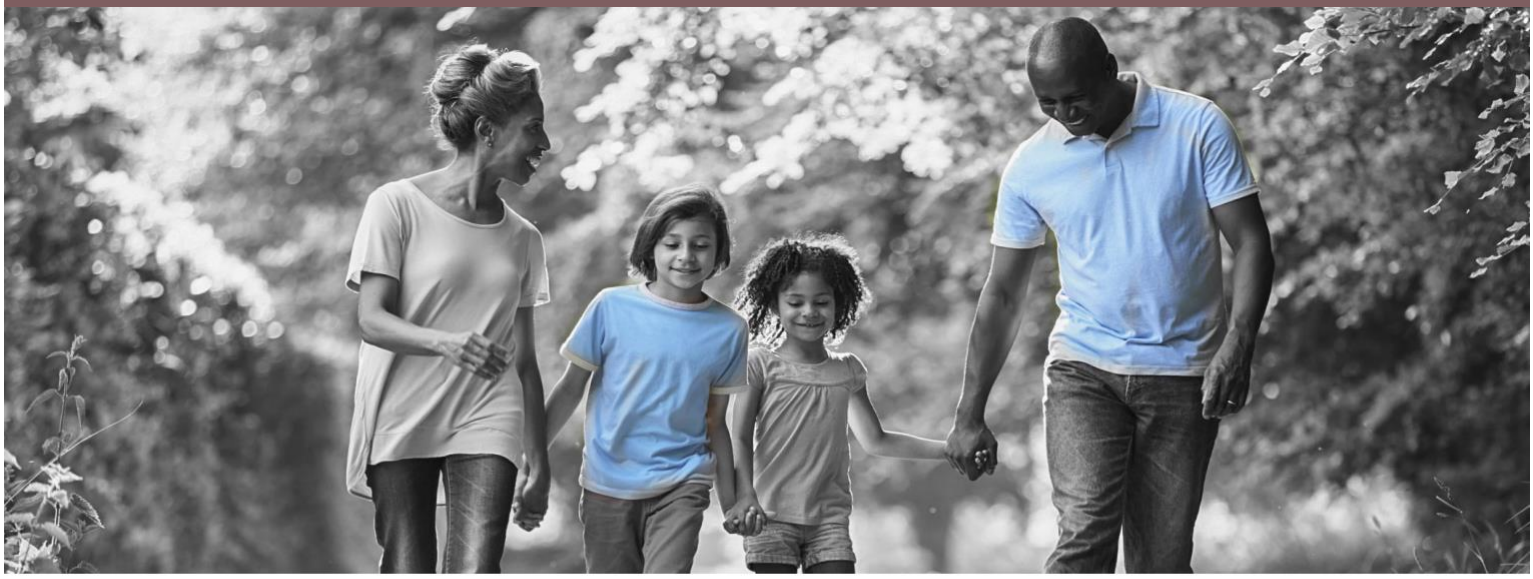
South Carolina:

Building Strong and Thriving Families

Title IV-E Prevention Plan



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As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the

South Carolina Department of Social Services

submits here a plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended, or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

Section I: Introduction

Pre-Print Section 4 (Consultation and Coordination)

The South Carolina Department of Social Services ("the Department" or SCDSS) is charged with protecting the state's most vulnerable populations; its mission, to promote the safety, permanency, and well-being of children while strengthening families. The Department's core principles of competence, courage and compassion serve as a foundation for our efforts. The Department envisions a child welfare system that is trauma-informed, family-centered, strengths-based, and culturally-responsive. Our goal is to ensure that children and families thrive in their communities.

On Feb. 9, 2018, President Donald Trump signed the Bipartisan Budget Act of 2018 (H.R. 1892) into law, which included the Family First Prevention Services Act (FFPSA; Public Law 115-123). This Act dramatically changed the way Title IV-E funds can be spent by states and points the nation toward robust prevention strategies. Multiple reforms within the legislation provide a novel opportunity for child welfare to transform into a system of well-being for children and families. This legislation, paired with our mission and vision, uniquely poises the State for systemic transformation.

Family First authorizes states, territories, and tribes with an approved Title IV-E prevention plan to provide time-limited prevention and treatment services for mental health, substance use prevention and treatment, and for in-home parent skill-based programs. Services may be provided to children who are identified as "candidates" for foster care and their parents or kin caregivers. It is through the provision of these empirically sound interventions and services that states may strengthen families, reduce the number of children entering out of home placements, and prevent the trauma associated with separating children from their family and natural supports.

The Department is electing to implement the optional Title IV-E Prevention Program authorized by Family First. We believe that by seizing this opportunity, the Department and our South Carolina partners will be able to leverage available resources to better achieve our mission and strategic vision of transforming to a system of well-being for the children and families of South Carolina.

Vision and System Transformation

Family First has come at an opportune time for South Carolina as the Department is currently undergoing tremendous system transformation. Our engagement in *Thriving Families, Safer Children: A National Commitment to Well-Being* (*Thriving Families*) exemplifies our commitment to promoting well-being of children, strengthening families, preventing foster care entry, and redesigning our system that envisions a system of well-being for children and families. South Carolina, and the three other jurisdictions in our cohort, aim to move the child welfare system from its traditional reactive child protection approach to a cross-sector system designed to support holistic and equitable child and family well-being. *Thriving Families* will require collaboration across public, private, and philanthropic sectors to design a system of well-being and to develop strategies to prevent child maltreatment and avoid unnecessary family separation.

Thriving Families and Family First together will create and enhance our networks of community-based supports, therefore strengthening South Carolina's prevention continuum and ability to achieve a true prevention and well-being orientation. Furthermore, a core tenant of both is engaging a diverse set of community stakeholders, including families and youth with lived

experiences, to identify supports, resources, services, and approaches to meet the unique needs of families and promote conditions to help them thrive. As the Department continues in its effort to become a prevention-oriented system, *Thriving Families* will offer important lessons that can be integrated in a later iteration of our Prevention Plan.

The Department believes that being in a safe and supportive family positively impacts a child's development. While most families can care for their children with the support of their family, friends and community, some need the additional support of our child welfare system and network of community partners. Providing supportive and preventive services to our most vulnerable children and families is necessary and urgent. Our success is dependent on our ability to engage, assess, team, and plan with families, and communities, so that families are not navigating this unfamiliar and often difficult path alone.

Our vision and system transformation are designed to provide the support necessary so that children and families get what they need, when and where they need it. The Family First Prevention Plan detailed herein articulates how South Carolina strives to elevate family voice and choice, fully understand individual strengths and needs, honor culture and beliefs, be sensitive to the trauma experienced, provide responsive services that are aligned with their needs, and collaborate as partners with families to achieve common goals. Ultimately, our Family First Prevention Plan is designed so that children's holistic well-being is improved, and their families stronger after engaging with us.

In addition to the pairing and cross-leveraging of *Thriving Families* and Family First, the Department is deploying a set of specific transformation strategies. Each is described below. These strategies combine to amplify each other and serve cohesively towards the development of a system of well-being for children and families across the entire child welfare continuum—from prevention to aftercare. Additionally, the Department, alongside its partners and stakeholders, are engaging in systems learning and continuous quality improvement in order to identify, deploy, and scale additional cross-sector strategies necessary to create a System of Family and Child Well-being. Our Prevention Plan provides a roadmap for the next five years. The Department will learn a great deal during that time in partnership with families, communities, and stakeholders. As that learning occurs, we anticipate augmenting our approach based on what works and the gaps we identify.

Strengthening SCDSS Workforce: Practice Model Development, Training, and Supervision

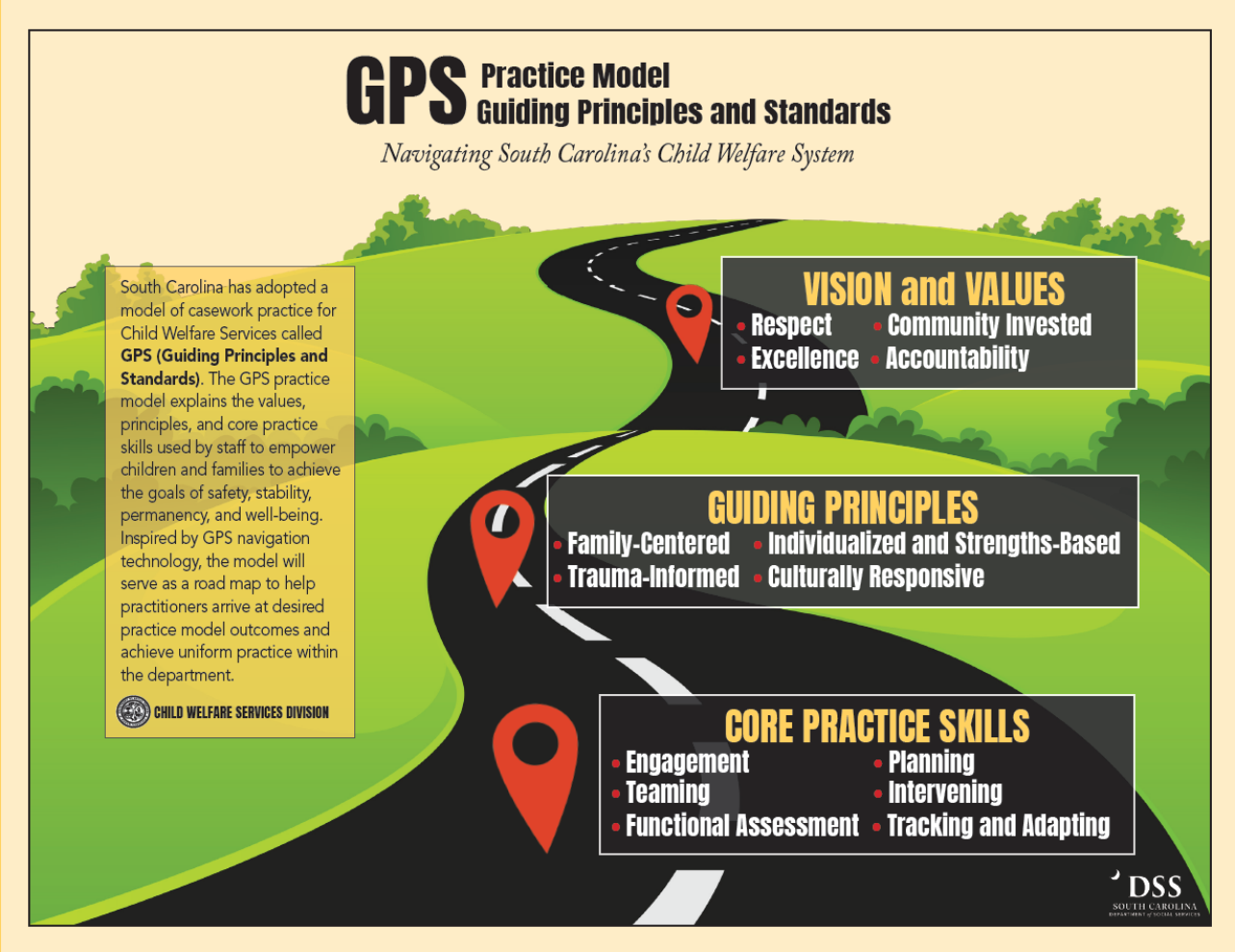
Guiding Principles and Standards (GPS) practice model and child and family teaming

The Department has developed and is implementing its Guiding Principles and Standards (GPS) practice model for Child Welfare Services. This new practice model will serve as a catalyst for the culture changes requisite for successful implementation of Family First. As a roadmap for daily practice with families and their support teams, the GPS practice model establishes a new vision for teaming with and serving children and families, demonstrates a commitment to a different way of working with communities and the broader child and family well-being system, and challenges long-held mindsets about how to partner with families.

The GPS practice model values are the behaviors and qualities we seek in those we hire and contract with for services. As we train and coach the workforce and educate partners on the approach and skills necessary, we expect the guiding principles to be present in every interaction with children, families and community partners. The values and guiding principles align with the

goals of Family First including the recognition that all families are worthy of and deserve respect; services are data-driven, evidence-informed and culturally relevant; a trauma-informed service array is available to meet the needs of families; and the workforce can deploy the array of community-based services and supports available to meet the needs of the children and families we serve.

Figure 1. SCDSS GPS Practice Model



The Department, as a core component of the practice model, is implementing a collaborative assessment approach and child and family teaming. Families and their support teams are at the center of assessment and decision-making in the team meetings and throughout the teaming process. Teaming with families will elevate their voice and promote alignment of service selection to assessed needs.

In order to ensure the new practice model is deployed consistently with families, the Department is redesigning the Child Welfare Pre-service Certification and ongoing in-service training. In 2019, the Department's Staff and Training Team began its partnership with Affinità Consulting and the University of South Carolina, Center for Children and Families Studies to assess current training and create the new curriculum. The new training curriculum focuses on strategies for building a prevention-oriented system by including an emphasis on how SCDSS staff can leverage kinship relationships and natural supports to preserve family relationships in order to prevent future

maltreatment and reduce the need for foster care. The training also provides guidance to staff to disrupt bias and overcome personal barriers to ensure best practice and encourage prevention opportunities for the best interest of the families. Chapin Hall at the University of Chicago is providing capacity building as SCDSS stands up new training and coaching of the workforce in child and family teaming. This includes train-the-trainer efforts so that the Department builds ongoing coaching capacity. Lastly, the Department established the Child Welfare Certification Review Team, made up of frontline DSS supervisors, county and regional leadership, consent decree monitors, and central office program staff, to assist with the training review and finalization. The new training curriculum will be completed in January 2021 and piloted in the Spring of 2021.

Along with training on the practice model and child and family teaming, the Department is working with the Capacity Building Center for States (the Center) to enhance supervisory practice. In collaboration with the Center, SCDSS is providing their supervisors workforce change management and other professional development through training and coaching on evidence-based practices so that supervisors, in turn, can train and coach frontline staff setting both expectations and accountability to an organizational culture focused on prevention and children remaining safely in their home. Using this approach, supervisors will engage with workers ahead of contact with families to prepare case managers to assess needs and identify strengths and opportunities to strengthen families and avert foster care entry.

In 2020, the Department established the Training Advisory group comprised of SCDSS and their organizational consultants and partners (e.g., Chapin Hall at the University of Chicago, the Center, the Annie E. Casey Foundation, the Center for Innovation in Public Health at the University of Kentucky and others involved in the Department's transformation to increase prevention of child maltreatment and foster care reduction). The Training Advisory group is focused on coordination and planned service delivery to support efforts to train and coach the SCDSS workforce on the implementation of the GPS practice model and evidence-based practice. Through the combined assistance of these consultants, SCDSS has already begun to see several positive changes in their practices as they work towards building their prevention framework to strengthen families and keep children out of foster care.

Strengthening SCDSS Infrastructure

The Department recognizes that along with an effective workforce, it needs the tools and accountability mechanisms to ensure family decision-making is informed by the best possible evidence. To that end, since 2019, the Department has been working to embed the Structured Decision-Making (SDM) tool into its intake screening model and is building an improved Continuous Quality Improvement system to strengthen our accountability to positive outcomes for children, youth, and families. Both initiatives will be important to an effective implementation of our Family First Prevention Plan.

To further improve practice and decision-making, the Department's Office of Safety Management has been partnering with the Center to improve safety practices and decision making across the continuum of care, from intake to case closure. The Center's efforts have focused on research, design, development of practice and policy; training; CQI to improve fidelity to practice; improve consistency of decision making at intake; investigation finding decision making; safety assessment threat criteria and safety decision making, in-home safety plan analysis to accurately determine if children can safely remain in the home and prevent out of home care; and, safely and timely reunify children from out of home placement thus reducing the foster care population. All of these activities, individually and in the aggregate, support one or more goals of Family First.

With support from the Center's Safety/In Home Services and Training Advisory group work, SCDSS is focused on creating an organizational culture focused on prevention services and maintaining the safety of children while continuing to keep children safely in their home and engaging families in a collaborative manner. Training and coaching the agency's workforce to set these expectations and hold the workforce accountable to this culture further promotes the Department's goals for Family First.

Assessment of Child and Family Needs and New Tools

Beginning in 2019, the Department has been engaged with the Children's Research Center to develop and implement the Structured Decision-Making (SDM) tool, a tool designed to analyze the information gathered during initial intake and assessment to determine whether a safety threat exists that meets the criteria warranting screening into a CPS investigation. The SDM differs from other assessment tools used during the course of an investigation, as there is a much lower threshold at the time of intake. Additionally, the Department is implementing the Family Advocacy Support Tool (FAST), a family preservation decision-making framework that will be aligned with strategies for improving assessment, engagement, safety and case planning, and the provision of services. While the SDM informs intake decisions, the Family Advocacy and Support Tool (FAST) will be completed at investigations and throughout the family's involvement with family preservation. Investigators are trained to utilize information gathered through the SDM and integrate it into the scoring of the FAST. Similarly, the Child & Adolescent Needs and Strengths (CANS) will be utilized with pregnant and parenting youth in foster care and will include information gathered through the SDM. (Please find a detailed description of SC-DSS implementation plans for the FAST & CANS below). With multiple assessment tools in place, integration of information is key. The FAST & CANS training that investigators, case managers, and their supervisors participate in emphasizes the importance of integration of all risk, safety, needs, and strengths data gathered throughout the case. Decision-making is enhanced through the use of these tools. The workforce has data points informing the opportunity for prevention, the need for specific interventions, measure progress or a lack there of overtime, and case closure.

Our historical data show that too many families enter the child welfare system unnecessarily and family preservation cases remain open far longer than is helpful to the family. The use of strengths-based assessment tools, like the FAST and later the CANS, will help increase practice consistency and assessment accuracy as well as help to limit bias and subjectivity in decision-making that can be harmful to children and families. These tools are also intended to help the Department determine with greater specificity which families can be served by prevention services rather than through foster care placement.

The implementation of the Family Advocacy and Support Tool (FAST) and the Child and Adolescent Needs and Strengths (CANS) are integral pieces of SCDSS' work to improve assessment of the needs of children, youth and families. In mid-2019, when initial engagement began, SCDSS approached the provider community for their recommendations for assessment and planning tools. The providers overwhelmingly recommended the CANS for youth in foster care and FAST for investigations and family preservation.

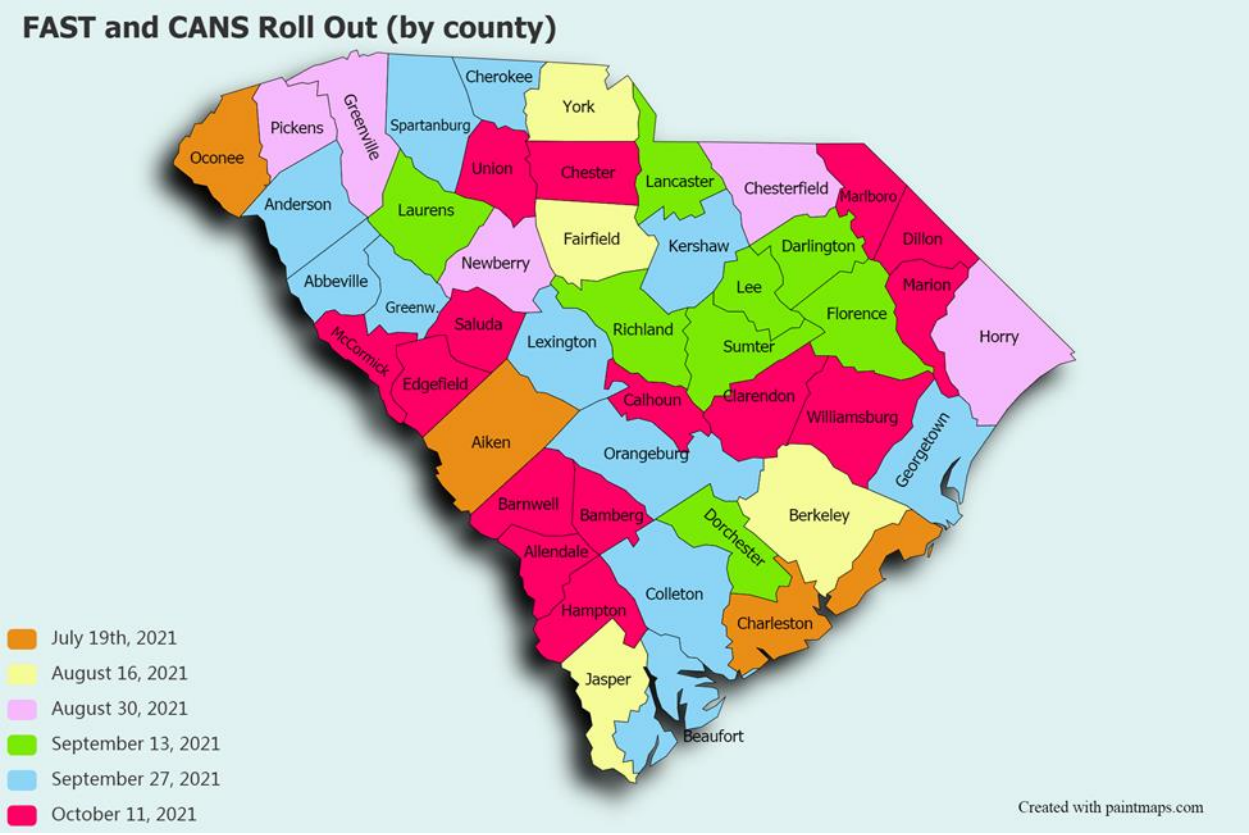
In September 2019, SCDSS staff engagement began with a workgroup that assisted in crafting a FAST/CANS reference guide and algorithm well suited to the state's specific needs. With support and assistance from the Praed Foundation, the FAST/CANS has been developed and was introduced to internal staff and the provider network in March 2020. Engagement continues

through information about FAST and CANS being embedded in other trainings such as the Child and Family Team Meeting trainings conducted quarterly throughout the agency.

Implementation science teaches us that Engagement, Implementation, Feedback Loops and Sustainability phases are crucial to implementation success. The implementation phase began in September 2020 with Assessment and Planning Coordinators receiving FAST/CANS training and certification. The four regional Assessment and Planning Coordinators will serve as subject matter experts and consultants for Case Managers and Supervisors who will be completing the FAST/CANS. Implementation for frontline staff will begin with five-county pilot in two different regions in February 2021.

Through implementing reforms, SCDSS has learned that training supervisors first to prepare them to implement any new practice is crucial in successful implementation and adoption of new practices. For the pilot counties, Investigations, Family Preservation, and Foster Care Supervisors will receive the Transformational Collaborative Outcomes Management (TCOM) training. This is an introductory training that helps staff understand what the FAST and CANS are and how they can be used for assessment purposes. Next supervisors will receive the FAST/CANS Item Orientation training in small groups of 25. This training is intended to help staff build skills in completing the FAST/CANS. This cohort of supervisors will also receive two other trainings, a Supervisor Training on how to supervise staff completing the FAST/CANS and Action Planning, translating FAST/CANS into service plans for children, youth, and families. Once supervisors are trained and working towards certification, case managers will then begin the TCOM, Item Orientation, and Action Planning training in March and April 2021. Using lessons learned from the four pilot counties, implementation will begin in the remaining six CFSR Program Improvement Program counties and finally statewide in October 2021.

Figure 2. FAST/CANS Roll-Out Dates



One of the key lessons learned during SCDSS' reform work thus far is how crucial feedback loops are, both in frequency and early in the process to successful implementation. Currently, implementation feedback loops consist of open weekly calls with frontline staff implementing and planning the reforms. Subject matter includes understanding concerns, addressing barriers and adapting implementation strategies. Implementation of the FAST/CANS will also use this strategy.

Once statewide implementation is completed, work to continually improve implementation of the FAST/CANS will be ongoing. One mechanism for continual quality improvement is Praed's Collaborative Helping Quality Inventory Survey. This is a survey completed by youth, parent/caregiver and frontline professionals. This process will provide information on how youth, parent, caregivers, and frontline professionals are experiencing their work with FAST/CANS. Information from the survey will identify areas needing improvement. A key component of the frontline survey assesses the frontline professionals' supervisory experience. Survey results will help SCDSS know where supervision needs attention and how to address those deficits.

Continuous Quality Improvement

The Department is also engaged with the Capacity Building Center for States to develop a continuous quality improvement system that will deepen a culture of data driven decision-making. Current CQI activities are focused on increasing workforce knowledge and skills, providing critical feedback, tracking performance on the key child maltreatment and foster care indicators so that SCDSS can target additional training, coaching, supervision, and evaluation efforts in a data informed fashion. Our Family First continuous quality improvement strategy is a key component and described in detail in Section 6.

Each of the above-described transformation efforts underway are crucial to the Department's development of a System of Family and Child Well-being and the implementation of Family First. We anticipate significant improvements in the safety, permanency, and well-being of children and families over the course of our five-year Family First Prevention Plan and through the deepening of our commitment to become a prevention oriented cross-sector system of support for and with families.

Family First: Development of a full continuum of care for prevention services

The Department's initial Family First Prevention Plan is narrowly focused on building a sustainable system of care for children and families brought to our attention. This initial plan allows us to align initiatives across multiple child and family serving agencies with the long-term goal of removing the stigma of seeking assistance and making the shift to a broad child and family well-being system that encompasses a holistic, life-course approach that enables families to thrive and grow.

The Department has strong partners working to support families across the continuum of prevention services. The Children's Trust of South Carolina offers prevention resources and programming, prevention training and professional development opportunities, including Adverse Childhood Experiences (ACEs) training to community members and professionals. ACEs training helps attendees to understand the impact of adverse experiences on neurodevelopment. Children's Trust also convenes coalitions, like the South Carolina Child Well-Being Coalition seeking to improve opportunities for South Carolina families living in poverty.

The Department contributes to this continuum of prevention service in its support of statewide prevention services through its Community-Based Prevention Services (CBPS) contract(s). These services are aimed at addressing conditions affecting the stability of family life such as: poverty, parental experience, relational issues, and parental or child disabilities where child abuse and neglect are not currently present. These services are designed to help the family develop a plan for stability and to connect them with resources to assist in reducing further hardships that may lead to issues such as homelessness or abuse and neglect. The Department's CBPS services are provided to families exhibiting these conditions and assist them in building protective capacity and may include voluntary case management services, assistance with concrete needs, parent education and skill building, behavioral goal setting, home visitation, and counseling services.

South Carolina is also fortunate enough to have a range of well-established providers offering evidence-based prevention services including Nurse-Family Partnership, Strengthening Families Program, Parents as Teachers, Triple P, and Healthy Families America.

Despite having strong prevention partners, South Carolina's child welfare system, as with those in many other states, has long focused the preponderance of resources on its foster care populations and often overlooked the service needs of its non-custodial children and families. Examples of this are apparent in that all foster children are Medicaid eligible (if they are documented citizens) and subsequently are eligible for services that are included in the SC Medicaid State Plan. This coverage enables children to receive services targeted at addressing healthcare needs, behavioral health issues, trauma, and other psychosocial stress responses. Children in care also receive other Departmental supports such as therapeutic wraparound services, educational and training vouchers, and access to family support resources provided by other entities in the state. Whereas children and families receiving Family Preservation services historically have been responsible for financing the provision of services at their own expense. This reality creates a complex conundrum for our socio-economically disadvantaged families, as they are sometimes placed in a position to choose between paying for services and meeting their basic needs.

Notwithstanding these challenges, the Department is committed to resolving these systemic barriers as we work towards expanding prevention supports and resources to families and children brought to our attention. The Department envisions Family First as a core tool to address these challenges, by building a system over time that is equipped to meet the needs of children and families. Because South Carolina is still in its early stages of transformation towards a prevention-oriented system, the Department will start with a narrow Family First candidacy population, including families with active and open cases, in order to strengthen our approach and service array to eventually be able to serve families further upstream the prevention continuum.

Family First: Stakeholder consultation and coordination in planning and implementation

The Department recognizes the critical nature of engaging and coordinating with its community partners, key stakeholders, and other members of the broader South Carolina family and child well-being system. These partnerships are critical to the development and scaling up of programs and ensure the sustainability and longevity of a continuum of evidence-based services and a system of care that supports families.

SCDSS convened a prevention services workgroup with representation from the Department of Mental Health (DMH), First Steps, Child Advocacy Centers, Project Best, Department of Alcohol and Other Drug Abuse Services (DAODAS), South Carolina Primary Health Care Association (SCPHCA), Department of Health and Human Services (DHHS), Department of Education (DOE), National Youth Advocate Program (NYAP), South Carolina Youth Advocate Program (SCYAP), Justice Works Behavioral Health Services, Carolina Youth Development Center (CYDC), SAFY, South Carolina Infant Childhood Mental Health Association (SCIMHA), Behavioral Health Services Association (BHSA; County 301s), Citizens Review Panel (CRP), A Child's Haven, Epworth Children's Home, the Palmetto Association for Children and Families (PAFCAF), the South Carolina's Children's Trust, the South Carolina Continuum of Care (COC), and the South Carolina Department of Children's Advocacy (SCDCA), members of the Joint Citizens and Legislative Committee on Children (JLCC), along with a number of other community partners. The workgroup also includes SCDSS designated leads working in collaboration across multiple other initiatives including Thriving Families Safer Children, FAST/CANS implementation, Guiding Principles & Standards Practice Model, CFSR/PIP, and Michelle H Consent Decree. By including the leads of these initiatives in the prevention services workgroup ensures communication, alignment of efforts, and cross-project collaboration.

We are also committed to the inclusion of family and youth voice when developing and implementing systems of care and have included persons with lived experiences in the child welfare system such as birth parents, kin caregivers, and youth. The inclusion of family and youth voice is central to long-term systemic change, practice improvement, and effective service provision.

The prevention services workgroup has been central in supporting planning and decision making for Family First including:

- cataloguing the existing EBPs across South Carolina,
- reviewing relevant data to better understand the characteristics of South Carolina's candidacy population, and
- providing recommendations regarding which prevention interventions best align with the needs of children and families in South Carolina and therefore should be included in this Prevention Plan.

The creation of an inventory of family preservation services is one of the most critical supports that SCDSS is building to create and contract with a varied network of providers who can deliver evidenced-based family focused services on a statewide level. With assistance from the Center, SCDSS has created a user-friendly database for caseworkers and supervisors to access to find services in their geographic region. The services offered to families are focused on strengthening parental capacities and addressing root causes of child maltreatment through the provision of therapeutic and concrete services that address family needs in the hope of maintaining a child in their home and preventing out of home removals.

Additionally, a sub-group of the prevention services workgroup was established to assist the state with developing its new Qualified Provider Listing (QPL) and crafting a Family First evidence-based practice capacity building grant. The QPL is the mechanism by which standardized business processes and service definitions provide consistent operationalization of Family First across providers and expands the Department's array of high-quality providers able to deliver evidence-based child and family services throughout the state.

The prevention services workgroup has also assisted the Department in identifying cross-sector funding opportunities to supplement the reimbursement opportunities through Family First. The

Department has determined that in order to build an effective continuum of resources and services for families, it will need to leverage funding opportunities and will need to continue seeking public-private partnerships in order to uncover all available resources necessary for lasting transformation in South Carolina.

This prevention services workgroup will continue to serve as a feedback loop between the Department, other members of the state's shared child well-being system, and community partners to ensure resources are collectively supporting the needs of children and families across South Carolina.

Section II: Eligibility and Candidacy Identification

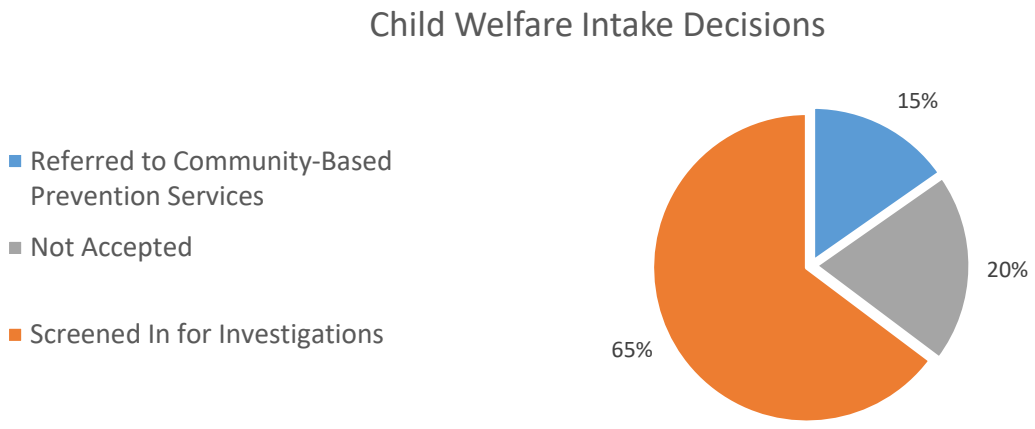
Pre-Print Section 9 (Child and Family Eligibility for Title IV-E Prevention Program)

Background Data

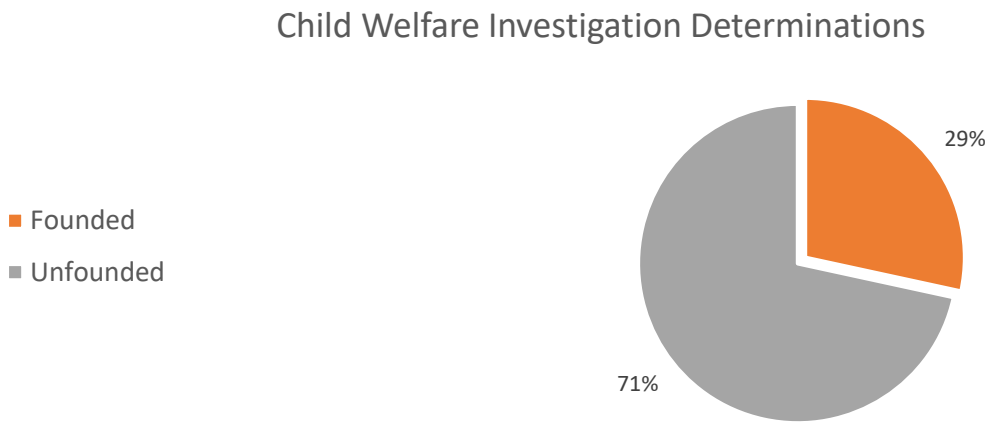
In 2019, the Department's Child and Adult Reporting Hotline received approximately 58,619 reports. Of those reports, 11,706 (20%) were not accepted as they did not meet the threshold to be screened in for investigation and required no further action; 8,959 (15%) were not accepted for investigation but did present with identifiable needs and were referred to Community-Based Prevention Services (CBPS); 37,954 (65%) were screened in for investigations.

Figure 3. Number of Reports by Intake Decision

Intake Decisions	# of Reports
Total Hotline Calls	58,619
Not Accepted (no further action)	11,706/20%
Not Accepted (identifiable needs, referred to CBPS)	8,959/15%
Screened in	37,954/65%



Of the reports accepted for investigations, 29% received a substantiated finding and 71% received an unfounded case determination. This percentage is a decrease in substantiated cases from previous years. In 2018, 33% of investigations were substantiated, and 35% in 2017. Investigations that received a substantiated determination led to the opening of a Family Preservation service case or Foster Care services.

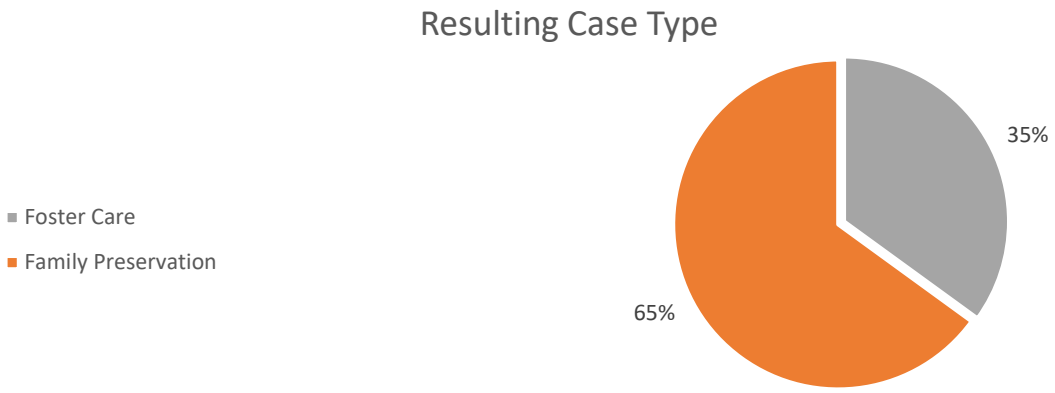


The Department undertook an analysis of the types of maltreatment present in founded cases during 2018 and 2019 in order to better understand the needs of children and families and the concerns bringing them to the attention of the Department. In both years, neglect and physical abuse were the top two concerns present in founded cases.

Figure 4. Number of Founded Instances of Maltreatment

Founded Types of Maltreatment	2019	2018	% Change
Abandonment	140	116	+21%
Contributing to the Delinquency of a Minor	34	43	-21%
Educational Neglect	841	793	+6%
Medical Abuse and Neglect	380	395	-4%
Mental Injury	71	98	-28%
Neglect	10,230	9,914	+3%
Physical Abuse	10,959	10,591	+3%
Sexual Abuse	1,026	1,070	-4%
Other	22	28	-21%
Note: Multiple maltreatment typologies may be associated with a single case			

Of the cases that were founded in the 2019 review period, approximately 65% were referred to Family Preservation, and 35% resulted in foster care entry. In 2018, 32% of founded cases resulted in foster care entry, and 31% in 2017. SCDSS will deploy Family First prevention services to reverse this trend when appropriate.



During the same review period, approximately 30.1% (n=1242) of children had Family Preservation services directly prior to entry into Foster Care. The Department recognizes this is an opportunity for improvement and will use Family First as a tool for strengthening Family Preservation services and service delivery to families to prevent entry into foster care.

Family Preservation service cases represent approximately two thirds of children and families involved with the Department. These cases are non-custodial and receive short-term, family-centered services designed to assist, support, and strengthen families who have an indicated case of child abuse, neglect, or harm. Services may be delivered to a family voluntarily or by court-order.

Within Family Preservation, services are delivered while children are living in their homes whenever it is safe to do so. The goals of Family Preservation services are to strengthen parental and family capacity to care for and protect children, prevent further maltreatment and trauma, promote overall child well-being, and prevent the need for foster care. Services are deployed based on our mission and GPS values that: all children deserve a safe and stable home in which to grow and that they thrive when raised with their families, near their support systems, siblings, extended family, friends, and schools. In keeping with these goals, the Department will leverage Family First to build the service array and strengthen the support families receive when they enter Family Preservation.

Note: Functional assessment data are not presently available to better understand mental health, substance abuse, and parenting needs. The implementation of FAST/CANS will also serve as a core strategy that will support the Department's increased understanding of child and family strengths and needs.

Identifying Candidates

There are two populations eligible for Family First prevention services 1) children who are determined to be candidates for foster care and 2) pregnant or parenting youth who are in foster care. South Carolina estimates the number of pregnant and parenting youth in foster care to be approximately 22 youth currently. When a child is determined to be eligible, the child, parent, and/or kin caregiver of the child may receive prevention services. The pregnant and parenting youth in foster care may have open cases as parents, in addition to being a child in foster care on their own parents' case. If this is the case, both the parenting youth and their child are provided services and resources as children in the child welfare system. Based on a review of available data, the Department has developed the following definitions for its candidacy population:

1. All children under 18 named in a Child Protective Services Investigation (not in Foster Care), or
2. All children under 18 who are receiving Family Preservation services; including, but not limited to these risk characteristics:
    a. Parent has a substance use disorder
    b. Family has prior child welfare experience
    c. Family has a history of presence of domestic violence or intimate partner violence
    d. Family is in unsafe living conditions
    e. Child or parent has complex psychological and/or behavioral health needs
    f. Child is age 0 to 5
    g. Child is living with kin, but not in the custody of the State
    h. Child or parent has complex medical needs
    i. Child is dually involved with the juvenile justice system
    j. Child has experienced human trafficking
    k. Assessment identifies risk of harm
3. All pregnant or parenting youth in foster care

South Carolina's analysis of the families receiving Family Preservation services statewide as of June 2020, show that there were approximately 14,000 children under the age of 18. Most of these families would be Family First candidates based on the presence of imminent risk characteristics. Once the Department has demonstrated improved success with these families, we will consider expanding our candidacy population to include additional children and their families beyond Family Preservation.

Imminent Risk Criteria

A child meets the criteria for candidacy for Family First when they are determined to be at imminent risk for removal if the identified risk and safety issues are not be addressed through the provision of needed specific preventative services. The Department reviewed administrative data to assist in defining the criteria for imminent risk for out of home placement and found the presence of the following characteristics in a majority of Family Preservation cases. These characteristics will be used for determining imminent risk for Family First candidacy and eligibility for prevention services:

Families experiencing substance use disorder- Parental substance use disorders have been found to be a leading contributing factor associated with children entering case in South Carolina. From August to September of 2019, the Department conducted qualitative reviews of Family Preservation and Foster Care populations to evaluate the impact of the opioid epidemic and prevalence of substance usage. Findings indicated that 45% of all Family Preservation cases had a presence of substance use with approximately 21% of which resulted in entry into care.

Families with prior child welfare involvement- Families who have had prior involvement with child welfare are at higher risk of foster care entry. The Department analyzed its Foster Care population to understand the extent to which children and families receiving Family Preservation Services later entered foster care. At least 30% of children in Foster Care in calendar year 2019 had a Family Preservation service directly prior to coming into or concurrent at entry into foster care. Additionally, children and families who exit to reunification are often referred to Family Preservation for transitioning and monitoring and are at risk for re-entry into foster care. In some instances, parents or caregivers receiving Family Preservation services were themselves in foster care.

Families with a history of domestic violence- Families with a history/presence of intimate partner violence and other forms of domestic violence are at risk of entry into care. Data not currently tracked but will be tracked moving forward.

Families in unsafe living conditions- The Department finds that unsafe housing, including homelessness, creates significant family instability, elevating parental stressors that contribute to maltreatment and safety concerns for children.

Families with complex psychological and/or behavioral health needs- Families experiencing complex psychological or behavioral health needs, such as serious and persistent mental illness or other psychological/behavioral health issues are acutely sensitive to psychosocial stressors that may contribute to child maltreatment and foster care entry. The presence of this characteristic is known to be a contributor to family instability.

Families with children 0-5- Families who have children that are age five and under in the home are at risk for foster care entry. Children in this age group are uniquely vulnerable and can experience long-lasting neurodevelopmental impacts of child maltreatment without appropriate intervention.

Informal kinship living arrangements- Kinship families caring for children who are not in foster care may need additional support to ensure children can remain with their families. Approximately 14% of Family Preservation cases fall into this category, however, we believe that this percentage is under-representative of the actual percentage due to inconsistent recording in the CCWIS system.

Families with complex medical needs - Families with complex medical needs include various situations such as parents with medical challenges, medically fragile children, failure to thrive, and children with significant disabilities. Families with complex medical needs would significantly benefit from additional support to build their caregiver capacities and prevent entry into care.

Children and youth with juvenile justice involvement - The Department and the South Carolina Department of Juvenile Justice (SCDJJ) conduct data matching on an on-going basis to determine the number and percentage of its children in foster care who have or had active cases with SCDJJ. Children in foster care who had been involved with SCDJJ at any point in time is

approximately 24%. The Department created a proxy measure, based on its calculated ratios of children in foster care ages 10-17, to identify Family Preservation child populations that likely had concurrent involvement with SCDJJ prior to foster care entry. Using those ratios, we estimate that approximately 1,100 children ages 10-17 in open Family Preservation cases as of June 1, 2020 were also involved with SCDJJ.

Children who have been trafficked - Any child or youth under the age of 18 who is a victim of either labor or sex trafficking regardless of whether the perpetrator is a parent, guardian, or other person responsible for the child's welfare.

Families with identified risk of harm - In addition to the specific populations of children and families identified above, SCDSS will use the Family Advocacy and Support Tool to rigorously identify families with elevated risk of harm, which places their children at imminent risk of foster care entry. This would also include families where there has been a child fatality or serious injury.

Candidacy Determination

The Department will automatically flag eligible candidates based on imminent risk criteria embedded within the assessment tools. Once the workforce enters the assessment findings into the CAPSS data system, eligible candidates would then be identified for Family First in CAPSS using the IV-E eligibility wizard and FAST.

South Carolina will be using the Family Advocacy and Support tool (FAST) to assist in determining eligibility and subsequent referral to appropriate evidence-based interventions. The FAST, a multi-purpose planning and decision support tool, with assist the case manager with the comprehensive family assessment that is completed in conjunction with families and their child and family team. Using the FAST, the case manager, along with the child and family team, will ensure services are matched to identified needs. The FAST will also assist in tracking the family's progress in services and as a communication tool across the family and child serving partners.

The FAST includes questions that align with the Department's imminent risk criteria for Family First candidates. Using the FAST, the investigator or case manager identifies specific imminent risk criteria. Once the investigator or a case manager enters the child and family's specific assessment information into the FAST, and a defined imminent risk is noted related to the candidacy determination, CAPSS will flag that youth and/or family as an eligible candidate.

The investigator or case manager will be in consultation with his/her supervisor during the functional assessment and candidacy determination process. Once candidacy eligibility has been determined, the investigator or case manager will consult with the supervisor to begin the development of the child specific prevention plan and service selection process as described in Section 4 of this Prevention Plan.

Figure 5. Candidacy Eligibility

Candidacy Population	Staff Determining Eligibility	Process of Determining Eligibility
Children under 18 (not in Foster Care) named in a CPS Investigation, OR	Investigations Case Manager and Supervisor	FAST/IV-E Eligibility Wizard, once the investigator enters the child and family assessment information into CAPPS to determine if 1 or more imminent risk criteria is met
Children under 18 being referred to or receiving Family Preservation with 1 or more imminent risk criteria, which can be determined via three (*3) eligibility pathways:*		
1. Through an investigation	Investigations Case Manager and Supervisor	FAST/IV-E Eligibility Wizard, once the investigator enters the child and family assessment information into CAPSS,
2. Existing Family Preservation case	Family Preservation Case Manager and Supervisor	FAST/IV-E Eligibility Wizard, the case manager updates the child and family assessment information into CAPSS at specified intervals.
3. Exiting Foster Care and entering Family Preservation	Foster Care Case Manager/Family Preservation Case Manager and Supervisors	CANS at discharge from Foster Care FAST, at Day 14, after the family moves into Family Preservation.
Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager and Supervisor	CANS, or when the Foster Care Case Manager becomes aware the youth is pregnant or parenting.

Identifying pregnant and parenting youth

Since Family First includes pregnant and parenting foster youth as an eligible population for prevention services, case managers will assess each pregnant and parenting youth in foster care, using the CANS, to determine when a prevention plan is needed to support their healthy parenting and avoid their child being placed away from their care and into Foster Care.

Eligibility documentation

Once the Investigations or Family Preservation case manager enters a child and family's FAST assessment information into CAPSS, the Department's information system, their eligibility will be automatically flagged and documented using the IV-E Eligibility Wizard. CAPSS will also be used to identify and document pregnant and parenting youth in foster care for FFPSA services. The pregnant and parenting youth's CANS will help determine the appropriate service needs.

Section III: Title IV-E Prevention Services

Pre-Print Section 1 (Service Description and Oversight)

Evidence-Based Practices

There is an ever-growing body of empirically-supported interventions that are prevention-focused and address the behavioral, social and emotional needs of child welfare-involved children and families. Family First requires that states utilize prevention services in the categories of mental health and substance use prevention and treatment and in-home parenting skills; and that they be evidence-based, trauma-informed and rated as “promising,” “supported” or “well-supported” by the title IV-E Prevention Services Clearinghouse, to receive federal reimbursement for these services.

South Carolina believes that by (a) anticipating the underlying needs driving the involvement of children and families when they enter the child welfare system, and by (b) rethinking the structure of services delivered throughout the system (i.e. via GPS practice model), and through (c) scaling up evidence-based interventions, we can better achieve meaningful and measurable improvements in child safety, permanency and child and family well-being. With this in mind, South Carolina is committed to introducing and expanding its use of evidence-based practices (EBPs) that are most likely to result in positive outcomes for children and families, and to measuring the impact of these approaches for the children and families we serve.

Landscape of Evidence-Based Practices in South Carolina

In early 2020, the Department partnered with the University of South Carolina’s Institute of Families in Society and the South Carolina Department of Licensing, Labor, and Regulation (SCLLR) to develop and disseminate a survey to help the Department better understand the landscape of evidence-based practices, provider readiness, and provider self-efficacy with evidence-based practices across the state. The SCLLR disseminated the survey via email to all licensed professional counselors, marriage and family therapists, social workers, psychologist, psycho-educational specialists, addiction counselors, and physicians. Concurrently, the Department, Palmetto Association for Children and Families (PAFCAF), and the Behavioral Health Services Association (BHSA) made their network providers aware of the survey to expand the reach of dissemination.

Over 2,600 individuals responded to the survey, with approximately half reporting they were currently serving children, families, or caregivers. Of the 1,298 respondents currently serving children, families, or caregivers, their geographic distribution spans all counties and regions across the state. The resulting data indicated there are many evidence-based practices being provided across the state. Additionally, the survey provided insight into the characteristics of South Carolina’s child and family serving workforce, and illuminated various factors related to implementation challenges. Each of the survey findings have application that are integral to the successful implementation of prevention services.

The data show that South Carolina’s professional child and family serving workforce is well experienced, with around seventy percent of respondents having over five years of direct service experience, and that service providers are trained on several evidence-based and/or evidence-informed services. Service providers also helped to identify a number of shared implementation barriers for South Carolina. For example, while interventionists overall are confident about their competence and skill using EBPs, they often lacked support from their organization and had insufficient access to supervision. They also reported that EBPs are not integrated with their caseloads or other duties, which can lead to difficulties with fidelity and sustainability, and that there is a lack of on-going training for EBPs available.

Regarding availability of services, South Carolina has mental health, substance use, parenting programs in each county of the state. Many of these are under review or rated in the Clearinghouse. The most often reported evidence-based practices available throughout the state are:

- Cognitive Behavioral Therapy (CBT),
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT),
- Parents as Teachers (PAT),
- Triple P, and
- Dialectical Behavior Therapy (DBT).

Additionally, other interventions of particular utility to stabilize families and prevent foster care entry are or have been in place in South Carolina include:

- Parent-Child Interaction Therapy (PCIT),
- Cognitive Processing Therapy (CPT),
- Multisystemic Therapy (MST),
- Nurse-Family Partnership (NFP), and
- Functional Family Therapy (FFT).

The survey findings regarding available evidence-based service array and workforce considerations have helped the Department make informed decisions about its selection of key practices for inclusion in this Prevention Plan. Additionally, the survey was instrumental in pointing the Department to better understand capacity building and implementation needs in order to ensure sustainability of EBPs under this plan. These findings are critically important to South Carolina's implementation and addressed further in the implementation approach section of this document.

Implementation and sustainability support factors will be included in capacity building grants and QPL efforts. The Department will contract with providers through a qualified provider listing (QPL). Providers participating in the QPL are expected to participate in Child and Family Teams (CFTMs) and abide by the same values held in the new GPS practice model. Provider partners will also participate in capacity building and evaluation of evidence-based practices.

Recognizing the current need for intensive in-home services and gap in accessibility, the Department is investing FFTA funds to build capacity around three well-supported evidence-based programs across the state. Additional information related to capacity building can be found in the subsection titled *Implementation Approach*.

Service Categories

As noted previously, Family First requires the selection of prevention services that are trauma-informed and fall into one of three categories: a) Mental Health Prevention and Treatment Services, b) Substance Use Prevention and Treatment Services, and c) In-home parent skills training. In addition to the categorical requirements, interventions must be rated as either 1) Promising, 2) Supported, 3) Well-Supported. These ratings must be assigned by the Title IV-E Prevention Services Clearinghouse (Clearinghouse), or through an approved independent systematic review conducted via a state.

The table below identifies the interventions that South Carolina is including in its Prevention Plan. These evidence-based prevention programs align with the needs of our target populations and

have been rated by the Clearinghouse. Each intervention is described in the following subsections.

Figure 6. South Carolina's Proposed Interventions

Targeted Prevention Services	
Brief Strategic Family Therapy	Multisystemic Family Therapy
Parent Child Interaction Therapy	Functional Family Therapy
Parents as Teachers	Homebuilders – Intensive Family Preservation and Reunification Services
Healthy Families America	Nurse-Family Partnership

Mental Health and Substance Abuse Prevention and Treatment Services

Eligible mental health programs and services include those that aim to prevent, reduce or eliminate behavioral and emotional disorders. Programs may be delivered to children and youth, adults, or families; can employ any therapeutic modality, including individual, family, and group therapy; and, may have any therapeutic orientation, such as cognitive, cognitive-behavioral, psychodynamic, structural, narrative, etc. Eligible substance abuse prevention and treatment programs and services include those that have an explicit focus on the prevention, reduction, treatment, remediation, and/or elimination of substance use, misuse, or exposure in general. Eligible programs and services can employ any therapeutic modality, including individual, family, or group and may have any therapeutic orientation, such as cognitive, cognitive-behavioral, psychodynamic, structural, narrative, etc.

All model information and ratings in the following section have been gathered from the Clearinghouse website which can be found at: https://preventionservices.abtsites.com/program. Since several programs concurrently serve both mental health and substance abuse services, we discuss our selected EBP services and rationale for them in the section below.

Parent-Child Interaction Therapy (PCIT):

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability**
Mental Health Program and Services	Parent-Child Interaction Therapy (PCIT)*	Families with children between the ages of 2-7 who experience emotional and behavioral problems that are frequent and intense.	• Build close relationships between parents and their children using adaptive strategies • Help children feel safe and calm by fostering warmth and security between the child and parent • Improve parent-child communication • Increase children's organizational and play skills • Decrease in child's frustration and anger • Enhance child's self-esteem • Improve children's social skills	Fidelity: PCIT: Treatment Integrity Checklist (TIC). The basic clinical fidelity tools are included as part of the standard PCIT protocols which can be found at www.pcit.org. More detailed research measures of therapist competency and fidelity have been developed for studying skill acquisition and fidelity (CEBC website) Manual: Eyberg, S., & Funderburk, B. (2011) Parent-Child Interaction Therapy protocol: 2011. PCIT International, Inc.	N = 26
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Description: In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and caregivers.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 38% meet the age criteria for PCIT and many of these would benefit from a structured mental health intervention. PCIT aligns with two of South Carolina's imminent risk criteria of children 0-5 and families with complex psychological and/or behavioral health needs. South Carolina currently has existing, though limited capacity, to offer

PCIT and will leverage Family First to build additional infrastructure and expand the availability of PCIT over the next five years.

Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), and Multisystemic Therapy (MST)

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability**
Mental Health and Substance Abuse Prevention and Treatment Programs	Brief Strategic Family Therapy (BSFT)*	Families with children or adolescents 6 to 17 who display or are at risk of developing problem behaviors, antisocial peer associations, bullying, truancy, or drug use and dependency	• Reduction in behavior problems, while improving self-control • Reduce associations with antisocial peers • Reduce drug use • Develop prosocial patterns • Improvements in maladaptive patterns of family interactions • Improvements in family communication, conflict resolution, and child family bonding	Fidelity: The BSFT Therapist Adherence Form & Clinical Supervision Checklist Manual: 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	N = 0
	Functional Family Therapy (FFT)*	Children and adolescents between 11-18 years old who experience problem behaviors such as conduct disorder, violent acting-out, and substance abuse	• Eliminate youth referral problems (i.e. delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e. school attendance) • Improve family and individual skills	Fidelity: FFT web-based Client Services System (CSS) is used to monitor program fidelity. Quarterly ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model. Fidelity and Dissemination Adherence Scores Manual: Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior	N = 31

				Problems. American Psychological Association	
	Multisystemic Therapy (MST)*	Youth 12 to 17 with possible substance use issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with juvenile justice systems	• Eliminate or reduce the frequency and severity of the youth's referral behavior(s) • Empower parents with skills and resources to independently address difficulties associated with the identified behavior(s)	Fidelity: 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 Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists. (CEBC website) Manual: 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.	N = 33
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Brief Strategic Family Therapy (BSFT):

Description: Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. There are three intervention components. First, counselors establish relationships with family members to better understand and 'join' the family system. Second, counselors observe how family members engage with one another in order to identify interactional patterns that are associated with problematic youth behavior. Third, counselors work in the present, using reframes, assigning tasks and coaching family members to try new ways of relating to one another to promote more effective and adaptive family interactions. BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes. BSFT counselors are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral interventions and family systems theory.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 56% meet the age criteria for BSFT. Data also show a percentage of active Family Preservation cases with concurrent juvenile justice involvement.

BSFT aligns closely with South Carolina's imminent risk criteria of dually-involved youth, and could also address child substance use disorder. BSFT is an appealing intervention for South Carolina because of broad eligibly age range of child and youth populations, cross-system treatment focus, and the flexibly of where it can be delivered, specifically in homes. The most recent Child and Family Services Review (CFSR), for example, identified transportation as one of the common challenges to parents accessing available services and the in-home delivery format would address this barrier. South Carolina is in the process of building the infrastructure to offer BSFT over the next five years.

Functional Family Therapy (FFT):

Description: Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of three to six months. Master's level therapists provide FFT. They work as a part of an FFT-supervised unit and receive ongoing support from their local unit and FFT training organization.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 29% meet the age criteria for FFT with a subset having concurrent juvenile justice involvement. FFT aligns closely with South Carolina's imminent risk criteria of dually-involved youth, families with complex psychological and/or behavioral health needs, and could also address child substance use disorder. This makes FFT an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibly of where it can be delivered (e.g. homes, schools). South Carolina is in the process of building the infrastructure to offer FFT over the next five years.

Multisystemic Therapy (MST):

Description: Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old youth. MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 23% meet the age criteria for MST with a subset having concurrent juvenile justice involvement. MST aligns closely with South Carolina's imminent risk criteria of dually-involved youth, families with complex psychological and/or behavioral health needs, and could also address child substance use disorder. MST is a desired intervention for South Carolina because of emphasis on dual-system youth, co-occurring mental health and substance use problems, and the flexibly of where it can be delivered (e.g. homes, schools). MST has been offered in South Carolina in the past and is in the process of re-building the infrastructure to offer it over the next five years.

In selecting these interventions (e.g., BSFT, FFT and MST), South Carolina is choosing three interventions for older youth with behavioral challenges as a combined strategy to reduce entries into foster care and subsequently into congregate care. Our data shows that far too many older youth who enter foster care are ultimately placed into congregate care. The constellation of these interventions is purposeful to bring extensive capacity to bear for these children and families and subsequently addresses one of our priority outcomes through Family First, to reduce entry and stay in congregate care.

In-Home Parent Skills-Based Programs

Eligible parent skill-based programs and services include those that are psychological, educational, or behavioral interventions or treatments, broadly defined, that involve direct intervention with a parent or caregiver. Direct intervention contact means that intervention services are provided directly to the parent(s) or caregiver(s); children may be present or involved but are not required to be present for a program to be eligible. Programs may be explicitly delivered as in-home interventions, or the skills learned by parents can be deployed in the home. All model information and ratings in the following section have been gathered from the Clearinghouse website which can be found at: preventionservices.abtsites.com/program.

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability **
In-Home Parenting Skills-Based Services	Homebuilders – Intensive Family Preservation and Reunification Services*	Families with children (birth to 18) at imminent risk of placement into or needing intensive services to return from, foster care, group, or residential treatment, psychiatric hospitals, or juvenile rehabilitation facilities	Teach families the skills needed to prevent placement or successfully reunify with children	Fidelity: HOMEBUILDERS Fidelity Measures- includes specific indicators and performance measures found within the HOMEBUILDERS Implementation Guide. Each of the 20 HOMEBUILDERS Standards has multiple fidelity measures available at www.institutefamily.org. Furthermore, HOMEBUILDERS uses a quality enhancement system known as QUEST to assure quality through the development and continual improvement of the knowledge and skills needed to meet model fidelity and service outcomes.	N = 5

				Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.	
	Parents as Teachers (PAT)*	Families with children 0-5	• Child Development and School Readiness • Family Economic Self-Sufficiency • Positive Parenting Practices (parent-child interactions) • Reductions in Child Maltreatment	Fidelity: The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. (CEBC) Manual: *Parents as Teachers National Center, Inc. (2016). Foundational curriculum.* *Parents as Teachers National Center, Inc. (2014). Foundational 2 curriculum: 3 years through kindergarten*. PAT Foundational Curriculum is available to support families birth to 3; PAT Foundational 2 Curriculum is available to support families 3 through Kindergarten. (Title IV-E Clearinghouse)	N = 23
	Healthy Families America (HFA)*	Families with children 0-5	• Reduction in child maltreatment • Improved parent-child interactions and	Fidelity: HFA requires implementing sites to utilize the HFA Best Practice Standards and to demonstrate fidelity to the standards through periodic	N = 18

			children's social-emotional well-being • Increase school readiness • Promote child physical health and development • Increase access to primary care medical and community services • Decrease child injuries and emergency department use	accreditation site visits. There are 152 standards and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model. Manuals: 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.	
	Nurse-Family Partnership (NFP)*	Young, first-time, low-income mothers beginning in early pregnancy through their child's first two years	• Measurable gains in individual self-worth of parents and children • Measurable gains in parental empathy and meeting their own adult needs in healthy ways • Utilization of dignified, non-violent disciplinary strategies and practices • Measurable gains in nurturing parenting beliefs,	Fidelity: Nurse-Family Partnership 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	N = 6

			knowledge and utilization of skills and strategies as measured by program assessment interventions	fidelity to the NFP model (CEBC). Manual: *Nurse Family Partnership. (2020). Visit-to-visit guidelines* Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamilypartnership.org/ Core education about the Nurse-Family Partnership (NFP) model. New nurses also learn the Visit-to-Visit Guidelines, which provide a consistent content and structure for each of the 64 planned home visits. (CEBC).	
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Homebuilders – Intensive Family Preservation and Reunification Services:

Description: Homebuilders provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Homebuilders practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. Homebuilders practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety. Homebuilders utilizes research-based intervention strategies including Motivational Interviewing, a variety of cognitive and behavioral strategies, and teaching methods intended to teach new skills and facilitate behavior change. Practitioners support families by providing concrete goods and services related to the intervention goals, collaborating with formal and informal community supports and systems, and teaching family members to advocate for themselves. Homebuilders services are concentrated during a period of 4 to 6 weeks with the goal of preventing out-of-home placements and achieving reunifications. Homebuilders therapists typically have small caseloads of 2 families at a time. Families typically receive 40 or more hours of direct face-to-face services. The family's therapist is available to family members 24 hours per day, 7 days per week. Treatment services primarily take place in the client's home. Providers are required to have a

master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience.

Rationale: Homebuilders aligns with many of the South Carolina's imminent risk criteria, and specifically can be utilized with families with prior child welfare experience or who are transitioning to family preservation from foster care. Because of the broad applicability to a wide range of children, youth and families, with the specific focus on family preservation and prevention of foster care entry, South Carolina intends to invest heavily in building the infrastructure to offer Homebuilders statewide.

Parents as Teachers (PAT):

Description: Parents as Teachers (PAT) is an intervention aimed at families with children 0-5 years old. PAT is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. 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. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 43% meet the age criteria for PAT. Moreover, analysis also show that children ages five and under are more likely than older children and youth to enter foster care after a finding of maltreatment. South Carolina believes that one strategy to reduce foster care entries is by expanding in-home parenting services to parents of young children. PAT is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there is an established PAT provider infrastructure and partnership through the states' Head Start program. Family First provides additional resources to expand the reach of PAT statewide.

Healthy Families America (HFA):

Description: Healthy Families America (HFA) is a home visiting program for new and expectant families with children 0-5 years old who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Each HFA site can determine which family and parent characteristics it targets.

Rationale: South Carolina's analysis of the children and families receiving Family Preservation services, as of June 2020, show that approximately 8% are one year of age or under and a subset meet the age criteria for HFA. Five-year fatality trends also show that children under one year of age account for over half of all maltreatment-related child fatalities. South Carolina believes that one strategy to reduce severe physical abuse resulting in child fatalities is by expanding in-home parenting services to new and expectant parents. HFA is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there is an established HFA provider infrastructure but with limited providers, primarily in the Greenville, SC area. Family First provides an additional opportunity to expand the reach of HFA statewide.

Nurse Family Partnerships (NFP):

Description: Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses for young, first-time, low-income mothers beginning in early pregnancy through their child's first two years. 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.

Rationale: NFP is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. NFP also aligns well with the imminent risk criteria of children 0-5 and families of children with complex medical needs. Presently, there is a sizable NFP network in specific regions of South Carolina with a good partnership for data sharing.

Future Service Considerations

As South Carolina continues to develop its prevention continuum, we will monitor changes to the Title IV-E Prevention Services Clearinghouse and will seek opportunities to expand our service array as the Clearinghouse grows. Specifically, South Carolina has a strong provider community offering TF-CBT (N=597 providers across the state), which is currently rated as "promising" by the Clearinghouse and requires a rigorous evaluation to receive federal Family First reimbursement. At this time, the Department does not plan to conduct an evaluation but will continue to monitor the rating status of TF-CBT. Once it achieves a "well-supported" rating, the Department plans to add this intervention to its Family First prevention services continuum and integrate it into the overall Family First Continuous Quality Improvement (CQI) process. A similar approach will also be used with two additional interventions with strong support in South Carolina: Attachment, Bio-Behavioral Catch-Up/ABC (N = 124) and Family Centered Treatment (N= 74). At this time, neither intervention is rated within the Clearinghouse. Finally, South Carolina intends to monitor other states' use of Motivational Interviewing as a cross-cutting intervention utilized by case managers and investigators to increase families' engagement and successful completion of their child specific prevention plan. As lessons learned are shared across jurisdictions, South Carolina will consider amending the prevention plan to include MI as a cross-cutting case management intervention.

Trauma-Informed Service Delivery

The Department's transformation efforts are steeped in its mission, vision and newly developed practice model (GPS) and commitment to ensuring that all services delivered to youth and families are family-centered, individualized and strengths-based, culturally responsive, and trauma-informed. Integration of South Carolina's trauma-informed framework into practice requires ongoing training and coaching for internal staff and contracted providers of the evidence-based practices included in this Prevention Plan. Initial training of the workforce is currently underway and will be spread and sustained through the statewide implementation of the GPS and Family First. Additionally, South Carolina is initiating a procurement process with contracted providers to ensure that all practice and services delivered are conducted in adherence to our GPS and using trauma-informed practices across the state. Through this practice, the Department will ensure that the services provided via Family First are responsive to the widespread impact of trauma and the potential paths for recovery. As SCDSS and its partners craft a service array that fully integrates knowledge of trauma and seeks to actively resist re-traumatization, the Department will monitor its implementation of the GPS and service delivery using new or revised policy and procedures, routine and structured contract reviews and continuous quality improvement strategies that are also trauma-informed.

Implementation Approach

South Carolina has a strong array of high-quality evidence-based programs and providers in its state to ensure effective implementation. Many of the EBPs selected for this Prevention Plan are well established in South Carolina, including its home-visiting programs (HFA, PAT, NFP). In 2008, the Duke Endowment endorsed and funded a number of evidence-based programs (PCIT, MST, TF-CBT, Triple P, etc.). The investment in this type of service array has supported a capable provider base and jurisdictional preparedness for implementing our selected EBPs to fidelity.

To further our implementation efforts, the Department administered a statewide survey to the workforce and provider community to prepare for and assist the state with Family First implementation. Survey findings revealed many strengths amongst South Carolina's workforce and provider network, but also significant challenges related to workforce and provider training, ongoing supervision and support and fidelity monitoring. The Department will rely on its Family First Prevention Services workgroup to address survey findings and assist with implementation and operationalization of this Prevention Plan inclusive of the evidence-based practices identified above. This group will meet on an on-going basis to discuss implementation challenges, utilizing feedback loops to bolster communications between SC DSS, community partners/providers, and stakeholders and leveraging existing and new infrastructures to monitor and review appropriateness of referrals, model fidelity, and outcomes. The scope of this workgroup will also focus on overall service array, information sharing of service-related initiatives, and bring together partners of South Carolina's shared Child and Family Well-Being System.

To deliver South Carolina's Family First service array, the Department will contract with providers through its Qualified Provider Listing (QPL). The QPL is the mechanism by which standardized business processes and service definitions provide consistent operationalization of Family First across providers. In addition to expanding the Department's array of high-quality service providers, the QPL ensures coordinated and consistent feedback between providers and the Department. Providers participating in the QPL are expected to participate in Child and Family Teams (CFTMs) and uphold the values and principles of the GPS practice model. Provider partners will also participate in capacity building efforts and continuous quality improvement of

evidence-based practices. SCDSS will use the QPL to address specific implementation challenges identified through the 2020 provider survey and the Family First Prevention Services workgroup to address implementation challenges and barriers. For example: The survey revealed that clinician caseloads, on-going supervision of service providers, and provider self-efficacy were factors that impacted the delivery and sustainment of EBPs. Understanding these findings enables the Department to create actionable items and supports that can be reinforced both in practice and on a contractual basis.

Additionally, a core implementation strategy will be to provide capacity building grants, funded through FFTA, to promote the high-quality scale up of evidence-based practices in this Prevention Plan. South Carolina has an especially strong interest in building the capacity of intensive in-home services and family focused interventions such as: a) Homebuilders, b) Brief Strategic Family Therapy, and c) Functional Family Therapy. The capacity building grants will be targeted initially to these interventions. These grants will allow providers to receive the requisite training for effective implementation of these models. Provider partners will also be eligible for a limited number of grants to support the ongoing costs of implementation and enable them to implement with model fidelity. The program area in partnership with model purveyors, implementation teams consisting of pilot sites, and provider partners will work through any technical or adaptive challenges during initial implementation and on an ongoing basis.

South Carolina Department of Social Services is currenting implementing pilot sites with two evidence-based programs (EBP): BSFT and Homebuilders. While SCDSS's system of record has not yet been fully developed to capture the information for these two EBPs and future EBPs, SCDSS has been capturing information on those pilot sites in excel spreadsheets. Data is reviewed bi-weekly with the providers for the purposes of continuous quality improvement, to aid in understanding the implementation of the programs, to capture barriers through the discussions and to decide and /or include, where necessary, additional information for a more informed understanding of the programs and to inform the IT development in CAPSS.

Finally, to balance the number of interventions being rolled-out across the state, the Department will also employ a phased approach to implementing the selected EBPs. South Carolina is currently preparing and establishing readiness to pilot HOMEBUILDERS and BSFT. Prioritization of additional EBPs will be determined based upon the emerging needs of candidates as well as the infrastructure in South Carolina. The Department will continue to work with its technical assistance providers at the Capacity Building Center for States and at Chapin Hall to successfully implement its Prevention Plan.

In addition to the implementation strategies described here, Section 6: Evaluation Strategy delineates how the Department will ensure fidelity of implementation and monitor outcomes. We also describe how South Carolina will use continuous quality improvement to learn from these monitoring activities to refine and improve service delivery on an on-going basis.

Section IV: Child Specific Prevention Plan

As previously stated, the Department believes that safety, permanency and well-being outcomes increase when families play a central role in their case plan development and decision-making process. Family voice in their own planning results in children spending less time involved with child welfare, and families are more successful when they are involved in creating their own plan and goals. Families who identify their strengths and build on them draw confidence from that experience and are better able to build their capacity to provide protection and stability in their households.

Process for assessing need and developing child-specific prevention plans

To initiate a child-specific prevention plan, the case manager and supervisor will make the decision as to whether Family First services (e.g., EBPs) fit the needs of a child/family based upon the review of available assessment findings. To assess family needs, SCDSS will use the Family Advocacy and Support Tool (FAST), Child and Family Teaming, and supervision between the investigator/case manager and the supervisor.

The FAST is a multi-purpose decision support tool developed to assist in family case planning, service matching, on-going safety and risk, and the monitoring of service outcomes. The FAST provides an understanding of a child and family's strengths, needs, and risk factors, all of which will help inform the child-specific prevention plan.

While the FAST is a supportive tool to help guide decision-making, SCDSS values partnering with families and their support teams to assess needs and to make child specific prevention plan and case planning decisions. The Department's implementation of Child and Family Team Meetings (CFTM) is another important method of engaging families receiving Family Preservation services in the case planning process, inclusive of the child-specific prevention plan. A CFTM includes the family's formal and informal supports, child welfare staff, friends, and family members. Using a strengths-based approach, the team identifies the reason for involvement and works collaboratively to build a plan that addresses the family's underlying needs. The child and family in partnership with the family's child and family team will utilize the assessment information and the child and family team's findings and recommendations to identify service needs that the family identifies as supportive to mitigating the risk of future maltreatment and strengthening parent capacity to prevent foster care placement. The culmination of this process is used to develop and inform the Department's child-specific prevention plan within the Family Permanency Plan and to continue with the functional assessment process.

For candidates with open investigations (and not in Foster Care), the Department will utilize the FAST during the investigation phase of a case. Using the FAST, the Investigation Case Manager will determine eligibility for prevention services – e.g., whether the child meets the definition and characteristics of a "candidate for care" for Family First. The Investigation Case Manager will document the need for prevention services in the Family Permanency Plan. Services will be authorized by the average duration of identified services as defined by the EBP or as otherwise determined by the Department.

Similarly, the Department uses the Child and Adolescent Strengths and Needs (CANS) assessment for youth in foster care. Therefore, the CANS will be used with pregnant and parenting youth in foster care to inform the development and selection of prevention services within the youth's case plan.

Figure 7. Candidacy Eligibility

Candidacy Population	Staff Determining Eligibility	Tools/Methods to assess need	Staff Responsible for Developing or Updating Prevention Plan	Documentation Form used for Child-Specific Prevention Plan
Children & Families in an open Investigation and not in Foster Care				
Child in an Investigation with one or more imminent risk criteria	Investigations Case Manager and Supervisor	FAST/IV-E Eligibility Wizard	*Eligibility is determined during Investigation (and not in Foster care).*	
Children & Families being referred to or receiving Family Preservation Services via Three Pathways				
To Family Preservation via Investigations with 1 or more imminent risk criteria	Investigations Case Manager and Supervisor	FAST/IV-E Eligibility Wizard	*Eligibility is determined during Investigation (and not in Foster care) in order to expedite services.*	*Family Permanency Plan*
In Family Preservation Cases with 1 or more imminent risk criteria	Family Preservation Case Manager and Supervisor	FAST CFTMs	Family Preservation Case Manager and Supervisor	Family Permanency Plan
To Family Preservation via exit from Foster Care	Foster Care Case Manager and Supervisor and/or Family Preservation Case Manager and Supervisor	Case Closure CANS Transition CFTM Review CANS at 14-day CFTM FAST 90 days CFTMs	Foster Care Case Manager and Supervisor and/or Family Preservation Case Manager and Supervisor (Court can order Family Pres. Considering requesting all cases be court ordered to Family Pres.)	Family Permanency Plan Updated
Pregnant and parenting youth in Foster Care				
Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager and Supervisor	CANS CAPSS Person Characteristic CFTMs	Foster Care Case Manager and Supervisor	Family Permanency Plan

Integrating the child-specific prevention plans within the CAPSS system

The Family Permanency Plan is a comprehensive case planning tool that is currently being enhanced within the DSS CAPSS system to include the child-specific prevention plan.
The child-specific prevention plan is entered and updated into CAPSS Family Permanency Plan (FPP) following the administration of the FAST by the Investigations and/or Family Preservation Case Manager. When needs are identified during the investigation, the Investigation Case Manager initiates the FPP prior to the CFTM. At the close of the initial and ongoing CFTM, the Investigations or Family Permanency Case Manager, with support from their supervisors, finalizes and enters the FPP into CAPSS. The FAST and FPP are then reviewed and updated within CAPSS at each subsequent CFTM that follows.

As previously mentioned, child and family team meetings continue throughout the family's involvement in both family preservation and foster care cases.to monitor and inform case planning and decision-making. CFTMs and case planning provide continued opportunities for ongoing

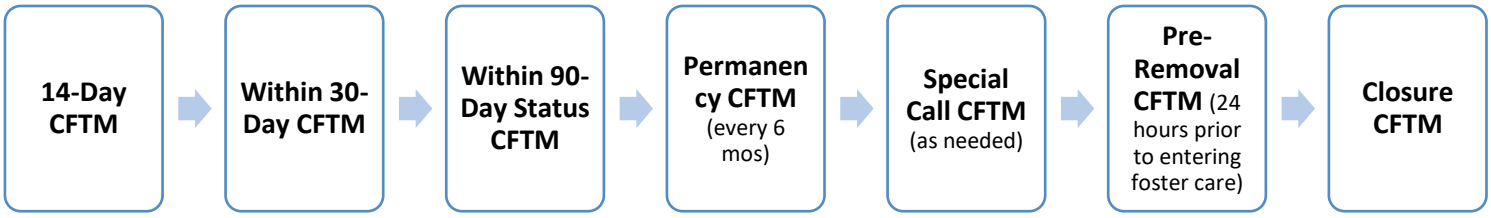
review of child and family needs using assessment tools (e.g., FAST and CANS, respectively), every 90 days. At the 12-month mark, children's candidacy will be re-determined based on a review of the on-ongoing FAST or CANS and service needs. Case Managers, with support from their supervisors, will be responsible for redetermination of eligibility of Family First services. Once the redetermination has been made, Case Managers, with support from their supervisors, will be responsible for updating the Family Permanency Plan, and its child-specific prevention plan, and entering it into CAPSS.

Service referral, linkage, and oversight

Linkage (service referrals) to available Family First services will follow the Child and Family Team meeting (CFTM) where the Family Permanency Plan, and its child-specific prevention plan, is developed. Information gathered from the FAST or CANS and the CFTM will guide case managers and families to determine appropriate services. Matching services to individualized needs are an important part of this process and is a pillar of the child and family teaming structure. The family's referrals, linkages and participation in services will be monitored by the family's case manager.

Ongoing engagement with the child, family, family supports, and providers through the CFTM will ensure appropriateness of services. In keeping with the GPS practice model, the family is present and actively involved in the monitoring and updating of the family's prevention plan. Changes to service planning efforts and prevention plan will be updated regularly in the Family Prevention Plan based on the evolving needs of the family. Below are the Family Preservation and Foster Care CFTM Timelines highlighting opportunities to measure progress and review and update goals, all of which will be documented in the Family Permanency Plan and its child-specific prevention plan.

Family Preservation CFTM Timelines



Foster Care CFTM Timelines

In addition to the CFTMs, the case manager monitors the family's safety and progress with the Family Permanency Plan, and its child-specific prevention plan, on a monthly basis. Monthly updates to the Family Permanency Plan include:

a. The child's and family's engagement with services
b. Progress made by the child and family as it relates to the reasons for Department's involvement, including the actions and services required to strengthen the family and assuring the safety, permanency and well-being for the child
c. Needs and strengths identified through formal and informal assessments
d. Safety or risk concerns identified by the Case Managers assessments and goals to address those concerns.
e. Child's adjustment to agency involvement

For Investigations:

The investigator monitors the family's safety and progress through face-to-face contact and with supervisory consultations, as defined below:

a. Initial contact (identify services) within first 24 hours of receiving case
b. Face-to-face contact with child or youth within 20 days (continue to assess for safety)
c. Monitoring continues through supervisory consultations as outlined in policy until a determination is made

Collaboration with IV-B services

South Carolina DSS will increase the array of services to families by coordinating Title IV-B funded prevention services with the Title IV-E prevention services. To simplify the process further, South Carolina will automate the process in CAPSS to minimize the burden on the case managers and subsequently reduce potential claiming errors.

Section V: Monitoring Child Safety

Pre-Print Section 3 (Monitoring Child Safety and Risk)

Initial and ongoing assessments of safety and risk are a critical part of the work of the Department's child welfare staff. In order to adequately monitor the safety of children during the 12-month period, the Department will leverage and enhance existing practices by systemically administering the FAST safety and risk items every 90-days. As with ongoing monitoring of family strengths and needs, the Department will monitor ongoing risk through 1) completing a formal risk assessment and 2) informally assessing risk on an ongoing basis during face-to-face observations and during regularly scheduled CFTMs.

During initial contact with the family, the Investigations Case Manager, collaborating with their supervisor, will review the SDM completed at intake, collaborate with the family, and complete the safety items of the FAST for all cases in order to identify any acute safety risks or needs. As new information becomes available, the full FAST will be updated throughout the course of the Investigation. If a case is substantiated and a family enters into Family Preservation, the Family Preservation Case Manager will review and update the FAST after the implementation of services to assess the family's strengths, needs, and safety concerns. This assessment will help case managers determine if the child(ren)'s safety is compromised and whether action needs to be

taken due to changes that have occurred within the family unit. The FAST contains information relevant to both safety and risk, but also helps to identify services a family may need. Based on the needs identified within the FAST assessment, case managers and supervisors will match services to identified needs. The FAST is re-administered every 90-days to monitor safety and risk while services are provided. The FAST helps case managers gather information, assess progress, and monitor safety and risk throughout the life of the case.

For pregnant and parenting youth in foster care, Foster Care Case Managers administer the CANS. For both Family Preservation and Foster Care cases, CFTMs are held no less than every 90 days and align with important case milestones offering regular opportunities for informal monitoring of risk and update of the FAST or CANS every 90 days as well.

As indicated above in the CFTM timeline for Family Preservation and Foster Care cases, the 90-day permanency CFTM provides an opportunity to assess family progress and monitor safety and risk using the FAST or CANS (completed within that same time frame). If services are needed for longer than the initial 12 months the CFTM, using the FAST or CANS, will determine the ongoing need to continue services and monitor case progress. A family's continued participation in services beyond 12 months will be determined jointly between the case manager and family in the CFTM.

Figure 8. Candidacy Risk and Safety

Candidacy Population	Staff Responsible for Monitoring Risk and Safety	Monitoring Tools/Protocols and Timeframes for Administering Them
Children under 18 named in a CPS investigation	Investigations Case Manager and Supervisor	FAST: - Review and consider Intake SDM findings - Complete safety items at initial contact - Following initial completion, Investigations Supervisor will review and finalize the FAST
Family Preservation Cases with 1 or more imminent risk criteria	Family Preservation Case Manager and Supervisor	FAST - Review and update the FAST after entry into Family Preservation - Review and update the FAST every 90-days after implementation of services CFTM: See Family Preservation timelines
Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager and Supervisor	CANS - Every 90 days CFTM: See Foster Care CFTM timelines

Section VI: Evaluation Strategy and Waiver Request

Pre-Print Section 2

South Carolina's Overall Approach to Evaluation and Continuous Quality Improvement (CQI) of Preventive Programs

Family First requires that each state continually assess if the EBPs provided to children and their families are achieving the desired outcomes. To accomplish this, each EBP service submitted in a state's Prevention Plan must include a well-designed and rigorous evaluation strategy. The

Children's Bureau, however, may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI requirements. South Carolina is requesting a waiver of the evaluation requirements for each of these well-supported programs:

- Parent-Child Interaction Therapy (PCIT)
- Brief Strategic Family Therapy (BSFT)
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- Homebuilders- Intensive Family Preservation and Reunification Services (Homebuilders)
- Parents as Teachers (PAT)
- Healthy Families America (HFA)
- Nurse-Family Partnership (NFP)

All of these have empirical evidence that they improve outcomes in the domains of child safety, child permanency, child well-being, and/or adult well-being and our justification is described in the section below.

Compelling Evidence for EBP Effectiveness and Waiver Justification

Mental Health and Substance Treatment Programs and Services

The most common types of identified maltreatment in South Carolina over the last few years have been neglect and physical abuse. Of these, approximately two-thirds have been referred to Family Preservation and one-third resulted in foster care entry. Research suggests that two of the most salient contributors to neglect and/or physical abuse are untreated mental health and/or substance-related problems in a child and/or caregiver (CDC). PCIT, BSFT, FFT, MST and MI are efficacious interventions designed to address untreated mental health and/or substance-related problems.

Parent-Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) PCIT is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. South Carolina's prevention plan aims to deliver PCIT to families with children ages two to seven that have identified stressors of child emotional behavior challenges. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 38% meet the age criteria for PCIT and some of these would benefit from a structured mental health intervention. Of South Carolina's 46 counties, 26 have one or more providers offering PCIT across the state and intends to build the infrastructure and expand the availability of the intervention over the next five years.

Evidence base justification

The Title IV-E Prevention Services Clearinghouse rated PCIT as a well-supported EBP following review of 21 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- Outcomes for children participating in Parent Child Interaction Therapy include improving child behavioral and emotional functioning and reducing problematic behaviors, improving

parent-child communication, increasing children's organizational and play skills and improving the child's self-esteem and social skills. Several different studies of PCIT have shown that participation improves child behavioral and emotional functioning in areas such as child compliance, internalizing and externalizing behaviors, and overall reduction in problematic behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009, Schuhmann, 1998; & Thomas, 2011).

Adult well-being outcomes

- Outcomes for adults participating in Parent Child Interaction Therapy include improving parent-child communication and reducing the frequency of corporal punishment. PCIT has demonstrated efficacy in enhancing positive parenting behaviors like such as using encouraging commands and praise, and effective child- and parent-led play skills and reducing laxness and the frequency of corporal punishment (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; McCabe, 2009; & Thomas, 2011). At least one study showed that PCIT reduced parental stress, depression and anxiety (Leung, 2015, 2017).

Program delivery and fidelity monitoring

PCIT is delivered using a dyadic approach based on the following manual: *Eyberg, S., & Funderburk, B. (2011) Parent-Child Interaction Therapy protocol: 2011. PCIT International, Inc.* Parents are coached by a trained therapist in behavior-management and relationship skills. Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to achieve mastery of the program content in 12 to 20 one-hour sessions. PCIT has a rigorous fidelity monitoring infrastructure with a prescribed clinical tool called the Treatment Integrity Checklist (TIC) (PCIT International).

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 56% meet the age criteria for BSFT. Data also showed a percentage of active family preservation cases with concurrent juvenile justice involvement. BSFT is an appealing intervention for South Carolina because of its broad eligibility age range of child and youth populations, cross-system treatment focus, and the flexibly of where it can be delivered, specifically in homes. The most recent Child and Family Services Review (CFSR), for example, identified transportation as one of the common challenges to parents accessing available services and the in-home delivery format would address this barrier. South Carolina is in the process of building the infrastructure to offer BSFT over the next five years.

Evidence base justification

The Title IV-E Prevention Services Clearinghouse rated BSFT as a well-supported EBP following review of 5 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- Outcomes for children participating in Brief Strategic Family Therapy include reduction in behavior problems while improving self-control, reduction in associations with antisocial peers, reduction in drug use, the development of pro-social behaviors, improvements in maladaptive patterns, and improvements in communication, conflict resolution and family

bonding. At least one study of BSFT has shown improved child well-being outcomes. Participation improved behavioral and emotional functioning by reducing externalizing behaviors (Horigian, 2015). Results of this study also showed reductions in delinquent behaviors such as the number of lifetime and past year arrests and incarcerations (Horigian, 2015).

Adult well-being outcomes

- Outcomes for adults participating in BSFT include Improvement in maladaptive patterns of family interactions and improvement in family communication, conflict resolution, and family bonding. BSFT has demonstrated effects in improving adult well-being outcomes. In one study, parents who participated in BSFT reported less alcohol use (Horigian, 2015b). In another study, significant overall improvements in family functioning were achieved (Santisteban, 2003).

Program delivery and fidelity monitoring

BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes. Invention delivery is based on the required manual: *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.* BSFT counselors are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral interventions and family systems theory. Fidelity monitoring includes counselor completion of The BSFT Therapist Adherence Form with monitoring by a clinical supervisor documented using the Clinical Supervision Checklist (CEBC, Robbins et al., 2011).

Functional Family Therapy (FFT)

FFT is a trauma-informed evidence-based therapeutic intervention for at-risk families and juvenile justice involved youth. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. South Carolina's Prevention Plan aims to deliver FFT to youth ages 11-18 years old who have family stressors, emotional behavior disabilities; children at risk of voluntary placement; and pregnant and parenting youth in foster care. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 29% meet the age criteria for FFT with a subset having concurrent juvenile justice involvement. In addition, South Carolina has at least one provider of FFT in 31 of their counties across the state. This makes FFT an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibly of where it can be delivered (e.g. homes, schools). In addition to existing provider network, South Carolina is in the process of building the infrastructure to offer FFT over the next five years.

Evidence base justification

FFT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse following review of 9 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes

- Outcomes for children participating in FFT include eliminating delinquency, oppositional behaviors, violence, and substance abuse. FFT also improves the child's prosocial behaviors. FFT has a proven track record in improving youth behavior and emotional functioning, and reducing youth alcohol and drug use (Celinska, 2013; Slesnick, 2009).

Participation in FFT has been shown to significantly reduce delinquent behaviors and the likelihood of out-of-home placements resulting from them (Celinska, 2013, Darnell, 2015, & Slesnick, 2009).

Adult well-being outcomes

- Outcomes for adults participating in FFT include enhanced family functioning and reduction in family conflict. FFT also has established efficacy in improving overall family functioning by reducing verbal aggression between family members (Slesnick, 2009).

Program delivery and fidelity monitoring

FFT is conducted in clinic and home settings. It can also be delivered in schools, child welfare facilities, probation and parole offices, aftercare systems, and mental health facilities. FFT is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of 3-6 months. Master's level therapists deliver the intervention based on the following manual: *Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association.* Therapists work as a part of a FFT-supervised unit and receive ongoing support from their local unit and FFT training organization.

FFT has a rigorous fidelity monitoring infrastructure. Contracted therapists providing FFT must show proof of training and fidelity to the model which includes three phases: clinical training, supervisor training, and maintenance phase. FFT has a web-based Client Services System (CSS), which is used to monitor program fidelity based on the Fidelity and Dissemination Adherence Scores. Quarterly ratings are then used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model (CEBC).

Multisystemic Therapy (MST)

MST is an intensive treatment for troubled youth delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use. The target population for MST is youth, ages 12 to 17, and for the families of youth who are (1) at risk for or engaging in delinquent activity or substance misuse, (2) experiencing mental health issues, and (3) at risk for out-of-home placement. South Carolina's Prevention Plan aims to serve youth ages 12 to 17 years old who are at risk of out of home placement. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 23% meet the age criteria for MST with a subset having concurrent juvenile justice involvement. Moreover, 33 counties across South Carolina have at least one treatment provider utilizing MST within their service array. MST is a desired intervention because of its emphasis on dual-system youth, co-occurring mental health and substance use problems, the flexibly of where it can be delivered (e.g. homes, schools) and its existing presence in South Carolina. South Carolina will continue to support their infrastructure to offer MST over the next five years.

Evidence base justification

MST is currently rated "well-supported" as a Mental Health Program and as a Substance Abuse Program by the Title IV-E Prevention Services Clearinghouse following review of 16 eligible studies that indicated favorable effects in the target outcomes of child permanency and child and adult well-being.

Child permanency outcomes

- MST has been shown to significantly reduce out-of-home placement for problematic youth behavior (Vidal et al., 2017).

Child well-being outcomes

- Outcomes for children participating in MST include eliminating or reducing the frequency and severity of the youth's difficult behaviors. Numerous studies of MST show significant improvements in youth behavioral and emotional functioning. MST participation reduces problematic mental health symptoms associated with conduct problems, conduct disorder, oppositional defiant disorder, impulsiveness, Attention Deficit Hyperactivity Disorder, and other kinds of internalizing and externalizing behaviors (Asscher et al., 2013, 2014; Dekovic et al., 2012; Fonagy et al., 2018; Henggeler, 1997; Manders, 2013; Ogden, 2004; and Weiss, 2013). MST also has a proven track record for reducing substance misuse and a wide range on delinquent behaviors like property offenses, subsequent arrests and adjudications, and violent and non-violent crimes (Asscher, 2013; 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1997; and Vidal, 2017).

Adult well-being outcomes

- Outcomes for adults participating in MST include empowering them with skills and resources to independently address difficulties associated with the identified behavior(s). Several studies of MST demonstrate improvements in positive parenting practices such a positive discipline, increased parental involvement, improvements in monitoring and supervision, and reductions in inconsistent discipline (Asscher, 2013; Borduin,1995, Fonagy, 2018). MST has also been shown to improve parent/caregiver mental and emotional health and overall improvements in family functioning, family satisfaction, family cohesion and family communication (Borduin, 1995; Fonagy, 2018).

Program delivery and fidelity monitoring

MST is delivered based on the following manual: *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.* The invention addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of 3-5 months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

MST has a rigorous fidelity monitoring infrastructure and includes measures for the therapist and the supervisor. 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 Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists (CEBC).

In-Home Parenting Skill-Based Services

Many parents involved with the child welfare system lack an understanding of child developmental needs (Landers et al., 2020). Research shows that parenting interventions that strengthen

parental knowledge, skills, will lead to better child well-being outcomes and reduce incidents of maltreatment. (Barth, 2015; Berliner et al., 2015; Glascoe & Leew, 2010; Huebner, 2002; & Luby et al., 2016). South Carolina is selecting a comprehensive in-home parenting service array in order to build skills and knowledge across all child and youth developmental levels. These include Homebuilders, PAT, HFA, and NFP.

Homebuilders-Intensive Family Preservation and Reunification Services (Homebuilders)

Homebuilders provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Because of the broad applicability to a wide range of children, youth and families with the specific focus on family preservation and prevention of foster care entry, South Carolina intends to invest heavily in building the infrastructure to offer Homebuilders statewide. At present, there are five (5) providers in the state offering the Homebuilders intervention. South Carolina will continue to build providers to support their infrastructure to offer Homebuilders across the state over the next five years.

Evidence base justification

Homebuilders is one of the oldest Intensive Family Preservation Services (IFPS) programs in the United States (Institute for Family Development). The intervention is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 3 eligible studies that indicated favorable effects in the target outcomes of child permanency and adult well-being.

Child permanency outcomes

- Participation in Homebuilders enhanced child permanency by preventing out-of-home placement directly after the intervention and at six and twelve months out (Walton, 1993). Additional research found that Homebuilders also improved reunification and family stability at the conclusion of child welfare involvement (Walton, 1993; 1998).

Adult well-being outcomes

- Homebuilders has demonstrated evidence in improving adult well-being outcomes such as overall economic and housing stability and food security (Westat, 2002).

Program delivery and fidelity monitoring

Homebuilders is delivered in the family's home. Services are provided when and where the family needs them, including other community locations (e.g. school). Homebuilders is delivered according to the following manual: *Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis*. Practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. Homebuilders practitioners 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. Homebuilders services are concentrated during a period of 4 to 6 weeks with the goal of preventing out-of-home placements and achieving reunifications. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience.

The Homebuilders model includes fidelity measures designed to track specific indicators and performance measures (CEBC, Institute for Family Development). South Carolina, and their designated Homebuilders providers, will work together with The Institute for Family Development, to obtain *Homebuilders Program Quarterly Reports* for each provider offering Homebuilders services. The Institute for Family Development offers technical assistance support and oversees compliance monitoring for each provider offering the Homebuilders program. They ensure the provider is delivering the Homebuilders model with fidelity and regularly evaluate service outcomes. To assess overall performance, they produce quarterly reports for each provider. South Caroline will use a subset of data in the quarterly reports for purposes of continuous monitoring. These include measures most aligned with South Carolina's practice model (Guided Principles & Standards/GPS) and current five-year strategic plan and consist of the following:

1. **Outcome measures**- placement prevention, safety concerns addressed, no new CPS reports, and improved family functioning
2. **Family engagement measures**- percentage of families engaged, client ratings of cultural humility, and client ratings of family centered service delivery
3. **Model fidelity measures**- immediate response to referrals, 24/7 availability, service intensity-direct contact hours, service intensity-frequency of contact, and contact with referent.

Parents as Teachers (PAT)

PAT is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. Enrollment may begin with the pregnant mom in foster care and continue through when the child enters kindergarten (i.e. prenatal to age 5). 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. South Carolina's Prevention Plan aims to deliver PAT to families that have identified stressors of being new parents and/or struggling with childcare responsibility, as well as pregnant or parenting youth in foster care. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 43% meet the age criteria for PAT. Moreover, analysis also show that children ages five and under are more likely than older children and youth to enter foster care after a finding of maltreatment. South Carolina believes that one strategy to reduce foster care entries is by expanding in-home parenting services to parents of young children. Presently, there is an established PAT provider infrastructure and data capture partnership through the states' Head Start program. There are 23 counties throughout the state with at least one service provider offering PAT. Family First provides an additional opportunity to expand the reach of PAT statewide.

Evidence base justification

PAT is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 6 eligible studies that indicated favorable effects in the target outcomes of child safety and child well-being.

Child safety outcomes

- Participation in PAT has been shown to increase child safety by reducing the occurrence of substantiated incidents of abuse and neglect (Chaiyachati, 2018).

Child well-being outcomes

- Outcomes for children participating in PAT include child development and school readiness. In two separate studies, participation in PAT was found to improve social functioning and cognitive functioning and abilities (Neuhauser, 2018; Wagner, 1999).

Program delivery and fidelity

The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally with the pregnant mom as the candidate and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs and delivered using one of two age-based curriculums: *PAT Foundational Curriculum is available to support families prenatal to 3; PAT Foundational 2 Curriculum is available to support families 3 through Kindergarten.* Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report (CEBC).

Healthy Families America (HFA)

HFA is a home visiting program for new and expectant families with children who are at-risk for maltreatment or Adverse Childhood Experiences. Enrollment may begin with the pregnant mom in foster care and continues up to 3 months after birth. South Carolina's analysis of the children and families receiving Family Preservation services as of June 2020, show that approximately 8% are one year of age or under and a subset them would meet the age criteria for HFA. Five-year fatality trends also show that children under one year of age account for over half of all maltreatment-related child fatalities. South Carolina believes that one strategy to reduce severe physical abuse resulting in child fatalities is by expanding in-home parenting services to new and expectant parents. Presently, there is an established HFA provider infrastructure but with limited providers. There are 18 counties with at least one provider statewide. Family First provides an additional opportunity to expand the reach of HFA statewide.

Evidence base justification

HFA is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 22 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Child safety outcomes

- Safety outcomes for children participating in HFA include reduction in child maltreatment and a decrease in child injuries and emergency department use. HFA has been shown to increase child safety by reducing incidents of neglectful behaviors, minor physical aggression, psychological aggression and frequency of severe and very severe physical abuse (Duggan, 2004; Mitchell-Herzfeld, 2005).

Child well-being outcomes

Well-being outcomes for children participating in HFA include improved parent-child interactions and social-emotional well-being, increase in school readiness, promotion of physical health and development and increase to primary care and community service access. Findings show that participation in HFA has been shown to improve behavioral

and emotional functioning and improvement in cognitive functions and abilities (Caldera, 2007, Duggan, 2005, DuMont, 2010 & Kirkland, 2012).

Adult well-being

- HFA also has a robust set of research documenting improvements in adult well-being. HFA participation has been linked to enhanced parenting practices, improved parent/caregiver mental or emotional health, reductions in parental stress and overall improvements in family functioning and reductions in domestic violence (Bair-Merritt, 2010, Duggan, 2004; DuMont, 2008; & McFarlane, 2013).

Program delivery and fidelity

HFA is delivered in the family's home and providers follow the following manuals: *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.* The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Each HFA site is able to determine which family and parent characteristics it targets. Enrollment may begin with the pregnant mom in foster care and continue up to 3 months after birth. Most families are offered services for a minimum of 3 years and receive weekly home visits at the start. After 6 months, families receive visits less frequently depending on their needs and progress. All HFA home visiting staff must have a minimum of a high school diploma or equivalent and are required to attend a four-day core training and receive supplemental wrap-around training.

HFA has required fidelity monitoring requirements. Implementing sites utilize the HFA Best Practice Standards and demonstrate fidelity to the standards through periodic accreditation through site visits. There are 152 standards, and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model (CEBC).

Nurse-Family Partnership (NFP)

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. 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. Because of the emphasis on young first-time parents, NFP is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there are at least 6 counties having one or more providers within the NFP network.

Evidence base justification

NFP is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 10 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Child safety outcomes

Safety outcomes for children participating in NFP include reduction in maltreatment and abuse. NFP has demonstrated effects of reducing the likelihood of Child Protective Services (CPS) involvement (Mejdoubi, 2015).

Child well-being outcomes

- Outcomes for children participating in NFP include fewer emotional disorders and behavioral problems, reduction in maltreatment and abuse, and improvement in overall health and well-being. Several studies have found that participation in NFP enhances cognitive functions and abilities and physical development and health (Kitzman, 1997, Robling, 2016 & Thorland, 2017).

Adult well-being outcomes

- Outcomes for adults participating in NFP include gains in individual self-worth, improved empathy, and meeting their own needs in healthy ways. Adults also show measurable gains in nurturing parenting beliefs as well as knowledge and utilization of parenting skills and strategies. NFP also has at least one study demonstrating that participation in NFP increases the likelihood of caregiver months employed after birth (Olds, 2002).

Program delivery and fidelity

NFP is delivered by nurses through the *core education about the Nurse-Family Partnership Model.* New nurses learn the visit-to-visit guidelines, which provide a consistent content and structure for each of the 64 planned home visits (CEBC). 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.

NFP has a robust fidelity monitoring process. Nurses collect client and home visit data as specified by the 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 (CEBC).

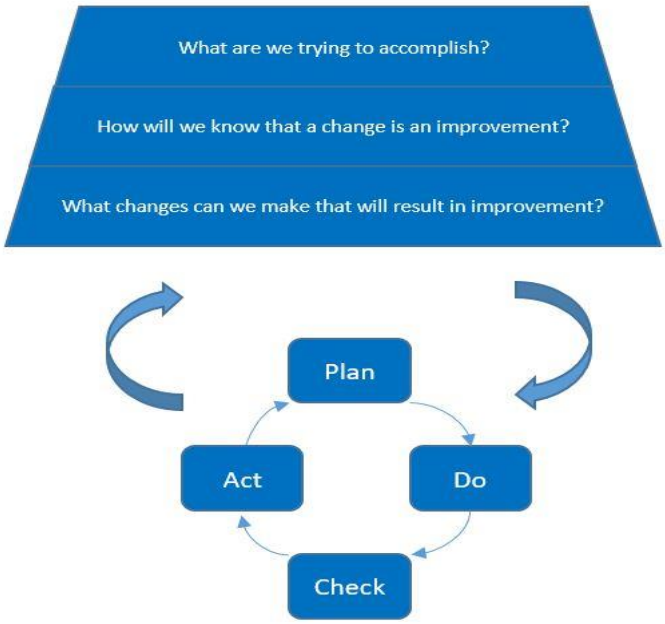
CQI Strategy for Proposed Well-Supported Interventions

South Carolina is creating a new statewide CQI structure and processes for the Prevention Plan that will be aligned with South Carolina's overall new strategic direction for program improvements. As part of this effort, South Carolina recently centralized its CQI infrastructure by reorganizing and aligning the divisions of Staff Development and Training; Accountability, Data, and Research; and Performance Management and Accountability under the Department's Chief of Staff. This newly formed formal and centralized approach has increased collaboration and communication by streamlining data, quality assurance, and workforce training into an active CQI process that is being leveraged to make recommendations for analysis and action steps to improve programs and outcomes for children and families.

South Carolina's CQI Strategy is based on the Model for Improvement, a widely used framework for CQI that consists of three fundamental questions and the Plan-Do-Check-Act (PDSA) Cycle

(Figure 3, adapted from Langley et al., 2009). This CQI model is being used in other statewide CQI activities and will be used for the CQI process for all nine of the selected well-supported intervention.

Figure 9: CQI Model for Improvement



All CQI processes will be guided by *A Measurement Framework for Implementing and Evaluating Prevention Services* (*Framework*) developed by Chapin Hall at the University of Chicago (2020). The *Framework* lays out metrics to understand the ***reach*** of the proposed interventions, to monitor the ***fidelity*** of the proposed interventions, and to assess if the intervention-specific and overall Family First desired **outcomes** are achieved. The CQI process for the nine proposed well-supported interventions will address a common set of cross-cutting research questions.

Cross-cutting research questions for nine well-supported EBPs

a. Cross-cutting research questions for **reach**:
   i. Are Family First candidate children/families being identified and referred to EBP services?
   ii. Are referred children/families receiving EBP services?
   iii. What are the characteristics of referred children/families receiving EBP services and do they differ from referred children/families not receiving services?
   iv. What is the length of time from referral to the start of services for children/families?
   v. Are children/families completing services?
   vi. Are there regional variations in EBP referrals, service receipt, and service completion?

b. Cross-cutting research questions for **fidelity**:
   i. Do the referred children/families meet the eligibility requirements for each specific EBP model?
   ii. Are the EBP services delivered as prescribed by each specific EBP model and guiding manual/curriculum (e.g. fidelity to the model)?
   iii. How many EBP service sessions took place and is this consistent with the EBP model?

c. Cross-cutting research questions for **outcomes**:
   i. *Child and family well-being outcomes:*
      1. Do children/families that *receive* an EBP service experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP *(this will be developed based on the EBP-specific program goals)?*
      2. Do children/families that *complete* an EBP service experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be developed based on the EBP-specific program goals*)?
   ii. *Child safety outcomes:*
      1. Does EBP service *receipt* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
      2. Does EBP service *completion* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?
   iii. *Child permanency outcomes:*
      1. 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?
      2. Does EBP service *completion* reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?

CQI implementation team(s)

Using core research questions to guide the CQI process, South Carolina will establish regionally based CQI teams responsible for reviewing EBP specific data, monitoring fidelity and outcome measures and making necessary adjustments to ensure that services are effective and meet the desired outcomes for children and families (see Figure 4). This will ensure that CQI efforts are regionalized and that each program is able to identify the performance successes and challenges and implement PDCA cycles that are tailored to their specific context.

The Office of Child Health and Well-Being, with support from the Office of Policy and Continuous Quality Improvement, will lead the regional CQI teams for each of the nine well-supported interventions. These regional teams will meet quarterly and be comprised of child welfare managers, program coordinators and frontline supervisors from each locality in the region, representatives from provider agencies, and community organizations. These team(s) will be responsible for identifying areas in need of improvement, selecting and implementing CQI activities designed to achieve the improvements needed, and monitoring the results of those activities.

During the initial phase of implementation, the CQI teams will primarily focus on the process and data related to the implementation of EBPs to inform how services are being implemented and the status of implementation drivers and supports. This will allow for any adjustments to be made in order to ensure implementation success. In later phases, South Carolina will establish data metrics based on the *Framework* to generate quarterly reports that will be used by the CQI teams to understand if there are barriers to EBP service delivery and to evaluate if outcomes are being achieved. This will allow CQI teams to make data-informed decisions and adjustments as needed.

Figure 10. Regional CQI Implementation Teams

Region	Counties in Region
Upstate	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, Newberry, Pickens, Spartanburg, and Oconee
Midlands	Aiken, Bamberg, Barnwell, Chester, Richland, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, McCormick, Saluda, Union, and York
Low Country	Allendale, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg
Pee Dee	Chesterfield, Clarendon, Darlington, Dillon, Georgetown, Florence, Horry, Lee, Marlboro, Marion, Sumter, and Williamsburg

CQI data sources

To answer research questions, the CQI teams will rely on data metrics and reports generated from CAPSS, the data system that houses all child welfare information, and the South Carolina provider portal within the QPL. CAPSS includes all administrative data on the children and families referred to or receiving services (child-specific plans) and their child welfare system involvement (e.g., child maltreatment screening and investigations; as well as foster care entries and exits). CAPSS also includes IV-E reports regarding eligibility for financial related determinations or needed determinations for claiming purposes. The provider portal will track all service delivery information such as the referral dates, eligibility, progress in treatment, and service completion.

CQI EBP fidelity monitoring

All treatment/service providers who receive reimbursement from South Carolina for EBP service delivery are required to collect, maintain, and report statistical data and information as requested for the purpose of program monitoring and evaluation. South Carolina plans to develop an annual fidelity monitoring on-site and/or virtual case review process for each of the nine EBP services provided to families. The review process will be developed in consultation with each of the EBP purveyors, and include verification of the required certifications/trainings, documentation of the prescribed fidelity measures, approved manual, trauma-informed delivery, and tracking of model-specific program goals.

Section VII: Child Welfare Workforce Training and Support

Pre-Print Sections 5 & 6

Training and Supporting the Evidence-Based Program Provider Agency Workforce

As discussed earlier in the prevention plan, all interventions must be evidence-based and trauma-informed. The Department will build upon and expand its existing provider network and their capacity to provide the evidence-based practices proposed in this plan. South Carolina has an accomplished and skilled workforce that is capable of effectively implementing and maintaining EBPs with support from the entire child and family well-being system.

The Department recognizes the need for ongoing training for providers to support continuous learning and growth. As we expand our array of services and partnerships, we will require providers of evidence-based and evidence-informed services to operate from trauma-informed

frameworks that meet the necessary training, credentialing, and fidelity monitoring requirements associated with each model.

The Department will also support South Carolina's transition to the use of evidence-based practices through capacity building grants and other fiscal and/or technical supports. We will work to ensure that both public and private workers and clinicians have the opportunity to collaborate through peer-learning and other training opportunities.

Training and Supporting the Child Welfare Agency Workforce

The Department in partnership with the University of South Carolina's Center for Child and Family Studies, offers a comprehensive Child Welfare Certification training curriculum with an emphasis on building competencies centered on the prevention and identification of child maltreatment and service provision related to abuse and neglect. The format of the Child Welfare Certification training provides an experiential learning platform for participants based on competencies and skills needed to provide quality case management child welfare services. Training curriculum are aligned with the agencies newly adopted Guiding Principles and Standards (GPS) Practice Model.

Child Welfare Certification Training

The Department's Child Welfare (CW) Certification training is a seven-week training series that provides four alternating weeks of skill-based, trauma informed classroom instruction with three alternating weeks of on the job (OJT) instruction and activities that newly hired case managers engage in with the assistance of Performance Coaches and Supervisors.

During the OJT sessions, participants are provided with coaching from Supervisors and Performance Coaches that focus on assessing underlying family needs that might have resulted in the agency's involvement. The coaching sessions also focus on assessing appropriate services needed to enhance the safety of children and youth. This blend of classroom and OJT instruction is designed to equip new case managers with foundational knowledge, competencies and skills needed to effectively meet the complex needs of children and families served by the Department.

The importance of the Child Welfare Certification training is to improve the safety, permanency and well-being of children and families. The CW Certification training provides a comprehensive review of each component of the GPS Practice Model and case practice opportunities by introducing a case story for each case type: Child Protection Services (CPS), Family Preservation, Foster Care and Adoption. The competencies and modules follow the GPS Practice Model framework.

Foundations Training Series

After the completion of Child Welfare Certification training, SCDSS requires newly hired case managers to participate in a series of courses within the first twelve (12) months of successful completion of CW Certification training. The Foundational Training Series builds upon the competencies, knowledge and skills that are introduced in CW Certification training. These courses are more intensely focused on the principles and practice skills within the agencies' GPS Practice Model. As a part of the foundation training series, new case managers also are required to take the National Adoption Competency Mental Health Initiative (NTI) training which is a comprehensive eight (8) module trauma informed training that is required for both case managers and Supervisors. NTI assists case managers with understanding how to access and deliver trauma-informed evidence-based services for children and youth traumatized as a result of

maltreatment. The courses within the Foundation Training Series will be modified as needed to incorporate aspects of the agencies' Prevention Plan.

In-Service

The Department's In-Service training courses are constantly evolving to meet the needs of the Child Welfare workforce. These in-service courses are heavily influenced by the GPS Child Welfare Practice Model, the Performance Improvement Plan and the Michelle H. Lawsuit Settlement Agreement. Along with the development and delivery of mandated in-service courses, there are more intense courses derived from the GPS Practice Model practice profiles. Practice profiles include but are not limited to case management training on the following areas: case manager visits with youth and family, functional assessments (FAST/CANS), case planning, child and family teaming, documentation, initial placement and placement change (kinship and traditional), parent-child and sibling visitation, and supervision.

South Carolina's Guiding Practices & Standards (GPS) Practice Model and Workforce Training

As mentioned earlier in this document, the Guiding Principles and Standards (GPS) Practice Model provides the values, principles and core practice skills used by Child Welfare staff to provide quality case management services. The overarching goal of the GPS Practice Model is to guide staff in ensuring the safety, stability, permanency, and well-being of the children and families. GPS provides an integrated and standardized framework for children and families which incorporates the following guiding principles: family-centered, trauma-informed, individualized and strengths-based, culturally responsive; and the following core practice skills: engagement, teaming, functional assessment, planning, intervening, tracking and adapting. Through quality coaching and the utilization of a strengths-based approach, case managers will be monitored and evaluated to ensure that appropriate services are delivered to children and families throughout the duration of the families' involvement with the Department. The GPS Practice Model is the foundation for all Child Welfare Certification training and In-service learning opportunities for child welfare staff. The Department has begun initial training on the GPS Practice Model through various forums and will continue throughout the calendar year 2021. Included in the rollout will be transfer of learning and coaching opportunities to support staff with implementation and integration of the GPS Practice Model into daily operations including how these practices apply in prevention services.

Training to Ensure Trauma-Informed Care

Trauma-Informed care is integral to the Department's transformation strategy and a foundational principle within its GPS Practice Model. The Department recognizes that building a trauma-informed framework into its practice will require ongoing training and coaching beyond its Child Welfare Certification training. As such, the Department's Training Office is committed to ensuring that its workforce has a stronger understanding of how trauma impacts and is central to a family's experience with the child welfare system and to teaching the skills necessary to recognize and mitigate child and family trauma reactions and build resiliency. In addition to the GPS Practice Model, the Department's Foundations training series will now include an eight-module trauma-informed training for case managers and supervisors. Moreover, SCDSS is also committed to addressing the impact of workforce trauma and secondary traumatic stress through the implementation of the University of Kentucky's nationally recognized Safety Science framework with their child welfare supervisory workforce.

Family First Specific Training

The Department created a Family First webpage and has been communicating with staff and providers the plan to incorporate training on Family First legislation and the opportunity it provides South Carolina to broaden the prevention continuum into the Child Welfare Certification Training.

Training to Identify Candidates; Assess and Develop Prevention Plans

Current training will be enhanced to include information about how to identify candidates for Family First services based on the identified risk criteria. Simultaneously, the Department is seeking ways to automate candidate identification within the CAPSS system and assist the case manager and supervisor with service recommendations based on needs identified by the Family Advocacy and Support Tool (FAST) or Child and Adolescent Needs and Strengths (CANS) assessments.

Because supervisors will play an essential role in making critical decisions about candidacy, service matching, and plan development, the Department will ensure robust training for supervisory guidance on these decisions.

Training to Refer and Link Families with Appropriate Interventions

The Department will enhance current training on service linkage to align with the new Family First service array; training DSS staff to take information from the assessment tools, CFTMs, and family preference to identify services that fit the needs of children and families. Similarly, DSS is seeking opportunities within CAPSS to automate matching between reported needs and available services.

Training to Conduct Risk and Safety Assessments

The Department will enhance current CANS and FAST assessment training for child welfare staff ensuring alignment with the GPS Practice Model. Existing Child Welfare Certification training includes a unit on assessment tools and understanding underlying conditions.

Section VIII: Prevention Caseloads

Pre-Print Section 7

Caseload size is an important factor in ensuring effective case management for families and children receiving prevention services. South Carolina has determined that the prevention caseload sizes can be maintained at their current rates given that candidates for prevention services will be limited to children who receive Family Preservation services, Investigations, and youth in Foster Care who are pregnant and parenting. The table below outlines the Department's caseload standards.

Figure 11. Child Welfare Caseload Standards

Case Type	Staff-to-Case Ratio
Investigations	1:12 families
Family Preservation	1:15 families
Foster Care	1:15 children

Caseload management and oversight

SCDSS Child Welfare Operations, which includes the Director of CW Operations, Regional Directors, County Directors, Adoption Administrators and frontline supervisors, regularly oversee and monitor caseload standards through ongoing CQI practices and regular agency-wide performance monitoring. Additionally, SCDSS will expect all EBP providers to uphold the staffing and caseload requirements specified by each intervention and in accordance with the intervention fidelity.

Section IX: Assurance on Prevention Program Reporting

Pre-Print Section 8

Appendix (x) contains the Department's assurance as required by ACFY-CB-PI-18-09 Attachment I, which the Department will comply with all the prevention program reporting requirements put forward by the Children's Bureau. The reporting requirements to date are contained in the Title IV-E Prevention Program Data Elements, Technical Bulletin #1. Consistent with this guidance and subsequent guidance, the Department will provide the following information for each child receiving services under the Title IV-E Prevention Program:

- Basic demographic information (e.g. age, sex, race, ethnicity)
- The child's identification as candidate or pregnant/parenting youth
- The child's foster care status, as applicable prior to receiving services, and at 12 and 24 months after receiving services
- Service types provided to the child and/or family
- The duration of services provided
- Total expenditures for each of the services provided to the child and/or family

Appendix A

South Carolina Family First Prevention Services Act Logic Model

	Inputs	Outputs	Outcomes	Impact
Infrastructure	• Policy identifying Family First processes • IT capacity to identify, track and monitor FF candidates • CQI prevention infrastructure	• Procedures and standards • CAPPS capacity to monitor FF cases • Data to inform need for course corrections • Fidelity monitoring	• Alignment of policy & practice • Data driven decision- making	As the number of children and **families served by Family Preservation increases**, the number of children entering **foster care decreases**. • Increased prevention services provided • Increased safety • Increased child and family well-being • Reduced foster care entry • Reduced foster care re-entry
Practice Supports	• GPS Practice Model • Enhanced CFTM process • FAST/CANS • Pre-service and veteran staff training • Model of Supervision • Coach Approach	• Clear vision, values, guiding principles, and skills • Network of support engagement • Comprehensive assessment of needs & strengths • Ability to match services to needs • Prepared workforce with ongoing supports	• Individualized and strength-based plans • Professional workforce	
Collaboration & Coordination	• University of South Carolina partnership • FFPSA Prevention Services Workgroup • DSS Training Initiative Planning Team • GPS Practice Model Implementation Team	• State Agency, university partner, community provider, advocacy group, and persons with lived child welfare experience contributing to candidacy, service array, and planning efforts	• Shared vision and prevention plan for South Carolina	
Services/ Interventions	• Multisystemic Family Therapy • Functional Family Therapy • Nurse-Family Partnership • Homebuilders • Healthy Families America • Parents as Teachers • Parent Child Interaction Therapy • Brief Strategic Family Therapy	• Evidence-based prevention service array • Matching of services to needs • Improved service capacity statewide	• Family First candidates improved mental health, decreased substance abuse, and strengthened parenting skills based on identified needs	
Candidates & Families	Children ages 0-18 and their parents/caregivers: • Served by Family Preservation • Served by Investigations • Foster youth pregnant or parenting	• Improved access to evidence-based practices for Family Preservation, Adoption, Guardianship, and Pregnant and Parenting Youth	• Engagement in prevention services • Sustained and supported families	

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