iowa, developed a report with recommendations, and provided the report to the Iowa Supreme Court. The Iowa Supreme Court decided to continue the taskforce for several more years as Iowa implements Family First.

Describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.

DHS will coordinate services provided for or on behalf of a child and the parents or kin caregivers of the child with services provided under Title IV-B, subparts I and II, of the Social Security Act. DHS utilizes Title IV-B subpart I (aka The Stephanie Tubbs Jones Child Welfare Services Program) funds for crisis intervention (family preservation services) and family reunification services. DHS utilizes Title IV-B subpart II funds (aka MaryLee Allen Promoting Safe and Stable Families (PSSF)) funding to provide services such as Family Preservation (e.g. Wrap-Around, Caring Dads and Parent Partners), Family Support (Iowa Child Abuse Prevention Program (ICAPP), Family Reunification (e.g. access and visitation services), and Adoption Promotion and Support Services. Family Preservation services provide additional resources beyond evidence-based interventions, e.g. wrap around services to meet the family's concrete needs, such as assistance with rent, utilities, or other one-time costs, and two programs to provide support to parents in crisis. Family Support funds provide approximately 31% of the funding for our child abuse prevention programs, which provide primary and secondary child abuse prevention services in local communities according to local need. DHS utilizes Family Reunification funds primarily for access and visitation services, which are not IV-E prevention services. Lastly, DHS may utilize our Adoption Promotion and Support Services to provide robust post-adoption services adoptive families to prevent re-entry into foster care.

For additional information related to service coordination, please see the Services Coordination section in Iowa's FFY 2020-2024 Child and Family Services Plan.[12]

[12] Available at https://dhs.iowa.gov/sites/default/files/FFY%202020-2024%20Child%20and%20Family%20Services%20Plan.pdf?040320201555

Section III: Child Welfare Workforce

Support

The state must describe the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including:

- *ensuring that staff is qualified to provide services that are consistent with the promising, supported, or well-supported practice models selected; and*
- *developing appropriate prevention plans and conducting risk assessments for children receiving prevention services.*

Iowa is a state administered and state supervised child welfare system. The Department of Human Services (DHS) is the state agency that purchases trauma-informed and evidence-based services from contracted child welfare, service organizations, who provide Iowa's family-centered services (FCS), inclusive of SafeCare® and Solution Based Casework (SBC), to families. Below are the contractor staff qualifications required to provide SafeCare and SBC, effective July 1, 2020.

- Any staff delivering a service intervention for which a professional licensure is required by state statutes will possess the current appropriate professional licensure.
- SafeCare has no minimal educational requirements. However, the Intervention Specialist (IS) providing SafeCare will be trained and certified in SafeCare or working toward certification.
- SBC does not have any minimum educational requirements apart from what DHS requires. DHS requires the Family Support Specialist (FSS) to possess a bachelor degree or master's degree from an accredited four-year college recognized by the Council for Higher Education Accreditation (CHEA). Alternatively, the FSS may possess an associate of arts degree in human services or related field from an accredited college or university plus the equivalent of two years of full time experience in human services or a related field.
    - The FSS providing SBC will be trained and certified in SBC or working towards training and certification.
    - As part of SBC, a Support Worker (SW) assists the FSS, e.g. with family interaction, transportation, etc. DHS requires the SW to possess a high school diploma with a minimum of one year of full time experience in human services; or an associate of arts degree in human services or related field from an accredited college or university with a minimum of six months of full time experience in human services; or a bachelor degree in human services or related field from an accredited four year college recognized by CHEA.

FCS contractors also assess for safety and risk throughout their provision of SafeCare and SBC through contract requirements related to contacts with the family. Please see *Section I, subsection Monitoring Child Safety*, for more information on DHS staff and FCS contractors staff conducting safety and risk assessments.

DHS' child protective workers (CPWs) conduct child protective assessments, which include developing appropriate prevention plans, if applicable, and conducting initial

safety and risk assessments. DHS' social work case managers (SWCMs) review and revise appropriate prevention plans and conduct ongoing safety and risk assessments. DHS, as an executive branch agency, must hire staff through the Iowa Department of Administrative Services (DAS). DAS will not certify individuals as meeting the minimum position requirements for CPWs and SWCMs, and send their information to DHS, unless they meet the required qualifications below:

- CPWs (aka Social Worker 3s):
  - Graduation from an accredited college or university with a Bachelor's degree and the equivalent of three years of full-time experience in a social work capacity in a public or private agency; or
  - graduation from an accredited college or university with a Bachelor's degree in social work and the equivalent of two years of full-time experience in a social work capacity in a public or private agency; or
  - a Master's degree in social work from an accredited college or university; or
  - an equivalent combination of graduate education in the social or behavioral sciences from an accredited college or university and qualifying experience up to a maximum of thirty semester hours for one year of the required experience; or
  - employees with current continuous experience in the state executive branch that includes the equivalent of one year of full-time experience as a Social Worker 2 shall be considered as qualified.
- SWCMs (aka Social Worker 2s):
  - Graduation from an accredited four-year college or university; OR
  - the equivalent of four years of full-time technical work experience involving direct contact with people in overcoming their social, economic, psychological, or health problems; OR
  - an equivalent combination of education and experience substituting the equivalent of one year of full-time qualifying work experience for one year (thirty semester or equivalent hours) of the required education to a maximum substitution of four years.

Training and support for DHS staff for developing prevention plans: In Iowa, the child's prevention plan is part of the child protective assessment summary that CPWs complete at the end of a child abuse assessment (CAA) or a child in need of assistance (CINA) assessment (CA). DHS CPWs, SWCMs, and supervisors will receive training on the prevention plan and corresponding services' changes made to the CAA and CA documents through a recorded training posted in June 2020. Supervisors will ensure that their staff complete the training prior to July 1, 2020. The recorded training will remain posted on the SharePoint site for staff to review at will. When the CAA and CA documents' changes go into production, DHS' child welfare information system (CWIS) Help Desk (HD) will send an email notice to all field staff with basic overview and instruction. DHS also will add corresponding guidance to the JARVIS User Manual.

DHS training staff are currently in the process of updating the materials for new worker training (SW020 and CP200) in regards to developing prevention plans (SW3) and revising prevention plans as needed (SW2). These updates to the new worker courses will occur by January 2021.

Supports provided to staff to develop prevention plans is multifaceted and includes but is not limited to:

- The trainers discuss the participants' experiences in the second part of their new worker trainings, which includes the safety and risk assessments as well as identification of service needs initially and ongoing.
- The trainers hold office hours for staff on a regular basis to address staff questions.
- Coordination occurs with the Service Help Desk when a worker requests a case consultation for how best to support a family.
- Supervisors support their staff in work completion and assist staff with any questions they may have related to service identification, foster care prevention strategy, etc.
- Mentoring: A multidisciplinary focus group convened to develop a standardized mentoring program for new CPWs and SWCMs during their first six months of employment. This framework formalized an informal system that was already in place in an effort to improve statewide consistency. The mentoring program aims to build the confidence level of a new worker as well as their competency in doing casework in the counties they serve. With this goal in mind, the design of the program is around experiential learning opportunities in the field that reinforce classroom learning. The desired outcome of the program is increased employee satisfaction and retention.

  To infuse the formalized mentoring program into the onboarding culture, the Bureau of Service Support and Training conducted a webinar required for supervisors providing an overview of the program and outlining responsibilities for supervisors, mentors, and mentees.

  The documents in the mentoring toolkit support the goals and objectives of the program and track required field learning experiences. The multidisciplinary group updated the Field Learner Experience Guides, essential tools for staff, this fiscal year to ensure they align with the core job duties of each position.

  The next step in the process in the coming fiscal year is to survey folks who participated in the mentoring program. The results will serve as feedback for evaluating and enhancing the mentoring program.

Training

The state must describe how it will provide training and support for caseworkers in assessing what children and their families need; connecting to the families served; knowing how to access and deliver the needed trauma-informed and evidence-based services; and overseeing and evaluating the continuing appropriateness of the services.

DHS and FCS contractors are committed to having a prepared, well-trained workforce. The organizations provide training and support for caseworkers in assessing what children and their families need, connecting to families served, knowing how to access and deliver needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services. Iowa's Family First, Blueprint for Iowa's Future Child Welfare System, "Family Connections are Always Strengthened and

Preserved" (Attachment A1) guides staffs' work with families and the training and supports staffs receive.

DHS requires newly hired social work staff to complete the New Worker Training Plans by the timeframes specified for each course (Attachment A8 for SW2/SW2 Supervisors and Attachment A9 for SW3/SW3 Supervisors). The New Worker Training Plans serve as a roadmap of the training requirements within the first year of hire. These documents also detail the learning modality and number of credit hours associated with each course. DHS contracts with the Child Welfare Research and Training Project at Iowa State University (ISU) to perform many of the necessary day-to-day activities related to the coordination of training. One of ISU's responsibilities is to review the New Worker Training Plan with learners during their New Worker Orientation phone call.

Training and support for DHS staff for overseeing and evaluating the continued appropriateness of services: Attachment A10 provides course descriptions for courses in the training plans. There are several courses, which focus on the skills of engaging, assessing, teaming, planning, and intervening. SW020 covers content related to overseeing and evaluating the continued appropriateness of services. Breakout sessions during the training engage learners in discussions around the development of the plan for the family and ensuring that the services are appropriate for families. Furthermore, several courses address assessing for safety and risk, addressing trauma, both primary and secondary, case planning through Family Team Decision-Making (FTDM) meetings, and preventing removals through child safety conferences.

Supports provided to staff for overseeing and evaluating the continued appropriateness of services includes but is not limited to:

- The trainers discuss the participants' experiences in the second part of their new worker trainings.
- The trainers hold office hours for staff on a regular basis to address staff questions.
- Coordination occurs with the Service Help Desk when a worker requests a case consultation for how best to support a family.
- Supervisors support their staff in work completion and assist staff with any questions they may have related to determining appropriateness of services, service sequencing, etc.
- Mentoring: A multidisciplinary focus group convened to develop a standardized mentoring program for new CPWs and SWCMs during their first six months of employment. This framework formalized an informal system that was already in place in an effort to improve statewide consistency. The mentoring program aims to build the confidence level of a new worker as well as their competency in doing casework in the counties they serve. With this goal in mind, the design of the program is around experiential learning opportunities in the field that reinforce classroom learning. The desired outcome of the program is increased employee satisfaction and retention.

  To infuse the formalized mentoring program into the onboarding culture, the Bureau of Service Support and Training conducted a webinar required for supervisors

providing an overview of the program and outlining responsibilities for supervisors, mentors, and mentees.

The documents in the mentoring toolkit support the goals and objectives of the program and track required field learning experiences. The multidisciplinary group updated the Field Learner Experience Guides, essential tools for staff, this fiscal year to ensure they align with the core job duties of each position.

The next step in the process in the coming fiscal year is to survey folks who participated in the mentoring program. The results will serve as feedback for evaluating and enhancing the mentoring program.

Training specific to prevention services will occur in two ways. First, since Iowa's FCS, which includes SafeCare and SBC, will begin July 1, 2020, DHS and contractor staff will participate in joint service implementation training in June 2020, which will cover the new services, referral process, and other pertinent contract requirements. Please see the previous section, Support, for more information regarding this training. Secondly, DHS staff, starting with management, supervisors, and then frontline workers, will receive broad information about SBC. Since DHS staff currently refer families to contracted child welfare service contractors for SafeCare, staff are already aware of the program.

FCS contractors not currently trained and certified to provide SafeCare® will work with the National SafeCare Training and Research Center (NSTRC) to begin training and the accreditation process. All FCS contractors will have until December 1, 2020 to work with the developer of SBC to get their staff trained and certified.

FCS contractors also have their own onboarding and initial and ongoing training requirements required of their staff. Contractual requirements related to training in the new contracts, effective July 1, 2020, are:

- Develop a training plan tailoring it to the needs of the workers and target populations for the services. Submit the training plan to DHS for review within 30 days after the contract start date. Submit a final training plan, which incorporated any changes requested by DHS, to DHS within 30 days after the first submission of the plan. The contractor shall execute, adhere to, and provide training set forth in the DHS-approved training plan. Changes to the plan must receive prior approval from DHS, and the contractor shall make any updates. The training plan shall include initial and ongoing training provided for all contractor or subcontractor staff on children and family identified needs, including but not limited to:
  a. Domestic violence,
  b. Mental health,
  c. Substance use/abuse,
  d. Cultural responsiveness, and
  e. Trauma informed care.

Child Welfare Provider Training Academy (Training Academy)

The Child Welfare Provider Training Academy (Training Academy) is a partnership between DHS and the Coalition for Family and Children's Services in Iowa. The purpose of the partnership is to research, create, and deliver quality trainings supportive to child welfare services frontline workers and supervisors throughout the state to help improve Iowa's child welfare system to achieve safety, permanency, and family and child well-being. The Training Academy provides accessible, relevant, skill-based training throughout the state of Iowa using a strength based and family centered approach. The Training Academy continues to improve the infrastructure to support private child welfare social service organizations and DHS in their efforts to train and retain child welfare workers and positively affect job performance that is in the best interest of children and families. Please Attachment A11 for CWPTA's FY 2020 Training Plan.

The Training Academy coordinates curriculum development and oversight with guidance and support from the Training Academy Workgroup and the DHS Training Committee. The Training Academy Coordinator leads the Training Academy Workgroup and is an active member of the DHS Training Committee.

For more information, please see The Coalition for Family and Children's Services in Iowa website, https://www.iachild.org/, CWPTA Training tab.

Prevention Caseloads

The state must describe how the caseload size and type for prevention caseworkers will be determined, managed, and overseen.

As mentioned in *Section I, Title IV-E Prevention Services and Programs, Assessment of Child and Family Eligibility for the Title IV-E Prevention Program*, DHS' child protective workers (CPWs) conduct child protective assessments, e.g. Child Abuse Assessments (CAAs) and Child in Need of Assistance (CINA) Assessments (CAs). During these assessments, CPWs conduct safety and risk assessments. CPWs utilize *Form 470-4133, Family Risk Assessment*, which comprises two scales that measure the level of risk regarding abuse and neglect in CAAs and CAs. The outcomes of high risk for CAA ("Confirmed") and moderate and high risk ("Founded") as well as high risk for CA indicates the child is at "imminent risk" of entering foster care. At the conclusion of the assessment process, the CPW's *Child Protective Services Child Abuse Assessment Summary, Form 470-3240*, or *CINA Services Assessment Summary, Form 470-4135*, (Attachments A4 and A5 respectively) reflects the CPW's work with the family to develop a plan of action moving forward, which comprises the child's prevention plan, including prevention plan requirements.

The CPW then meets with the family, DHS' social work case manager (SWCM), and the family-centered services (FCS) contractor to transfer the case to the SWCM for ongoing case management. Throughout the rest of the case, the SWCM conducts informal and formal safety and risk assessments and risk reassessments, including through monthly caseworker visits with the child and family, and reviews and revises the child's prevention plan, as outlined *Section I, Title IV-E Prevention Services and Programs,*

Monitoring Child Safety. These activities occur through engagement and collaboration with the family and the FCS contractor.

Supervisors assign cases to the CPW or SWCM. In assigning cases, supervisors may consider the worker's caseload size or the types of cases the worker has. CPW cases typically vary by the type of assessment, e.g. CAA, CA, Family Assessment (Iowa's differential response), and Dependent Adult Abuse. The type of cases SWCMs have varies across the state. In some of DHS' five service areas, there are dedicated units, e.g. Native Unit in Woodbury County, another planned permanent living arrangement (APPLA) unit in the Cedar Rapids Service Area, etc. However, the majority of SWCMs have a variety of case types, i.e. foster care and in-home services cases. DHS does not have caseload size limits for its workers. In its 2019 Child Welfare by the Numbers report, DHS reported the following for calendar year 2019:

- 199 DHS child protective workers were assigned an average of 15 cases a month, including cases alleging adult abuse.
- 310 DHS case managers [SWCMs] had an average child welfare caseload of 33

CPW and SWCM supervisors continue to manage and oversee the workers' caseloads through clinical case consultations between the supervisor and the worker and supervisory monitoring of caseload sizes across all their workers in their unit. Service area leadership, e.g. the social work administrator (SWA), also keep track of caseloads and may send some cases to another county if one county is overloaded.

While DHS acknowledges the roles and activities its CPWs and SWCMs have related to the prevention plan, as noted above during the assessment and ongoing case management processes, including referring families to FCS contractors, DHS does not consider its CPWs or SWCMs to be "prevention caseworkers". Instead, DHS defines "prevention caseworkers" as the entity providing the prevention service, e.g. FCS contractor staff, the Intervention Specialist (IS), who provides SafeCare. Since the Children's Bureau has not defined "prevention caseworkers", DHS will apply its definition of "prevention caseworkers", as discussed below.

DHS program management staff determined that caseload size for each prevention service should be in accordance with each service's model. In the new package of FCS that will begin on July 1, 2020, FCS contractors will have a Family Support Specialist (FSS) providing Solution-Based Casework (SBC), with no more than 14 families assigned to their caseload at one time. These contractors also will have an IS providing SafeCare, with no more than 15 families assigned to their caseload at one time. The contractors will provide these services on open DHS child welfare cases, which includes intact families on in-home cases, when children are in kin caregiver placements, or when in foster care placements. The contractors also provide SBC for non-DHS (voluntary) cases for cases they manage, for up to three months. DHS delineated these requirements in the request for proposals (RFP) for the services, which will be included in the contracts.

Supervision and oversight of prevention caseworkers' caseload size and type occurs through case consultations between the FCS contractors' supervisors and their FSS and IS. Supervisors will have case consultations with their staff in accordance with their accreditation requirements and in accordance with any oversight required by the services' models. DHS contracts require the contractors to maintain accreditation at all times in accordance with their respective accrediting body. The contractors also must utilize their quality assurance system. Quality assurance means the procedures established and activities undertaken by the contractor to ensure service delivery occurs in accordance with requirements established by DHS and to improve the quality of services to achieve safety, permanency, and well-being. DHS also requires contractors to submit a DHS developed staffing report on a quarterly basis.

DHS' service contract specialists will conduct monitoring and oversight activities, outlined above under *Section I, Service Description and Oversight*, to oversee execution of the contracts and the contractors' compliance with the requirements. This includes developing a quarterly compliance review report for review by DHS' contract owner and service area managers, conducting site reviews to ensure compliance with quality assurance requirements, etc.

Attachments

- Attachment A: Iowa SafeCare Evaluation Plan
- Attachment A1: Comm. 534, Family Connections are Always Strengthened and Preserved
- Attachment A2: Form 470-4132, Safety Assessment
- Attachment A3: Form 470-4133, Family Risk Assessment
- Attachment A4: Form 470-3240, Child Protective Services Child Abuse Assessment Summary
- Attachment A5: Form 470-4135, CINA Services Assessment Summary
- Attachment A6: Form 470-4134, Risk Reassessment
- Attachment A7: Family First Implementation Workgroups and Teams
- Attachment A8: New Worker Training Plan – SW2s and SW2 Supervisors
- Attachment A9: New Worker Training Plan – SW3s and SW3 Supervisors
- Attachment A10: FFY 2020-2024 Training Plan
- Attachment A11: FY 2020 CWPTA Training Plan
- Attachment A12: Family-Centered Services Contract Example

PART B – JUVENILE JUSTICE

Introduction

In 2017, Iowa's juvenile population for youth ages 10-17 years old was 331,434.[13] During that same year, Iowa's Juvenile Court received 14,003 juvenile complaints, which was a 17.4% reduction for all race and gender categories from 2013-2017.[14] Because of those complaints, 3,420 juveniles received informal probation, 798 received consent decrees, 255 received waiver to adult court, 946 youth received delinquent adjudication and 683 received formal probation[15]. The average recidivism rate for the eight highest populated counties; Polk, Linn, Woodbury, Pottawattamie, Scott, Dubuque, Black Hawk and Johnson, was 35.78%.[16] In addition to the financial costs associated with processing and supervising these complaints, there are significant expenses incurred when youth require out-of-home placement. For example, in 2016, Iowa spent $7,158,068 in federal funds and $23,449,698 in state funds on residential placement for youth.[17]

The monetary expenses of the court process are not the only costs associated with juvenile delinquency. Families and communities experience significant losses, as well, especially when removal of youth from their homes occurs. However, community-based supervision programs for youth both cost less than confinement and provide increased rehabilitative benefits for youth.[18] These programs show recidivism reduction by up to 22%, at a cost significantly lower than imprisonment, places an emphasis on behavior change, decision-making, and the development of social skills among different groups.[19] The best programs tend to be those that focus on developmentally and empirically based family-centered interventions. Without services, such as these, youth frequently re-offend, dropout of school, become homeless, use drugs and alcohol, are unemployed

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[13] OOJDP, 2019. *Easy Access to Juvenile Populations: 1990-2018*. Retrieved https://www.ojjdp.gov/ojstatbb/ezapop/asp/comparison_selection.asp?selState=0

[14] CJJP, 2018. *Iowa's 3-Year Plan Program Narrative: Juvenile/Needs Analysis Data Elements*. Retrieved https://humanrights.iowa.gov/sites/default/files/media/2018_Juvenile_Needs_Analysis_Data_Elements.pdf

[15] CJJP, 2017. *State of Iowa Juvenile Delinquency Annual Statistical Report*. https://humanrights.iowa.gov/sites/default/files/media/2017%20State%20Annual%20Report%20for%20JCS.pdf

[16] Ibid.

[17] Child Trends, 2016. *Child Welfare Spending SFY 2016: Iowa*. (The Annie E. Casey Foundation). https:/www.childtrends.org/wp-content/uploads/2018/12/Iowa_SFY2016-CWFS_12.13.2018.pdf

[18] Richard A. Mendel, *No Place for Kids: The Case for Reducing Juvenile Incarceration* (Baltimore: The Annie E. Casey Foundation, 2011), www.aecf.org/noplaceforkids.

[19] National Mental Health Association, 2004

and fail to seek appropriate medical care. As youth's difficulties in these areas increase, so do the social and economic costs to the community.

The purpose of Iowa's juvenile justice system is holding youth accountable for their delinquent acts, providing treatment to correct their behavior, and promoting public safety. To accomplish this purpose, Iowa's Juvenile Court Services (JCS) began utilizing evidence-based practices in 1997, when it implemented standardized case planning and motivational interviewing. By 2004, all juvenile court officers received training in evidence-based practice. By 2007, JCS had developed and implemented the Iowa Delinquency Assessment (IDA).

The IDA is a standardized risk assessment tool that predicts the likelihood a youth will recidivate and directs treatment and services by identifying a youth's criminogenic risk and need areas. Risk refers to the likelihood a youth will reoffend and prediction of risk occurs by conducting an actuarial assessment of the characteristics or "risk" factors identified by research as correlated to future delinquent behavior. There are two types of risk factors – static and dynamic. Static risk factors are those that are unchangeable due to their historical context. Dynamic risk factors, however, are those characteristics that change over time through treatment or the normal developmental process.

Criminogenic needs are variables related to dynamic risk factors that predict recidivism and when treated are associated with reductions in the risk of reoffending. Research shows there are four "Big" criminogenic factors that when targeted generate the greatest decrease in risk, i.e. antisocial attitudes, antisocial peers, antisocial personality and antisocial behavior/thinking.[20] Substance abuse, mental health issues and deficits in parenting skills and family relationships, areas of focus identified by Family First, are also criminogenic risk factors. These risk factors, identified by the IDA and targeted by juvenile court officers (JCOs), are a part of comprehensive approach to treatment.

Table B1: Iowa Delinquency Assessment (IDA) - Criminogenic Risk Factor Domains Scoring Items

Record Complaints	12
Demographics	1
School History	4
Current School Status	11
Free Time Historic Use	2
Free Time Current Use	3
Employment History	4
Employment Current	4
Relationships History	2
Relationships Current	6

[19] Andrews, D.A. and Bonta, J. (1994). *The Psychology of Criminal Conduct*. Anderson Publishing Co.

Table B1: Iowa Delinquency Assessment (IDA) - Criminogenic Risk Factor Domains Scoring Items	
Family History	5
Family Current Living Arrangements	16
Alcohol & Drug History	6
Alcohol and Drug Current Use	4
Mental Health History	8
Mental Health Current	5
Attitudes and Behaviors	11
Aggression	6
Skills	11

Source: Juvenile Court Services

In 2012, Iowa was one of three states selected by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to be a demonstration site for their Juvenile Justice Reform and Reinvestment Initiative (JJRRI). The goal was the implementation of an evidence-based assessment and guide for program improvement. As a result, Iowa implemented the Standardized Program Evaluation Protocol system SPEP™ in five districts to assess the treatment services of residential programs statewide and community-based services locally. This afforded JCS a standardized method to assess services, enhance placement and programming recommendations, and guarantee the fidelity and quality of services. [21]

Since 2012, Iowa has maintained its commitment to providing quality services and programming for youth and their families by implementing, to varying degrees, numerous EBP services across its eight judicial districts. Contracts for these services are according to each district's needs and budgetary limitations. The passage of Family First provides Iowa's JCS a viable funding mechanism for the expansion and consistent use of EBP services for delinquents across the state.

Acronyms and Abbreviations

Table B2: Acronyms and Abbreviations	
ART	Aggression Replacement Training
CJCO	Chief Juvenile Court Officer
CJJP	Criminal and Juvenile Justice Planning
CQI	Continuous Quality Improvement
CSG	Council State Government
CST	Candidacy Screening Tool

[21] Husseman, J. and Liberman, A. (2017). *Implementing Evidence Based Juvenile Justice Reforms.* https://www.urban.org/sites/default/files/publication/90381/implementing_evidence-based-juvenile-justice-reforms.pdf

Table B2: Acronyms and Abbreviations	
DHS	Department of Human Services
DOJCS	Director of Juvenile Court Services
EPICS	Effective Practices in Community Supervision
Family First	Family First Prevention Services Act
FFT	Functional Family Therapy
ICIS	Iowa Court Information System
IDA	Iowa Delinquency Assessment
Prevention Plan	Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024
JCO	Juvenile Court Officer
JCS	Juvenile Court Services
JJSI	Juvenile Justice System Improvement
MDFT	Multi-dimensional Family Therapy
MST	Multisystemic Family Therapy
NCSC	National Center State Courts
NYSA	National Youth Screening Assessment
PSP	Prevention Services Plan
SAMHSA	Substance Abuse and Mental Health Services Administration
SCA	State Court Administration
SPEP	Standardized Program Evaluation Protocol

Section I: Title IV-E Prevention Services and Programs

Assessment of Child and Family Eligibility for the Title IV-E Prevention Program

On June 26, 2020, DHS entered into a IV-E Agreement with JCS pursuant to section 472(a)(2)(B)(ii) of the Social Security Act, which replaced any prior IV-E agreement DHS had with JCS. In accordance with the Agreement, JCS alone determines Title IV-E Prevention Services program eligibility for the children and families they serve.

For purposes of the title IV-E prevention services program, a child is:
1. 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) of 471(e).
2. A child in foster care who is a pregnant or parenting foster youth.

Research shows there are several factors that increase a youth's risk of foster care placement. These factors include parental risk factors associated with substance abuse, mental illness, deficits in parenting skills, lack of social supports and connections and child maltreatment. Factors related directly to the child include previous out-of-home

placements, developmental delays and physical or intellectual disabilities.[22] The Center for the Study of Social Policy and the Administration on Children, Youth and Families also indicated protective factors, resilience, social connectedness and the cognitive and social/emotional competence of youth could directly affect a youth's risk of out-of-home placement.[23]

JCS based its definition of a "child who is a candidate for foster care" on Family First's definition, research, and Iowa Code sections 232.2 and 234.1, which provide a definition for "child" and a "child in need of assistance". JCS defines a "child who is a candidate for foster care" as a child whose involvement with JCS is for the specific purpose of either removing the child from the home or providing prevention services, such that if the services are unsuccessful, the plan is to remove the child from the home and place him/her in foster care. JCS' involvement with the child may be informal or formal, and the child may not be an eligible candidate. However, if a substantial change occurs or safety issues emerge that places the child at imminent or serious risk of removal from the home and placement in foster care, a child may become an eligible Title IV-E candidate for foster care. A child is not a candidate for foster care if the planned out-of-home placement is an arrangement other than foster care, such as placement in a detention, state training school, or psychiatric facility.

The state must describe how it will assess children and their parents or kin caregivers to determine eligibility for title IV-E prevention services.

At the initial intake for each youth for whom JCS receives a complaint, JCS will utilize a structured method to determine eligibility, based on the following:

1. Completion of the Iowa Delinquency Assessment (IDA) (Attachment B1) to identify the child's risk and protective factors. The IDA contains assessments in eleven domains, including family factors related to maltreatment, substance abuse and mental health. Based on the Ecological Model[24], the IDA takes into consideration the complex interactions between individual, relationship, community, and societal factors and identifies the scope of characteristics that put youth at risk of perpetrating or experiencing violence. The IDA detects areas of need across multiple levels of the ecological model, which is necessary for long-term prevention. For youth who score as moderate or high risk to reoffend, JCOs will complete the Title IV-E Candidacy for Foster Care Screening Tool (CFST) (Attachment B2).

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[22] English, D. et al (2015). *Predicting Risk of Entry into Foster Care from Early Childhood Experiences: A Survival Analysis using LongScan Data*. Child Abuse and Neglect 45: 57-67.
[23] Harper Browne, C. (2014). *The Strengthening Families Approach and Protective Factors Framework*. https://cssp.org/wp-content/uploads/2018/11/Branching-Out-and-Reaching-Deeper.pdf
[24] Center for Disease Control (2020). *The Social-Ecological Model: A Framework for Prevention.* https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

2. Completion of Title IV-E CFST. The CFST provides a structured methodology for JCOs to accurately identify Family First candidates based on whether a child meets the candidacy threshold score, which is a composite tally of the family's and child's identified risk factors associated with foster care placement.
3. Completion of the JCS child prevention plan, which clearly states that absent prevention services or should preventative services fail, the JCO will remove the youth from the home and placed in foster/group care. The prevention plan requires JCOs to:
   a. identify the foster care prevention strategy required for the child to remain safely in the home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver, and
   b. list the services to be provided to or on behalf of the child to ensure the success of that prevention strategy.

   For those youth who are pregnant or parenting, the prevention plan will:
   a. be in the youth's foster care case plan;
   b. list the services to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of parenting foster youth) to be a parent; and
   c. describe the foster care prevention strategy for any child born to the youth.

   The JCS prevention plan also includes youth and family strengths, objectives and related services and the date the youth became an eligible candidate. Prevention plans are progressive documents with a requirement to update and modify the plan as the needs of the child and family change.
4. Evaluation of eligibility occurs every six-months or when changes in circumstances occur and a new prevention plan is developed.

Service Description and Oversight

Describe the HHS approved services the state will provide, including:

- *whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse;*
- *how the state plans to implement the services, including how implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;*
- *how the state selected the services;*
- *the target population for the services;*
- *an assurance that each HHS approved title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III); and*
- *how providing the services is expected to improve specific outcomes for children and families.*

Services: The driving philosophy for Iowa's Juvenile Court Services (JCS) has been the least proscriptive intervention for children and families is the best approach. Consequently, JCS has strived to implement a wide spectrum of treatment and prevention services to meet the multi-faceted needs of the children and families it serves.[25] Recognizing the need for standardized policies and practices to enhance the quality and breadth of services and supports, JCS recently worked cooperatively with the Division of Criminal Juvenile Justice Planning (CJJP) to initiate this process. Subsequently, in October 2019, Iowa finalized its Juvenile Justice System Improvement (JJSI) plan, which provides a structured strategy to accomplish this goal.

A child and the parents or kin caregivers of the child may receive services, when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to prevent the child from entering foster care. JCS provides the following services or programs throughout the state.

- Aggression Replacement Training(ART),
- Multi-Dimensional Family Therapy (MDFT),
- Functional Family Therapy (FFT),
- Multisystemic Therapy (MST),
- In-Home Family Services,
- Strong African American Families,
- Love & Logic Parenting,
- Juvenile Court School Liaison Support,
- Standardized Case Management,
- Tracking and Monitoring,
- Mentoring,
- Substance Abuse Assessment and Treatment,
- Mental Health Assessment and Treatment,
- Adolescent Sexual Offender Treatment, and
- Day Treatment Programming.

In addition to these services, all Juvenile Court Officers (JCOs) in Iowa received training in Motivational Interviewing and use it regularly in client interactions. JCOs also utilize Effective Practices in Community Supervision (EPICS), which employs a cognitive behavior therapy and motivational interviewing approach to structure client interactions. The JCO documents the type and dosage of each EPICS intervention in case notes. Tables B3 and B4 summarizes the services JCS provides and their evidence-based ratings, outcomes and population served.

[25] US Congress, (1988). *HR 1801 to Reauthorize the Juvenile Justice Delinquency Prevention Act*.

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Aggression Replacement Training (ART)[26]	Utilizes cognitive behavior therapy approach to teach youth social skills, anger control and moral reasoning.	Thirty sessions over 10 weeks	Moderate and high-risk juvenile delinquents ages 11 to 18	CEBC – Promising NIJ - Effective	• Increased social program solving • Increased anger management • Reduced physical aggression • Reduced trait anger levels • Reduced problem behaviors	No
Cognitive Behavior Intervention – Core Youth (CBI-CY)[27]	Uses cognitive behavioral strategies to teach youth methods to control risk factors in a way that is developmentally appropriate. Skill building activities are strongly emphasized to assist with cognitive, social, emotional, and coping skill	Forty-seven 1-hour sessions	Moderate and high-risk juvenile delinquents ages 11 to 18	Not yet rated	• Reduced anti-social behaviors • Reduced recidivism	No

[26] National Institute Justice (2012). *Program Profile*. https://www.crimesolutions.gov/ProgramDetails.aspx?ID=256
[27] University of Cincinnati Corrections Institute. *Cognitive-Behavioral Interventions*. https://cech.uc.edu/about/centers/ucci/products/interventions/group-interventions.html

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	development. The program includes modifications to meet the needs of youth with mental illness.					
Cognitive Behavior Intervention – Substance Abuse (CBI-SA)[28]	Employs cognitive behavioral strategies to teach youth methods to avoid substance abuse. Skill building activities are strongly emphasized to assist with cognitive, social, emotional, and coping skill development	Thirty-nine 1-hour sessions	Youth ages 11-18 with moderate to high needs in the area of substance abuse	Not yet rated	• Reduced substance use • Reduced recidivism	No
Decision Points[29]	A cognitive behavior structured program constructed on the tenet "Strategy of Choices." It teaches youth different methods to analyze their negative thinking and behaviors. The program can be utilized as brief intervention or an extended service.	Minimum of five 90-minutes sessions	Juvenile justice involved youth ages 11-18.	Not yet rated	• Increased problem-solving skills • Reduced anti-social behaviors • Reduced recidivism	No

[28] Ibid
[29] Decision Points Program Overview. www.decisionpointsprogram.com/

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Effective Practices in Community Supervision (EPICS)[30]	Integrates the Risk-Need-Responsivity (RNR) principle with cognitive behavior therapy techniques to structure interactions between juvenile court officers and youth that are based on the eight evidence-based principles of effective interventions and youth learning styles, motivation levels, abilities and strengths.	One to two weekly sessions over 12 months	Moderate and high-risk juvenile delinquents ages 11 to 18	NIJ - Promising	• Increased problem-solving skills • Increased relationship skills • Reduced recidivism	No
Effective Practices in Community Supervision Influencers (EPICS-I)[31]	An extension of EPICS that enables pro-social supports to structure everyday interactions with youth based on evidence-based practices to increase youths' ability to identify risky situations and practice skills to manage successfully these challenges.	One to two weekly sessions over 12 months	Moderate and high-risk juvenile delinquents ages 11 to 18	Not yet rated	• Increased problem-solving skills • Increased relationship skills • Reduced recidivism	No

[30]Blasko, B., et. Al. *Performance Measures in Community Corrections: Measuring Effective Supervision Practices with Existing Agency Data* (2016). https://www.uscourts.gov/sites/default/files/80_3_3_0.pdf

[31] Latessa, E. (2015). *Understanding the Principles of Effective Intervention and the Importance of Using and Applying Risk Assessment*.

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
Functional Family Therapy (FFT)[3233]	Family-based prevention and intervention program that treats complex and multidimensional family issues using a culturally sensitive and flexible clinical approach. Focuses on reducing risk factors and on improving protective factors that directly affect youth.	Twelve to fourteen sessions over 3-5 months	Youth 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral and/or emotional problems and their parents/caregivers	IV-E PSC – Well Supported CEBC – Supported NIJ - Effective	• Improved family interactions • Increased parental involvement • Improved family functioning • Reduced negative youth behaviors • Reduced youth out of home placements • Reduced youth recidivism • Reduced youth substance abuse	Yes
Mentoring[34]	A structured relationship between a youth involved in the juvenile justice system and an adult with the	One to three hours per week for a minimum of 12 months	Youth ages 11 to 18 who are juvenile justice involved and	Not yet rated	• Reduced substance use • Reduced anti-social behavior	No

[32] Alexander, J.F., Waldron, H.B., Robbins, M.S., & Neeb, A.A. (2013). *Functional Family Therapy for adolescent behavior problems.* American Psychological Association

[33] Sexton, T. L. (2010). *Functional Family Therapy in clinical practice: An evidence based treatment model for at risk adolescents.* Routledge.

[34] National Institute Justice. (2019). *Practice Profile: Mentoring*. https://www.crimesolutions.gov/PracticeDetails.aspx?ID=15

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	objective of developing the skills and abilities of the youth.		moderate to high risk.		• Improved family relationships • Improved academic performance	
Motivational Interviewing (MI)[35]	Youth focused and structured approached to increase motivation to change behavior. It focuses on discovering and resolving ambivalence by advancing intrinsic motivation to make change.	Two to three 30-50-minute sessions	Youth 11 to 18 at-risk of delinquency with behavioral and/or conduct problems and/or substance abuse issues	IV-E PSC – Well Supported CEBC – Well Supported NIJ - Effective	• Increased motivation to change behavior • Increased engagement in treatment	No
Multi-dimensional Family Therapy (MDFT)[36]	Family-based treatment that focuses on four domains - the adolescent, the parents, the family, and the community to enhance motivation and facilitate behavior and relational changes.	One to three sessions a week for 3-6 months	Youth 11 to 18 with substance use, delinquency, and/or other behavioral and emotional problems and their parents	IV-E PSC – Next to be rated CEBC – Well Supported NIJ - Effective	• Reduced delinquent behavior • Reduced substance abuse • Reduced out of home placements • Improved family	No

[35] IV-E Prevention Services Clearinghouse. (2019). https://preventionservices.abtsites.com/programs/142/show
[36] Multi-dimensional Family Therapy. (2019). http://www.mdft.org/Effectiveness/Family-functioning

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
					functioning	
Multisystemic Therapy (MST)[37][38]	Intensive community-based family treatment that utilizes an empirically based clinical approach to change a youth's criminal behavior, reduce family risk factors and empower parents.	One to several sessions per week dependent upon the family's needs. Averaging 3-5 months. Therapists are on call 24/7	Youth 12 to 17 at-risk of out of home placement due to anti-social or delinquent behaviors and substance abuse issues and their parents	IV-E PSC – Well Supported CEBC – Well Supported NIJ - Effective	• Reduced youth recidivism • Reduced out of home placements for serious offenders • Improved family functioning • Decreased youth problem behaviors • Decreased youth mental health problems	Yes
Thinking for a Change (T4C)[39]	An integrated, cognitive behavioral change program for individuals that includes cognitive restructuring, social skills development, and development of problem-	Two 90-120 minutes sessions weekly for 13 weeks	Juvenile justice involved youth ages 11-18.	IV-E PSC – Not yet rated CEBC – Not yet rated NIJ - Promising	• Increased problem-solving skills • Increased Positive social interactions	No

[37] Multisystemic Family Therapy (2019). https://preventionservices.abtsites.com/programs/121/show
[38] MST Manual Version - 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.
[39] Justice Research Center. (2019). *What Works Curriculum: Thinking for a Change (T4C)*. http://thejrc.com/wwi-curriculum.asp

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
	solving skills.				• Decreased negative behaviors • Decreased anti-social attitudes • Decreased recidivism	
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)[40]	A cognitive-behavioral, family focused psychotherapy approach to decreasing emotional and/or behavioral problems stemming from traumatic life events.	Twelve to eighteen weeks. Separate weekly sessions for the child and parent during initial phase of treatment; then joint sessions with parent and child	Youth 3 to 18 and parents/caregivers of youth 3 to 18, exposed to traumatic life events and are experiencing PTSD symptoms and/or depression, anxiety or shame related to their trauma.	IV-E PSC – Promising CEBC – Well Supported NIJ - Effective	• Improved trauma symptoms and responses • Increased parent effective coping skills • Increased positive parenting skills • Increased effective family communication • Increased parent ability to manage stress	No

[40] Child Welfare Information Gateway (2018). *Trauma-Focused Cognitive Behavioral Therapy: A Primer for Child Welfare Professionals.* https://www.childwelfare.gov/pubPDFs/trauma.pdf

Table B3: Program Category: Mental Health and Substance Abuse Prevention and Treatment Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base Rating**	**Proximal Outcomes**	**Requesting Family First Payment**
					• Increased parent behavior management skills	

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
Common Sense Parenting[41]	Parenting class that focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior.	One 2-hour weekly session for 6 weeks	Parents and other caregivers of children ages 6 - 16 years	CEBC – Supported	• Increased positive parental strategies for managing negative behaviors • Increased positive behaviors • Increased positive parent-child communication	No

[41] California Evidence Based Clearinghouse (2019). *Common Sense Parenting*. https://www.cebc4cw.org/program/common-sense-parenting/detailed

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
Homebuilders[42]	A home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning.	Three to five 2-hour sessions contacts per week; an average of 8 to 10 hours per week of face to face contact, with telephone contact between sessions.	Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities	Title IV-E Clearinghouse – Well Supported CEBC – 2 Supported	• Reduced child abuse and neglect, family conflict, and child behavior problems. Increased parenting skills.	No
Love and Logic Parenting[43]	Parenting class that teaches caregivers how to decrease stress while teaching youth necessary life skills. Based on the concept that children	Minimum of one 8-hour training. Can be up to six 8-hour training days.	Parents, grandparents, teachers, and other caretakers working with	CEBC – Not able to be rated	• Improved decision-making skills • Improved problem-solving	No

[42] Title IV-E Prevention Services Clearinghouse (2020). Homebuilders. https://preventionservices.abtsites.com/programs/176/show
[43] Fay, C. Love and Logic Curriculum Research: Effects of Becoming a Love and Logic Parent. https://www.blottcom.com/love-and-logic-research.html

Table B4: Program Category: In-Home Parent Skill-Based Services						
Service	**Description**	**Average Length of Service**	**Target Audience**	**Evidence Base**	**Outcomes**	**Requesting Family First Payment**
	learn the best when allowed to make their own choices and failure it met with love and empathy.		children 0 – 18		skills • Increased positive parenting strategies • Improved family relationships	
On the Way Home[44]	Integration of three interventions: Check & Connect, Common Sense Parenting, and homework support to meet the educational and family-based transition needs of youth. Primary goal is to foster stability of youth in home and school.	Two-hour weekly sessions over 12 months.	Youth ages 12-18 at-risk for, emotional and behavioral disorders transitioning from residential placements back into the home and community school settings and their caregivers	CEBC - Promising	• Increased academic performance • Increased school engagement • Decreased out-of-home placements • Improved family relationships	No

At this time, JCS does not have the infrastructure or financial capacity required to implement multiple Family First prevention services. In addition, JCS is currently working with Georgetown University and the University of Cincinnati to

[44] California Evidence Based Clearinghouse (2019). *On the Way Home*. https://www.cebc4cw.org/program/on-the-way-home-otwh/detailed

complete an evidentiary review and evaluation of services in Iowa. Upon completion of that review, JCS will have a broader knowledge base to identify and select the programming and services best suited to meet the needs of the youth and families it serves. Until this review is completed and JCS has identified viable funding mechanisms, JCS is requesting that only Functional Family Therapy (FFT) and Multisystemic Therapy (MST) be included as an approved Family First prevention service.

Outcomes: Iowa's JCS commitment to improving youth and family outcomes are visible through its long-term goals to expand and improve mental health and substance abuse services and improve treatment services to produce positive youth outcomes and reduce recidivism.[45]

In addition, JCS's participation in the Juvenile Justice System Improvement Project (JJSI) provided an opportunity for JCS to collaborate with nationwide experts, e.g. the Council of State Governments Justice Center (CSG), National Youth Screening and Assessment Partners (NYSAP), and the Center for Juvenile Justice Reform at Georgetown (CJJR). The purpose of the collaboration was to perform a comprehensive evaluation of Iowa's juvenile justice system. This evaluation, which identified strengths and areas for improvement for JCS, resulted in the development of a comprehensive statewide plan to standardize policies and practices and ensure the quality and effectiveness of services that youth receive.[46]

1. *Selected Services and Evidence-Base Rating* – JCS selected only two Mental Health Services, FFT and MST, for inclusion in Iowa's Family First Five Year plan. The Title IV-E Prevention Services Clearinghouse rated both of these services as "well-supported". In addition, FFT received a level "2 supported" rating and MST a level "1 well supported" rating from the California Clearinghouse.

   Research on FFT, conducted throughout the United States, has shown FFT produces improvement in family relations and statistically significant decreases in recidivism.[47]

   FFT is a prevention and intervention program that treats complicated and multi-dimensional family problems using a culturally sensitive and flexible clinical approach. Trained therapists spend twelve to fourteen sessions over 3-5 months

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[45] CJJP (2018). *2018 Iowa Criminal and Juvenile Justice Annual Plan Update.* https://humanrights.iowa.gov/sites/default/files/media/2018%20Iowa%20Criminal%20and%20Juvenile%20Justice%20Annual%20Plan%20Update.pdf

[46] Iowa Department of Human Rights (2018). *Juvenile Justice System Improvement (SMART) Project*. https://humanrights.iowa.gov/juvenile-justice-system-improvement-smart-project

[47] Blueprints for Healthy Youth Development. (2020). *Functional Family Therapy*. https://www.blueprintsprograms.org/programs/28999999/functional-family-therapy-fft/

working with youth and their families to reduce risk factors and improve protective factors. The program has three distinct intervention phases, engagement and motivation, behavior change, and generalization, with each phase having specific goals and assessment objectives.

The expected proximal outcomes for FFT include improved family functioning, reduced delinquent behavior, improved mental health, reduced youth substance use, fewer out-of-home placements and higher treatment completion rates. Distal outcomes anticipated include reductions in recidivism, increased family stability, decreased trauma and improvement in overall life outcomes for youth.[48]

MST is an intensive community-based therapy for high-risk juvenile delinquents ages 12-17 with possible substance abuse issues and their families. A master's level therapist provides services in the home for youth at times when it is convenient for the family. Treatment typically lasts three to five months with the therapists "on-call" 24/7. There is a broad base of research on the effectiveness of MST. Results, replicated through numerous independent studies, show 54% fewer arrests for juvenile offenders and 54% fewer out-of-home placements. Communities with MST offered saw reductions in incarceration rates, mental health services and crime rates.[49] MST treatment has two primary goals, to reduce delinquent behavior and to decrease out-of-home placements. Critical components of MST include (a) incorporation of evidence based treatment methods to target complex risk factors found across environments (family, friends, education and community); (b) empowering caregivers and changing a youth's behavior within the community context; and (c) meticulous quality assurance procedures that concentrate on accomplishing outcomes through preserving program fidelity and creating approaches to surmount obstacles to behavior change.

Proximal outcomes associated with MST include reductions in delinquent behavior and out-of-home placements, improvements in family functioning, and decreased behavior and mental health problems for high-risk juvenile offenders. Long-term outcomes of MST show improvements in child-parent relationships, improvement in youth-peer relationships, reductions in youth substance abuse, and reductions in child maltreatment.[50]

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[48] EPIS Center. (2014). *FFT Logic Model*. Penn State University. http://www.episcenter.psu.edu/sites/default/files/ebp/Functional-Family-Therapy-Logic-Model-REV%204-2014.pdf

[49] MST Services (2020). *MST's Juvenile Delinquency Prevention Program.* https://www.mstservices.com/mst-juvenile-delinquency-prevention-program

[50] Zajac K, Randall J, Swenson CC. *Multisystemic Therapy for Externalizing Youth. Child Adolescent Psychiatry Clin N Am*. 2015;24(3):601–616. doi:10.1016/j.chc.2015.02.007

2. *Implementation and Monitoring of Fidelity*

a. Implementation:

Functional Family Therapy (FFT) - FFT requires completion of a three-phase training process, clinical, supervision and maintenance, and site certification prior to provision of services. Clinical training consists of a five-day in-person training followed by weekly phone consultations provided by an FFT expert trainer. Individuals selected to be site supervisors attend a two-day in-person training supported by monthly phone supervision. During phase II of FFT training, all therapists receive a one-day on-site training or a regional training. Phase III of the training process includes a review of Clinical Supervision System (CSS) to evaluate an agency's adherence, service delivery and outcomes. Therapists also receive a one-day continuing education training.

Multisystemic Therapy (MST) - MST requires a pre-implementation assessment of an agency to identify the organizational, clinical and financial resources needed to implement MST. Upon completion of this assessment, the agency identifies a team of qualified clinicians. This team of clinicians attends a five-day intensive training, followed by weekly telephone consultation, and quarterly on-site booster trainings to monitor treatment fidelity and adherence to the model. Any agency providing MST must complete a certification process to ensure it meets the training, program management, performance, and adherence requirements set forth by MST.

Through a competitive process, JCS selected qualified service providers who successfully completed the required FFT and MST training and site certification. JCS established a contract with the providers that included allowable expenses, scope of service, rates of payment and billing codes, process evaluation criteria, administrative reporting and required training/certification protocols. JCS also required providers to report on data related to adherence, exposure, quality of delivery and participant responsiveness semi-annually.[51]

JCS districts worked cooperatively to develop and distribute information packets to JCOs, support staff and additional referral sources to provide an overview of FFT and MST, including program objectives, structure, outcomes and eligibility guidelines. In addition, JCS will train staff on the referral processes respective of both. Districts have also collaborated with service providers to develop and provide program training and updates to JCS staff.

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[51] Bell, James (2009). *Measuring Implementation Fidelity*. https://www.acf.hhs.gov/sites/default/files/cb/measuring_implementation_fidelity.pdf

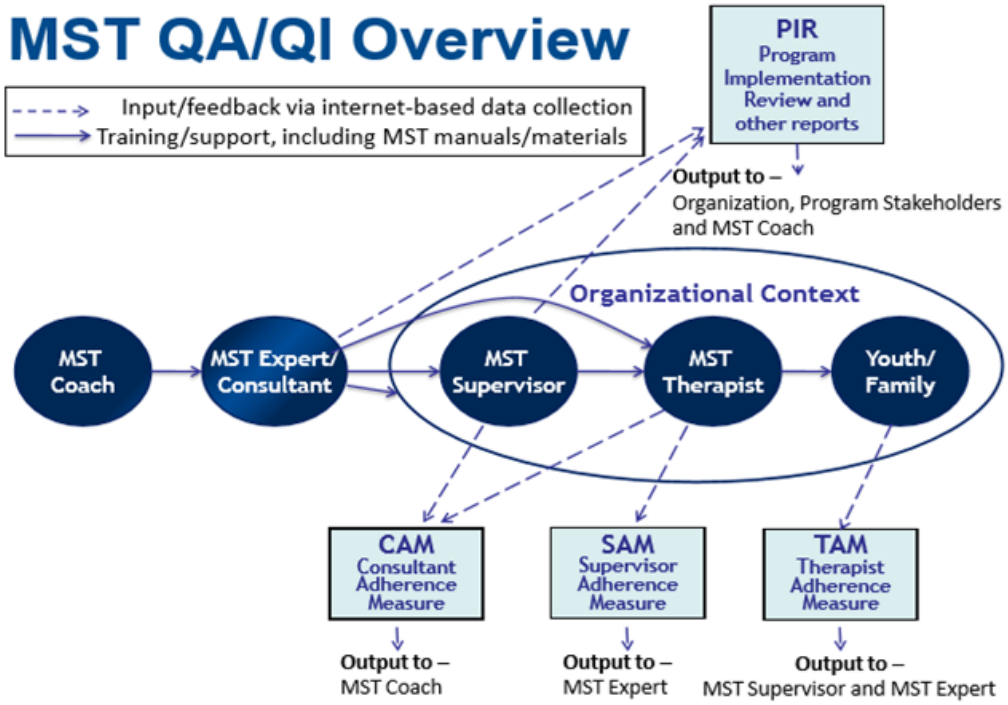
b. FFT and MST outcomes, data, and fidelity (how outcomes will be identified, how data collected regarding these outcomes will occur, and how fidelity will be monitored to ensure fidelity to the practice model):

Functional Family Therapy (FFT) - FFT has a systematic approach to training and program implementation, as well as a comprehensive system of client, process, and outcome assessment. This has allowed FFT to establish a fidelity model that ensures strong adherence to and high competency in the provision of FFT. To ensure continued fidelity, the organization responsible for providing FFT training, FFT LLC, developed the Clinical Services System (CSS), which gathers data input from FFT therapists. This system is used to track both individual and agency fidelity measures.

Multisystemic Therapy (MST) - MST has a rigorous qualify assurance/improvement program that evaluates elements on four levels – therapist, supervisor, expert/consultant and program – to ensure fidelity of and adherence to the MST treatment model. The MST Institute oversees the MST QA/QI program, who is responsible for setting quality assurance standards and measuring and monitoring program implementation. Through MST, agencies offering MST receive various tiers of training, support, and feedback (see Figure B1).[52]

[52] MST Institute.

Figure B1. MST QA/QI Overview



a. Outcome Identification: Using the Theory of Change model, outcomes will be identified based on the following:
   1. Juvenile Court Service's purpose (to rehabilitate or habilitate youth and ensure public safety)
   2. Published research
   3. Historical data analysis
   4. Evaluations
   5. Program model standards

   Measures will be on two levels – outcome and process. Outcome measures will be specific to the youth and family will be specific to the youth and family and focus on measuring the effect of the treatment/service. Process measures, which will monitor fidelity, will examine the specific steps in the service process. Tables B4(a) and B4(b) illustrate at a minimum the outcome and process measures that may be collected by JCS.

Table B4(a) Key Outcome Measures	
Functional Family Therapy (FFT)	• Percentage of participants who report improved family functioning as measured by the Client Outcomes Measure (COM) administered at the completion of the program - (Annual) • Percentage of parents/guardians who report a reduction in the level of family conflict post-therapy, as indicated by a score of 3 or higher

Table B4(a) Key Outcome Measures	
	on the Client Outcome Measure • Percentage of parents/guardians reporting improvement in their parenting skills, as indicated by a score of 3 or higher on the COM-P - (Annual) • Percentage of parents/guardians who report improvement in their child's behavior as measured by the Youth Outcome Questionnaire (Y-OQ 2.01) pre to post - (Annual) • Number of youths with decreased recidivism • Number of youths not placed outside of the home at 6, 12, 18, and 24 months
Multisystemic Therapy (MST)	• Number of youths with decreased recidivism • Number of youths not placed outside of the home at 6, 12, 18, and 24 months. • Number of youths in school or working

Table B4(b): Key Process (Fidelity) Measures	
Functional Family Therapy (FFT)	• Therapists will meet the model developer required staff qualifications • Therapist will complete the required certified model training prior to serving clients • Therapists will carry the recommended caseload of 10-12 families at any given time • Therapists will meet the model developer's standards for dosage (number and duration) of client contacts. • Therapist will meet the supervision/consultation program model requirements • Providers delivering the model will be site affiliates as required by the model developer • Providers will meet the model developer metrics requirements for fidelity and quality assurance • Cases will be completed within the model developer's recommended timeframe of 3 to 4 months • Clients will be from the target population • Number of clients served
Multisystemic Therapy (MST)	• Therapist Adherence Measure score • Supervisor Adherence Measure score • Therapists will meet the model developer required staff qualifications • Therapists will complete the required certified model training prior to serving clients • Therapists will serve a maximum of 6 families per year • Therapists will meet the model developer's standards for dosage (number and duration) of client contacts. • Therapist will meet the supervision/consultation program model requirements • Providers delivering the model will be site affiliates as required by the model developer • Providers will meet the model developer metrics requirements for fidelity and quality assurance • Cases will be completed within the model developer's recommended

Table B4(b): Key Process (Fidelity) Measures	
	timeframe of 4 to 6 months • Clients will be from the target population • Number of clients served

b. Data Collection: For each outcome, JCS will generate a data collection plan. This plan will include the following:
   1. Data (variable)
   2. Operational Definition
   3. Input or Output data
   4. Unit of measurement
   5. Data Type
   6. Data Sources
   7. Collection Method/Instruments
   8. Historical Data References
   9. Operational Definition
   10. Sample
   11. Data Collector
   12. Collection Date/Time

JCS will collect both qualitative and quantitative data. Process outcome data will derive from service provider reports. These reports are from three sources, provider completion of a quarterly fidelity questionnaire, a yearly service provider audit conducted by the JCS Contract Administrators, and each service's respective case management system (FFT - Clinical Services System and MST – MSTI Enhanced System). Data from these systems is based on client questionnaires and therapist observations.

Outcome data collection will come directly from the Juvenile Court Service's Case Management (CM) system or reports from the Criminal and Juvenile Justice Planning (CJJP) agency. The CJJP reports derive from the Justice Data Warehouse (JDW), a central repository of key criminal and juvenile justice information from the Judicial Branch Case Management System[53]. Data collected within CM can be on an individual or aggregate level. JCS is also currently working with the Judicial Branch Information Technology (JBIT) department to develop and implement forms in the Case Management system specific to FFPSA that will assist in collecting and aggregating data accurately.

[53] CJJP (2020). *Justice Data Warehouse*. https://humanrights.iowa.gov/cjjp/justice-data-warehouse

As JCS enhances its CQI infrastructure, additional data will be collected from youth/parent surveys and case file reviews and analyzed to ensure a comprehensive evaluation of all programs and practices.

c. Fidelity Monitoring: JCS will monitor fidelity in four ways:
   1. Data related to the service outcomes identified by the program model and JCS will be collected through quarterly service provider reports and yearly audits of service provider contracts. A standardize quarterly reporting form will be developed to ensure all districts are collecting and reporting the same data. The CQI teams will then analyze this data, with statewide reporting.
   2. The Contract Administrator/Accountant (CA/As) will review service provider contracts in all districts and develop standard contract language for use statewide to ensure service providers are reporting outcomes directly related to program fidelity.
   3. The Standardized Program Evaluation Protocol (SPEP™) will occur yearly for eligible SPEP services.
   4. Data collected from other CQI processes will be used to augment the above three methods to ensure a comprehensive approach to fidelity

In addition to the identified fidelity measures for FFT and MST, JCS will monitor and enhance fidelity by taking the following actions:

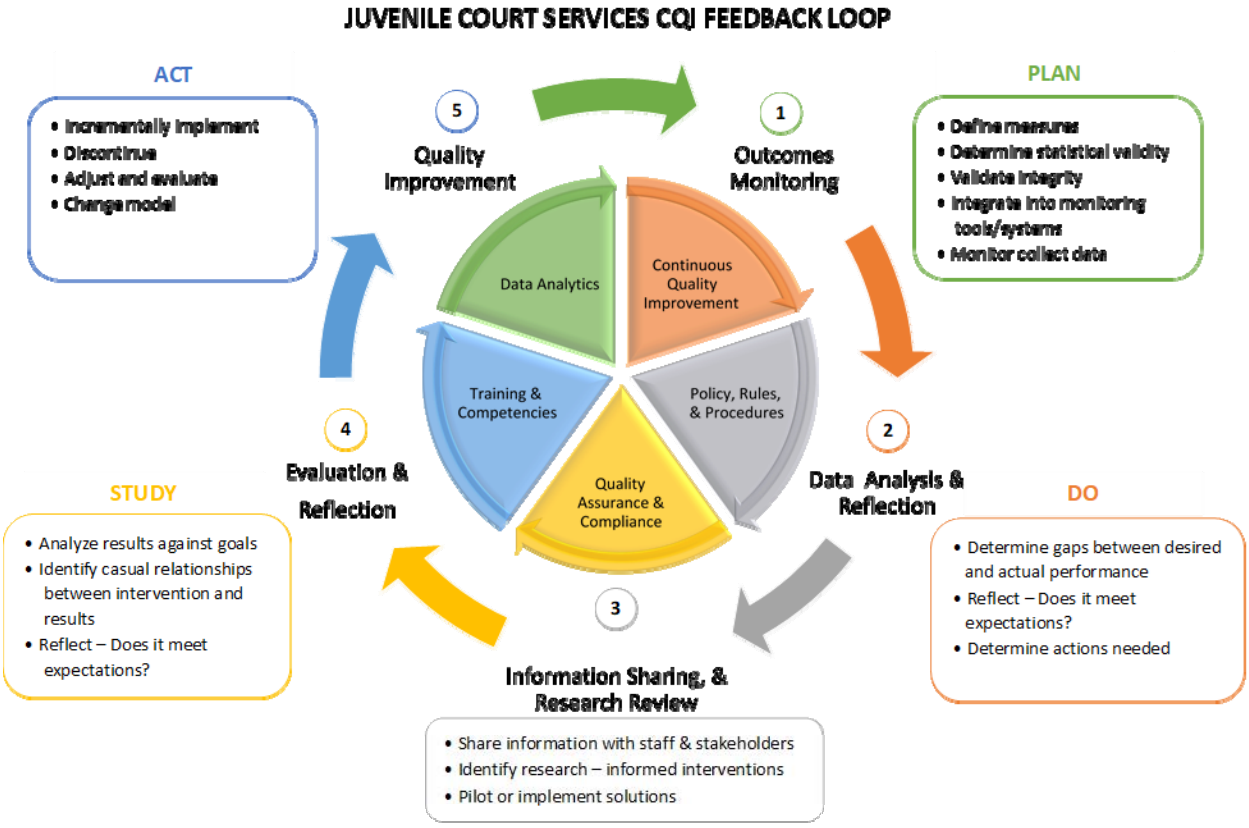
- Conduct yearly meetings with providers to review progress, identify strengths and address any process and/or delivery issues.
- Participate in joint learning opportunities with providers, when feasible

c. How information learned from CQI for FFT and MST refines and improves practices: JCS will utilize the feedback loop (Figure. B2) to ensure a structured approach to Continuous Quality Improvement. This feedback loop will give JCS the opportunity to use the information learned from the CQI process for FFT and MST to refine and improve practices by providing JCS with a data-driven and informed approach to decision-making. This approach will allow JCS to enhance and ameliorate its services and practices by using CQI results to guide the agency in:

- Identifying which services/programs to maintain, expand, or terminate
- Modifying services that do not meet expectations
- Implementing new services that are more conducive to achieving desired outcomes
- Improving delivery of services
- Improving internal processes (i.e. changes in policies, procedures, and training)
- Improving external relationships
- Addressing barriers to service delivery
- Identifying and addressing gaps in programming
- Understanding underlying conditions

- Identifying solutions
- Identifying if Technical Assistance is needed
- Identifying if there are collection, communication, or technology issues
- Identifying trends
- Addressing performance issues

Figure B2. JCS CQI FEEDBACK LOOP



3. Service Selection

JCS utilized a comprehensive and longitudinal process to select its services. The process identified programs for their effectiveness in reducing criminogenic risk and ameliorating criminogenic needs, which are the overriding factors that contribute to a juvenile justice youth being a candidate for group foster care. This process included the following actions:

- Chief Juvenile Court Officers (CJCO) identified individual district needs and budgetary constraints through a detailed analysis of data obtained from the Iowa Court Information System (ICIS), the Iowa Delinquency Assessment (IDA) and research initiatives, such as the SMART project.

The SMART project was a result of Iowa receiving one of three OJJDP planning grants for system improvement. Iowa used this grant to initiate the Juvenile Justice System Improvement Project (SMART). The SMART project allowed Iowa the opportunity to collaborate with experts from the Council of State Governments Justice Center (CSG), National Youth Screening and Assessment Partners (NYSAP), and the Center for Juvenile Justice Reform at Georgetown (CJJR). The purpose of the collaboration was to perform a comprehensive evaluation of Iowa's juvenile justice system for identifying strengths and deficit areas in Iowa's juvenile justice system. The long-term outcomes for the SMART project were to reduce reoffending, enhance outcomes for youth and families, improve community safety, and decrease disproportionate minority contact. Because of the project, the development of a comprehensive plan occurred that included recommendations to systematize policies and procedures and assure the quality and efficacy of services that youth receive. The SMART leadership team, which comprised juvenile justice participants from all three branches of government, worked collaboratively with expert advisors and local consultants to reach agreement on priorities for improvement, ascertain essential stakeholders, and generate a plan for Iowa's juvenile justice system that was progressive and realistic.

- CJCOs consulted with a variety of experts in the juvenile justice field, such as Dr. Edward Latessa (Director and Professor of the University of Cincinnati School of Criminal Justice); Dr. Robert Macy (founder and president of the International Trauma Center in Boston); Dr. Mark Lipsey (Research Professor at Vanderbilt Peabody College); and Diana Wavra, Orbis (consultant and trainer for evidence based services in juvenile justice). The purpose of the consultation was to identify evidence-based services and programs best suited to the identified needs of Iowa's youth and families.
- Assessment of funding and resources needed to implement each selected service or program occurred to evaluate its feasibility.
- Services and programs were selected based on overall assessment of criteria related to the service or program's evidence-base, level of suitability, outcomes, availability and required time, resources and costs associated with delivery and administration.

To continue the process of service selection, JCS is currently working with Georgetown University and the University of Cincinnati to complete an evidentiary review of programs/services in Iowa.

4. Target Population

The target population for FFT are youth age 11 to 18, who are justice-involved or at risk for delinquency, violence, substance use, or other behavioral and/or emotional problems and their parents/caregivers. The target population for MST are youth age 12 to 17 at-risk of out of home placement due to anti-social or delinquent behaviors and substance abuse issues and their parents. The target population for other services currently offered by JCS but not included in the Family First Prevention Plan is in Tables B3 and B4.

5. *Trauma Informed Delivery Assurance*

   Iowa Juvenile Court Services recognizes the importance of trauma-informed approach to service delivery and evaluates all service/program delivery based on SAMHSA's six key principles of a trauma-informed approach. These principles include 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) Empowerment, voice and choice, 6) Cultural, historical and gender responsivity.[54]

6. *Service/Program Evaluation - Services and Programs Eligible for Waiver of Evaluation Requirements (Well-Supported Practice)*

   The Title IV-E Prevention Services Clearinghouse designated both FFT and MST as "Well-Supported." In addition, both models have highly structured processes for program evaluation that providers are required to meet on a yearly basis. JCS has also established measures for program evaluation of FFT and MST, based on CQI and the Standardized Program Evaluation Protocol (SPEP) that includes semi-annual provider reporting of outcome and process measures, quarterly provider meetings, yearly audits and semi-annual provider trainings. Due to this, JCS is requesting a Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation for FFT.

Evaluation Strategy and Waiver Request

- *The state must include a well-designed and rigorous evaluation strategy for each service, which may include a cross-site evaluation approved by ACF.*
- *Consistent with section 471(e)(5)(C)(ii) of the Act, the Children's Bureau may waive this requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state may request this waiver using Attachment II to the five-year plan and must demonstrate the effectiveness of the practice.*

JCS bases its evaluation strategy on Theory of Change, which provides a coherent framework for evaluating programs, processes and practices to determine if an intervention is working as planned and how to improve it. As part of this strategy, JCS will also use the Continuous Quality Improvement[55] (CQI) process to develop individual

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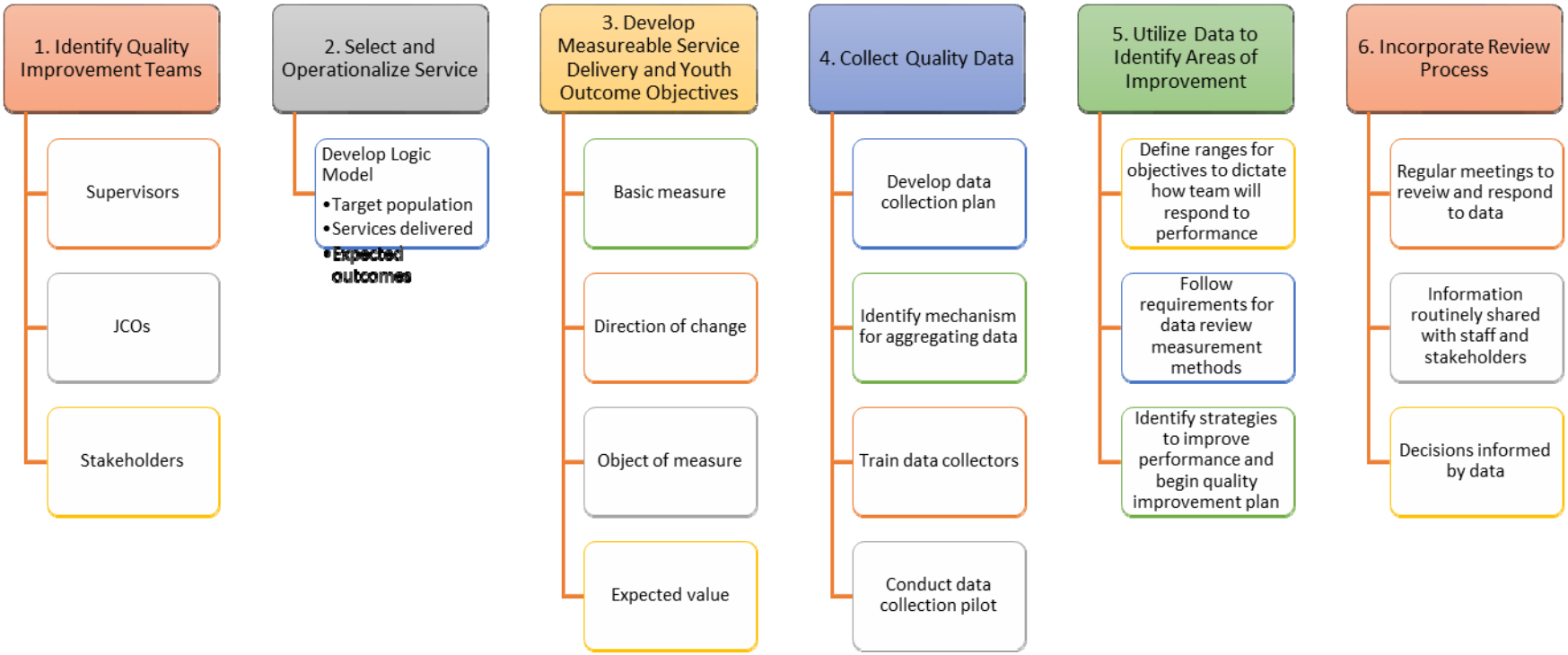
[54] SAMHSA (2014). *Samhsa's Concept of Trauma and Guidance for a Trauma Informed Approach* https://store.samhsa.gov/system/files/sma14-4884.pdf

[55] National Center for Juvenile Justice (2012). *Continuous Quality Improvement Guide for Juvenile Justice* Organizations. http://www.ncjj.org/pdf/Qii%20Improvement%20Guide%20for%20Juvenile%20Justice.pdf

assessment practices for each selected Family First service or program. The evaluation plan for each service selected for Family First implementation will contain the below listed CQI components. If a service or program, such as Functional Family Therapy (FFT) or Multisystemic Therapy (MST) has already identified an appropriate evaluation strategy, JCS will follow the requirements of that strategy to complete an evaluation of the service/program.

- Identify CQI teams in each district comprising Supervisors, JCOs and service providers. Connection of these teams will occur to form a larger statewide CQI team.
- Teams will operationalize the service or program by developing a logic model that includes target population, services delivered, and expected outcomes.
- Develop measurable proximal and distal service delivery and youth outcome objectives, including fidelity to the model
- Collect quality data, in particular, outcomes related to recidivism and out-of-home placement, by developing a data collection plan, identifying mechanisms for aggregating data, training data collectors and conducting a data collection pilot.
- Analyze and utilize data to identify areas of program improvement
- Incorporate a review process by holding regular meetings to review and respond to data, sharing information routinely with staff and stakeholders, and making data-driven decisions.

Figure B3. Juvenile Court Services Continuous Quality Improvement Diagram



As an additional measure to ensure a comprehensive program evaluation occurs, JCS will utilize the Standardized Program Evaluation Protocol (SPEP) to evaluate program performance for all eligible services. The SPEP process is a data-driven tool derived from meta-analytic research designed to compare existing juvenile justice services to the

characteristics of the most effective services found in the research. It evaluates the effectiveness of four characteristics of juvenile programs: service type, amount of service, quality of service and risk level of youth served.

SPEP identified 14 therapeutic services as effective in reducing delinquent behavior and recidivism. These fourteen service types divide into five separate services groups and assigned a point value based on the size of the effect that research has indicated that particular service group is likely to have upon recidivism. A trained evaluator will match the Family First identified services to the SPEP service groups and assign a corresponding rating.

Quality of service is the second element of the SPEP evaluation, with rating of low, medium or high. The basis for these ratings are individual assessments in four areas: 1) the presence of a comprehensive written protocol/manual 2) the level of staff training on the service and its protocols 3) staff supervision and monitoring of service delivery and 4) organizational procedures for responding to drift from protocol.

The third element of the SPEP evaluation is dosage or amount of service. This assesses the duration (number of weeks) and frequency (contact hours) the youth received services against the research identified target amount, which differs for each of the fourteen service types. The basis for the SPEP dosage score is the percentage of youth who receive at least the minimum, targeted amount of service.

The final element of the SPEP evaluation examines the risk level of youth served. This score comprises a formula that measures the proportion of moderate to high-risk youth, as identified by the Iowa Delinquency Assessment (IDA), who participated in the service. Simplified, the more moderate and high-risk youth served, the more likely a service is able to reduce recidivism.

A sum of the scores of these four elements produce two overall SPEP evaluation scores, the Basic Score and a Program Optimization Percentage (POP). The Basic Score compares the service to other intervention services found in the research, regardless of type. It is a reference for the expected overall recidivism reduction when compared to other service types. The POP is a percentage score that indicates where the service compares to its potential effectiveness if optimized to match the characteristics of similar services found in research. All of the scores described above, plus the accompanying recommendations provided in the report form, are the core of this diagnostic evaluation and establish a baseline intended for use in individual service improvement.

The Director of Juvenile Court Services will oversee this evaluation process in conjunction with each district's CJCOs, JCO Supervisors, Contract Administrator Accountants and Contract Administrator Auditors.

JCS requests a waiver for the following services:

- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)

JCW will follow each program's established protocols to monitor, evaluate, and report fidelity and outcomes data as part of its continuing effort to assess the efficacy of the selected prevention interventions.

The Title IV-E Prevention Services Clearinghouse rated both programs as "well-supported".

Compelling Evidence for Effectiveness of FFT and MST (how is the effectiveness of FFT and MST compelling?)

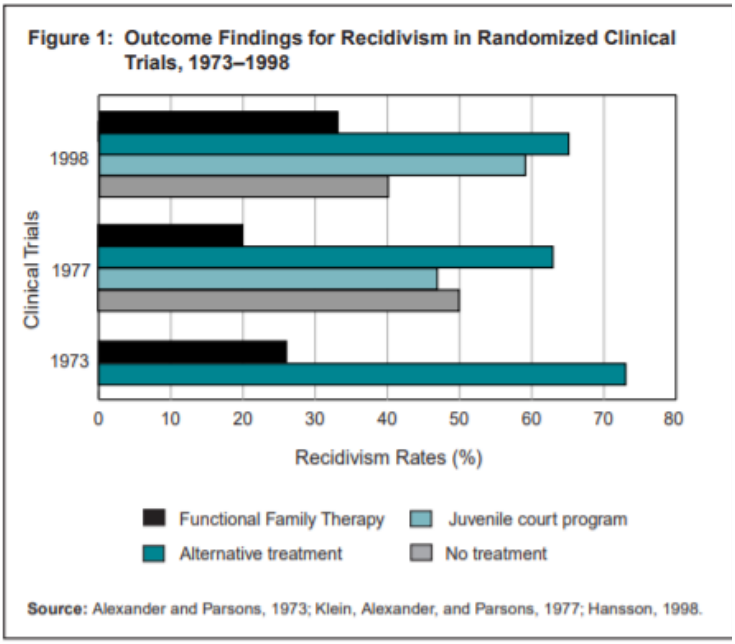
Functional Family Therapy (FFT): JCS is requesting a waiver of the evaluation required for FFT based on compelling evidence that FFT 1) improves family interactions; 2) decreases recidivism; and 3) decreases out-of-home placements. Below is a summary of the research conducted on FFT, which provides evidentiary support for this request.

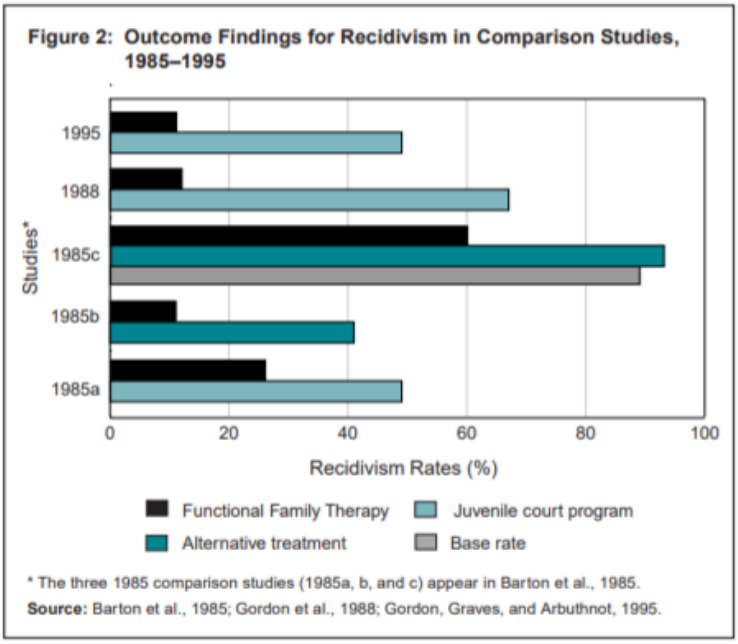
Functional Family Therapy (FFT) has been utilized successfully in a variety of settings to treat high-risk youth and families. It is a treatment approach that combines "established clinical theory, empirically supported principles, and extensive clinical experience"[56] into a discrete and comprehensive clinical model that is flexibly structured and culturally sensitive. Because FFT spans the continuum of juvenile justice involvement, it is effective as an intervention or a prevention program.

As a result of numerous peer-reviewed studies, FFT has been identified as a "blueprint program" (Alexander et al., 2000), an "exemplary model" program (Alexander, Robbins, and Sexton, 1999), and a "family based empirically supported treatment" (Alexander, Sexton, and Robbins, 2000).

The outcome findings of FFT studies conducted during the past 30 years is summarized in Figures 1 (randomized clinical trials) and 2 (comparison studies). The figures show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services, FFT reduces adolescent rearrests by 20–60 percent.[57]

[56] Alexander, J., Sexton, T.L. (2000). *Functional Family Therapy. "*OJJDP Bulletin" https://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf
[57] Ibid.





FFT has a proven body of research that validates its efficacy with a wide variety of negative youth behaviors, including violence, substance abuse, and delinquent acts. Most notable is the fact that FFT's positive outcomes are comparatively stable even after five-years.[58]

Below are several other studies that provide additional compelling evidence for the use of FFT in the treatment of juvenile delinquents and their families.

- Alexander J. F., & Parsons, B. V. (1973). *Short-term behavioral intervention with delinquent families: Impact on family process and recidivism.* "Journal of Abnormal Psychology", 81(3), 219-225.

  This study examined the impact of FFT on the recidivism rates of delinquent teenagers and their families. Results of the study showed the FFT treatment group had a 26% recidivism rate. No-treatment control group had a 50% recidivism rate, the client-centered family group had a 47% recidivism rate, the psychodynamic family treatment group had a 73% recidivism rate.

- Klein, N., Alexander, J., & Parsons, B. (1977). *Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation*. "Journal of Consulting and Clinical Psychology, 45(3), 469-474."

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[58] Gordon, D. A., Arbuthnot, J., Gustafson, K. E., & McGreen, P. (1988). Home-based behavioral-systems family therapy with disadvantaged juvenile delinquents. *American Journal of Family Therapy, 16*(3), 243–255. https://doi.org/10.1080/01926188808250729

FFT produced significant reductions in recidivism and improvements in improvement in family relationships. In a 3 ½ year post-treatment, the siblings of youth receiving FFT had lower arrest rates than siblings who received an alternative treatment.

- Lantz, B. L. (1982). *Preventing adolescent placement through Functional Family Therapy and tracking.* Grant. CDP 1070 UT 83-0128020 87-6000-545-W). Kearns, UT: Utah Department of Social Services

  FFT had lower rates of recidivism and out-of-home placement than those receiving an alternative treatment.

- Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). *Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. "*Journal of Consulting and Clinical Psychology*,"* 69(5), 802-813.

  FFT showed significant reductions in heavy marijuana that persisted until the 7-month assessment.

- Stout, B. D., Holleran, D. (2013). *The impact of evidence-based practices on requests for out-of-home placements in the context of system reform*. "Journal of Child and Family Studies," 22, 311–321. doi:10.1007/s10826-012-9580-6.

  FFT had an estimated reduction of 31 out-of-home placements month – an annual reduction of 372 out-of-home placements – and an estimated cost savings of $1.33 million.

Multi-systemic Therapy (MST): Compelling evidence for MST shows MST 1) Reduces long-term recidivism rates for serious juvenile offenders by a median of 42%; 2) Reduces out-of-home placements by a median of 54%; and 3) Improved family functioning.[59] MST has had 79 published peer-review studies completed with more than 58,000 families included in those studies. MST targets risk factors at the individual, family, school, and community levels. Developed precisely for this reason, MST shown through multiple studies to be highly effective in treating serious clinical issues that increase a youth's risk of out-of-home placement, including juvenile offending, serious externalizing behaviors, substance abuse, and parental physical abuse and neglect. Researchers for MST have proven the importance of "high treatment fidelity and

[59] MST Services (2020). Multisystemic therapy research at a glance 2020 summary. https://www.mstservices.com/mst-whitepapers

pioneered a quality assurance system that allows for replication of positive outcomes in community settings through ongoing supervision and support from MST experts."[60]

Additional studies providing evidentiary support for MST are below.

- Xuan Tan, J. and Lourdes Restrepo Fajardo, M.(2017). *Efficacy of multisystemic therapy in youths aged 10–17 with severe antisocial behaviour and emotional disorders: systematic review*. "London Journal of Primary Care (Abingdon)". Nov; 9(6): 95-103.

  MST is an effective intervention for reducing delinquency and incarceration for youth with severe antisocial behavior.

- McCart, M., Sheidow, A.J. (2016). *Evidence-Based psychosocial treatments for adolescents with disruptive behavior.* "Journal of Clinical Child and Adolescent Psychology", Sep-Oct; 45(5); 529-563.

  MST meets the criteria for a well-established for treatment youth presenting with serious anti-social behavior and substance abuse issues. It has also been adapted for other particular problems in adolescents and young adults, such as "juvenile sexual offenders; youth in psychiatric crisis; youth with physical abuse; youth with chronic health conditions; emerging adults with justice involvement and mental illness."

- Sawyer, A.M., Borduin, .C.M. (2011). *Effects of multisystemic therapy through midlife: A 21.9-year follow-up to a randomized clinical trial with serious and violent juvenile offenders.* "Journal of Consulting and Clinical Psychology" 79(5):643–652. doi: org/10.1037/a0024862.

  MST has demonstrated long-term outcomes, including sustained disruptive behavior outcomes for MST versus individual therapy at 14- and 22-years posttreatment.

- Painter K. (2009). *Multisystemic therapy as community-based treatment for youth with severe emotional disturbance.* "Research on Social Work Practice." 19(3):314-324. doi:10.1177/1049731508318772

  MST can prevent families from surrendering custody of their children to obtain successful treatment for them and avoid involvement in the juvenile justice system.

[60] Zajac, K., Randall, J., Cupit Swenson, C. (2015). Multisystemic therapy for externalizing youth. Child and Adolescent Psychiatric Clinics of North America, July; 24(3): 601-616.

- Sheidow, A.J., Woodford, M.S. (2003). M*ultisystemic therapy: An empirically supported, home-based family therapy approach*. "The Family Journal." 11(3):257-263. doi:10.1177/1066480703251889.

  MST has been validated as an effective treatment for serious clinical problems presented by adolescents and their families. Numerous randomized clinical trials have shown MST reduces out-of-home placements, delinquent behavior, substance use, and mental health symptoms.

Please see Attachment II: State Request for Waiver of Evaluation Requirements for a Well-Supported Practice for each service.

Monitoring Child Safety

The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.

The mission of Juvenile Court Services (JCS) is to serve the welfare of children and their families within a sound framework of public safety. To accomplish this, JCS is committed to providing the guidance, structure and services needed by every child under its supervision. Iowa's Juvenile Court System will utilize the following established tools and practices to assess and monitor child safety.[61]

Safety Assessment

At the initial intake with a youth and family, the JCO will utilize the Iowa Delinquency Assessment (IDA) to assess a youth's risk and protective factors in eleven domains. Included in these eleven domains are a youth's exposure to physical, emotional and sexual abuse and neglect. In addition to assessing a youth's risk factors, the IDA also assesses a family's risk factors in substance abuse, mental health, criminal conduct and child maltreatment. The IDA is a developmentally appropriate, structured decision-making tool based on the Risk-Need-Responsivity (RNR) principle. The JCO administers the IDA every six-months and anytime thereafter when there is a change in the youth's circumstances.

For any youth that scores as a moderate or high risk to reoffend, and who is determined to be a "candidate for foster care" or a pregnant or parenting youth in foster care, the

[61] Tuell, J. and Harp, K. (2016). *Letting Go of What Doesn't Work for Juvenile Probation, Embracing What Does.* Juvenile Justice Exchange.

JCO will complete a Treatment Outcome Package (TOP) assessment. The TOP is an evidence-based tool that captures multiple perspectives of a child's well-being and functioning in twelve behavioral health categories. These categories include suicide, violence, psychosis, depression, substance abuse, ADHD, mania, social conflict, sleep, conduct, work/school functioning and sexually worrisome behavior.[62]

The TOP, which documents statistically significant change in 96% of patients, enables the parent, child and other individuals involved in the child's care to have a voice in the assessment process. Results from the TOP are in real time; the JCO receives immediately notifications of worsening of symptoms or a degeneration in youth functioning. In addition, the JCO receives critical alerts anytime there is an identification of an immediate concern of suicide or violence. These alerts provide a detail of the items that precipitated the alert and required same day contact with the youth and parent. The JCO will administer the TOP every six months and anytime a significant change in circumstance occurs.[63]

The JCO also will assess and monitor a youth's safety through periodic reviews of the child's Prevention Case Plan. The JCO will review the child's Prevention Case Plan quarterly and at least once during a 12-month period by a supervisor.

Safety Monitoring: JCO assessment and monitoring of child safety is not limited to the IDA and TOP. JCS will also assess and monitor child safety through standardized policies and procedures, family engagement, supervision, collaboration and training.

Each district has a policy and procedure work group that periodically reviews JCS policy and procedure. This includes policies and procedures related to assessing and monitoring child safety. Currently, JCOs are required to provide a verbal report of any suspected child abuse to DHS within 24 hours, with a written report of the suspected abuse submitted to DHS within 48 hours. Districts also have written policies detailing the process for developing a safety plan when a JCO has determined a child's safety is at risk. Policy is aligned with the practice of 1) Respond 2) Report 3) Record and 4) Refer.[64]

JCS provides for flexible and authentic opportunities for family engagement, which allows the JCO to assess and monitor youth safety through observations of family dialogue and interactions. These opportunities include interactions with the family in the home, community and office settings.

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[62] Outcome Referrals. (2020). *Treatment Outcome Package*. http://www.outcomereferrals.com/main/sub-page/category/top-assessment/top-assessment
[63] IBID
[64] ACF. *Safety Plan*. https://training.cfsrportal.acf.hhs.gov/section-2-understanding-child-welfare-system/3016

For moderate and high-risk youth, JCOs provide intensive monitoring and supervision integrated with effective services and programs to ensure child safety. Monitoring and supervision include weekly in-person contacts with youth and their families in settings that include the office, school, home and the community. During these visits, JCOs utilize evidence-based approaches, such as Effective Practices in Community Supervision (EPICS) and Motivational Interviewing (MI), to conduct semi-structured open-ended interviews with youth and family members that assess potential and immediate potential threats to a child's safety.[65]

Individual districts also worked to establish partnerships that promote the sharing of information and resources. These relationships exist on multiple levels to promote child safety, and includes collaboration with:

- Community mental health providers to establish reliable and timely access to mental health and substance abuse treatment services. These relationships have created an advanced level of support for safety assessment of youth and have allowed some districts to provide on-site mental health services.
- Agencies who provide services, such as Functional Family Therapy (FFT), Multi-dimensional Family Therapy (MDFT), Multisystemic Therapy (MST) and Behavioral Health Intervention Services (BHIS).
- School districts to provide liaison services, which increases consistent monitoring and supervision and enhances the sharing of contemporaneous information relevant to assessing child safety.

JCS districts also employ a team approach to case-management, which allows JCOs to review cases with colleagues weekly and gather collateral information that allows for a more comprehensive safety assessment. District teams typically include a JCO supervisor, JCOs, a mental health provider and school liaisons.

To ensure that all JCOs have the knowledge necessary to identify certain types of safety threats to children, JCS requires all JCOs to participate in Mandatory Reporter Training. This training provides JCOs with the information necessary to recognize the categories and signs of child abuse and the knowledge needed to report suspected instances of child abuse. The Iowa Department of Human Services (DHS) provides the training and requires it every three years.

Safety Planning: To establish what constitutes a viable threat to child safety, JCOs evaluate the information from the IDA, TOP, prevention plan and other sources of information based on the following criteria:

- Potential to cause child serious harm and/or pain and suffering.

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[65] Pecora, P., Chahine, Z. Graham, J.C. (2013). *Safety and Risk Assessment Frameworks: Overview and Implications for Child Maltreatment Fatalities*. Child Welfare 92(2), 143-160.

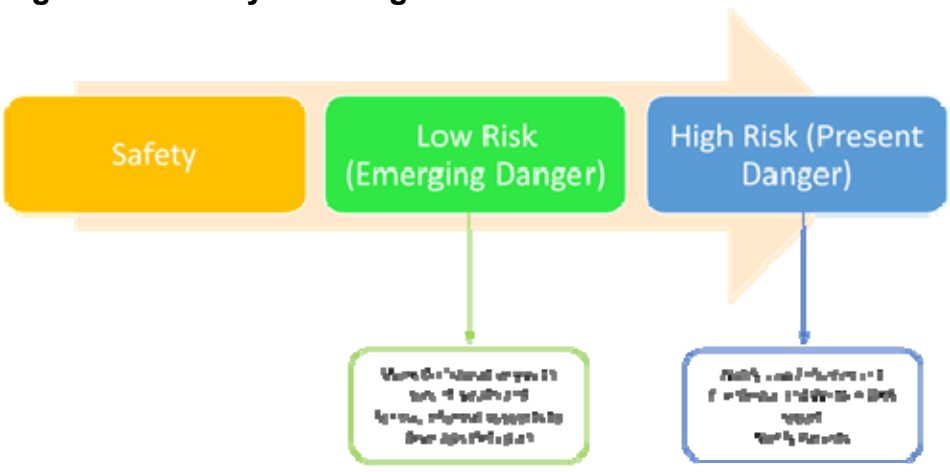
- Condition is clearly identifiable – specific and observable
- Situation is out of control and family has no mean to assume control
- Child is vulnerable – susceptible to danger and unable to protect self
- Danger is imminent – could happen at any time

JCS views child safety on a continuum ranging from safety to danger. At any time a JCO identifies a threat to a child's safety, the JCO will work collaboratively with the parent, child, and involved parties to determine the level of threat, low or high, which will dictate the course of action taken by the JCO.

A low-level threat is one in which serious harm to a child is not immediately present but may occur in the near future. JCS procedure in this category requires JCOs to work cooperatively with the parent, youth and formal/informal supports to develop a written safety plan. This safety plan identifies the services, actions, activities and responsible parties necessary to immediately control and mitigate any threats to child safety. The safety plan remains in effect for the duration that a threat to a child's safety exists and the family is unable to ensure the child's safety.

A high-level safety threat is a threat that presents the capacity for immediate and serious harm to a child. These threats require an immediate response by the JCO. This response, which is dependent upon each child's situation, may include contacting law enforcement, filing a verbal and written report with DHS, and notifying the parents/caregivers.

Figure B4. Safety Planning



Section II: Consultation and Coordination

The state must describe: 1) how it will consult with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services (including community-based organizations), in order to foster a continuum of care for children, parents and caregivers receiving prevention services; and 2) how the prevention services provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state title IV-B plan.

Consultation with State, Public and Private Agencies: Iowa's JCS employs the Systems of Care model to guide cross-system consultation and collaboration. The Systems of Care model is an approach to service delivery that creates collaborative relationships to develop a comprehensive process for addressing a family's complex needs. Research has shown that agency adoption of and adherence to its principles, which include cross agency cooperation; culturally competent, strength-based, and individualized care; family engagement; community-based services; and responsibility result in improved outcomes for children, youth, and families.[66] JCS engages in consultation with state, public and private agencies to achieve safety and permanency for children and improve agency efficiency, resources and opportunities.

JCS believes that an open and mutual exchange of information is integral to effective collaboration. Relationships must be mutually beneficial and built around common goals that motivate stakeholders to improve the assessment and delivery of individualized services for youth and families. This requires the development of trust and an effort to understand and consider the effects of any action taken on all involved parties.

To initiate the consultation process, JCS uses the strategic approach below:

- Define area of need
- Identify purpose of consultation
  - Outreach – provide information, exchange data, opinions and options
  - Information exchange
  - Recommendation – non-binding options that provide influential/expert advice
  - Agreement – reach a practical and feasible arrangement
  - Stakeholder action – empower stakeholders to act
- Based on purpose of consultation identify appropriate consultation model
  - Expert – evaluation of problem and technical assistance in identifying solution
  - Process –how to solve problem and system's role in problem

[66] Child Welfare Information Gateway (n.d.). *Systems of Care*. US Department of Health and Human Services.

    - Medical – interactive decision making focusing on primary intervention
    - Emergent – evolving process for discovery and shaping
- Identify and contact possible state, public and private agencies available and interested in consultation
- Utilize consultation to
    - Identify and clarify problem/issue
    - Recognize factors that influence change process
    - Review technical and structural factors connected to change
    - Collect data
    - Formulate, organize and present data
    - Identify interventions
    - Implement, monitor, assess and modify policies, procedures and/or services

The described consultation approach is inclusive of assessment, program formulation and development of recommendations. It ensures that a process of dialogue and measurement occurs that leads to decisions about comprehensive system improvement for JCS.

JCS has utilized all four models of consultation. JCS collaborated with national experts in the juvenile justice field:

- Dr. Edward Latessa, director and professor of the University of Cincinnati School of Criminal Justice;
- Dr. Robert Macy, founder and president of the International Trauma Center in Boston;
- Dr. Mark Lipsey, Research Professor at Vanderbilt Peabody College; and
- Diana Wavra, Orbis, consultant and trainer for evidence based services in juvenile justice to identify evidence-based services and programs best suited to the identified needs of Iowa's youth and families.

JCS also established consultative relationships with national and local higher learning institutes, e.g. the University of Cincinnati, Georgetown University, the University of Iowa and Iowa State University for the purpose of program evaluation and implementation of evidence-based practices. JCS sought consultation with nationally recognized agencies for system improvement guidance, which includes state and federal agencies, such as:

- the Iowa Department of Human Services (DHS),
- the National Center for State Courts (NCSC),
- the Council for State Governments (CSG),
- the Office of Juvenile Justice and Delinquency Prevention (OJJPD),
- the Center for Juvenile Justice Reform,
- the Iowa Criminal and Juvenile Justice Planning (CJJP),
- the Iowa Department of Education (DE),
- the Iowa Department of Labor and
- the Iowa Vocational Rehabilitation Services.

Individual districts also consult locally. These local collaborative partnerships include advisory groups, oversight committees, work groups and service provider meetings. The purpose of this local consultation is to assess goals, objectives, data and progress by establishing working relationships with individuals and agencies in the private sector. This learning collaborative approach allows JCS to adopt and adapt best practices across diverse settings and create changes in the agency that promote effective interventions and services. Organizations can learn from each other and experts in specific areas and collaborate on where and how to improve practice. Members of these consultation teams, which include attorneys, judges, faith-based organizations, school representatives, Native American tribe members, service providers and law enforcement, often assist JCS in closing the gap between what it knows and what it does.

Service Coordination: Under Title IV-B, subpart I and II, states may claim certain allowable expenses for youth identified as an eligible candidate for foster care. The purpose of Title IV-B, the Stephanie Tubbs Jones Child Welfare Service Program, is to promote state flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based organizations. Allowable expenses under Title IV-B, subpart I, are JCO case management services and contracted services, such as crisis intervention. The goal of Title IV-B, subpart II, is to promote safe and stable families through developing, expanding, and operating coordinated programs of community-based services for family preservation. Eligible expenses for Title IV-B, subpart II, include specific expenses related to family preservation, family reunification, community-based family support and administrative costs (maximum of 10% of total costs).

JCS will work collaboratively with DHS to develop a Memorandum of Understanding (MOU) detailing the responsibilities of JCS and DHS. This memorandum will outline the purpose of the MOU, each agency's role and responsibilities, financial and data sharing arrangements, reporting requirements, and time period.

Section III: Child Welfare Workforce

Support

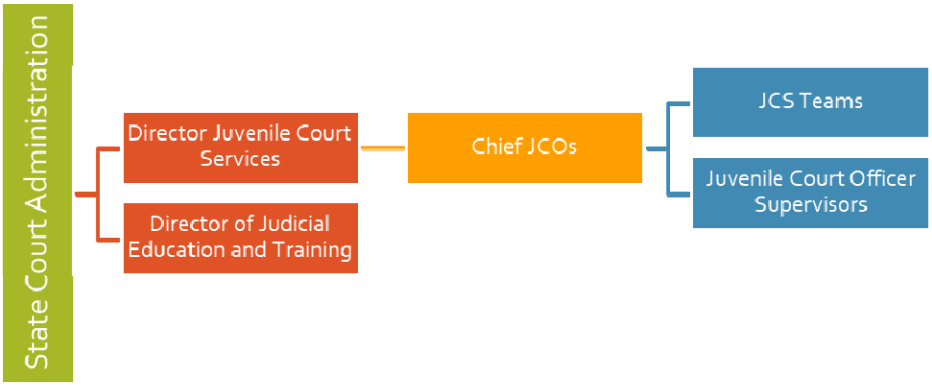
The state must describe the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including:

- *ensuring that staff is qualified to provide services that are consistent with the promising, supported, or well-supported practice models selected; and*
- *developing appropriate prevention plans and conducting risk assessments for children receiving prevention services.*

A. Assurance of Staff Qualifications:

Juvenile Court Services (JCS) Staff: Iowa's JCS structure provides assurance of staff qualifications, as well as support for JCS employees.

Figure B5. Juvenile Court Services (Structure)



JCOs play a critical role in the justice process and have a unique opportunity to intervene in a youth's life. Because of this, it is imperative that JCOs are properly trained and qualified.[67]

To increase assurance of staff qualifications, JCS has an intensive training process that requires completion of training requirements set by the Iowa Supreme Court. This includes 100 hours of mandated orientation the first year of employment and fifteen hours of mandated yearly continuing education units.[68]

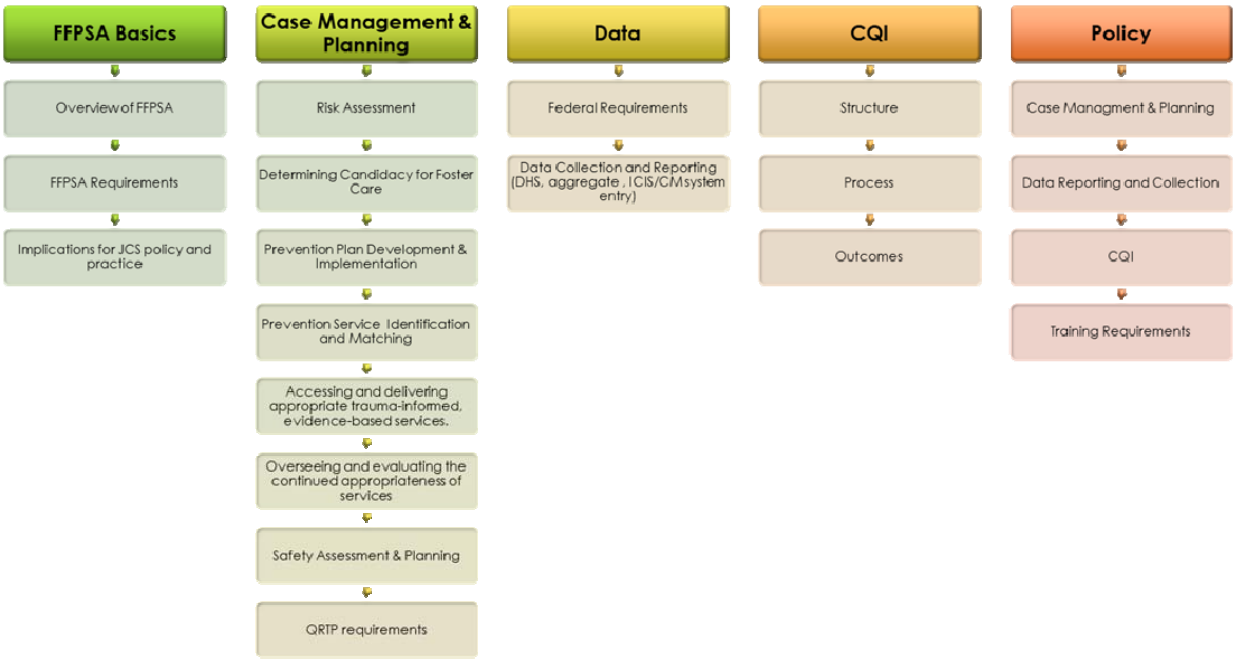
Because JCS recognizes the importance of highly qualified staff, it also provides additional training opportunities through seminars, professional conferences and in-house trainings. Recent training topics have included youth development, cultural diversity (Implicit Bias and Race the Power of Illusion), communication skills (Motivational Interviewing), assessment, safety planning, case management and supervision, ethics, resources and time management, substance abuse, human trafficking, gender differences, trauma, community supervision (EPICS), services and programming and family engagement. In addition, JCS collaborates with a variety of local agencies to provide training on specific topics, such as trauma, opioid addiction, and vaping. Individual training opportunities are also available through the Iowa Judicial Branch online learning management system "i-learn."

[67] Harvell, S. et al (2018). *Building Research and Practice in Juvenile Probation: Rethinking Strategies to Promote Long-term Change.* Urban Institute.
[68] Reddington, F. and Kreisel, B. (2000). *Training Juvenile Probation Officers: National Trends and Patterns.* Federal Probation 64(2).

JCS also employs annual performance reviews, based on competency, self-assessment, feedback and specifically identified criteria to ensure a highly qualified JCS staff.

JCS recognizes that there is a need to provide additional staff training to prepare JCS staff to implement Family First. In anticipation of this, JCS developed a training plan for staff to ensure they are qualified to implement properly all elements of Family First. Figure B5 provides an outline of the training plan elements (for detailed information, see Attachments B3 and B4).

Figure B6: Family First Training Plan for JCS



Service Provider Staff: Because JCS is committed to quality programming to youth and families, JCS monitors all service provider contracts for quality assurance and compliance. To ensure further that service provider staff are qualified to provide services/programs that are consistent with the promising, supported, or well-supported practice models selected, JCS will implement the following procedures:

- Service contracts will have a framework for accountability included in the contract language. This framework will include identification of service delivery outcomes (performance domains, indicators, and measures), defined responsibilities in the areas of monitoring and reporting outcomes, data collection, program evaluation and fidelity, and provider qualification and training.
- Service providers will submit quarterly compliance reports to ensure they are meeting the accountability standards outlined in the contract. These reports will include written verification regarding staff, who deliver the services, professional training and licensing, as required by the specific service.
- Contracts reviews at the district level will occur annually for compliance of these requirements.

- A district level Contract Administrator (CA) will conduct independent contract audits. The CA will be responsible for ensuring providers meet contract expectations and submit monthly outcome reports.

Quality assurance is not a method for assuring that something was done but rather a process of assuring that something was done well. To that end, JCS will use the Continue Quality Improvement (CQI) process for service planning, implementing, assessing, and adjusting. As part of this process, JCS will elicit youth and family feedback, engage in quarterly meetings with providers, assist with providing booster trainings (when financially feasible), peer to peer consultation and individual coaching.[69]

B. Prevention Plan Development: JCS utilized information from research, ACF technical bulletins, other state agencies and the Iowa Department of Human Services (DHS) to identify the key components and requirements of the prevention plan. An established workgroup met to develop the policies and procedures related to prevention plan development and implementation.

Because of the workgroup's efforts, JCS developed a child's Title IV-E Prevention Plan (Attachment B5). The JCO completes this prevention plan, a separate document from a child's case plan, following the JCO's completion of the Candidate for Foster Care Screening Tool. The prevention plan identifies the specific family and child strengths and needs and the child's criminogenic risk factors. The prevention plan requires JCOs to enter a prevention strategy, treatment objectives and appropriate service(s). It also instructs JCOs to enter the recipient(s) of the service(s) and dates of service(s), which includes initial start date and completion dates.

JCS requires a JCO to develop the prevention plan with input from the family and child. The JCO's supervisor will review and approve the prevention plan prior to implementation. The JCO will review prevention plans at six- and twelve-month intervals, or when a substantial change in family circumstance occurs.

Training and support for JCS staff, as it relates to the development of the Child Prevention Case Plan: Training for JCS staff, as it relates to the Child Prevention Case Plan (CPCP), was a multi-step process that involved the creation of specific FFPSA workgroups and the development of several new policies and a training plan (see Attachment B3). JCOs are also required to complete training on the Iowa Delinquency Assessment (IDA), which is the JCS risk assessment tool, prior to participating in any of the FFPSA trainings.

[69]Pennsylvania Juvenile Justice System (2019). *Continuous Quality Improvement (CQI) Sustainability Planning Guide.* Juvenile Justice System Enhancement Strategy.

All FFPSA related trainings went through a review and feedback process by DHS, the FFPSA training workgroup, Director of Juvenile Court Services (DCJS), Chief Juvenile Court Officers (CJCO), and the JCO IV supervisors prior to publication.

The training process began with introducing JCS staff to FFPSA through a web-based iSpring training that provided an overview of FFPSA. This 60-minute training provided JCS staff with a context for future learning related to FFPSA. JCS staff were required to pass successfully a short exam prior to advancing to the next FFPSA training.

Following the FFPSA introductory training, JCS staff were required to complete the Title IV-E Candidate for Foster Care Determination training. This web-based training introduced JCS staff to the structured process for determining if a youth is a Title IV-E eligible candidate. Using the iSpring interactive platform, the training provided JCS staff with instruction in the definition of candidacy and the methods of determining and documenting candidacy, in particular, the use of the JCS Candidate for Foster Care Screening Tool (CFST)(see Attachment B2).

Upon successful completion of the Title IV-E Candidate for Foster Care Determination Training, JCS staff received training on the process for developing the Child Prevention Case Plan (CPCP). In preparation for the CPCP training, JCS used FFPSA guidance to develop a CPCP policy and a FFPSA specific CPCP form. Using this policy and form, JCS created a web-based training for JCS staff.

The learning objectives for the CPCP training are on the JCS FFPSA training plan (see Attachment B3). The training, which is an interactive iSpring training, consists of two modules. Module one introduces JCS staff to the CPCP and summarizes its purpose, requirements, and key components. Module two utilizes an interactive case scenario to guide JCS staff through actually completing each section of the CPCP sections (see Attachment B5) from start to finish in real-time. JCS staff are required to pass a short exam at the conclusion of the training to verify successful completion of the training.

Prior to the CPCP training, JCS staff received training support materials to complement CPCP instruction. These materials included the CPCP policy document (see Attachment B6), a hard copy of the CPCP form (see Attachment B5), a PDF training handout with accompanying notes, and a CPCP desk reference. In addition to these resources, JCS assigned a Point of Contact (POC) to each district's office. This POC is responsible for providing coaching and aggregating and fielding questions related to the CPCP training. Questions from all districts were compiled and put into a Q & A document that will be updated regularly and stored on the Judicial Branch's (JB) SharePoint file; so JCS staff has access when needed. In addition, the CPCP training is accessible on the JB SharePoint.

All future JCS staff will be required to complete the CPCP training, as part of their orientation. In addition, JCS will offer a refresher training for those who require it or

at any time changes need to be made to the process. JCS staff will also be required to complete a safety training upon completion of the CPCP training. This safety training introduces JCS staff to the components of formal safety assessment and planning and provides instruction and guidance for JCS staff in the practical skills and knowledge required to complete safety assessments and plans for youth and their families.

Training

The state must describe how it will provide training and support for caseworkers in assessing what children and their families need; connecting to the families served; knowing how to access and deliver the needed trauma-informed and evidence-based services; and overseeing and evaluating the continuing appropriateness of the services.

To ensure families receive quality treatment and supervision, JCS is committed to providing the training needed to retain a highly skilled and competent workforce. JCS recognizes the passage of the Family First Prevention Services Act (Family First) will create changes in the Juvenile Justice System. These changes necessitate the development and implementation of a workforce-training plan to ensure all JCS staff have the knowledge and skills required to incorporate successfully Family First policies into daily practices.

To assist in the training process, the Director of Juvenile Court services and Chief Juvenile Court Officers (CJCOs) created Family First implementation teams. These teams were tasked with assisting with the development and implementation of training related to Family First in six areas, Family First basics, case planning and management, data, CQI, youth and family needs, and policy. JCS will implement training in these areas with a phased approach (see Attachment B4). Phase one of the training will focus on providing JCS staff a context for learning through an overview of Family First and its requirements. This phase of training will cover case planning and management related to Family First requirements, inclusive of risk/needs assessment, candidacy determination screening tool, prevention plan development and implementation, identification, matching, monitoring and evaluation of services and family needs/safety assessment planning.

Phase two of training will introduce JCS staff to the data required for Family First. This will include data collection, reporting, entry and RMS. Phase three of training will focus on youth and family needs and address topics, such as trauma informed care, child development, cultural diversity and family engagement. Phase four of training will center on training specific JCS staff in the Continuous Quality Improvement (CQI) process. The final phase of training, phase five, will train staff on policy changes related to Family First. This phase will serve to bring all the components related to Family First together in a comprehensive manner.

JCS will utilize a blended learning approach throughout the trainings. This approach will include direct and on-line instruction, discussion, demonstration, and collaborative learning.

JCS will also continue to provide ongoing training opportunities for staff in family engagement, accessing and delivering trauma informed services and evidence-based practices. The Director of Juvenile Court Services and CJCOS will work collaboratively with the Judicial Branch Director of Education and Training in identifying future statewide and individual district training needs. JCS will elicit additional input on training needs on the local level through feedback from JCS staff, youths and families and service providers.

Training and Support for JCS staff, as it relates to overseeing and evaluating the continuing appropriateness of services: Training and support for JCS in the area of overseeing and evaluating the continuing appropriateness of services developed in the same manner as the CPCP training described above.

JCS developed a policy outlining the procedures for identifying, accessing, monitoring, and assessing prevention services (see Attachment B6). JCS utilized this policy, along with guidance from relevant research, to develop a web-based iSpring training that introduced JCS staff to what an FFPSA prevention service is and provided JCS staff with instruction and guidance on the process and tools for overseeing and evaluating these services. Instruction included program monitoring and evaluation using the use of the Iowa Delinquency Risk Assessment (IDA); screening tools; parent, child, and service provider input; collateral contact information; and quality, frequency, intensity, and availability of service. In addition, the training, which contained an interactive case-scenario, provided JCS staff with timeframes for evaluation and courses of action for services deemed ineffective.

Support for JCS staff included training support materials to complement instruction. These materials include the policy document (see Attachment B6) and a PDF training handout with accompanying notes. In addition to these resources, JCS assigned a Point of Contact (POC) to each district's office. This POC is responsible for providing coaching and aggregating and fielding questions related to the training. Questions from all districts were compiled and put into a Q & A document that will be updated regularly and stored on the Judicial Branch's (JB) SharePoint file for JCS staff to access as needed. In addition, the training was also accessible on the JB SharePoint.

To complement this training, JCS staff will also be required to complete a training on Continuous Quality Improvement (CQI). This training will introduce them to program evaluation and familiarize them with the process and outcome measures associated with specific prevention services.

All future JCS staff will be required to complete these trainings as part of their orientation. In addition, a refresher training will be offered for those who require it or at any time changes occur to the process.

Prevention Caseloads

The state must describe how the caseload size and type for prevention caseworkers will be determined, managed, and overseen.

Currently JCS does not have an established client to JCO ratio. Because JCOs handle a variety of case types that fall on a continuum of court involvement, supervision and service needs, typical staffing formulas based solely on case counts are not able to differentiate the amount of time needed to manage cases. Due to JCOs' need to provide varying amounts of supervision to be effective and efficient, their practice lacks the consistency needed to establish workload standards for JCOs. In addition, caseloads vary significantly between urban and rural areas, with rural areas often having larger coverage areas and higher travel time requirements.[70]

Iowa currently has 193 JCO positions. These positions are responsible for a continuum of cases that range from intake to formal probation and adult waivers. When considering the youth on informal probation, formal probation, consent decrees and adult waivers, JCOs managed 5,156 cases in 2017. This produced a caseload ratio of 26.7 youth to 1 JCO.[71] This is lower than the President's Commission on Law Enforcement and Administration of Justice recommended caseload of 35 clients per JCO[72] and the national average caseload of 40 to 1.[73]

JCS will utilize the Iowa Court Information System to monitor and evaluate time spent on Title IV-E activities to determine if prevention caseloads will need adjusting in the future.

Attachments

- Attachment B1: Iowa Delinquency Assessment (IDA)
- Attachment B2: IV-E Candidacy for Foster Care Screening Tool (CFST)
- Attachment B3: JCS Training Plan
- Attachment B4: JCS Training Summary
- Attachment B5: Child Prevention Case Plan (CPCP)
- Attachment B6: CPCP Policy Document

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[70] Moran, B. (2013). *Juvenile Court Officers Perceptions of Innovation Adoption.* University of Nebraska
[71] CJJP, 2017. *State of Iowa Juvenile Delinquency Annual Statistical Report*. https://humanrights.iowa.gov/sites/default/files/media/2017%20State%20Annual%20Report%20for%20JCS.pdf
[72] Bilchik, S. (1999). *Workload Measurement for Juvenile Justice System Personnel: Practices and Needs*. US Department of Justice
[73] Torbet McFall, P. (1996). *Juvenile Probation: The Workhorse of the Juvenile Justice System*. US Department of Justice.

PART C: PLAN ASSURANCES AND ATTACHMENTS

Assurance on Prevention Program Reporting

The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).

The Director of Juvenile Court Services and the Chief Juvenile Court Officers (CJCOs) will work collaboratively with DHS to identify all required reporting elements and timeframes for the submission of data to DHS. JCS will then utilize the Iowa Court Information System (ICIS) as the mechanism for collecting data. JSC already began the work to identify data collection points in the system and to build the Candidate for Foster Care Screening Tool and Prevention Plan into the case management system. JCS will work with the Criminal and Juvenile Justice Planning (CJJP) agency to aggregate and analyze data and develop a mechanism for reporting data in timely fashion to DHS.

Assurance of Trauma-Informed Service-Delivery

An assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program)

Attachments III (a), (b), and (c)

Attachments

- Attachment B: Plan Submission Certification

- Attachment I: State title IV-E prevention program reporting assurance
- Attachment II:
  - (a) State request for waiver of evaluation requirement for a well-supported practice - Functional Family Therapy (FFT)
  - (b) State request for waiver of evaluation requirement for a well-supported practice - Multisystemic Therapy (MST)
- Attachment III
  - (a): State assurance of trauma-informed service-delivery – SafeCare®
  - (b) State assurance of trauma-informed service-delivery - Functional Family Therapy (FFT)
  - (c) State assurance of trauma-informed service-delivery - Multisystemic Therapy (MST)

- Attachment IV: State annual maintenance of effort (MOE) report