Presentation Title
Month #, 2017
Margaret Schultze, VDSS Commissioner

Family First: Designing a Blue Print to Implement Evidence-Based Trauma-Informed Services in Virginia

Presentation Outline

- Family First Implementation
- Three Branch Model
- Scaling up Evidence-Based Services

Family First Prevention Services Act

Public Law 115-123
Division E – Health and Human Services Extenders Title VII – Family First Prevention Services Act

Three Tiers of Family First

- Family First
- Prevention Services
- Foster Care Changes
- Other Programmatic Changes
Implementing Family First

Family First can be implemented as early as October 2019; however, it must be implemented by October 2021.

Implementing Family First

We are committed to using data to improve decision making and ensure services provided are informed by outcomes.

We will promote reliable, accurate, transparent and timely two-way communication among stakeholders throughout the implementation of Family First.

True transformation will take time, and implementation will continually be monitored and updated to meet emerging needs.

Collaboration and partnerships with systems across the state are the key to successful implementation of Family First. Every person and every organization, provider and system have an important role to play.

Three Branch Model

Adapted from the National Governor's Association, National Conference of State Legislatures and Casey Family Programs Three Branch Institute

Three Branch Leadership Team (Judicial, Executive and Legislative Branches of Government)

Three Branch Home Team

Finance

Prevention Services

Appropriate Foster Care Placements

Evidence-Based Services

Public Law 115-123

DIVISION E—HEALTH AND HUMAN SERVICES EXTENDERS TITLE VII—FAMILY FIRST PREVENTION SERVICES ACT

Virginia Department of Social Services (IV-E Funding Entity)

Virginia Office of Children's Services (State Foster Care Funding Sources)
Three Branch Communication

- Monthly Workgroup Meetings
- Every 6-8 weeks Core Team Meetings
- Quarterly Full Team Meeting
- Monthly Co-Chair Calls and Workgroup Summaries

Virginia's Three Branch Work Plan

Finance
- Maintenance of Effort
- Implementation Supports
- Payment Procedures

Prevention
- Defining the Population
- Establishing the Prevention Continuum
- Developing the Prevention Case Workflow

Foster Care
- QRTP’s
- Model Licensing Home Standards
- Foster Family Recruitment

Evidence-Based Services
- Analysis of Current Evidence Based Programs (Survey)
- Evaluation Plan
- Scaling Up Evidence-Based Programs

Current Funding Structure

DMAS + CSA = Services for children at-risk of entering foster care

Family First Funding Structure

DMAS (state) + CSA (state) + VDSS (Federal) = Services for children at-risk of entering foster care
**Title IV-E Reimbursable Services**

- Mental Health Prevention and Treatment Services
- Substance Abuse Prevention and Treatment Services
- In-home Parent Skill-Based Programs

**Initial List of Services Under Review**

**Mental Health Prevention Treatment Services**
- Parent-Child Interaction Therapy
- Trauma-Focused Cognitive Behavioral Therapy
- Multisystemic Therapy
- Functional Family Therapy

**Substance Abuse Prevention Treatment Services**
- Motivational Interviewing
- Multisystemic Therapy
- Families Facing the Future
- Methadone Maintenance Therapy

**In-Home Parent Skill-Based Programs**
- Nurse-Family Partnership
- Healthy Families America
- Parents as Teachers

**Well Supported (1)**
- Improved outcome must be based on the results of at least 2 studies that used a random control or quasi-experimental trial
- Carried out in a usual care or practice setting
- Sustained effect for at least one year beyond the end of treatment

**Supported (2)**
- Improved outcome must be based on the results of at least one study that used a random control or quasi-experimental trial
- Carried out in a usual care of practice setting
- Sustained effect for at least 6 months beyond the end of treatment

**Promising (3)**
- Improved outcomes must be based on at least one study that uses some form of control group

**Hexagon Tool**

**CAPACITY**
- Well-defined program
- Aligns with state and local initiatives
- Target population identified
- Well-defined metrics to evaluate program effectiveness
- Adequate evidence to support program

**EVIDENCE**
- Strength of evidence
  - Number of studies
  - Population similarities
  - Diverse cultural groups
  - Efficacy or Effectiveness
  - Outcomes - Is it worth it?
  - Fidelity data
  - Cost-effectiveness data

**NEED**
- Target population identified
- Disaggregated data indicating population needs
- Parent & community perceptions of need
- Addresses service or system gaps

**IMPLEMENTATION SITE INDICATORS**
- **SHAPE**
  - Structural
  - Heterogeneous, regional, or culturally diverse
  - Time to implementation
  - Fit with family and community values, culture, and history
  - Improvements in allergy and injury initiatives

- **SUPPORTS**
  - Expert assistance
  - Staffing
  - Coaching & supervision
  - System improvements
  - Technology support
  - Initial Start-up

- **FIT**
  - Good fit with community values, culture, and history
  - Identifies needs, priorities, and success measurements

- **USABILITY**
  - Well-defined program
  - Aligns with state, local, and community values
  - Technology support
  - Initial Start-up
Survey Results

- 657 child welfare stakeholders
- Average of 15.5 yrs in CW (range: 1-27 yrs)
- 22% of clinicians in training; 86% of brokers in training
- 81% women; 74% White, 19% Black/African American, 3% Hispanic/Latino

GAPS

Gaps
- Collected as open ended text
- Codebook was created to reflect all responses
- Each response was coded

Parenting Gaps (23%)
- Parenting interventions needed were diverse: abuse specific, neglect specific, co-parenting, young children, teens
- 50% of parenting gaps described focused on tangible supports for caregivers (e.g., housing, transportation, childcare issues)
  “In-home parenting support and one-on-one parenting education would be helpful for families who are not appropriate for our group-based parenting education models.”
Substance Use Gaps (13%)

- More focused on caregiver substance use services than youth

“The overlap of child welfare and substance use issues is huge for us, as is chronic neglect - and there doesn't seem to be a model to handle these.”

I would say that the fastest growing issue in our community is substance abuse and the negative impact that it is having on children and families. I feel that there are not enough service providers in the area who specifically treat this need. The mental health system is overloaded in general, so clients who need substance abuse treatment in particular often slip through the cracks.”

Mental and Behavioral Health (17%)

- More focused on youth mental/behavioral health than caregiver

  - Trauma, complex trauma, and behavioral problems in young children and teens most commonly reported gaps

  “While these students are meeting with counselors to improve behaviors in the classroom, we are disregarding the immense needs and complex trauma however do not have time to grow in understanding…”

Kinship Care (2%)

- Less likely to be mentioned; but many parenting/caregiver gaps are consistent with the goals of kinship care

  “Need more services geared specifically towards diversionary families - relatives/family friends who have obtained custody of a child in order to keep that child out of foster care when the biological parent(s) was not able to maintain custody of the child…”

Out of Home Placement Needs (9%)

“[some youth] struggle with the intimacy of a foster home due to the trauma they have experienced. More specialized foster homes will be needed for them as well as respite homes.”

“…Foster care placements for teens and, specifically, teens transitioning from residential settings or teens with particularly challenging behaviors—e.g., elopement, gang involvement, aggressions, defiance, suicidal ideation…”
Cultural Competence (8%)

“I believe culturally informed treatment is a major need…this applies to both language barriers and cultural competency in providing mental health services to those with different societal, religious and cultural backgrounds.”

Specific Populations (11%)

“…best practices with transgender populations…”
“…we need more services, like vocational programs, for transition age youth”

General Service Delivery (17%)

“I feel that there are not enough service providers…”
“We would benefit from increased therapists and psychiatrist/psychiatric nurse practitioners…”
“more time to communicate and coordinate care…”

Top Gaps x Region
ATTITUDES

Senior Leaders and Brokers

ICS Subscales Scores

Clinicians

Clinician Attitudes x Region
Survey Results

ADDITIONAL COMMENTS

General Feedback/Additional Comments

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<th>Percentage</th>
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<tbody>
<tr>
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“Looking forward to its implementation”
“Evidence based treatment options in SWVA are very much needed.”
“This is a positive move for VDSS!”

“Help agencies that are innovating test these practices and develop the evidence base…”
“Funding to receive training in evidence based approaches is always helpful! These can be very expensive; especially if you seek out extra supervision/consultation in order to implement the model to fidelity.”

“Therapy would be profoundly diminished should the eclecticism of it be eclipsed by EBP”
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“it is essential to be able to use additional techniques with families when spending more than one hour a week with them.”

“the high turnover rate means that a lot of money is lost on training if someone leaves…”

**General Feedback/Additional Comments**

- 21% Positives about FFPSA
- 24% Implementation Concerns or Considerations
- 25% Negatives about EBPs
- 17% Fit in Child Welfare System
- 9% Need for Education/Transparency
- 4% Unintended Consequences

“I am looking forward to learning more and hope for learning opportunities to be provided to local departments in the near future so that staff can be prepared for the changes coming as a result of the Family First Prevention Services Act.”

**General Feedback/Additional Comments**

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“…how are rural localities supposed to benefit at all from these funds and services when we cannot even access providers now without the requirement of EBT services?”

“Please do not make it more difficult to connect families to services of any type.”

**Summary**

- Stakeholders have positive attitudes towards EBP and are eager to increase access
- Gaps are consistent with FFPSA
  - But contextual fit is key
- Stakeholders have unique expertise regarding details of implementation
  - E.g., evaluating Virginia programs, considering turnover rates, ensuring equal access to not increase disparities
Complexities of Implementation

- Multiple systems of care involved
  - Child welfare, adult and child mental health, substance use
- Systemic issues it aims to address (e.g., decreased use of congregate care, focus on prevention prior to child removal) have been the context for EBT evaluation
- Includes culture shift towards prevention mindset
  - Perceptions and attitudes towards families, but also systems, policies, and procedures

Resource Allocation

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<th>Pooling State Resources</th>
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<td>OCS(CSA)</td>
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VDSS will be developing a Request for Proposal

Evidence-Based Programs and QRTP

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<th>Federal Prevention Services Clearinghouse Programs</th>
<th>Qualified Residential Treatment Facility</th>
<th>Evidence-Based Services Basics</th>
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Envisioning the Future

Long Term Vision

- Targeted prevention services across developmental span and parental contexts

Short Term Goals

- Pooling resources; increasing access to EBPs; building infrastructure for evaluation
- What do you envision?
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and
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