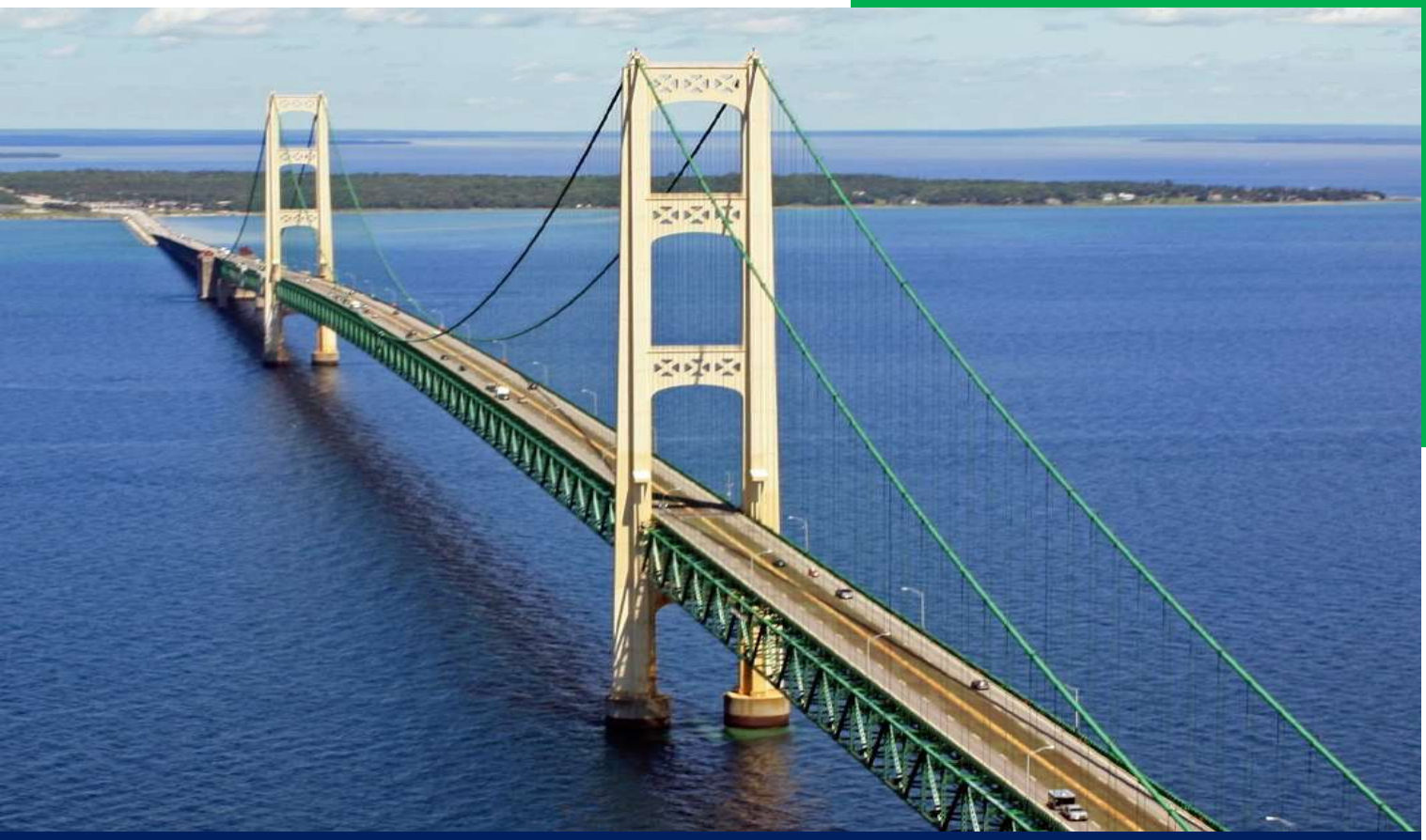
MDHHS

Michigan Department of Health & Human Services

2021-2026



Michigan Title IV-E Prevention Plan

Submission August 2021

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Section I: Introduction

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

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

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

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

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

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

Overview of System Transformation Efforts

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

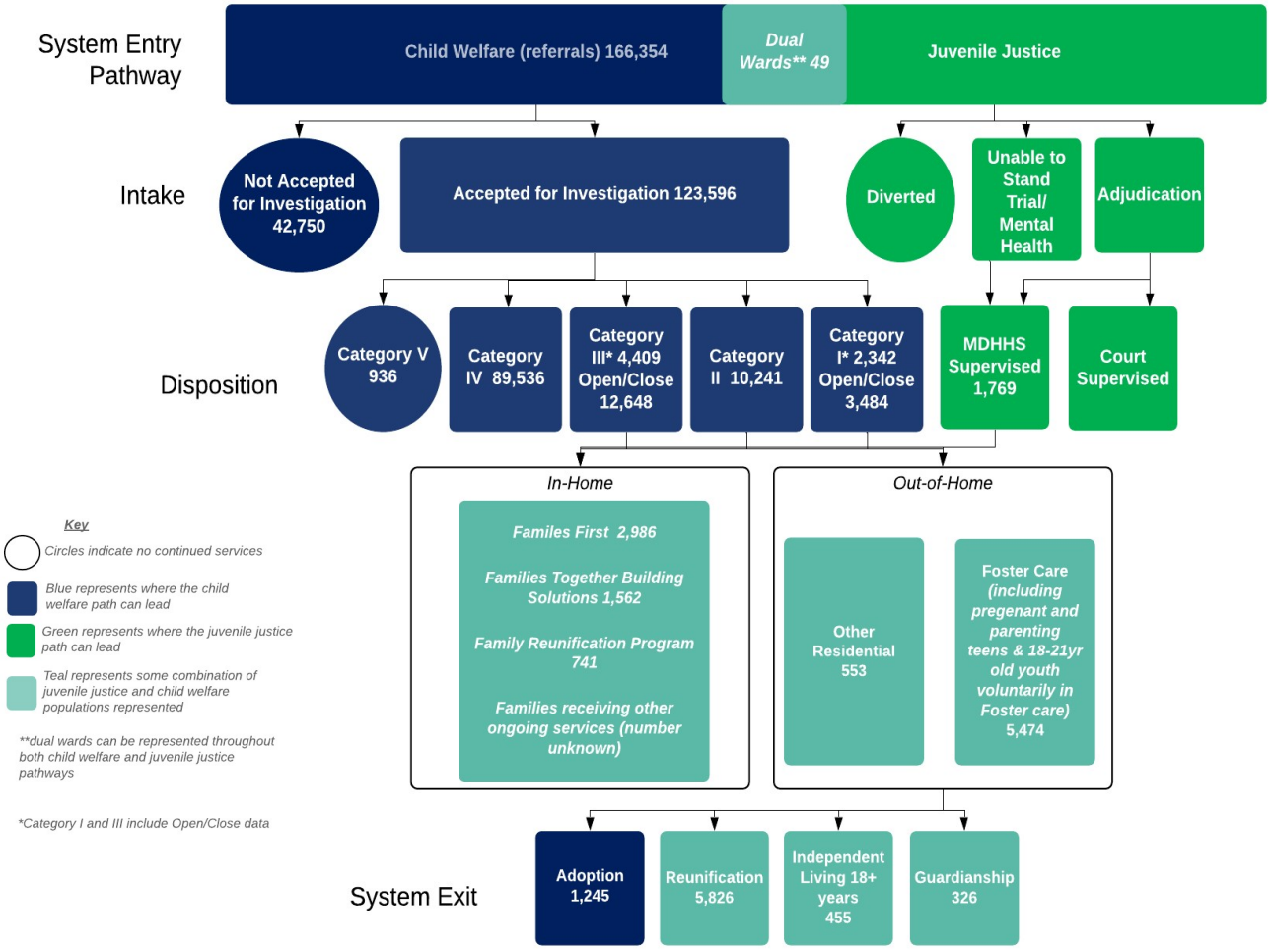
This shift in approach will require increased funds to prevent abuse/neglect and preserve families. Historically, Michigan has spent disproportionately more on removal and placement of children into foster care compared with funds spent on prevention services for families to keep children safe at home.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

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

Figure 1. Outcome Measures FY2019 and FY2020

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

Figure 2. Child Welfare and Juvenile Justice Pathways FY2018



By fiscal year 2023, MDHHS aims to 1) significantly reduce the number of children who experience abuse/neglect and 2) reduce the foster care population. To achieve these targets, Michigan plans to implement strategies to reduce entry into care as well as strategies to speed time to reunification. Strategies implemented will include high quality assessments and service linkages to strengthen families and only leverage foster care when it is necessary. For a comprehensive overview of the department's current initiatives, please see Appendix A. Following are five notable strategies planned or underway.

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

1. Front End System Redesign

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

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

While a final tool is expected in the spring of 2022, full implementation of the tool, including tool automation and training, is expected by January 2023.

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

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

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

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

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

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

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

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

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

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

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

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

Evidence-Based Home Visiting (EBHV)

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

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

3. Assessing Families First of Michigan and HOMEBUILDERS

In 2019, MDHHS devoted fifteen million dollars (TANF) to its Families First of Michigan (FFM) preservation contracted services, serving approximately 3,000 families at intensive risk of removal in all 83 counties. The program was designed after, but does not fully adhere to, the HOMEBUILDERS model (outlined further in Section III). MDHHS completed a comprehensive comparison of the two models to determine the current gaps in programming. MDHHS is testing implementation of the HOMEBUILDERS model (as approved in the Title IV-E Clearinghouse) in seven counties and will compare outcomes between Families First of Michigan and HOMEBUILDERS to determine if the HOMEBUILDERS model will replace Families First of Michigan over a period of time. Michigan will only claim for title IV-E prevention for those HOMEBUILDERS programs fully implemented within the standards of the Title IV-E Prevention Services Clearinghouse.

4. Overhaul Training and Workforce Supports

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

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

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

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

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

5. Incorporating the Use of Evidence-Based Risk Assessment

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

Partnership with Tribal Representatives

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

Stakeholder Engagement

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

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

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

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

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

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

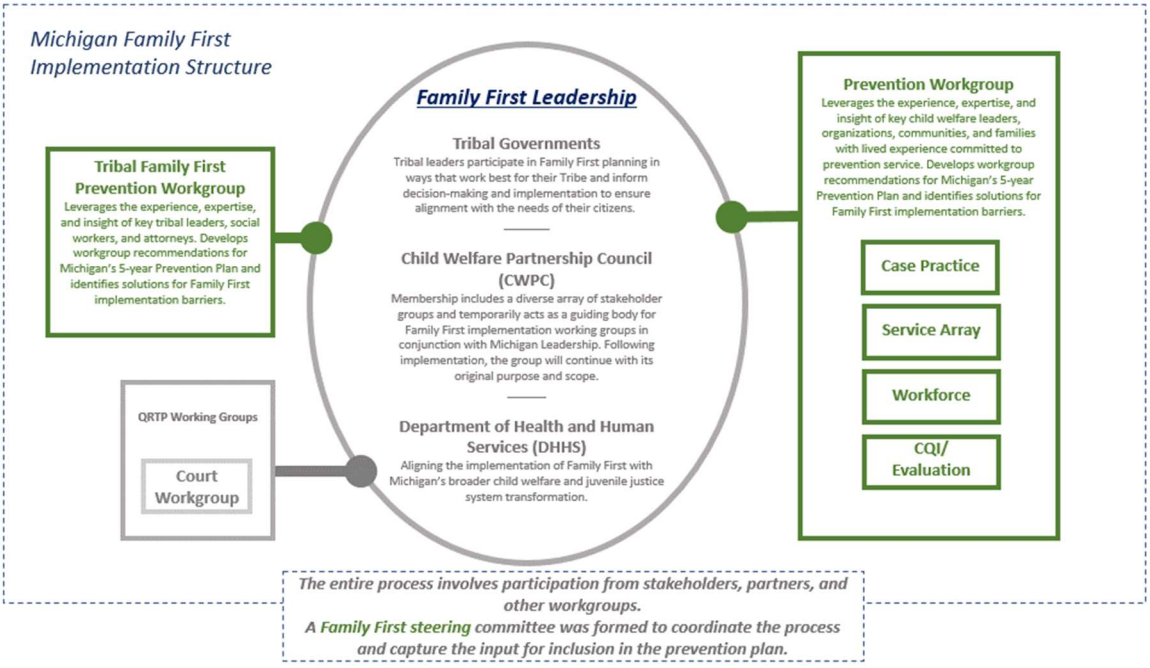
Michigan's commitment to build a system that identifies and connects families to the supports and services to strengthen and thus prevent unnecessary involvement with the child welfare agency is evident in its collaboration with valued community stakeholders. This commitment embeds concrete efforts to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

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

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

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

Figure 3. Family First Governance Structure



Section II: Eligibility and Candidacy Identification

Pre-print section 9

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

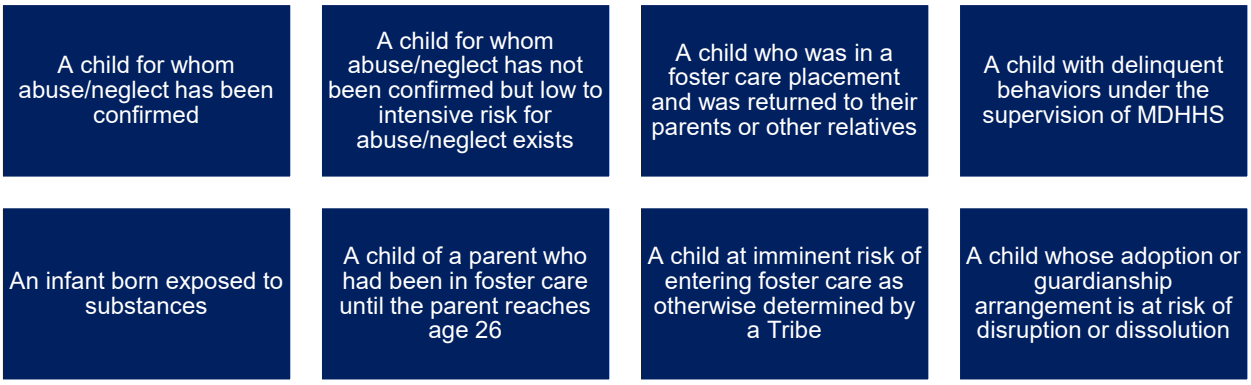
- *A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1).*
- *A child in foster care who is pregnant or parenting.*

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

Prevention Candidate Definition

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

Figure 4. Family First candidacy populations



Eligibility determinations for title IV-E prevention services will be made by employees of MDHHS; or employees of another public agency that has entered into a title IV-E agreement with MDHHS to determine eligibility for title IV-E prevention services.

Candidacy Eligibility Determination and Documentation

A child for whom abuse/neglect has been confirmed

A MDHHS caseworker will determine eligibility for a child for whom abuse/neglect has been confirmed and any siblings at least partially residing in the household. The child is eligible if there is a preponderance of evidence of abuse or neglect, and the child remains in the home. This eligibility determination will be documented in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS) prior to transferring the case to a caseworker who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process). A child will remain an eligible candidate for 12 months from the date CPS closed the case.

A strength-based collaborative Family Team Meeting (FTM), or similar meeting, will be held as part of the case transfer process from the investigative to the in-home services caseworker involved in developing the child-specific prevention plan (meeting inclusive of family members, familial or community supports, representatives from the child's tribe, investigative and in-home services caseworkers.) In-home service provision includes formal and informal risk assessments within the first 60 days and every 90 days thereafter utilizing the Family Needs and Strengths Assessment (FANS) and Child Needs and Strengths Assessment (CANS) tools along with SDM safety assessment tools. The assigned caseworker is responsible to ensure coordination of services when multiple evidence-based programs are being provided to a family. FTMs or a similar meeting will be utilized to engage the family in ongoing safety planning and service planning.

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

A MDHHS caseworker will determine eligibility for a child and any siblings residing in the same household, or in the partial care or custody of a parent to a child that is a candidate for foster care, using the SDM risk assessment. The child is eligible if the investigation is denied, and the risk assessment yields a score of low to intensive. If MDHHS closed the case upon conclusion of the disposition and the family declined to participate in services, a child will remain an eligible candidate for 12 months from the most recent investigation disposition date. Although Michigan does not assign a caseworker if abuse/neglect was not confirmed, MDHHS plans to pilot programs to expand involvement with community partners and evidence-based home visiting providers to provide title IV-E prevention services to those families that may need services to reduce the risk of a child entering foster care. The eligibility determination

will be documented in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS). Case oversight will be provided by an MDHHS caseworker or evidence-based home visiting provider who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process). These services are voluntary and will be coordinated in partnership with the family.

If a family would like to participate in services, a strength-based collaborative FTM, or similar meeting will be held and will involve the development of the initial child-specific prevention plan (meeting inclusive of family members, familial or community supports, representatives from the child's tribe, investigative and prevention caseworkers.). The caseworker will meet with the family within seven to 14 calendar days to complete an assessment utilizing the FANS and CANS and engage the family in identifying a service that best meets identified needs.

MDHHS will conduct a pilot in counties implementing the first expansion of evidence-based home visiting programs utilizing the home visiting provider as the entity providing on-going monitoring of the child-specific prevention plan. In pilot counties, a MDHHS prevention worker will be the primary worker for the initial 30 days of opening a prevention case. Once the family has engaged/enrolled with the home vising provider, the prevention worker will function as a prevention monitor maintaining monthly contact with the home visiting provider. The assigned home visiting provider will be the primary entity responsible for ongoing work with the family utilizing program specific tools to monitor risk and safety and the child-specific prevention plan.

Infant born exposed to substances

An infant is defined as a baby from birth through 12 months of age. For purposes of IV-E prevention, MDHHS defines born exposed to substances as an infant testing positive through a testing procedure; experiencing withdrawals; a parent receiving medically assisted treatment for substance use; or parental self-report of substance use during pregnancy anytime through the infant's 12 month of age. An infant will remain an eligible candidate through 12 months of age.

An infant born exposed to substances may come to the attention of MDHHS when exposure to substances and other risk factors exist and may be determined eligible based on the above pathways of confirmed abuse/neglect or at risk of abuse/neglect. However, Michigan intends to expand their prevention services to a broader array of families than just those who come to the attention of the department. MDHHS plans to engage hospitals and community partners in the identification of a child who is at risk of entering foster care due to being born substance exposed without additional risk factors but may not yet meet the requirements to make a report to Centralized Intake. Peer

Service Navigators will be established to liaise with the family, hospital or other community partners, and a caseworker determining candidacy eligibility at MDHHS to assess need, determine eligibility, and arrange service delivery. This coordinated effort will start as pilot programs with prioritization given to urban and rural areas based on prevalence of need using data analyses with intentional leveraging of existing home-visiting partnerships and the medical community. MDHHS will conduct a pilot in counties implementing this expansion effort of evidence-based home visiting programs utilizing the home visiting provider as the entity providing on-going monitoring of the child-specific prevention plan. In pilot counties, Peer Service Navigators, Centralized Intake or the MDHHS CPS caseworker will transfer an eligible family to a prevention worker or CPS ongoing caseworker for initial eligibility determination and development of the initial child-specific prevention plan. If a family is not currently enrolled in an eligible IV-E home visiting program, the assigned caseworker will meet with the family within seven to 14 calendar days to complete an assessment utilizing the FANS and CANS and engage the family in identifying the home visiting service that best meets identified needs. If a family identifies an IV-E funded home visiting program, the prevention worker will assist the family with engaging with the home visiting program. Once the family has engaged with the home visiting provider, the assigned worker will function as a prevention monitor maintaining monthly contact with the home visiting provider. If a family is enrolled in an eligible IV-E home visiting program, MDHHS will determine eligibility and assign a MDHHS caseworker as a monitor. The assigned home visiting provider will be the primary entity responsible for ongoing work with the family utilizing program specific tools to monitor risk and safety and updating the child-specific prevention plan.

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

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

relative, the caseworker will document the IV-E eligibility in MiSACWIS. A private agency will route the prevention eligibility record to MDHHS for approval.

A family team meeting (FTM), or similar meeting is held prior to a child's return home to identify necessary supports and coordinate service delivery. FTMs include the family, their identified formal and informal supports, members of the judicial community including parent and child attorneys, tribal community, and agency caseworkers. The FTM participants collaborate in a proactive, strength-based, solution-focused approach to develop a thorough reunification plan that supports successful reunification. The caseworker explores service availability utilizing the Evidence-Based Practice (EBP) selection document (to be developed) that would best meet the family's needs. After developing the child-specific prevention plan with the family, the caseworker (public or private) will document the plan, make any necessary service referrals, and provide ongoing case management to monitor the child's safety and the family's benefit from referred services until case closure. A child will remain an eligible candidate for 12 months from the date the foster care case closed.

A child with delinquent behaviors under the supervision of MDHHS

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

The Juvenile Justice specialist will conduct a FTM with the family, youth, and service providers to identify needs and services to meet identified needs. The meeting participants collaborate in a proactive, strength-based, solution-focused approach to develop a thorough plan so the child can remain in the community safely with the prevention services in place. The assigned Juvenile Justice specialist will provide the coordination across community agencies when a family is receiving more than one evidence-based intervention.

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

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

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

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

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

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

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

This is a new pathway for MDHHS and will phase in this group of candidates in year three and four. This will allow MDHHS sufficient time to build staffing and capacity to serve this population. Initial planning includes utilizing a prevention caseworker, where available, to conduct and document initial eligibility determinations. MDHHS will also explore utilizing the Michigan Youth Opportunities Initiative (MYOI) worker as an option to complete initial eligibility determinations. Depending on the county and the available number of MYOI coordinators and assigned responsibilities, MYOI currently provides support and coordination of service delivery for youth in out-of-home care and young adults that have exited custody of MDHHS. Through their current supportive role to exited care youth and their children, the MYOI caseworker will assist in identifying youth meeting this eligibility criteria. When a youth previously in foster care is identified as pregnant or parenting, the MYOI caseworker will assess need and determine candidacy eligibility. In areas where there is an available prevention worker, the MYOI caseworker will initiate a meeting with the prevention worker and youth to develop the child-specific prevention plan and refer families to home visiting service or another eligible evidence-based program. Documentation of candidacy determination, prevention plan, service delivery, and ongoing monitoring will be documented in MiSACWIS by the prevention caseworker, where available. Once the youth is engaged with an eligible home visiting provider, the prevention worker will become a prevention monitor maintaining contact with the home visiting provider. Referrals to the prevention worker for parents up to age 26 could include MYOI caseworkers, Youth in Transition workers or other community organizations such as churches, providers, or others working with these parents within the community. During initial implementation of the prevention plan, MDHHS will evaluate current caseworker activities to assess feasibility of MYOI caseworkers functioning in this capacity.

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

A representative from the child's Tribe will document a candidacy recommendation for a child and any siblings residing in the same household or in the partial care or custody of a parent to a child that is a *candidate for foster care* if there is any risk of abuse or neglect, regardless if there was confirmed abuse/neglect. If MDHHS or the Tribe closed the case upon conclusion of the disposition and the family declined to participate in

services, a child will remain an eligible candidate for 12 months from the most recent investigation disposition date. When a tribe identifies that a child is a *candidate for foster care*, the tribe will provide MDHHS with documentation that will include the following: a recommendation that an Indian child as defined by the ICWA/MIFPA is at imminent risk of removal and identification of the candidate type and supporting documentation for the corresponding candidate type. The documentation will also identify if the tribe has a Title IV-E Prevention Agreement with the State and if the Tribe will be managing the case. This recommendation will be determined based on the laws and customs of the tribe.

A Tribe's candidate recommendation will be reviewed and confirmed by MDHHS to determine IV-E eligibility and the determination will be documented and approved in a prevention record in the Michigan Statewide Automated Child Welfare Information System (MiSACWIS). MDHHS will notify the Tribe of approved eligibility determination prior to transferring the case to a caseworker who will be responsible for developing the child-specific prevention plan (see Section IV for more detail on the child-specific prevention plan development and process).

Ongoing Assessments and Redetermination

MDHHS or a Child Placing Agency caseworker providing case management to an eligible candidate for foster care or a pregnant or parenting youth in foster care will follow current policy regarding use of assessment tools including risk, safety and strengths and needs for ongoing monitoring. Prevention plan requirements are included within the child's case plan and will be reviewed and updated according to current policy expectations.

When evidence-based home visiting program or other approved contracted community service is providing ongoing oversight, program specific assessment tools and timeframes will be utilized to monitor ongoing risk and safety and update the prevention plan, as needed.

When a Tribal government with a Title IV-E agreement with MDHHS is providing oversight, the caseworker will utilize MDHHS assessment tools including risk and safety for ongoing monitoring. Tribal governments are currently collaborating with MDHHS on the revision of the state's SDM Risk and Safety assessment tools.

Prevention services will be authorized for the expected length of the intervention or 12 months, whichever is less. If services are expected to exceed the 12-month allotment, a child will be reassessed for candidate eligibility status at the end of each 12-month prevention episode utilizing the processes and tools outlined above. MDHHS will review and determine eligibility for all redetermination requests. A new child specific prevention plan is developed to document new candidate determination and need for continued evidence-based prevention services. For children and families identified by a Tribe at the end of the 12-month period, the Tribe will submit to MDHHS for confirmation

and approval an updated attestation recommendation for an extension of services if the Tribe determines the child to need the prevention services.

Identifying Pregnant or Parenting Foster Youth

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

When caseworkers identify that a youth in foster care is pregnant or parenting, they capture this information in MiSACWIS. This includes youth in young adult voluntary foster care (YAVFC) and youth who are expecting a child with another person when they are believed to be the biological parent of the expected child as eligible for IV-E prevention services. A CANS assessment is completed with the youth that includes parenting skills to identify needs and service linkage. This assessment occurs no later than 30 days after placement in out of home care or no later than 30 days after the caseworker learns that the youth is pregnant or parenting. The CANS assessment is completed at 90-day intervals to assess progress and tailor service delivery. The agency is considering the utilization of the FANS to support enhanced service need identification related to parenting skills to ensure the most appropriate service linkage to IV-E prevention services.

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

Figure 5. Case Practice Pathways for Family First

Investigative Caseworker	Juvenile Justice Specialist	MDHHS Caseworker/ Prevention Worker	Tribes	Post Adoption Resource Center	Peer Service Navigator	Child-Placing Agency
Determine eligibility using SDM Safety and risk assessments.	Determine eligibility using the MJJAS.	Determine eligibility using SDM Safety and Risk assessments & CANS/FANS.	Recommends eligible candidates to MDHHS using attestation and supporting documents. MDHHS reviews, confirms, and approves candidacy recommendation.	Recommends eligible candidates to MDHHS using Family Centered Plan. MDHHS reviews and approves candidacy recommendation.	Recommends eligible candidates to MDHHS. MDHHS reviews and approves candidacy recommendation.	Recommends eligible candidates to MDHHS using SDM safety assessment, FANS & CANS. MDHHS reviews and approves candidacy recommendation.
Transfer to ongoing caseworker.	Develop child-specific prevention plan.	Develop child-specific prevention plan.	May develop child-specific prevention plan.	Develop child-specific prevention plan.	May develop child-specific prevention plan.	Develop child-specific prevention plan.
For the following populations:	**For the following populations:**	**For the following populations:**	**For the following populations:**	**For the following populations:**	**For the following populations:**	**For the following populations:**
A child for whom abuse/neglect has been confirmed A child for whom abuse/neglect has not been confirmed but low to intensive risk for maltreatment exists Infant born exposed to substances A child whose adoption or guardianship arrangement is at risk of disruption or dissolution	A child with delinquent behaviors under supervision of MDHHS	Multiple candidacy populations from different pathways A child of a parent who had been in foster care until the age of 26	A child determined to be at imminent risk of entering foster care as otherwise identified by a Tribe	A child whose adoption or guardianship arrangement is at risk of disruption or dissolution	Infant born exposed to substances that does not meet assignment criteria for CPS involvement	A who is in foster care and pregnant or parenting A child who was in foster care and returned to their parents or other relative
Transfer to ongoing caseworker for ongoing monitoring.	Monitors ongoing risk and safety of the population identified above.	Monitors ongoing risk and safety of the population identified above, those identified by the CPS investigator, and/or oversees EBP or Contracted providers providing ongoing risk and safety assessments.	May monitor ongoing risk and safety of the population identified above.	Monitors ongoing risk and safety of the population identified above.	Connect to MDHHS and home-visiting provider for development of prevention plan and ongoing monitoring of risk and safety.	Monitors ongoing risk and safety of the population identified above.

Section III: Title IV-E Prevention Services

Pre-print Section 1

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

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

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

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

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

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

Sobriety Treatment & Recovery Team

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

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

Substance Use Disorder Family Support Program (SUDFSP)

MDHHS intends to utilize state funds to implement the SUDFSP and request IV-E reimbursement for the motivational interviewing intervention components. SUDFSP provides home based assessment, treatment, and recovery intervention for individuals with substance use and co-occurring mental health disorders, and their families. The goals of the program include:

- Increase child safety and permanency.
- Increase adult well-being.

Components of the program include:

- Assessment and written treatment plan in consultation with the family.
- Use of evidence-based interventions such as motivational interviewing and cognitive behavior therapy.
- Increase awareness of the impact the substance has on parenting.
- Psychoeducation on substance use as it relates to the brain and trauma.
- Relapse prevention strategies.
- Stages of Change.
- Recovery planning.
- Connection to additional resources.

Motivational Interviewing (MI) – is used in the SUDFSP. Motivational Interviewing (MI) is an evidence-based, client-centered method designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through the stages of change. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. During interactions with families, the SUDFSP program uses MI to help clients identify reasons to change their behavior and reinforce that behavior change is possible. MI has been shown to be an effective intervention when used by itself or together with a combination of other treatments to reduce risk of maltreatment and placement into out of home care. Numerous studies and evidence support the conclusion of Motivational Interviewing (MI) as a well-supported evidence-based service.

Family First Prevention Service Array Overview

Table 1. Manual version for MDHHS Prevention Evidence Based Practices	
Nurse-Family Partnership (NFP)	Nurse Family Partnership. (2020). *Visit-to-visit guidelines*.
Parents as Teachers (PAT)	Parents as Teachers National Center, Inc. (2016). *Foundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.*
Healthy Families America (HFA)	Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America. Healthy Families America. (2018). *State/multi-site system central administration standards*. Prevent Child Abuse America.
HOMEBUILDERS	Kinney, J., Haapala, D.A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.
SafeCare	Lutzker, J.R. (2016)/ *Provider Manual*, version 4.1.1.
Multi-Systemic Therapy (MST)	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press.
Brief Strategic Family Therapy (BSFT)	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse.
Motivational Interviewing	Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents.* Guilford Press. Judith A. Cohen, Anthony P. Mannarino, Esther Deblinger, second edition (2017) *Treating Trauma and Traumatic Grief in Children and Adolescents (Second Edition)* The Guilford Press, New York, NY 10001 MDHHS will be implementing the program/service as approved by the Clearinghouse, and the developer of the title IV-E prevention program has updated the book/manual that was reviewed and approved by the Clearinghouse when it assigned the rating. MDHHS does not intend to claim for group applications of TF-CBT as included in the section edition of the manual.
Family Spirit	The Family Spirit® Implementation Guide is implemented in conjunction with the Lesson Plans: *Family Spirit Program: Implementation guide.* (2019). Johns Hopkins Center for American Indian Health. *Family Spirit Program: Lesson plans.* (2019). Johns Hopkins Center for American Indian Health.

 Parenting

 Mental Health

 Substance-use Disorder

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

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

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
Nurse-Family Partnership (NFP)	Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother. NFP aims for 60 visits that last 60-75 minutes each in the home or a location of the mother's choosing. For the first month after enrollment, visits occur weekly. Then, they are held bi-weekly or on an as-needed basis.	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service: • **Child safety** *Relevant measures to be collected:* ○ Rate of injury-related visits to the Emergency Department (ED) since enrollment among children enrolled in home visiting ○ Percent of children enrolled in home visiting with at least 1 investigated case of maltreatment following enrollment within the reporting period • **Adult well-being: Economic and housing stability** *Relevant measures to be collected:* ○ Adult participants by education attainment ○ Adult participant by employment status ○ Household income in relation to federal poverty guidelines These select distal outcomes are identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for NFP. MDHHS will be integrating these outcomes and measures into ongoing CQI activities.	Nurse Family Partnership (NFP) is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. MDHHS intends to utilize NFP to support its target population of pregnant and parenting youth in foster care.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			Furthermore, Michigan is partnering with the NFP National Program Office, the MDHHS Home Visiting Unit, and other stakeholders to identify the NFP proximal measures impacting these and additional outcomes for inclusion in its FFPSA CQI measurement framework (e.g., maternal and child health), as described in Section VI.	
Parents as Teachers (PAT)	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child abuse/neglect. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse, and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks.	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service: • **Child safety** *Relevant measures to be collected:* ○ Rate of injury-related visits to the Emergency Department (ED) since enrollment among children enrolled in home visiting ○ Percent of children enrolled in home visiting with at least 1 investigated case of maltreatment following enrollment within the reporting period • **Child well-being: Social functioning** *Relevant measures to be collected:* ○ Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. MDHHS target population is children 0-5 with parents that have risk factors of substance use, mental health issues, and domestic violence. MDHHS will refer eligible candidates that meet PAT eligibility who are ages birth to five. MDHHS will also refer eligible pregnant or parenting youth in foster care.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			○ Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool ○ Percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner These select distal outcomes are identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for PAT. MDHHS will be integrating these outcomes and measures into ongoing CQI activities. Furthermore, Michigan is partnering with the PAT National Center, the MDHHS Home Visiting Unit, and other stakeholders to identify the PAT proximal measures impacting these and additional outcomes for inclusion in its FFPSA CQI measurement framework for continuous monitoring, as described in Section VI.	
Healthy Families America (HFA)	Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for abuse/neglect or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service: • **Child safety** *Relevant measures to be collected:*	HFA seeks to engage parents facing challenges such as single parenthood; low income; childhood history of abuse and other adverse child experiences; and current or previous issues related to substance abuse, mental health issues, and/or domestic violence.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
	nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term, and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.		○ Rate of injury-related visits to the Emergency Department (ED) since enrollment among children enrolled in home visiting ○ Percent of children enrolled in home visiting with at least 1 investigated case of maltreatment following enrollment within the reporting period • **Child well-being: Behavioral and emotional functioning** *Relevant measures to be collected:* ○ Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool • **Adult well-being: Positive parenting practices** *Relevant measures to be collected:* ○ Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool ○ Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day • **Adult well-being: Parent/caregiver mental or emotional health**	Individual HFA sites select the specific characteristics of the target population they plan to serve (such as first-time parents, parents on Medicaid, or parents within a specific geographic region); however, the HFA National Office requires that all families complete the parent survey (formerly the Kempe Family Stress Checklist), a comprehensive psychosocial assessment used to determine the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences. The HFA National Office requires that sites enroll families before the child's birth or within three months of the child's birth. After families are enrolled, HFA sites offer them services until the child's third birthday, and preferably until the child's fifth birthday. HFA programs expanding to support candidates for foster care have applied for the Child Welfare Protocol which will expand the eligible child population to those less than 24 months of age. MDHHS target population is children birth to five with parents that have risk factors of substance use, mental health issues, and domestic violence. MDHHS will refer eligible candidates that meet HFA eligibility who are ages birth to twenty-four months. MDHHS will also refer

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			Relevant measures to be collected: ○ Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) ○ Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts These select distal outcomes are identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for HFA. MDHHS will be integrating these outcomes and measures into ongoing CQI activities. Furthermore, Michigan is partnering with the HFA National Office, the MDHHS Home Visiting Unit, and other stakeholders to identify the HFA proximal measures impacting these and additional outcomes for inclusion in its FFPSA CQI measurement framework for continuous monitoring, as described in Section VI.	eligible pregnant or parenting youth in foster care.
HOMEBUILDERS	HOMEBUILDERS provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service:	Families with children (birth to 18) at imminent risk of placement into care, or needing intensive services to return from, foster care, group or

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
	and cannot be reunified without intensive in-home services. HOMEBUILDERS' practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. HOMEBUILDERS' practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety.		• **Child permanency: Out-of-home placement** *Relevant measures to be collected:* ○ Children remaining at home six months post intervention. This distal outcome is identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for HOMEBUILDERS. Michigan also intends to measure impacts on **child safety and family functioning to maintain children safely in the home or successfully reunify families with their children.** MDHHS will be integrating these outcomes and measures into ongoing CQI activities. Michigan is partnering with the model developers and other stakeholders to identify the Homebuilders' proximal measures impacting these outcomes for inclusion in its FFPSA CQI measurement framework for continuous monitoring, as described in Section VI.	residential treatment, psychiatric hospitals, or juvenile justice facilities
SafeCare	SafeCare is an in-home behavioral parenting program that promotes positive parent-child interactions, informed caregiver response to childhood illness and injury, and a safe home environment. SafeCare is designed for parents and caregivers of children birth through five who are either at-risk for or have a history of child neglect and/or physical abuse. The program aims to reduce child abuse/neglect. The SafeCare curriculum is delivered by trained and certified providers.	*supported*	At a minimum, Michigan expects to see improvements in the following proximal and distal outcomes for children receiving this service: **Proximal** • Improved parenting behaviors • Increased safety in the home • Improved child health decisions **Distal** Child Safety	SafeCare is designed for parents and caregivers of children birth through five who are either at-risk for or have a history of child neglect and/or physical abuse. The program aims to reduce child abuse/neglect.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
	The curriculum includes three modules: (1) the home safety module targets risk factors for environmental neglect and unintentional injury by helping parents/caregivers identify and eliminate common household hazards and teaching them about age-appropriate supervision; (2) the health module targets risk factors for medical neglect by teaching parents/caregivers how to identify and address illness, injury, and health generally; (3) the parent-child/parent-infant interaction module targets risk factors associated with neglect and physical abuse by teaching parents/caregivers how to positively interact with their infant/child, and how to structure activities to engage their children and promote positive behavior.		• Reduced confirmed maltreatment Child Permanency • Reduced child removals • Reduced child reentries • Sustained reunification Michigan is partnering with the University of Michigan to conduct a process and outcome evaluation of SafeCare. The evaluation team will facilitate quarterly meetings to discuss model support and implementation. The evaluation team will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with MDHHS leadership throughout the life of the evaluation. These outcomes and data provided by the evaluation team will be included in Michigan's FFPSA Measurement framework and integrated into ongoing CQI activities for continuous monitoring, as described in Section IV.	
Multi-Systemic Therapy (MST)	Treatment using MST typically involves multiple weekly visits between the therapist and family, over an average timespan of 3 to 5 months. The intensity of services can vary based on clinical needs. The therapist and family work together to determine how often and when services should be provided throughout the course of treatment.	*well-supported* 	At a minimum, Michigan expects to see improvements in the following proximal and distal outcomes for children receiving this service: • Child well-being: Delinquent behavior This select distal outcome is identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for MST. The relevant proximal measure includes: • Reduction in frequency and severity of youth's referral behaviors.	This program provides services to youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			Michigan will be integrating these outcomes into ongoing CQI activities for continuous monitoring. Michigan will partner with the model developer and other stakeholders to identify additional MST proximal measures for inclusion in its FFPSA measurement framework, as described in Section VI.	
Brief Strategic Family Therapy (BSFT)	BSFT is typically delivered in 12 to 16 weekly sessions, depending on individual and family needs.	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service: • Child well-being: Delinquent behavior • Adult well-being: Family functioning These select distal outcomes are identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for BSFT. The relevant proximal measures include: • Reduction in behavior problems, while improving self-control • Effective parenting, including successful management of children's behavior and positive affect in the parent-child interactions Michigan will utilize data from BSFT Adherence Certification Checklist to monitor fidelity as well as administrative data to monitor safety and preventing foster care entry outcomes. MDHHS will be integrating these outcomes into	BSFT is designed for families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying, or truancy.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			ongoing CQI activities for continuous monitoring.	
Motivational Interviewing	MI is typically delivered over one to three sessions. Each session typically lasts for 30 to 50 minutes. The dosage may vary if MI is delivered in conjunction with other treatment(s).	*well-supported* 	At a minimum, Michigan expects to see improvements in the following outcomes for children and families receiving this service: • **Adult well-being: Parent/caregiver substance use** This distal outcome is identified as having favorable impact through the independent review of research conducted by the title IV-E Prevention Services Clearinghouse for Motivational Interviewing. MDHHS will be integrating this outcome into ongoing CQI activities. Michigan also seeks to measure impacts on **child safety through enhanced internal motivation for change within families to address challenges that present safety risks to children so that children can be maintained safely in the home and avoid repeat maltreatment.** Furthermore, Michigan is partnering with the model developer/purveyors and other stakeholders to identify the Motivational Interviewing proximal measures impacting this outcome for inclusion in its FFPSA CQI measurement framework for continuous monitoring, as described in Section VI.	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas. Michigan will use MI as a strategy to serve adolescents and adults with challenges in the areas of substance abuse and mental health and increase motivation to improve parenting skills.
Trauma Focused Cognitive	TF-CBT serves children and adolescents who have experienced trauma. This	*promising*	At a minimum, Michigan expects to see improvements in the following proximal	TF-CBT serves children and adolescents who have experienced

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
Behavioral Therapy (TF-CBT)	program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment if they did not perpetrate the trauma and child safety is maintained.		and distal outcomes for children and families receiving this service: **Proximal** • Increased caregiving coping skills • Increased caregiver perceptions of parenting support • Increased trauma management skills in children and caregivers • Improved parenting behaviors **Distal** Child Safety • Reduced confirmed maltreatment Child Permanency • Reduced child removals • Reduced child reentries • Sustained reunification Michigan is partnering with the University of Michigan to conduct a process and outcome evaluation of TF-CBT. The evaluation team will facilitate quarterly meetings to discuss model support and implementation. The evaluation team will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with MDHHS leadership throughout the life of the evaluation. These measures and data provided by the evaluation team will be included in Michigan's FFPSA Measurement framework and integrated into ongoing CQI activities, as described in Section VI.	trauma. This program targets children/adolescents who have PTSD symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment if they did not perpetrate the trauma and child safety is maintained.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
Family Spirit	Family Spirit is designed to serve mothers for as long as possible, from 28 weeks gestation until 3 years postpartum. Home visitors teach 63 lessons during 52 home visits. Each visit is 45-90 minutes long. Visit frequency tapers over time. Specifically, mothers receive weekly visits from 28 weeks gestation to 3 months postpartum, biweekly visits between 3 months and 6 months postpartum, monthly visits between 7 months and 22 months postpartum, and bimonthly visits between 23 and 36 months postpartum.	*promising* 	At a minimum, Michigan expects to see improvements in the following proximal and distal outcomes for children and families receiving this service: **Proximal:** • Increased maternal knowledge and self-efficacy • Increased protective factors • Decreased parenting stress and maternal depression • Decreased substance use • Fewer behavioral problems in children through age 3. **Distal** • Reduced confirmed maltreatment findings • Reduced child removals • Reduced child reentries Michigan is partnering with the University of Michigan to conduct a process and outcome evaluation of Family Spirit. The Program Evaluation Group will engage in regular contact with MDHHS and the tribal communities implementing the Family Spirit program. Meetings will occur a minimum of quarterly to discuss model and implementation support. The Program Evaluation Group will facilitate these meetings as a form of quality assurance and quality improvement. Process findings will be shared with the participating tribal programs and MDHHS.	Family Spirit is designed to serve young American Indian mothers (ages 14-24) who enroll during the second trimester of pregnancy. Other family members can participate in the program lessons alongside mothers.

Table 3. MDHHS Prevention Evidence Based Practices				
Evidence-Based Program (EBP)	**Model Information**	**Title IV-E Prevention Services Clearinghouse Rating/Service Category**	**Intended Outcomes for Michigan's Target Population**	**EBP Eligibility Criteria/Target Population**
			These measures and data provided by the evaluation team will be included in Michigan's FFPSA Measurement framework and integrated into ongoing CQI activities for continuous monitoring, as described in Section VI.	

Implementation Plans for Evidence-Based Programs

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

Table 4. Family First EBP Implementation Plans and Trauma-Informed Service Delivery

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

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

	preventing youth from entering the juvenile justice system; or from more serious juvenile justice system involvement.
Trauma-Informed Service Delivery	Service model framework includes trauma-informed care for youth affected by trauma.
 **Brief Strategic Family Therapy**	
Strategies for Implementation	Brief Strategic Family Therapy (BSFT) is currently being delivered in five separate sites in Michigan. Michigan plans to utilize BSFT to address problem behaviors in adolescents that are at risk of entering foster care. To maximize title IV-E expansion of prevention services while leveraging a variety of funding sources, BSFT will be phased in based on targeted needs and capacity through a request for proposal (RFP) process.
Trauma-Informed Service Delivery	The BSFT model is a trauma sensitive, culturally competent, and strength based.
 **Motivational Interviewing**	
Strategies for Implementation	Michigan aims to enhance its MiTEAM practice model through the implementation of Motivational Interviewing (MI). Research and evaluation to date have highlighted MI as an effective service delivery strategy with both adult and youth populations to enhance motivation to accomplish a wide range of goals, making it an ideal fit for MDHHS's prevention candidates with service needs in all three Family First service categories--in-home parenting, substance abuse, and mental health. The goal of implementing MI in Michigan is to assure improved engagement and participation of children, youth, and families to achieve the goals set forth in the child-specific prevention plan and to support engagement with and completion of services, including additional EBPs when indicated, being offered. Through increased engagement, we also anticipate better service matching over time to the needs of each child and families and improved prevention and well-being outcomes. MI's client-centered approach will support sustainment of the family's motivation toward progress, so each child and family are able to continue to receive an appropriate dose and level of support and service. MI will be used at each encounter with their families as a core EBP and fully integrated into all casework practice. This will require community-based EBP service providers, Substance Use Disorder Family Support Program providers, caseworkers (public and private), and supervisors to be trained in the use of MI. Supervisors will provide critical support to caseworkers in using MI in the development and monitoring of the child-specific prevention plan. As part of the Substance Use Disorder Family Support Program, all specialists and supervisors are expected to utilize MI and apply this evidence-based approach with fidelity. Within 60 days of starting employment, all new specialists and supervisors complete a 20-hour training through Improving MI Practices which includes 10 different modules. In addition, supervisors receive five additional hours of supervisory training. Following this training, specialists complete 90 days of coaching which includes shadowing from supervisors who will score the observed interaction using the Behavior Change Counseling Index (BECCI). Feedback is provided to the specialist during supervision to assist in the continued growth of MI skills. The BECCI is used to indicate the degree to which the practitioner has successfully implemented behavior change skills. Any specialist or supervisor that is not showing competencies over the 90-day period, will continue in supervision for an additional period to ensure that they are successfully integrating the skills of MI into practice. After the 90-day period has been completed, each clinician will have a case review, shadowing by supervisors using the BECCI as well as supervision

	sessions on a quarterly basis for continued coaching. After one year, clinicians will have completed the Motivational Interviewing Implementation Plan and participate in continuous learning in accordance with the standards of the Michigan Certification Board of Addiction Professionals (MCBAP).
Trauma-Informed Service Delivery	All child welfare case workers trained in Motivational Interviewing will also be trained in trauma-informed care.
Trauma-Focused Cognitive Behavioral Therapy	
Strategies for Implementation	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most prevalent evidence-based practice in Michigan. Currently there is a trained therapist and supervisor in each community mental health authority in Michigan. In addition, there are numerous private agency and private practice therapists that are certified TF-CBT therapists. TF-CBT may be used for children ages 3-18 and currently is provided to numerous children that are eligible for community mental health services through a severe emotional disturbance (SED) diagnosis. To maximize title IVE expansion of prevention services while leveraging a variety of funding sources, TF-CBT will be phased in based on targeted needs and capacity through a request for proposal (RFP) process.
Trauma-Informed Service Delivery	Service model includes trauma affected youth and training on trauma informed care.
Family Spirit	
Strategies for Implementation	Family Spirit is currently being delivered in 12 separate sites within Michigan borders by tribal agencies. Michigan plans to partner with the tribes to determine the locations for Family First implementation and determine supports needed.
Trauma-Informed Service Delivery	Family Spirit as a model supports a trauma informed approach and practice. There are specific elements within the training, quality assurance, on-going affiliate education and support, as well as the strengths-based content within the curriculum that align with trauma informed practice.

Section IV: Child Specific Prevention Plan

Pre-print Section 4

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

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

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

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

Child Specific Prevention Plan

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

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

For open CPS in-home and prevention cases served by MDHHS or a Child Placing Agency

- SDM Risk Assessment (open CPS case) and Safety Assessment (open CPS or Foster Care case);
- Family Assessment of Needs and Strengths;
- Child Assessment of Needs and Strengths;
- Juvenile Justice Strength and Needs Assessment;
- Michigan Juvenile Justice Assessment System (MJJAS) risk assessment tool;

For open prevention cases served by an evidence-based home visiting program

- Social Determinants of Health Screening;
- Family-Centered Assessment and Plan; and
- Other service specific risk assessment tools.

For open prevention cases served by Post Adoption Resource Center

- Family-Centered Assessment and Plan

For open prevention cases served by the Substance Use Disorder Family Support Program

- ASAM CONTINUUM or GAIN I-Core
- Family Service/Treatment Plan

For open prevention cases served by a contracted community service provider

- Contracting with a community-based provider to serve a candidate for foster care is a new pathway under development. MDHHS will submit an amendment to its Title IV-E Prevention Plan when plans are finalized.

Once a family's needs are identified, the assigned caseworker will engage the family and share service availability utilizing the service array selection document to identify a service that best meets the family's needs. Services identified will be documented in the child-specific prevention plan. All information shared between the MDHHS, community providers, and evidence-based home visiting providers will be shared with appropriate signed consent from the family. The assigned worker will partner with the family to obtain the information necessary and to make the service referral and connect the family with the service provider.

Cases opened (in-home and prevention) and assigned to a MDHHS or Child Placing Agency Caseworker

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

Ongoing needs, strengths, and formal and informal safety and risk assessments assessments are completed on a periodic basis by the assigned worker. When a family is involved in services including evidence-based home visiting (Parents as Teachers, Healthy Families America, or Nurse Family Partnership), information is regularly gathered from service providers when appropriate consents are in place to update assessment information, risk and safety assessments and the prevention plan.

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

Cases opened and assigned to a Evidence-based Home Visiting Provider or Substance Use Disorder Family Support Program-Motivational Interviewing with a MDHHS Prevention Monitor

A child who meets one of the following candidate criteria may be served by an evidence-based home visiting program or **Substance Use Disorder Family Support Program-Motivational Interviewing** (PAT, HFA, NFP, SUDFSP-MI):

- A child with no confirmed abuse or neglect but low to intensive risk exists.
- Infants exposed to substances.
- Child of a former youth in foster care until the youth is age 26.
- Confirmed abuse/neglect but the CPS program type has closed, and the family continues to have risk factors that support ongoing involvement in an evidence-based home visiting service.

The MDHHS prevention worker meets with the family to discuss involvement in prevention services. The prevention worker will complete the FANS/CANS to assist in determining the service that will best meet the family's needs. If determined that the family will be referred to an evidence-based home visiting service, or contracted community partner (SUDFSP-MI), the prevention worker will refer the family to the service and will review the prevention plan with the home visitor or community partner. Once a family is enrolled in the service, the prevention worker will become a prevention monitor and the home visiting or community partner will become the primary provider for the family. A prevention monitor will be assigned to families referred to a contracted community provider for case management and service delivery (once the pathway has been developed and implemented) or enrolled in Parents as Teachers, Healthy Families America, Nurse Family Partnership, Substance Use Disorder Family Support Program-Motivational Interviewing under the title IV-E prevention program. The home visitor or Family Support specialist will complete program specific assessments and create a family plan that includes goals and action steps. The family plan will serve as the child-specific prevention plan will be updated as needed as the family's goals or needs change.

Families participating in Substance Use Disorder Family Support Program-Motivational Interviewing or an evidence-based home visiting program at the time the family achieves completion of the program, or the family is not making progress, the home visiting provider or Family Support specialist may contact the prevention monitor to assist with engaging the family in services. After attempts have been made to engage the family and the family decides not to accept services, the prevention monitor will end the services. The prevention monitor will assess the current risk and safety by reviewing

information from the provider. The prevention monitor will consult with the assigned supervisor to determine next steps which could include reviewing other service options with the family or closing the prevention plan.

Throughout the service period, the prevention monitor will maintain open communication with the home visitor, Family Support specialist, or community partner. The evidence-based home visiting provider or Family Support specialist will provide the ongoing monitoring of risk and safety based on the programs assessment tools. The home visitor or Family Support specialist will assist in coordinating other services as identified during the intervention and if an additional need for an evidence-based program is identified, the home visitor or Family Support specialist will connect with the assigned prevention monitor to review the prevention plan and discuss additional needs and referrals.

During the 12-month period a family is eligible for Family First services, the prevention monitor maintains the open prevention case and collaborates with the home visiting provider or Family Support specialist at least monthly to ensure child safety throughout the life of the open case. If the family continues in services throughout the 12-month period, the prevention monitor will initiate a new candidacy determination during month eleven. The MDHHS prevention worker will gather information necessary to determine if the child remains a candidate for foster care by conferencing with the home visitor or Family Support specialist and determining if the family continues to work on identified goals and has a desire to continue in services. The new candidacy determination will be documented in MiSACWIS.

Pregnant or Parenting Youth in Foster Care

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

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

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

An assigned caseworker (public or private) will complete eligibility redetermination if the case remains open at 12 months from the prevention plan start date. The MDHHS supervisor will approve the plan in the system. The MDHHS supervisor will review and approve all eligibilty redeterminations.

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

Tribal Government Determinations

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

Integrating the child-specific Prevention Plans within MiSACWIS

All child-specific prevention plans will be documented in MiSACWIS. The child-specific prevention plan will include those children and parents or caregivers who are eligible; will identify the prevention plan begin date; list the services to be provided to or on behalf of the child to ensure the success of the prevention strategy; and include the prevention strategy so the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safety achieved, or live permanently with a kin caregiver. Children with an open CPS, foster care or juvenile justice case, the data elements of the child specific prevention plan in MiSACWIS will be incorporated and part of the existing CPS, foster care, or juvenile justice case service plans. Children

served by a Post Adoption Resource Center, an evidence-based home visiting program, or SUDFSP-MI, the child specific prevention plan elements will be documented in MiSACWIS and the program specific Family Centered Plan will be the printed prevention plan for the child.

Prevention Services and Coordination with IV-B

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

Section V: Monitoring Child Safety

Pre-print Section 3

During the period that services are being offered to eligible children and families MDHHS and/or EBP service providers will monitor the safety of the children and determine any risks present. When there is an eligible candidate or a pregnant or parenting youth in foster care a prevention, CPS, foster care, or juvenile justice caseworker will be assigned as primary, MDHHS and contracted child placing agencies will follow current MDHHS policy to monitor risk and safety. MDHHS policy requires initial and ongoing assessments of risk and safety of all children receiving services utilizing Structured Decision-Making tools. Additional populations, such as a child for whom abuse/neglect has not been confirmed but low to intensive risk for abuse/neglect exists, an infant born exposed to substances not assigned for an investigation, a child of a parent who had been in foster care until the parent reaches age 26, or a child whose adoption or guardianship arrangement is at risk of dissolution, are determined for prevention services as part of the five-year prevention plan that would not traditionally be provided by MDHHS. Safety and risk assessments for these populations will be provided by the evidence-based home visiting program, SUDFSP-MI program or contracted organizations and monitored by MDHHS through its continuous quality improvement process. In instances when a MDHHS prevention worker is assigned as primary, ongoing monitoring of safety and risk occurs during each home visit and through engaging the family in assessing needs and strengths. The prevention worker will document progress on needs and strengths on the SDM Family Assessment of Needs and Strengths and Child Assessment of Needs and Strengths Tools. In addition, all providers of services have a responsibility to report any instances of suspected child abuse or neglect as part of the mandated reporting laws.

Assessment and SDM Safety and/or Risk Assessment Tool: MDHHS and contracted child placing agency caseworkers with open CPS, foster care, or Juvenile Justice cases will use SDM safety and risk assessment tools, among other strategies, to evaluate safety and risk to children to determine initial eligibility and throughout any open cases to ensure the continued safety and well-being of children and families.

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

Family Assessment/Reassessment of Needs and Strengths: A section of the Family Assessment/Reassessment of Needs and Strengths (FANS) tool assesses health, well-being, and parental skills of caregivers. MDHHS and contracted child placing agency

caseworkers are responsible for administering FANS every 90 days with families receiving in-home services through MDHHS. The 90-day assessment may occur at an earlier interval of 60 days based on risk categories identified through the initial assessment. This tool will aid in monitoring any risk present with families receiving prevention services.

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

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

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

Contact with the Family: CPS, foster care and juvenile justice policy requires MDHHS and contracted child placing agency caseworkers to regularly meet face-to-face with children and their caregivers. MDHHS and contracted child placing agency caseworkers must meet with the child and caregivers at least monthly. Juvenile justice specialists are required to meet with children and their caregivers at least monthly but for higher risk levels, as deemed by the MJJAS, require more frequent contact. Regular and purposeful visiting with the child and family enables the caseworkers to assess safety, risk, and determine other needs of the family and/or caregivers.

Contracted agencies that will have oversight of prevention services will be required to assess risk and safety of the children through an array of tools such as the Framework for Risk Assessment, Management and Evaluation (FRAME), protective factors survey, and the Children's Trauma Assessment Center Trauma Screening Checklist.

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

Contracted Community Based Provider: Contracting with a community-based provider to serve a candidate for foster care is a new pathway under development. MDHHS will submit an amendment to its Title IV-E Prevention Plan when plans are finalized.

Substance Use Disorder Family Support Program-Motivational Interviewing (SUDFSP-MI)

SUDFSP-MI programs assess and develop a written service/treatment plan in consultation with the family within 14 days of accepting a referral. The assessment includes assessing the client's current living conditions including, but not limited to stable housing, income/employment, developmental history, substance use/abuse, family structure, support system, physical health, emotional and mental health status, and the client's view of the presenting concern. The provider utilizes the ASAM Continuum or Global Appraisal of Individual Needs (GAIN-I) assessment tool to assess level of treatment needed for substance use issues. The assessment tool is completed within 14 days of referral acceptance. During the intervention, the family support specialist works with the family and modifies the service/treatment plan as necessary to meet the needs of the client/family. The family support specialist coordinates and support the use of available resources when multiple agencies are indicated to meet the client/family's needs. The family support specialist also facilitates prevention activities and education for the family and child(ren) to understand the dynamics of substance use disorders and provides appropriate referrals, resources, and education to the families. During each interaction, the family support specialist ensures that the children in the household are in a safe and healthy environment, by addressing the safety of all family members living in the home and report any suspected child abuse or neglect to MDHHS.

Evidence-based Home Visiting: Parents as Teachers (PAT), Healthy Families America (HFA), and Nurse Family Partnership (NFP) home visiting programs assess and screen families to identify any special needs they may have and then provide resources and referrals for services utilizing principles of motivational interviewing. This includes screening and assessing for mental health services, substance use/misuse, developmental delays, intimate partner violence and social determinates of health.

Home visitors complete a Family-Centered assessment within defined intervals based on the program. The Family-Centered assessment is updated as needed and reviewed at least annually.

Parents as Teachers, Healthy Families America, and Nurse Family Partnership use both formal and informal risk assessment tools and processes throughout their involvement with a family. During each home visit, whether in-person or virtual, home visitors utilize informal assessment processes to assess and monitor for risks. This can include mental health concerns, home safety, child safety, intimate-partner violence, basic needs, among many others. All home visitors are mandated reporters under Michigan law and receive annual training on mandated reporting as well as child abuse and neglect.

Parents as Teachers, Healthy Families America, and Nurse Family Partnership use formal screening tools for depression, intimate partner violence, as well as substance misuse.

Screening tools for Depression, Intimate Partner Violence, and Substance Misuse

Area of Assessment	Program and Tool	MDHHS-Home Visiting Unit Required Frequency *Programs complete screenings at a minimum of these intervals.	National Model Required Frequency
Maternal Depression	PAT, HFA, and NFP can use the PHQ-9 or Edinburgh	Either tool is completed no less than three months post enrollment or three months post-natal if caregiver is enrolled during pregnancy.	HFA: if enrolled prenatally, screen at least once prenatally and at least once within three months after birth of baby. If enrolled postnatally, within 3 months of enrollment and within 3 months of any subsequent births. PAT model: after first few years of implementation, programs are required to complete depression screening annually. Programs can choose to complete depression screening earlier in implementation. NFP model: PHQ-9 complete during first 7 visits, pregnancy at 36

			weeks, and 1-6 weeks postpartum, Infancy 4-6 months, Infancy 12 months and additional as needed.
Inter-Personal Violence (IPV)	PAT and HFA – Relationship Assessment Tool or Hurt, Insult, Threaten and Scream. NFP – program specific Inter-Personal Violence assessment tool	Screening is completed within no less than six months of enrollment.	HFA model does not require an IPV screening. PAT model: after first few years of implementation, programs are required to complete IPV screening annually. Programs can choose to complete IPV screening earlier in implementation. NFP model: completed during 5th-7th pregnancy visit, by 12 weeks postpartum, when toddler is 16 months, and as needed.
Substance misuse screen	HFA, PAT, and NFP-Parents, Peers, Partner, Past, Pregnancy (five P'S) for prenatal and UNCOPE for postnatal.	Substance use screening is completed no less than six months of enrollment and repeated at least annually.	HFA model does not require a substance misuse screening. PAT model has questions related to substance use in the Parent Guardian Information Record which must be completed within 90 days and at least annually thereafter. NFP model: Health Habit form done at Pregnancy intake, Pregnancy 36 weeks, and Infancy 12 months.

Each model also utilizes unique risk assessment tools.

Risk Assessment Tools

Program	Tool	Frequency
HFA	Parent Survey Tool Beginning Summer 2022- Family Resilience & Opportunities for Growth (FROG)	Risk assessment tool is completed at the beginning of service and used to create an HFA service plan. This plan is updated over the course of services as new challenges or needs are identified.
PAT	Screening tools can include but are not limited to developmental screening, child health review, and adult screening	Completed within 120 days of enrollment and at least annually thereafter.
NFP	Strengths and Risks Framework	Intake, 36 weeks of pregnancy, eight weeks post-partum, one-year post-partum, and 18 months post-partum.

Healthy Families America (HFA) programs use the parent survey tool to assess the presence of various risk factors associated with increased risk for child maltreatment and other adverse childhood experiences. HFA home visiting staff use the responses to create a prevention plan that helps organize the risks, concerns, and needs identified by families with activities, interventions and supports provided to help ameliorate family risk.

HFA sites currently complete the Parent Survey for the assessment. The Parent survey assesses the following domains:

- Parent's Childhood Experience
- Lifestyle Behaviors & Mental Health
- Parenting Experience
- Coping Skills & Support System
- Stresses
- Anger Management Skills
- Expectations of Infant's Developmental Milestones & Behaviors
- Plans for Discipline
- Perception of New Infant
- Bonding & Attachment

Beginning in summer 2022, HFA sites will transition to the Family Resilience & Opportunities for Growth (FROG) Scale with the following domains:

- Social & Emotional Competence
    - Family Environment
    - Perception of the Child
- Knowledge of Parenting & Child Development
    - Infant & Child Development
    - Plans for Discipline
    - Child Protective Service (experience as a parent or caregiver)
- Parental Resilience
    - Positive Childhood Experiences
    - Stressful Childhood Experiences
    - Behavioral Health
    - Mental Health
    - General Stress Level
- Social Factors
    - Social Connections
    - Intimate Partner Support
    - Intimate Partner Conflict Management
- Concrete Resources
    - Concrete Support Services

The assessment/tool is completed at the start of services. Any needs identified at that time, or any new challenges identified over the course of services, are added to the HFA Service Plan. This Service Plan includes activities to address identified issues and build protective factors, it also prioritizes the pacing of these activities which are then implemented during home visits.

Parents as Teachers (PAT) programs utilize screening tools to assist in developing the Family-Centered Assessment with the family. Screening tools can include but are not limited to developmental screening, child health review, and adult screening. PAT programs also utilize an assessment tool that measures parenting skills, practices, stress, and capacity to monitor family outcomes.

Parents as Teachers (PAT)- Programs complete a Family Centered Assessment. Programs can choose to complete the Family Centered Assessment Synthesis Record, or they can use a PAT approved tool, which include Life Skills Progression, Family Map, North Carolina Family Assessment Scale for General Services, or Mid America Head Start Family Assessment. Family Centered Assessment is completed within 120 days of enrollment and at least annually thereafter. Resource connections, goals, and topics covered during home visits should all be informed by the synthesis of information the family-centered assessment offers.

The Family Centered Assessment covers, at a minimum, the strengths, resources, and needs in the following categories:

- Parenting (e.g., parent knowledge, capacity, parenting practices, and parent-child relationship)
- Family relationships and formal and informal support systems
- Parent educational and vocational information
- Parent general health
- Parent and child access to medical care, including health insurance coverage
- Adequacy and stability of income for food, clothing, and other expenses
- Adequacy and stability of housing

Nurse Family Partnership (NFP) programs use the Nurse Family Partnership Strengths and Risks Framework at every visit. NFP nurse home visitors use input from parents, nursing experience, nursing practice, and model-specific resources coupled with motivational interviewing to promote low-income, first-time mother's health during pregnancy care for their child and own personal growth and development.

Nurse Family Partnership programs utilize Strengths and Risks Framework (STAR) to assess risk factors. The STAR needs to be completed at intake, 36 weeks of pregnancy, eight weeks post-partum, one-year post-partum, and 18 months post-partum.

The categories that are assessed include:

- Substance use and misuse
- Chronic illness and/or pregnancy complication
- Developmental and intellectual disability/limitation
- Depression, anxiety, and mental health
- Caregiving attitudes and behaviors
- Child health and development
- Childcare
- Client education and work
- Pregnancy planning
- English literacy limitations
- Criminal justice/legal issues
- Loneliness and social isolation
- Intimate partner violence
- Unsafe family or friend network
- Economic insecurity
- Homelessness and residential instability
- Environmental health
- Home safety
- Health services utilization
- Well-child - infancy and toddlerhood
- Use of other community services

- Protective factors: keeps appointments/engaged in NFP, has psychological resources, protects health, demonstrates commitment to protect child, social support, spirituality

If risk factors increase to a level which requires assistance from MDHHS, the home visitor will contact the assigned prevention monitor for assistance.

Providers delivering prevention services are mandated reporters and have an obligation to be vigilant to any suspected child abuse and neglect which provides additional monitoring of child safety during the engagement in services. If there is concern of abuse or neglect to report, providers will report concerns of child abuse or neglect to Centralized Intake at the MDHHS.

Tribal Representative: Tribal governments expressing interest in providing oversight of children eligible for IV-E prevention services will enter into a title IV-E Agreement to participate in title IV-E prevention services under this plan. A Tribe must designate in their title IV-E agreement whether a representative from the child's tribe will continue to monitor the risk and safety of the children receiving prevention services. Tribal governments with an IV-E agreement with MDHHS will utilize MDHHS's risk and safety tool for monitoring risk and safety and the Prevention Services Case Plan for Children and Families to document the child-specific prevention plan. The Tribe will continuously monitor the safety and risk of the child throughout service delivery through regular visitation and update MiSACWIS with the required data elements for Family First. As noted in Section VII, MDHHS is providing training and mentoring supports to tribal governments to ensure adherence to Family First requirements related to eligibility determination, child specific prevention plan development, and ongoing monitoring of risk and safety.

Table 5. Monthly contact standards MDHHS ongoing and juvenile justice

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

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

Section VI: Evaluation Strategy and Waiver Request

Pre-print Section 2; Attachment II

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

Table 6. Family First EBP CQI and Evaluation Strategies

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

Family First Logic Model

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

Figure 6. MDHHS Family First Logic Model

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

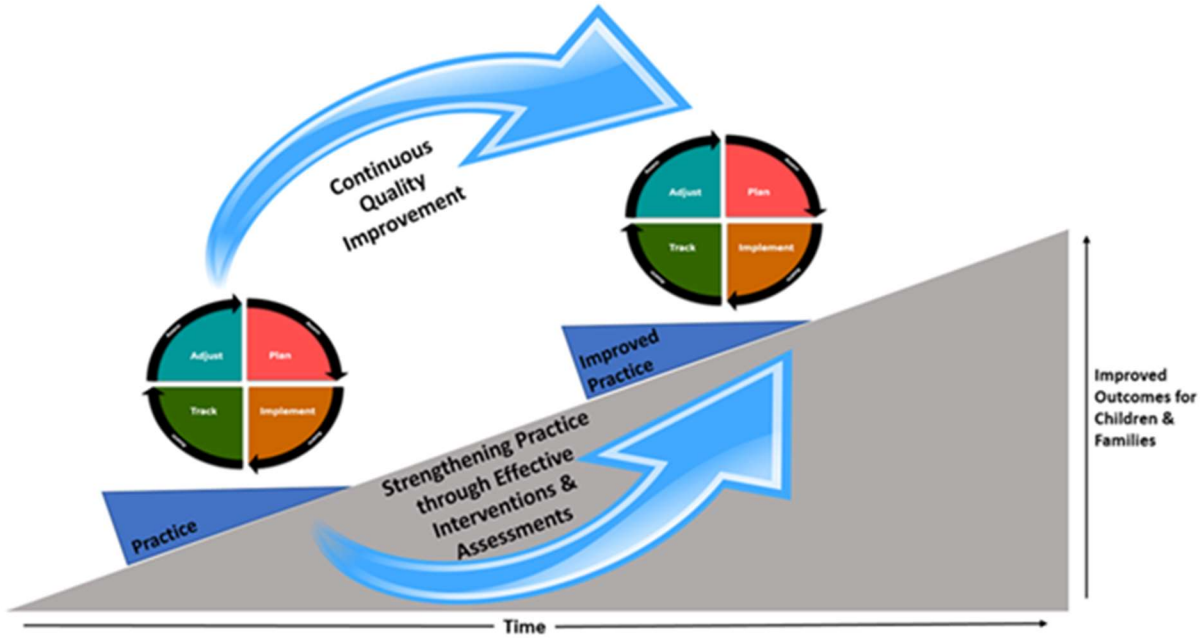
Overview of MDHHS Continuous Quality Improvement Strategy

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

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

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

Figure 7. Department of Continuous Quality Improvement CQI Strategy Overview



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

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

Community Service Analysts

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

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

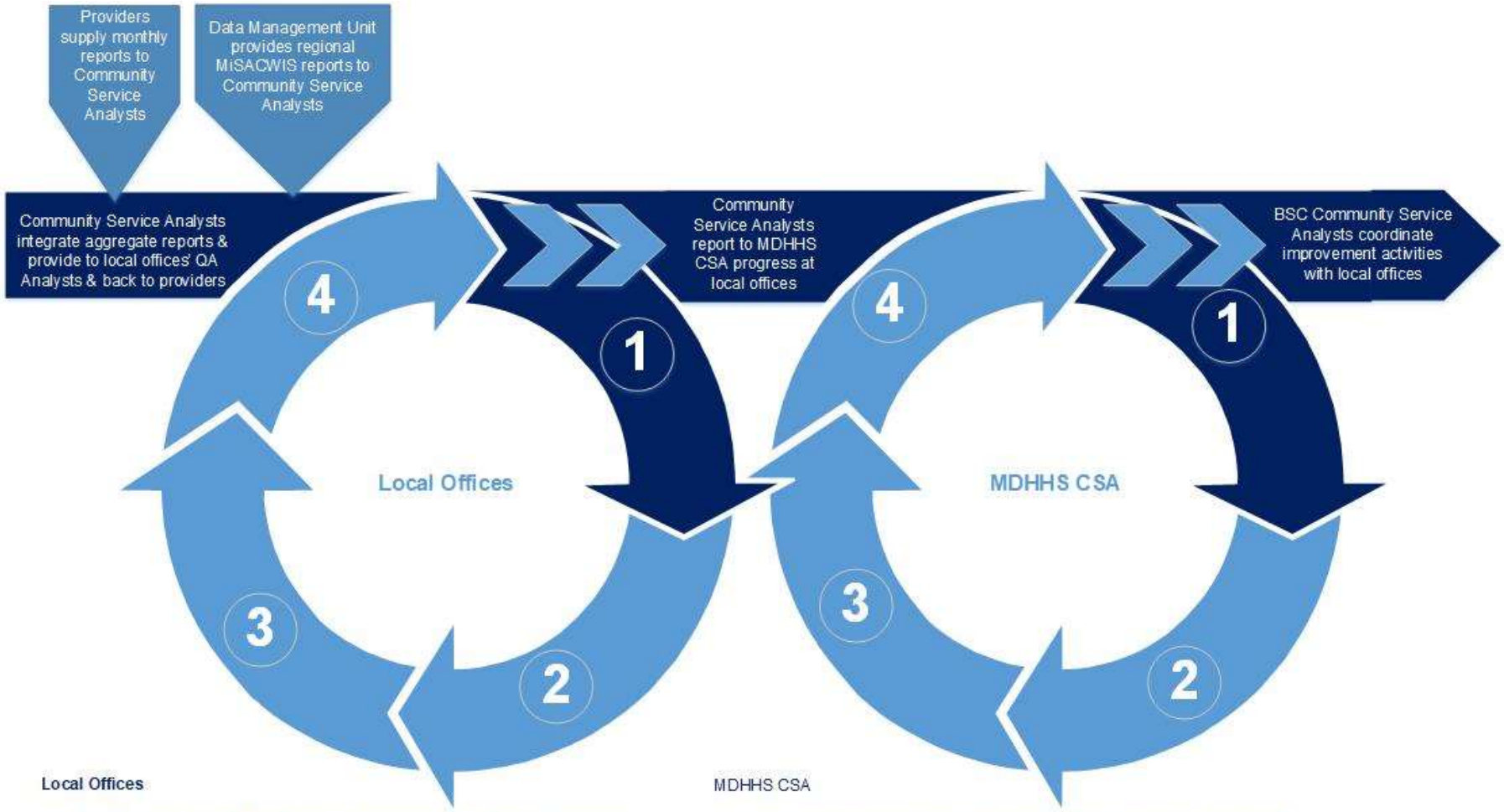
Community Service Analysts will serve as a unique support to the field as well as the prevention provider network to monitor adherence to contract requirements, performance measures, and opportunities for improvement through CQI process. Prevention providers are expected to complete intervention specific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

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

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

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

Figure 8. Enhanced Family First CQI Strategy Overview



Local Offices

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

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

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

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

MDHHS CSA

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

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

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

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

Figure 9. CQI Measurement Framework

Reach Measures

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

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

Fidelity Measures

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

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

Outcome Measures

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

Child and family well-being outcomes:

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

Child safety outcomes:

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

Child permanency outcomes:

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

Family First Preventive Service Array CQI Strategies

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

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

Evidenced Based Home-Visiting Programs

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

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

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

All grantees participate in local, or individual level, CQI projects to address program-identified areas for improvement to ensure that their evidence-based model is being implemented with fidelity and quality. Those grantees who are expanded under Family First will have the opportunity to utilize local CQI projects to specifically address improvements they may wish to see to support improvements specific to families served

through the five-year prevention plan. All aspects of the HVU CQI work is supported by including parent voice as members of statewide, regional, and local CQI teams. Parent voice and leadership is a hallmark of Michigan's home visiting and larger early childhood systems.

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

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

HOMEBUILDERS

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

Reporting requirements specified in the contract for the HOMEBUILDERS pilot sites will include fidelity and outcome measures. The regional Community Service Analyst will coordinate with a liaison from each of the seven non-profit child and family service agencies for contract monitoring which includes CQI activities. The Community Service Analyst, in collaboration with the BSC QA Analysts, will determine the best outlets for improvement strategies and the effect on contract monitoring.

Motivational Interviewing

Our goal is to have Motivational Interviewing (MI) used at each encounter with our families. This will require community-based prevention service providers, Substance Use Disorder Family Support Program, prevention caseworkers and supervisors, child welfare caseworkers (CPS, Foster and Adoption), and child welfare supervisors to be trained in the use of MI. MDHHS will partner with Motivational Interviewing Network of Trainers (MINT)-certified trainers to provide training to supervisors who will provide critical support to caseworkers in using MI in the development and monitoring of the five-year prevention plan. Community-based EBP service providers and the Substance Use Disorder Family Support Program will use MI in delivering services. Integrating MI into our current practice model will equip caseworkers with a *well-supported*, evidence-based service to enhance partnering with families to set goals within the child-specific prevention plan, craft strategies and goals, make plans to reach those goals, and boost motivation and internal resolve to follow-through. It will be used seamlessly throughout the life of the family's prevention case to promote uptake of services, ensure completion of services, reduce premature drop-off, and to increase the successful attainment of the child-specific prevention plan including individualized case goals related to improved parenting skills, mental health, and reductions in substance abuse. MDHHS does not intend to claim Title IV-E reimbursement for CPS investigators' use of Motivational Interviewing. MDHHS is including CPS investigators in MI training to support enhanced engagement with families during the assessment process. MDHHS will begin claiming for use of MI as a case service as of the service begin date.

MDHHS is seeking approval for Motivational Interviewing to be utilized with the Substance Use Disorder Family Support Program, see pages 24, 25 and 38 for how MI is used and implemented in the SUDFSP program.

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

The contracted provider of the SUDFSP will submit monthly status updates to MDHHS including the number of staff trained, fidelity results/outcomes, and any plan updates as part of the contractor's continuous quality improvement process. In addition, MDHHS will utilize monthly reports from the provider and annual case reviews to assess impact of MI on families involved in the SUDFSP program.

MDHHS reviewed the available MI fidelity tools and choose the one that will embed within our case practice the most effectively. MDHHS chose the Behavior Change Counseling Index (BECCI).

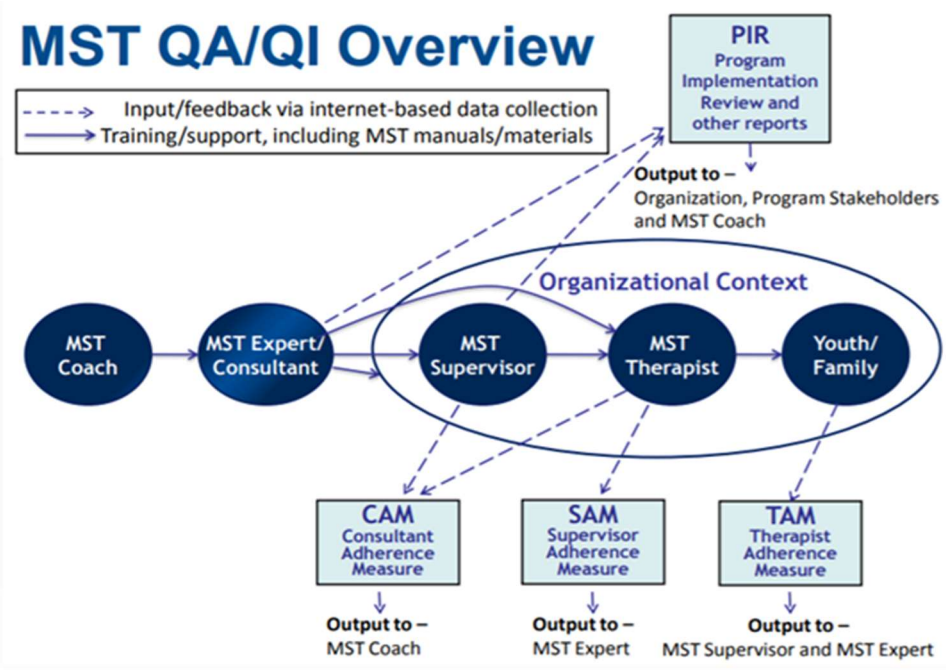
Behavior Change Counseling Index (BECCI) is an instrument designed for trainers to score practitioners' use of Behavior Change Counseling in consultations (either real or simulated). BECCI is currently being used by prevention providers in Michigan, including the SUDFSP.

Home - Motivational Interview

Multi-Systemic Therapy

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

Figure 10. Multisystemic Therapy QA/QI Overview



A Program Implementation Review (PIR) is compiled by the MST provider, in consultation with the MST Institute, every six months and shared with program stakeholders. The PIR documents both youth outcomes and adherence to the MST

model. Program stakeholders review the document with MST providers to identify program strengths and areas to target for improvement.

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

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

Brief Strategic Family Therapy

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

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

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

SafeCare

SafeCare is rated as *supported* on the Title IV-E Prevention Services Clearinghouse and will undergo a rigorous evaluation strategy that MDHHS will integrate into the state's CQI processes. A contractual relationship will be developed with model

developers to support fidelity monitoring and CQI processes. SafeCare providers will provide standardized reports, to regional Community Service Analysts, monthly and MDHHS will hold a quarterly meeting with evaluation staff to discuss model support and implementation. Community Service Analysts will incorporate data from both pathways into the CQI process to refine and improve practices. Please see Appendix B for more information about the evaluation strategy.

Trauma-Focused Cognitive Behavioral Therapy

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

Family Spirit

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

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

Table 7. Summary description of fidelity requirements, processes, and measures for MDHHS Prevention Evidence Based Practices	
	by MST therapists. The measure is based on the principles of MST and the model of supervision presented in the MST Supervisory Manual. More information is available at: https://www.msti.org/mstinstitute/qa_program/sam.html.
Brief Strategic Family Therapy (BSFT)	The program representatives (contact information listed below) administer Standardized Fidelity Rating Instruments for both Competency and Adherence at various intervals of the BSFT® implementation. There is a formal required adherence/fidelity program provided to the BSFT®-competent Therapists via periodic adherence supervision sessions. Self-report checklists, trained observations, and video/audio recordings are included in the fidelity rating process. Fidelity Measure Requirements: Clinicians' performance is rated after each session using the BSFT Adherence Certification Checklist and it is based on a rating of the clinician's videotaped session. The rating is initially done by BSFT Institute Faculty until the agency develops its own BSFT Certified Supervisor. The BSFT Adherence Certification Checklist is provided to the agency's staff during training.
Motivational Interviewing	*Behavior Change Counseling Index (BECCI)* is an instrument designed for trainers to score practitioners' use of Behavior Change Counseling in consultations (either real or simulated). BECCI is currently being used by prevention providers in Michigan.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	The TF-CBT Brief Practice Checklist is a self-report form that is available in Appendix 4 of the TF-CBT Implementation Manual. The manual is available from the program representative listed at the end of the entry.
Family Spirit	Family Spirit utilizes a Quality Assurance Form on at least a quarterly basis. A trained supervisor or staff member administers the form in-person during a home visit. They assess the home visitor on specific tasks grouped according to three domains: 1) visit structure; 2) relationship with participant; and 3) adherence, competence, and flexibility. This measure is administered more often if there are concerns with a home visitor's performance. All home-visiting staff members are trained on using this measure during the in-person Family Spirit training. Home visits can also be audio-recorded if the visits cannot be observed. Recording all of them for a period of time and listening to 20% of randomly selected recordings for each home visitor can provide additional quality assurance feedback on home visits. In addition to the Quality Assurance Form, all home visitors are required to complete curriculum knowledge assessments prior to the in-person training and pass with at least 80% on each of the 63 assessments. These knowledge assessments help ensure content mastery leading up to the in-person training session. A copy of these measures can be obtained by emailing Allison Ingalls at aingalls@jhu.edu.

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

Evaluation Waivers for Well-Supported Interventions

Healthy Families America

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

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

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

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

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

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

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

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

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

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Parents as Teachers

The Parents as Teachers (PAT) model is a well-supported evidence-based program that has evidence of effectiveness. It can support a family to achieve positive outcomes including reduction of child maltreatment, increased school readiness, awareness and assessment of developmental delays and positive parenting practices. PAT fills a specific gap in services within Michigan, allowing children who are over the age of 24 months to be enrolled in the program. The recent 2020 Statewide Home Visiting Needs Assessment demonstrated that across 83 counties that participated, nearly a quarter identified improving outcomes in reduction of child maltreatment as a priority area, with child development and school readiness identified in just under 20% of counties. PAT has a demonstrated body of evidence that it can impact both of these outcomes and is a beneficial model being implemented in Michigan.

The needs assessment also showed that there are gaps in available evidence-based programs for children aged 3-5 due to age at enrollment requirements in other EBPs (e.g., HFA up to 2 years; NFP before 28 weeks gestation). The MI specific FFPSA data analysis indicated that families with children under six years old are a priority population. PAT, as one of the only eligible EBPs to allow enrollment past two, is an important part of Michigan's intent to further support families experiencing risk.

The factors that impact child maltreatment stem from poor parent-child relationships, a lack of understanding about child development or unrealistic expectations, frustration caused by a possible developmental delay, a lack of parenting skills, and stress due to financial issues or other social determinants of health. PAT programs funded under the MDHHS Home Visiting Unit (HVU) help to ameliorate these circumstances to prevent child maltreatment. The HVU funded programs supported 60% of caregivers to enroll in, remain enrolled, or complete a high school degree or equivalent after enrollment in home visiting, a measure of economic self-sufficiency. PAT programs also addressed behavioral concerns with over 97% of families, ensuring families had the tools to support early learning, resulting in 75% of families employing strategies that improved a child's early language and literacy. Over 50% of families received supportive parent child interaction observations using a validated tool, to assess ways to understand and support improved parent child attachment while over 60% of children received a developmental screening to assess for developmental concerns. In FY20, of the families who were served by PAT programs funded under the HVU and Children's Trust Fund, 99% did not have a confirmed case of child maltreatment.

The PAT model, as all home visiting models, emphasizes the relationship between implementation fidelity and demonstrated model outcomes – meaning, if a program implements the model to fidelity, the family should experience the positive outcomes that are associated. To ensure high fidelity to the model and to support quality implementation, Michigan has created a PAT state office whose role will be to ensure programs are implemented with fidelity, supporting positive outcomes for families. Michigan is planning to move to a common data system for PAT programs. This will allow Michigan to collect the required data in a more uniform manner, and to be able to better understand the outcomes parents who are enrolled in PAT are achieving.

PAT is a well-supported home visiting program as listed on both the FFPSA Clearinghouse, and HOMVEE (Home Visiting Evidence of Effectiveness), with evidence of reduction of child maltreatment and has a substantial body of evidence of outcomes in several areas (Effectiveness | Home Visiting Evidence of Effectiveness (hhs.gov)).

A large research study, conducted to investigate the impact of home visiting on child maltreatment, published in the Journal of Child Abuse and Neglect (2018), found a 22% decreased likelihood of substantiated cases of child maltreatment as reported by CPS for families enrolled in PAT. (New Research Shows Parents as Teachers Home Visiting Model Significantly Reduces Child Abuse and Neglect — Parents as Teachers) Further research shows children who participated in PAT had improved academic

outcomes and significant decreases in absenteeism and suspensions. Participating parents showed significant increases in Protective Factors including Family Functioning, Social Support, and Concrete Support. NEW DATA SHOWS PARENTS AS TEACHERS PRODUCES POSITIVE RESULTS — Parents as Teachers. Additional research identifies that Parents as Teachers was associated with a significantly lower likelihood of Child Protective Services recidivism (Jonson-Reid, et.al, 2018).

PAT has demonstrated evidence that the model supports parents with their needs and provides sustainable parenting tools that support parents with young children to succeed. PAT was selected as a quality EBP because it will continue to support positive outcomes for families in Michigan.

Reference:

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Nurse-Family Partnership

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

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

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

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

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

NFP is built on the premise that visiting nurses can build trust with families, serve as a parenting resource, and provide a support network while engaging a family to develop their own network. NFP only enrolls first time mothers who are less than 28 weeks pregnant. MDHHS will utilize this model to meet the needs and support pregnant or parenting youth in foster care who are first time mothers. The model will serve families

until the child reaches their second birthday. As a *well-supported* and evidence-based home visiting program, it is an essential part of Michigan's home visiting system.

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

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HOMEBUILDERS

HOMEBUILDERS is an intensive, in-home family preservation program that works with families to avoid placements in foster care, residential programs, psychiatric hospital, and juvenile justice facilities. The HOMEBUILDERS model believes that working with families in the home environment helps to engage families as partners in assessment, goal setting, and treatment planning. Also used for reunification, HOMEBUILDERS helps prepare families to re-integrate children back into the home and prevent future removals. HOMEBUILDERS activities include improving parenting skills, addressing home repairs, teaching life-skills, addressing mental health needs, and accessing concrete needs.

HOMEBUILDERS is a flexible intervention which has demonstrated favorable outcomes that reduce the risk of out-of-home care and re-entry into care when observed in its intended target group. HOMEBUILDERS is family-centered and can address multiple concerns while reducing risk and increasing family functioning.

The primary known risk factors for child welfare involvement in Michigan for this target population include parental and youth **substance-use**; parental and child **mental health**; and **domestic violence**. HOMEBUILDERS staff are equipped to address

multiple concerns that increase family functioning and reduce multiple risks by using in-depth assessment via the North Carolina Family Assessment Scale, Motivational Interviewing, cognitive-behavioral therapeutic approaches, and intensive subject matter and intervention training. This provides HOMEBUILDERS with a means to target specific problem areas and address them accordingly using internal or external resources. HOMEBUILDERS versatility includes reunification services for children returning from out-of-home placements. These examples make HOMEBUILDERS an ideal service option for Michigan families as they often have multiple areas of concern and priority of expedient, safe reunification.

A study of HOMEBUILDERS from 2002 indicated some states demonstrated better parenting skills with less use of inappropriate application of discipline, more use of alternative methods of discipline, setting firm limits, and more quality time including family recreation activities. One state reported a reduction in negative child behaviors while caseworkers observed growth in demonstrating affection to children and use of learning opportunities to promote positive behaviors. Family functioning also increased in some states, specifically in areas of economic insecurity.[1]

Subsequent child maltreatment remained low in experimental groups during HOMEBUILDERS interventions. Rates of placement, however, were similar between the experimental groups and control groups over time. Researchers indicated this was likely due to inappropriate application of the target group which included children at imminent risk of removal. The intentions of Michigan are to implement HOMEBUILDERS with fidelity while utilizing the resources available from the Institute of Family Development including their consultation services and quality enhancement system known as QUEST.[2]

Michigan is committed to reuniting families with children from foster care as quickly and safely as possible. As stated, HOMEBUILDERS can also be used for reunification services. A study in 1993 demonstrated 93% of families who participated in HOMEBUILDERS services for reunification did not have any subsequent out-of-home placements six and 12 months after conclusion of services. In contrast, the control group who received traditional services experienced a subsequent removal rate of 72%. This high rate of success significantly aligns HOMEBUILDERS with Michigan's priority of reunification.[3]

HOMEBUILDERS efficacy can be attributed, in part, by Motivational Interviewing (MI) as part of its standard service. MI is also listed as a well-supported intervention in the Title IV-E Prevention Services Clearinghouse.

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[1] Westat, Chapin Hall Center for Children, & James Bell Associates. (2002). Evaluation of Family Preservation and Reunification Programs: Final Report. Washington, DC: U.S. Department of Health and Human Services.

[2] Ibid.

[3] Walton, E., Fraser, M. W., Lewis, R. E., & Pecora, P. J. (1993). In-home family-focused reunification: An experimental study. Child Welfare, 72(5), 473-487.

As noted, substance use is an identified risk factor in Michigan. A study in 2010 by Dr's Field and Caetano indicated a significant reduction in alcohol use upon 12-month follow-ups after MI.[4] Another study demonstrated a decrease in cocaine use greater than 50% among participants of MI compared to assessment alone.[5]

According to a 2018 narrative review of 16 articles discussing the use and effectiveness of MI in child welfare, 12 studies suggested MI's "value in parenting skills, parent/child mental health, retention in services, parent/child mental health, substance use, and CW [child welfare] recidivism."[6] These studies point to MI's potential to address the risk factors of substance-use and mental health, and to enhance the likelihood of success of conjunctive services such as those aiming to reduce domestic violence.

Finally, the use of MI not only enhances the intervention but also has a synergistic effect coupled with Cognitive Behavioral Therapeutic (CBT) interventions. The implications of such indicate a wide range of benefits to families experiencing substance abuse, domestic violence, child and adult mental health issues, and child behavioral concerns.

A literature review conducted by Cameron L. Randall and Daniel W. McNeil published in 2017 notes that:

> *MI has been applied as an adjunct for treatments such as CBT [cognitive behavioral therapy] in order to increase motivation for and commitment to the intervention, especially when components of the treatment may be challenging (e.g., exposure, cognitive restructuring). […] Limitations and the preliminary nature of the work in this area notwithstanding, it appears that it is feasible to supplement or integrate CBT with MI and that doing so has the potential to improve treatment initiation and engagement, as well as clinical outcomes.*[7]

Several studies of the HOMEBUILDERS Model, as well as its use of MI in practice, demonstrate HOMEBUILDERS to be a well-supported program. The efficacy has been clearly demonstrated in child welfare practice for reunification services and implied for prevention services when applied to the appropriate target population. The HOMEBUILDERS model is designed to promote increased family functioning and child

[4] Field, C., & Caetano, R. (2010). The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with Hispanics. Alcoholism, 34(2), 262-271.

[5] Stein, M. D., Herman, D. S., & Anderson, B. J. (2009). A motivational intervention trial to reduce cocaine use. Journal of Substance Abuse Treatment, 36(1), 118-125.

[6] Shah A, Jeffries S, Cheatham LP, et al. Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society. 2019;100(1):52-67. doi:10.1177/1044389418803455

[7] Randall CL, McNeil DW. Motivational Interviewing as an Adjunct to Cognitive Behavior Therapy for Anxiety Disorders: A Critical Review of the Literature. Cogn Behav Pract. 2017 Aug;24(3):296-311. doi: 10.1016/j.cbpra.2016.05.003. PMID: 28871216; PMCID: PMC5580948.

safety. A holistic approach using multiple vectors to achieve these outcomes aligns with Michigan's target population and the priorities of the MDHHS.

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Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based, client-centered method designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through the stages of change. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible.

☑ *Broad application of MI*

MI is a cross-cutting intervention which has demonstrated flexibility and favorable outcomes to promote behavior change with a range of target populations, cultural backgrounds and for a variety of problem areas.

As stated earlier in this Prevention Plan, the primary known risk factors for child welfare involvement in Michigan for this target population include parental and youth **substance-use**; parental and child **mental health**; and **domestic violence**.

The Title IV-E clearinghouse lists parent/caregiver substance use as significant impact area for MI, which is supported by the extensive list of studies provided as sources on

the clearinghouse. In summary, “Adult well-being: Parent/caregiver substance use” showed an effect size of 0.16 and implied percentile effect of 6. Six individual studies detailed on the Title IV-E Clearinghouse showed positive statistically significant effect sizes in at least one outcome area.[8]

According to a 2018 narrative review of 16 articles discussing the use and effectiveness of MI in child welfare, 12 studies suggested MI’s “value in parenting skills, parent/child mental health, retention in services, parent/child mental health, substance use, and CW [child welfare] recidivism.”[9] These studies point to MI’s potential to address head-on the risk factors of substance-use and mental health, and to enhance the likelihood of success of conjunctive services such as those aiming to reduce domestic violence.

A study published in 2008 further demonstrates MI’s positive impacts on behavior change in domestic violence offenders.[10]

Though MI was originally designed to treat substance use disorders, there is clear evidence of expanded applicability, which covers all three of the primary risk factors addressed in Michigan’s Prevention Program.

- ☑ *MI as standalone intervention and an enhancement for the delivery of other EBPs*

MI has been shown to be an effective intervention when used by itself or together with a combination of other treatments to reduce risk of abuse/neglect and placement into out of home care. Michigan intends to capitalize on the benefit of being able to use MI independently as part of the case management practice model and the Substance Use Disorder Family Support Program as well as adjointly with other prevention services, such as those listed in this Title IV-E Prevention Plan.

A literature review conducted by Cameron L. Randall and Daniel W. McNeil published in 2017 notes that:

> *MI has been applied as an adjunct for treatments such as CBT [cognitive behavioral therapy] in order to increase motivation for and commitment to the intervention, especially when components of the treatment may be challenging (e.g., exposure, cognitive restructuring). […] Limitations and the preliminary nature of the work in this area notwithstanding, it appears that it is feasible to supplement or integrate CBT with MI and that doing so*

[8] Title IV-E Prevention Services Clearinghouse. Accessed 10/20/2021. https://preventionservices.abtsites.com/programs/256/show

[9] Shah A, Jeffries S, Cheatham LP, et al. Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society. 2019;100(1):52-67. doi:10.1177/1044389418803455

[10] Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. Violence and victims, 23(5), 558-570.

has the potential to improve treatment initiation and engagement, as well as clinical outcomes.[11]

Additionally, Mark Chaffin, et al, reported in 2011 a synergistic relationship between self-motivational orientation and parent-child interaction therapy among parents with chronic and severe child welfare histories. These results were found both in a laboratory setting and a field implementation setting.[12]

Case management staff and supervisors who work with candidate populations will be trained in MI. Case management staff will utilize MI techniques to engage with caregivers and motivate them toward positive behavior changes. This in and of itself can be a critical component of successfully reducing the risk of foster care. Furthermore, MDHHS expects MI to support positive behavior changes that make it likely the family will experience success and positive outcomes from other EBPs provided to the family. Contracted service providers may also provide MI as a component of their service delivery model to better enhance the primary contracted service, such as the Substance Use Disorder Family Support Program (SUDFSP).

As part of SUDFSP, all specialists and supervisors utilize MI and apply this evidence-based approach with fidelity. Within 60 days of starting employment, all new specialists and supervisors will complete a 20-hour training through Improving MI Practices which includes 10 different modules. In addition, supervisors will receive 5 additional hours of supervisory training. Following this training, specialists will complete 90 days of coaching which includes shadowing from supervisors who will score the observed interaction using the Behavior Change Counseling Index (BECCI). Feedback will be provided to the specialist during supervision to assist in the continued growth of MI skills.

☑ *Sufficiency of evidence relevant to Michigan's target population*

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

[11] Randall CL, McNeil DW. Motivational Interviewing as an Adjunct to Cognitive Behavior Therapy for Anxiety Disorders: A Critical Review of the Literature. Cogn Behav Pract. 2017 Aug;24(3):296-311. doi: 10.1016/j.cbpra.2016.05.003. PMID: 28871216; PMCID: PMC5580948.

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previous studies and evaluation reports and the applicability to Michigan's prevention population, MDHHS believes that CQI measures will be sufficient.

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Multi-Systemic Therapy

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

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

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

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

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

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

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Brief Strategic Family Therapy

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

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

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

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

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

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

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

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

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Section VII: Child Welfare Workforce Training and Support

Pre-print Section 5

Training Plans and Strategies for Child Welfare and Juvenile Justice Workforce

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

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

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

will also undergo enhancements to include specific information about prevention programs and new processes as it relates to determining eligibility and child-specific prevention plan development. The PSI training also includes a half day training on the Indian Child Welfare Act. This training educates CPS, Foster Care, and Adoption workers on MDHHS policy regarding the Indian Child Welfare Act (ICWA) as well as practice. The training will provide frontline staff the opportunity to identify obstacles to the application of these policies and practices. Thorough and inclusive safety assessment and planning increases immediate child safety, assists in better placement decisions, and can enhance worker relationships with families, courts, and other community partners. The workforce training task team will review this training and offer recommendations for inclusion of FFPSA related competencies to develop, deliver, and conduct assessments and child-specific prevention plans for Tribal children. All recommendations will be shared with and reviewed by the Tribal workgroup for feedback.

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

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

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

Develop a new Family First training module

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

1) Family First overview.

2) Caseworker supports and sequencing activities.

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

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

Trauma specific assessment tools to ensure a trauma-informed workforce

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

Integration of an equity lens to training

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

Targeted training to identify candidates and service linkage

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

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

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

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

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

4. ***Goal 4:*** Identify changes required to the Comprehensive Child Welfare Information System (CCWIS) to capture data required for Plan of Safe Care reporting to the National Child Abuse and Neglect Data System (NCANDS) and to inform agency leadership about Plan of Safe Care implementation.

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

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

Recommended for new hires within a year of hire date
NCSACW Online Tutorial for Child Welfare Training | National Center on Substance Abuse and Child Welfare (NCSACW) (samhsa.gov)

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

Working with Substance Affected Families Webinar Training
Office of Workforce Development &Training Webinar Series

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

Webinar 1
Reduce the stigma we may unintentionally be displaying towards clients who use substances and help instill a desire to partner with them.

Webinar 2
Discuss the tools and resources available to caseworkers to assist in identifying substance abuse issues. Evaluate the impact of substance use on the Townsend family (case study).

Webinar 3
Discuss the substance use recovery process—what recovery means, caseworker role in the process, and how to assess the person who uses substances to determine family safety and parenting time. Review the Townsend family case study again and look at how we can create a long-term safety plan for them.

Webinar 4
The facilitator will lead a panel of internal and external partners to answer questions related to field practice with families who have substance use issues. The discussion will summarize/reinforce the topics discussed in webinars 1 through 3. Learners will listen to success stories from champions in CPS and foster care. Learners may also share their own experiences.

Mentorship

Experienced caseworkers in the field are assigned to all new employees as part of PSI to provide hands-on support in the field. Mentors assist new hires in progressively building case practice knowledge and shadow the new hire as they complete key activities in a case. The mentor will model and demonstrate key practice skills for engagement with families and linkages to services as part of direct field assessment activities. They serve as a secondary support and liaison between the caseworkers, their supervisor, and the community. Additionally, field mentors will serve as a Family First prevention services expert to assist new caseworkers in engaging with families to identify needs and connect families with appropriate prevention services. This will include support in building out the new caseworkers' resource list. Private foster care caseworkers that will be identifying and linking candidates to services also have access to the mentor training and support. All counties have identified two ICWA Points of Contact and these individuals will be trained in FFPSA requirements to support Tribal governments implementing prevention activities. Tribal governments with a Title IV-E Prevention Agreement with MDHHS choosing to provide ongoing oversight of child-specific prevention plans will be required to participate in training regarding FFPSA requirements. As part of the PSI Re-design, Mentoring is being redesigned to have a universal structure across the state of Michigan. This includes MDHHS child welfare staff, private agencies, and will also be available to Tribal governments. The goal is to create a standard training for mentors and applying core principles that will enhance policy to practice and staff retention.

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

MDHHS plans to develop Learning Labs for caseworkers to develop skills to identify children and families' service needs for the child-specific prevention plan development related to Family First. These trainings occur in the field as a refresher to content provided in PSI and NSI. They are more individualized and able to be tailored to specific case scenarios as caseworkers gain more field experience. The Learning Labs will support individual capacity building and will be provided after receiving PSI training and

a foundational understanding of Family First legislation (candidacy eligibility determination, prevention programming, ongoing safety monitoring). Learning labs offered during PSI currently include report writing, adoption assessment, critical thinking, consent, and subsidy, staying organized, Safety/Risk/FANS/CANS assessment and safety planning.

Training for juvenile justice specialists

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

Motivational Interviewing training for caseworkers

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

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

Training for Tribes

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

EBP Provider Workforce Training

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

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

Section VIII: Prevention Caseloads

Pre-print Section 7

Families served by MDHHS CPS, foster care, juvenile justice specialist, or a contracted Child Placing Agency caseworkers have established caseloads as identified in the chart below. CPS and foster care caseloads were derived from a caseload study completed by the National Council on Crime and Delinquency. MDHHS adopted the recommendations from the caseload study. Caseloads for foster care and juvenile justice staff were included in Michigan's Child Placing Agency Licensing rules, R400.12205 Required Staff. Caseloads are monitored by each county and agency director as well as by Business Service Center (BSC) directors and executive leadership.

Currently, MDHHS does not have a set case load ratio for prevention workers serving children that do not have confirmed abuse/neglect or for Post Adoption Resource Center caseworkers serving families whose adoption or guardianship is at risk of disruption or dissolution.

MDHHS prevention workers will maintain a caseload ratio of 1:17 families. The caseload ratio is based on current practice in counties with active prevention workers serving families in the Prevention Services for Families pathway.

When a prevention caseworker also maintains cases where the caseworker is functioning as a secondary worker for families engaged in an evidence-based home visiting program, each family will be weighted as .5 (half a case) in the caseload ratio. The prevention caseworker will not exceed a 1:17 caseload when the caseload is mixed.

The prevention monitor will perform such duties as receiving updates and processing documents related to the program, assure start and end dates of service and other data elements are accurate, serve as a contact person for the home visitation provider, and serve as a connection for any changes in service status.

Caseworkers serving families in post adoption instances have mixed caseloads supporting families with various level of needs. The average caseload sizes for families receiving case management services from the Post Adoption Resource Center caseworker is between 1:8 (families) to 1:10 (families). Supervisors monitor caseloads to ensure that sizes are appropriate based on a variety of factors including worker experience and casework requirements. MDHHS will monitor and oversee caseload standards through ongoing CQI practices and will make recommendations for a standard caseload size based on ongoing analysis.

Community-based private prevention providers will maintain caseloads in accordance with the individual EBP model. Fidelity to the model will be included in MDHHS contracts, monitored, and overseen as part of the contract monitoring by the Community Service analysts within each Business Service Center. Requirements

specific to caseload, staffing, trauma-informed model, and training will all be embedded within contractual documents and monitored through site visits, meetings, and report reviews utilizing the contract monitoring tool.

MDHHS in partnership with Tribal governments through the Tribal Prevention Workgroup will propose a caseload that meets each Tribe's specific needs. Once a caseload size is determined, a monitoring plan will be included in the IV-E Prevention Agreement for Tribes electing to provide ongoing oversight of child-specific prevention plans. At the writing of this plan, maintaining caseloads that align with CPS ongoing workers is being discussed.

Table 8. Family First Caseloads

Prevention Staff	**Caseload standard**
MDHHS In-home CPS Ongoing worker	1:17 (families)
Public or Private Foster Care worker or juvenile justice specialist	1:15 (children)
MDHHS Prevention worker/Monitor	1:17 (families)
Post Adoption Resource Center caseworkers	1:8 (families) to 1:10 (families)
EBP community provider	In accordance with individual EBP caseload standards