DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D.C. 20201

February 24, 2021

Ms. Kelly Garcia
Director
Iowa Department of Human Services 1305 East Walnut Street
Des Moines, IA 50319

Dear Ms. Garcia,

Thank you for submitting Iowa's title IV-E prevention program five-year plan for fiscal years (FYs) 2020-2024. The title IV-E prevention program is authorized under the Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115-123, which amended titles IV-B and IV-E of the Social Security Act (the Act). The FFPSA is an important tool that, if utilized effectively, will help move child welfare in the United States to a more preventative system that works to strengthen families and reduce unnecessary family disruption.

Plan Approval

Iowa submitted a title IV-E prevention program five-year plan to the Children's Bureau (CB) Regional Office on June 29, 2020. We completed a review of this submission and identified areas requiring further documentation to support compliance with state plan requirements. On January 25, 2021, Iowa provided a revised plan that addressed the identified provisions.

We are pleased to notify you that we reviewed Iowa's title IV-E prevention program five-year plan submitted January 25, 2021, and find it to be in compliance with applicable federal statutory and regulatory requirements. Iowa's title IV-E prevention program five-year plan for FYs 2020-2024 is approved as outlined below. An amendment must be submitted any time there is a substantial change to information in the approved plan.

The effective date of Iowa's plan is 10/01/2020. Please maintain this approval letter as a part of the final, approved plan.

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in an approved public assistance cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative costs in accordance with applicable regulations at §95.509(a)(3).

Approval of Services under the Title IV-E Prevention Program
Pursuant to Sections 471(e)(1) and 471(e)(5)(B)(iii) of the Act, only services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse or a state's designation based on an independent systematic review approved for transitional payments as part of the title IV-E prevention program five-year plan by the U.S. Department of Health and Human Services (HHS) are permitted. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse). The title IV-E agency must also provide an assurance each program or service will be continuously monitored to ensure fidelity to the practice model, to determine outcomes achieved, and that the state will use information gleaned from the continuous monitoring efforts to refine and improve practices. CB has approved the following allowable programs and services under this program:

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

Approval of Request for Waiver of Evaluation Requirements
Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of Section 471(e)(5)(B)(iii)(II) are met. CB approves Iowa's request for waiver of the evaluation requirement for the following approved services:

Functional Family Therapy (FFT)
Multisystemic Therapy (MST)

Data Collection and Reporting Requirements
Pursuant to Section 471(e)(4)(E) of the Act, states electing the title IV-E prevention program are required to collect and report on child-specific data to HHS for each child who receives title IV- E prevention services. Iowa has provided an assurance that the state will collect and submit information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures. CB will provide additional information on how to report this information in future guidance.

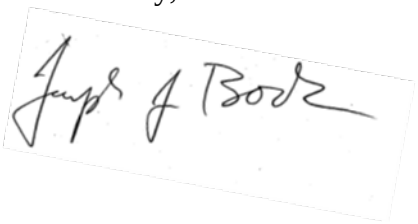
Payer of Last Resort
In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

The title IV-E prevention program is part of CB's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please contact Kendall Darling, Child Welfare Regional Program Manager in Region 7, at (816) 426-2262 or by e-mail at Kendall.Darling@acf.hhs.gov. You also may contact Amy Hance, Children and Families Program Specialist, at (816) 426-2230, or by e-mail at Amy.Hance@acf.hhs.gov.

We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,



Joseph J. Bock
Acting Associate Commissioner
Children's Bureau

Enclosures

cc:
Kendall Darling, Child Welfare Regional Program Manager; CB, Region 7; Kansas City, MO
Amy Hance, Children and Families Program Specialist; CB, Region 7; Kansas City, MO
Janee Harvey, Division Administrator, Adult, Children, and Family Services; Iowa DHS; Des Moines, IA
Vern Armstrong, Division Administrator, Adult, Children, and Family Services; Iowa DHS; Des, Moines, IA
Kara Lynn Regula, Title IV-E Program Manager; Iowa DHS; Des Moines, IA
Janice Davis Caldwell, Director of Family Protection & Resilience Portfolio, ACF Office of Grants Management, Dallas, TX
Janice Realeza Grants Management Officer, Central Region, Family Protection & Resilience Portfolio, ACF Office of Grants Management; Philadelphia, PA.

OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

B. STATE PLAN FOR TITLE IV-E OF THE SOCIAL SECURITY ACT: PREVENTION SERVICES AND PROGRAMS

STATE OF IOWA

U.S. Department of Health and Human Services
Administration for Children and Families
Children's Bureau
November 2018

SECTION 1. Service description and oversight
SECTION 2. Evaluation strategy and waiver request
SECTION 3. Monitoring child safety
SECTION 4. Consultation and coordination
SECTION 5. Child welfare workforce support
SECTION 6. Child welfare workforce training
SECTION 7. Prevention caseloads
SECTION 8. Assurance on prevention program reporting
SECTION 9. Child and family eligibility for the title IV-E prevention program

ATTACHMENT I: State title IV-E prevention program reporting assurance
ATTACHMENT II: State request for waiver of evaluation requirement for a well-supported practice
ATTACHMENT III: State assurance of trauma-informed service-delivery
ATTACHMENT IV: State annual maintenance of effort (MOE) report

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

Iowa Department of Human Services

submits here a plan, inclusive of Part A – Child Welfare and Part B – Juvenile Justice, 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.

PART A – CHILD WELFARE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
Section 1. Services Description and Oversight		
471(e)(1)	A. SERVICES. The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care: 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.	Not Applicable Attachment 1: Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024, pp 9-10; Attachment A13: Employee's Manual 18-C(3), Family-Centered Services, pages 10-12
471(e)(5)(B)(i)	B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.	Attachment 1, page 11; Attachment A13 - page 10

[1] Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

PART A – CHILD WELFARE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
471(e)(5)(B)(iii)(I)(IV) **471(e)(4)(B)**	1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and 6. how each service or program provided will be evaluated.	Attachment 1, pp 11-12 Attachment 1, pp 14-21 Attachment 1, pp 12-14 Attachment 13, page 10 Attachment III (a) Attachment A: Iowa SafeCare® Evaluation
Section 2. Evaluation strategy and waiver request		
471(e)(5)(B)(iii)(V)	A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the	Attachment A

PART A – CHILD WELFARE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
	Secretary, unless a waiver is approved for a well-supported practice; and	
471(e)(5)(C)(ii)	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Not Applicable
Section 3. Monitoring child safety		
471(e)(5)(B)(ii)	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	Attachment 1, pp 21-25; Attachment A2: Form 470-4132, Safety Assessment; Attachment A3: Form 470-4133, Family Risk Assessment; Attachment A4: Form 470-3240, Child Protective Services Assessment Summary; Attachment A5: Form 470-4135, CINA Services Assessment Summary;

PART A – CHILD WELFARE		
Federal Regulatory/Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
		Attachment A6: Form 470-4134, Risk Reassessment
Section 4. Consultation and coordination		
471(e)(5)(B)(iv) and (vi)	A. The state must: 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and 2. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.	Attachment 1, pp 25-31
Section 5. Child welfare workforce support		

PART A – CHILD WELFARE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
471(e)(5)(B)(vii)	The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including— A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	Attachment 1, pp 32-34; Attachment A12: Family-Centered Services Contract Example, page 18 Attachment 1, pp 21-24; Attachment A10: FFY 2020-2024 Training Plan
Section 6. Child welfare workforce training		
471(e)(5)(B)(viii)	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	Attachment 1, pp 34-37; Attachments A1, A8 through A11
Section 7. Prevention caseloads		
471(e)(5)(B)(ix)	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	Attachment 1, pp 37-39; Attachment A12, pages 4-5 (1.3.1(2) Operations), 15 (definition of Intervention Specialist), 18, 19 (Quality Assurance and

PART A – CHILD WELFARE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
		Improvement Reporting, D)
Section 8. Assurance on prevention program reporting		
471(e)(5)(B)(x)	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	Attachment I
Section 9. Child and family eligibility for the title IV-E prevention program		
471(e)(2)	A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is: 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e). 2. A child in foster care who is a pregnant or parenting foster youth.	Attachment 1, pp 8-9; Attachment A14: Iowa Code § 234.1(2)(a); Attachment A4; Attachment A5 Not Applicable

PART B – JUVENILE JUSTICE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
Section 1. Services Description and Oversight		
471(e)(1)	A. SERVICES. The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care: 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.	Attachment 1: Iowa's Title IV-E Prevention Services and Programs Five-Year Plan: FFY 2020-2024, pp 46-57 Not Applicable
471(e)(5)(B)(i)	B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.	Attachment 1, pp 57-58

[1] Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

PART B – JUVENILE JUSTICE		
Federal Regulatory/Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
471(e)(5)(B)(iii)(I)(IV) **471(e)(4)(B)**	1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and 6. how each service or program provided will be evaluated.	Attachment 1, p 57 Attachment 1, pp 59-65 Attachment 1, pp 65-66 Attachment 1, page 66 Attachment III (b) and (c) Attachment 1, page 67
Section 2. Evaluation strategy and waiver request		
471(e)(5)(B)(iii)(V)	A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and	Attachment 1, page 67-71

PART B – JUVENILE JUSTICE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
471(e)(5)(C)(ii)	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Attachment 1, pp 71-75; Attachment II (a) and (b)
Section 3. Monitoring child safety		
471(e)(5)(B)(ii)	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	Attachment 1, pp 75-78; Attachment B1 - Iowa Delinquency Assessment (IDA); Attachment B7: TOP Clinical Scales Form
Section 4. Consultation and coordination		
471(e)(5)(B)(iv) and (vi)	A. The state must: 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and	Attachment 1, pp 79-81

PART B – JUVENILE JUSTICE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
	1. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.	Attachment 1, page 81
Section 5. Child welfare workforce support		
471(e)(5)(B)(vii)	The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including— A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	Attachment 1, pp 81-84 Attachment 1, pp 84-86; Attachment B1; Attachment B2 - CFST; Attachment B3 – JCS Training Plan; Attachment B5 - CPCP; Attachment B6 - CPCP Policy
Section 6. Child welfare workforce training		

PART B – JUVENILE JUSTICE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
471(e)(5)(B)(viii)	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	Attachment 1, pp 86-87; Attachment B3; Attachment B4 – JCS Training Summary; Attachment B1; Attachment B6
Section 7. Prevention caseloads		
471(e)(5)(B)(ix)	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	Attachment 1, page 88
Section 8. Assurance on prevention program reporting		
471(e)(5)(B)(x)	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	Attachment I
Section 9. Child and family eligibility for the title IV-E prevention program		
471(e)(2)	A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is: 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).	Attachment 1, pp 33-34; Attachment B1 - Iowa Delinquency Assessment (IDA); Attachment B2

PART B – JUVENILE JUSTICE		
Federal Regulatory / Statutory References[1]	**Requirement**	**State Regulatory, Statutory, and Policy References and Citations for Each**
	2. A child in foster care who is a pregnant or parenting foster youth.	

OMB Approval No: 0970-0433
Expiration Date: 11/30/2022

Title IV-E Plan – State of Iowa

PLAN SUBMISSION CERTIFICATION

Instructions: This Certification must be signed and submitted by the official authorized to submit the title IV-E plan, and each time the state submits an amendment to the title IV-E plan.

I, Kelly K. Garcia, hereby certify that I am authorized to submit the title IV-E Plan on behalf of Iowa. I also certify that the title IV-E plan was submitted to the governor for his or her review and approval in accordance with 45 CFR 1356.20(c)(2) and 45 CFR 204.1.

Date June 16, 2020

(Signature)

Director

(Title)

04-01-2020

APPROVAL DATE:

2/24/2021

EFFECTIVE DATE:

Joseph Bock

(Signature, Associate Commissioner, Children's Bureau)

Acting

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

Revised January 2021

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PART A – CHILD WELFARE

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

Introduction

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

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

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

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

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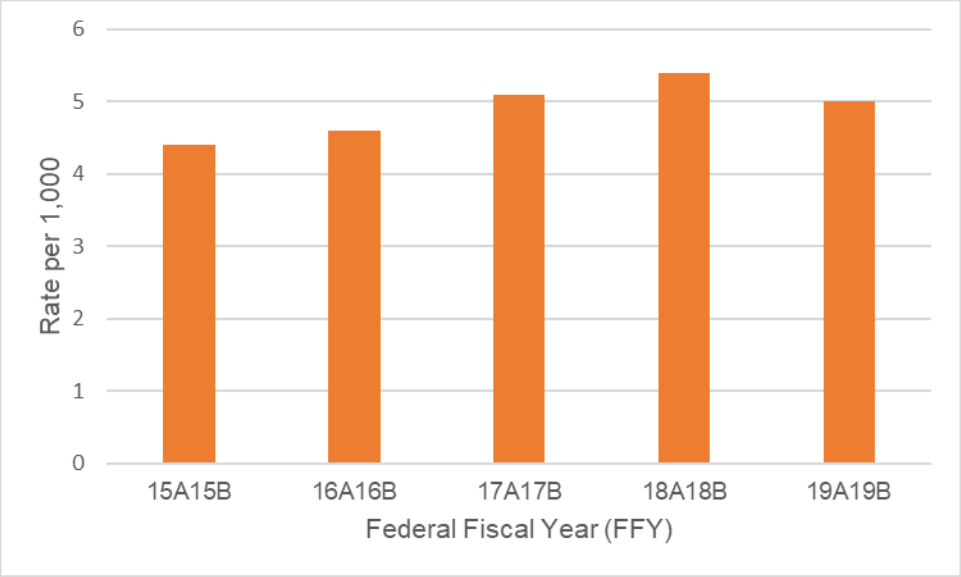
[1] Iowa, Child and Family Service Review (CFSR 3) Data Profile, Context Data, dated February 2020; population estimate 2018 utilized for 2019
[2] DHS, 2019 Child Welfare By The Numbers, available at https://dhs.iowa.gov/sites/default/files/childwelfarebythenumbers2019.pdf?060920201749
[3] Ibid.

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

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



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

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

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

Acronyms and Abbreviations

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

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

Section I: Title IV-E Prevention Services and Programs

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

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

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

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

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

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

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

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

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

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

  The CA risk level determines service availability to the family:

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

For purposes of the title IV-E prevention services program, a child is:
1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).
2. A child in foster care who is a pregnant or parenting foster youth.

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

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

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

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

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

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

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

Services Description and Oversight

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

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

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

The categories of prevention services and programs include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Evaluation Strategy and Waiver Request

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

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

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

Not Applicable

Monitoring Child Safety

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

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

1. Periodic Risk Assessments:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Prevention Plan Review

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

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

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

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

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

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

Section II: Consultation and Coordination

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

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

Mental Health and Substance Abuse Prevention and Treatment Services

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

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

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

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

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

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

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

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

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

Family Support

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

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

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

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

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

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

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

Family First Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section III: Child Welfare Workforce

Support

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Child Welfare Provider Training Academy (Training Academy)

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

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

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

Prevention Caseloads

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

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

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

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

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

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

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

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

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

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

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

Attachments

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

PART B – JUVENILE JUSTICE

Introduction

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

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

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

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

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

[16] Ibid.

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

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

[19] National Mental Health Association, 2004

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

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

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

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

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

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

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

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

Source: Juvenile Court Services

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

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

Acronyms and Abbreviations

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

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

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

Section I: Title IV-E Prevention Services and Programs

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

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

For purposes of the title IV-E prevention services program, a child is:
1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e).
2. A child in foster care who is a pregnant or parenting foster youth.

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

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

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

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

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

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

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

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

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

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

Service Description and Oversight

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[37] Multisystemic Family Therapy (2019). https://preventionservices.abtsites.com/programs/121/show
[38] MST Manual Version - Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for antisocial behavior in children and adolescents (2nd ed.). Guilford Press.
[39] Justice Research Center. (2019). *What Works Curriculum: Thinking for a Change (T4C)*. http://thejrc.com/wwi-curriculum.asp

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. *Implementation and Monitoring of Fidelity*

a. Implementation:

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

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

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

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

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

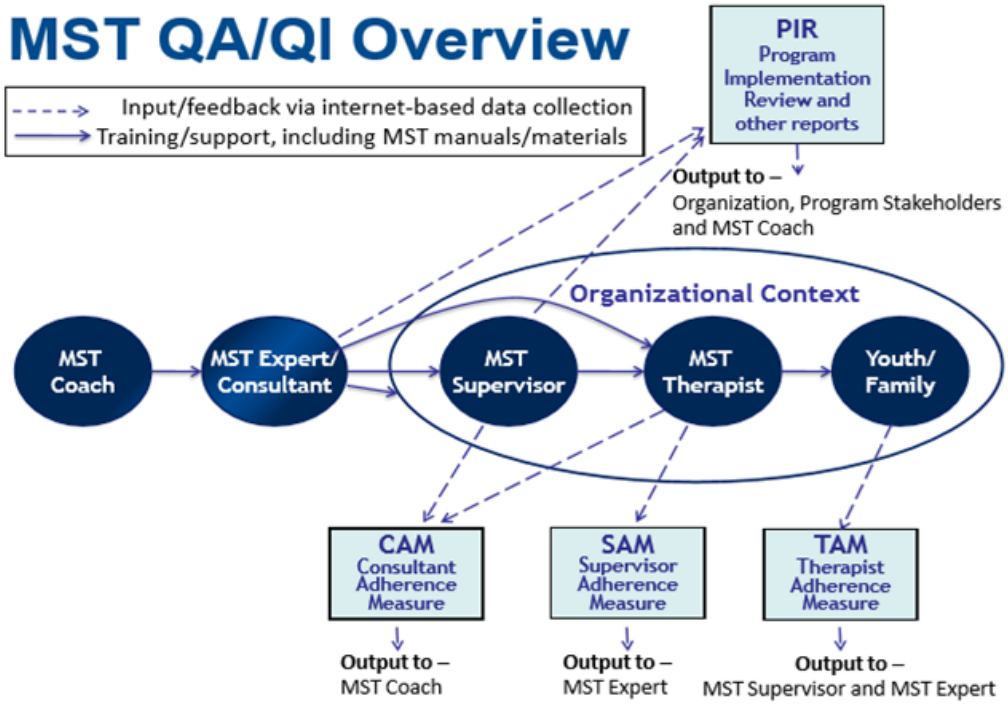
b. FFT and MST outcomes, data, and fidelity (how outcomes will be identified, how data collected regarding these outcomes will occur, and how fidelity will be monitored to ensure fidelity to the practice model):

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

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

[52] MST Institute.

Figure B1. MST QA/QI Overview



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

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

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

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

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

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

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

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

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

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

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

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

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

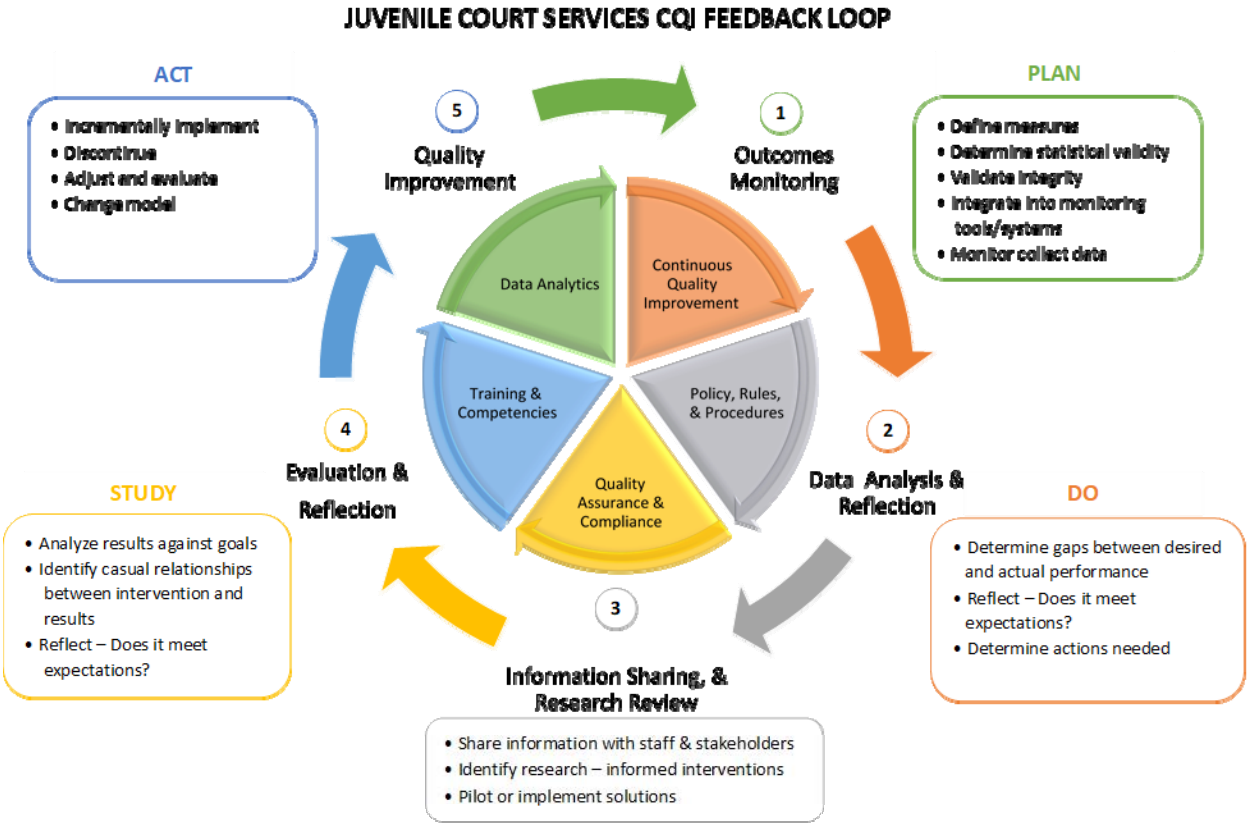
- Conduct yearly meetings with providers to review progress, identify strengths and address any process and/or delivery issues.
- Participate in joint learning opportunities with providers, when feasible

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

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

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

Figure B2. JCS CQI FEEDBACK LOOP



3. Service Selection

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

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

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

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

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

4. Target Population

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

5. *Trauma Informed Delivery Assurance*

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

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

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

Evaluation Strategy and Waiver Request

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

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

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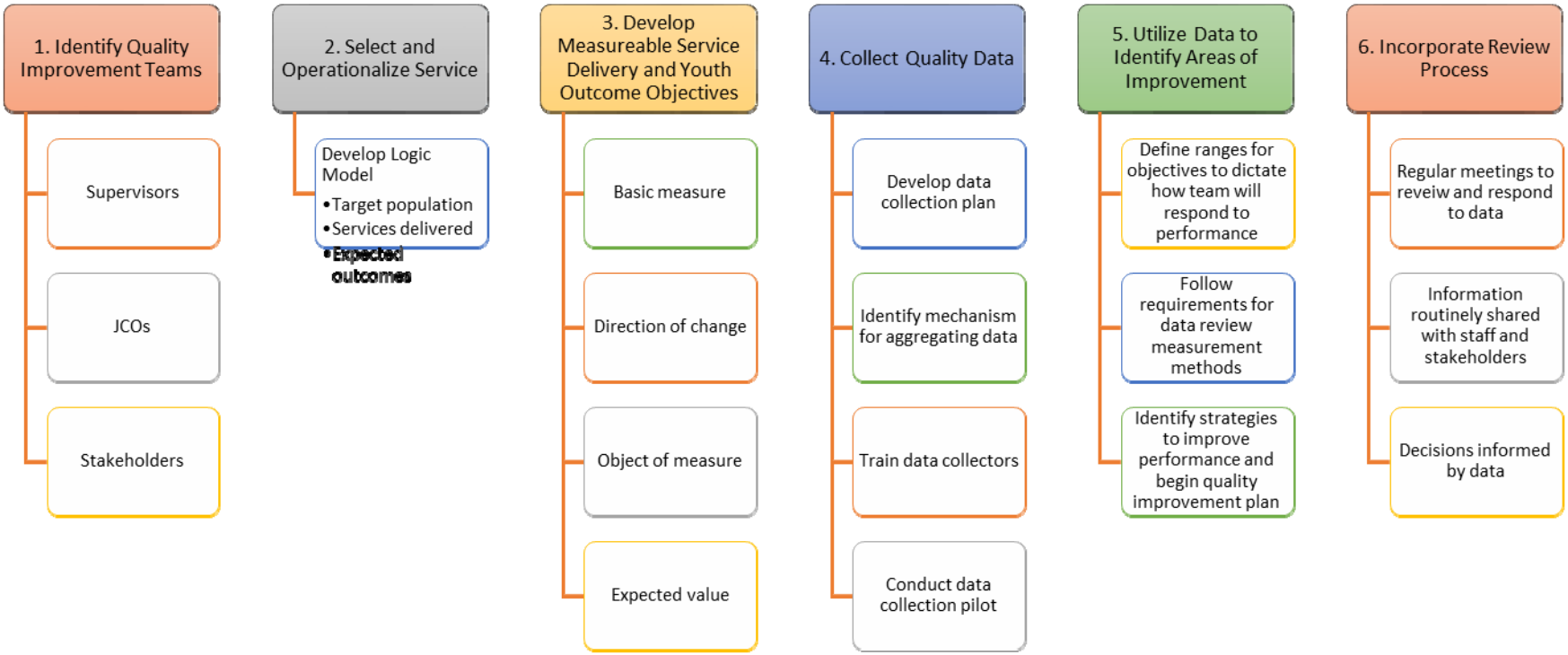
[54] SAMHSA (2014). *Samhsa's Concept of Trauma and Guidance for a Trauma Informed Approach* https://store.samhsa.gov/system/files/sma14-4884.pdf

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

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

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

Figure B3. Juvenile Court Services Continuous Quality Improvement Diagram



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

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

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

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

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

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

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

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

JCS requests a waiver for the following services:

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

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

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

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

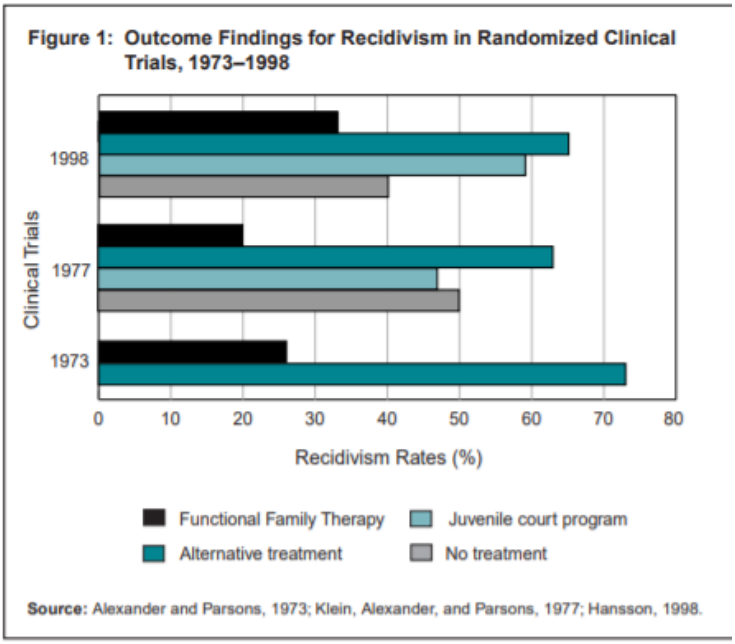
Functional Family Therapy (FFT): JCS is requesting a waiver of the evaluation required for FFT based on compelling evidence that FFT 1) improves family interactions; 2) decreases recidivism; and 3) decreases out-of-home placements. Below is a summary of the research conducted on FFT, which provides evidentiary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

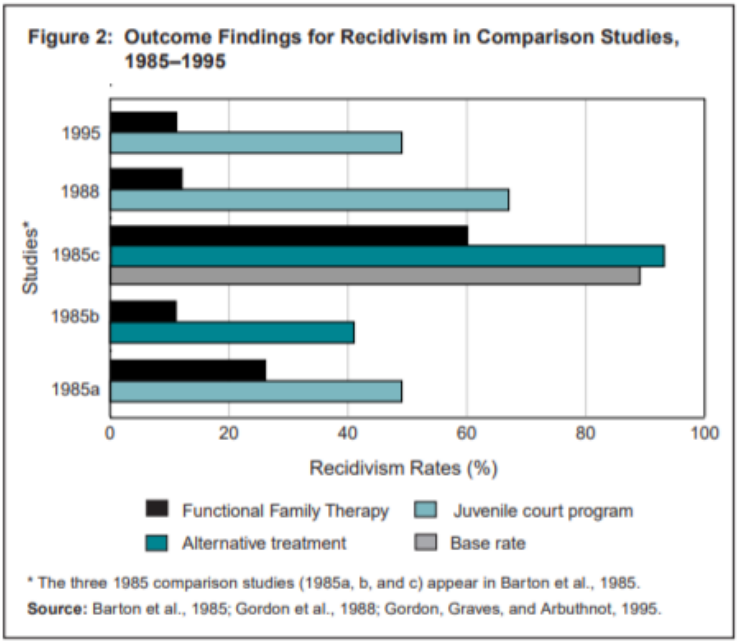
Functional Family Therapy (FFT) has been utilized successfully in a variety of settings to treat high-risk youth and families. It is a treatment approach that combines "established clinical theory, empirically supported principles, and extensive clinical experience"[56] into a discrete and comprehensive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

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

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

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





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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional studies providing evidentiary support for MST are below.

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

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

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

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

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

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

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

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

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

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

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

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

Monitoring Child Safety

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

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

Safety Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

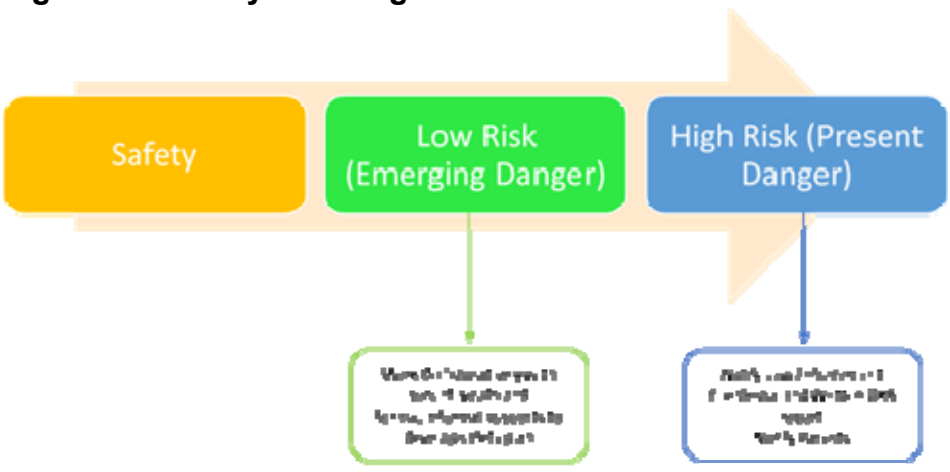
- Condition is clearly identifiable – specific and observable
- Situation is out of control and family has no mean to assume control
- Child is vulnerable – susceptible to danger and unable to protect self
- Danger is imminent – could happen at any time

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

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

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

Figure B4. Safety Planning



Section II: Consultation and Coordination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section III: Child Welfare Workforce

Support

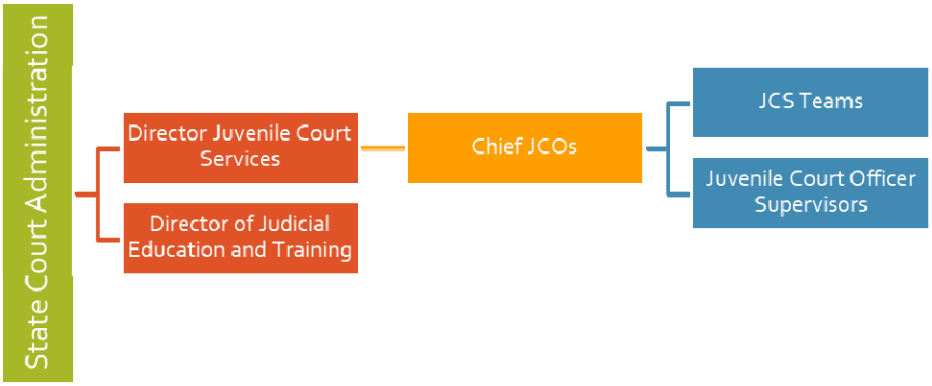
The state must describe the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including:

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

A. Assurance of Staff Qualifications:

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

Figure B5. Juvenile Court Services (Structure)



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

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

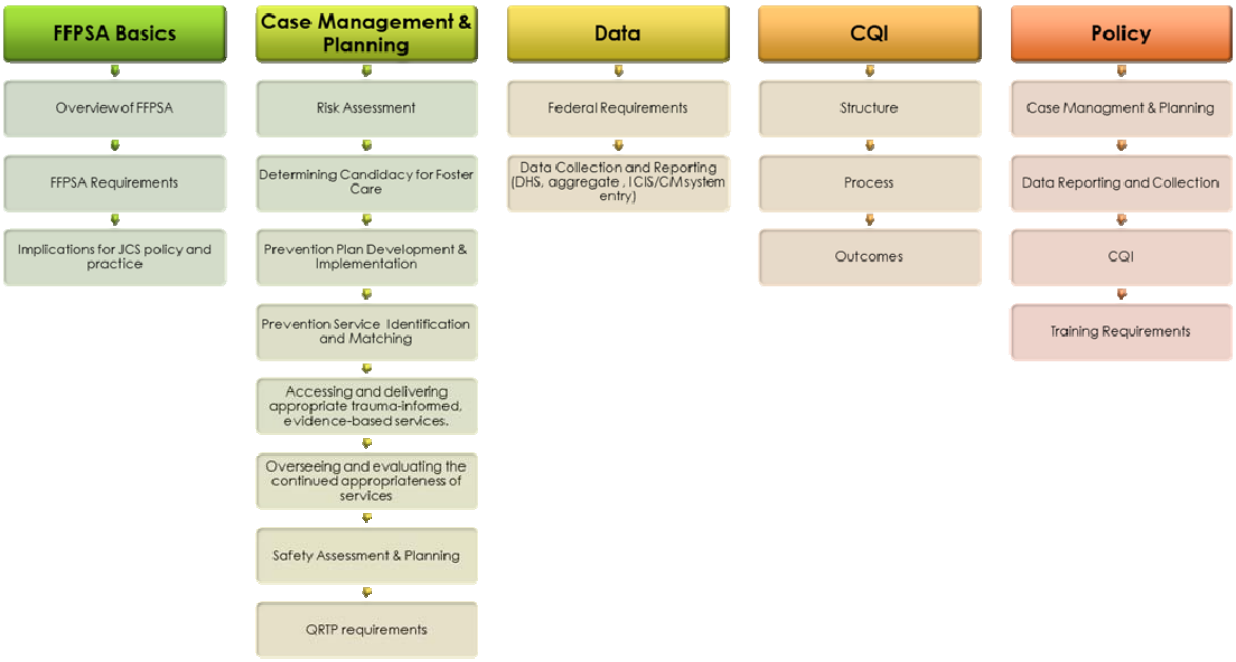
Because JCS recognizes the importance of highly qualified staff, it also provides additional training opportunities through seminars, professional conferences and in-house trainings. Recent training topics have included youth development, cultural diversity (Implicit Bias and Race the Power of Illusion),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

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

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

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

Figure B6: Family First Training Plan for JCS



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Training

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

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

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

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

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

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

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

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

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

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

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

Prevention Caseloads

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

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

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

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

Attachments

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

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

PART C: PLAN ASSURANCES AND ATTACHMENTS

Assurance on Prevention Program Reporting

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

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

Assurance of Trauma-Informed Service-Delivery

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

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

Attachments

- Attachment B: Plan Submission Certification

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

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

Department of HUMAN SERVICES

FAMILY FIRST

BLUEPRINT FOR IOWA'S FUTURE CHILD WELFARE SYSTEM

"Family Connections are Always Strengthened and Preserved"

Principles and Commitments

1. **Family Voice and Choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of involvement. Nothing about the family without the family.
   - A. Case planning and services must be family-centered.
   - B. Children's concerns and identification of caring adults will be specifically solicited and included in case planning.
   - C. Children in foster care deserve normalcy and access to activities and experiences similar to their peers.
2. **Team Based.** The team consists of individuals agreed upon by the family and are committed to them. The team is family inclusive, but not family exclusive.
   - A. Conferences will be held at multiple key junctions: child safety (pre-removal), case planning, Family/Youth Team Decision-Making meetings, and risk of changes in placement.
   - B. Intentional in ensuring team members understand their role in advocating for the preservation and support of family connections.
3. **Natural Supports.** The team actively seeks full participation of team members drawn from family members' networks of natural support. This is particularly true when a child is being placed out of home. This must occur from the first contact with a family and ongoing.
   - A. Parents and natural support caregivers receive support equivalent to, or greater than, what foster parents receive.
   - B. Placement is with a known, caring adult.
4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating the family's case plan. The plan reflects a blending of team member perspectives, mandates, and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
   - A. In-person meetings are necessary to positive engagement, cohesive case planning, and building trust.
   - B. Relationship-based work enhances engagement, trust, services, and outcomes. Consistency of workers is critical to effective work. Fewer workers involved with a family are better.

Comm. 534 (05/19)

5. **Community-Based.** The team implements service and support strategies that take place in accessible and least restrictive settings possible; and that safely promote child and family integration into home and community life.

   A. Use opportunity of involvement with families to enhance well-being and prevent maltreatment, such as addressing safe sleep and connecting families to Early ACCESS.

   B. Services, such as domestic violence, public assistance, mental health and substance abuse, are strategically embedded where family engagement and planning takes place.

   C. Connections to community of origin are important.

6. **Culturally Responsive.** The team demonstrates respect for, and builds on the values, preferences, beliefs, culture and identity of, the child/youth and family and their community.

   A. Intentional strategies towards recruiting, hiring, and supporting staff who reflect the culture and life experience of the population served.

   B. Family history, culture, life experiences, and ethnic identities are relevant and important to establishing a trusting and productive relationship.

7. **Strengths Based.** The case plan must identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family by utilizing their community and other team members.

   A. All families and communities have inherent strengths and value.

   B. Leadership will identify opportunities to match worker's strengths and skills with specific family needs.

8. **Persistence and Creativity.** Despite challenges, the team persists in strengthening and preserving family connections by considering possibilities outside the status quo.

   A. Treating every family as though they were our own drives practice.

   B. Have the courage to recognize when something isn't working and commit to pursuing alternative solutions.

9. **Outcome Based.** Goals and strategies of the system and case planning are observable, have measurable indicators of success, monitor progress in terms of these indicators, and are revised accordingly.

   A. Documentation of the team's work with a family is timely, accurate, and comprehensive.

   B. Case plan goals are measurable, concrete, behaviorally-specific, and created by the team.

   C. Contracted services are performance-based.

   D. Integrated data from Departments and external sources will be utilized by DHS leaders and service providers to inform, develop, and enhance our system of care and outcomes.

10. **Universal.** Practice commitments are relevant, true, and applicable for micro and macro interactions.

    A. Insisting on the value of family connections amongst staff at every level is critical to success.

    B. Gaps in the system supporting families and natural supports will be resolved through fiscal, policy, and contracting commitments.

Iowa Department of Human Services

Safety Assessment

Case name:	Incident number/FACS number:
Worker name: County:	Date *Safety Assessment* completed: Time:

Safety Assessments:

- ☐ Initial CPS safety assessment (*Completed at first visit with child/supervisory consultation within 24 hours)*
- ☐ CPS safety assessment (At the end of the child protection assessment on all assessments)
- ☐ Unsafe situations safety assessments (Whenever circumstances suggest the child is in an unsafe situation. *Completed by worker with supervisory consultation.*)
- ☐ Unsupervised visitation safety assessment *(Prior to decision, with supervisory consultation)*
- ☐ Reunification safety assessment (*Prior to decision, with supervisory consultation)*
- ☐ Case closure safety assessments *(Prior to decision, with supervisory consultation)*

Signs of Present or Impending Danger:

Yes	No	Current Child Well-Being
		1. Caretaker is unwilling or unable to provide for the child's medical or mental health care needs.
		2. Child is fearful of the caretaker, other family member, or other people living in or having access to the home.
		3. Child is unable to self-protect, prevent maltreatment, or access protective relationships to assure safety; and at least one other concern exists.
Narrative:		

Yes	No	Current Parent (Caretaker) Capabilities
		1. Caretaker alleged or observed substance use affects the caretaker's ability to supervise, protect, or care for the child.
		2. Caretaker is unable to provide sufficient supervision to protect the child from potential maltreatment.
		3. Caretaker's alleged or observed emotional instability or developmental delay affects the caretaker's ability to supervise, protect, or provide care for the child.
Narrative:		

Yes	No	Current Family Safety
		1. Child has nonaccidental injuries or history is at variance with injury.
		2. Caretaker in the home is violent or out of control. Domestic violence exists in the home and poses an imminent danger of physical or emotional maltreatment to the child.
		3. Caretaker is causing maltreatment to the child or has made recent credible threats.
		4. Child sexual abuse is suspected and circumstances suggest that the child's safety is of immediate concern.
		5. Caretaker previously abused or neglected a child (or is suspected of such) and the severity of the past maltreatment or caretaker's response to previous intervention, along with at least one other safety concern, suggest imminent danger to the child. Such circumstances include, but are not limited to: • Bodily injury to a child due to assault • Death of a child due to maltreatment • Prior placement of any child due to maltreatment • Prior termination or relinquishment of parental rights due to maltreatment
		6. The family refuses access to the child or there is reason to believe the family might flee.
Narrative:		

Yes	No	Current Family Interactions
		1. Caretaker describes or acts toward the child in predominantly negative terms or has unrealistic expectations likely to cause maltreatment.

Narrative:		
Yes	**No**	**Current Home Environment**
		1. Caretaker is unwilling or unable to meet the child's immediate needs for food, clothing, shelter and physical living conditions, which may result in maltreatment to the child.
Narrative:		

Describe the threats of maltreatment that are present at this time (aggravating factors that combine to produce a potentially dangerous situation)**:**

Describe the child's vulnerability to maltreatment (the degree to which a child cannot, on the child's own, avoid, negate, or minimize the impact of present or impending danger):

Describe the caretaker's protective capacities (family strengths and resources that reduce, control, or prevent threats of maltreatment from arising, as well as factors and deficiencies that have a negative impact on child safety):

Safety Decision:

☐ Safe	• No signs of present or impending danger identified OR one or more signs of present or impending danger identified and child vulnerability or caregiver's protective capacity offset the current danger. The child is not likely to be in imminent danger of maltreatment.
☐ Unsafe	• One or more signs of present or impending danger identified. Child vulnerability or protective capacities do not offset the impending danger of maltreatment, or caretaker has refused access to the child. Removal sanctioned by court order or *Voluntary Placement Agreement* for placement into foster care is the only controlling safety intervention possible.
☐ Conditionally Safe (Safety Plan needed; develop jointly with the family)	• One or more signs of present or impending danger identified. Child's vulnerability or protective capacities do not offset the present or impending danger of maltreatment. Controlling safety interventions have been initiated as identified and agreed upon by all necessary parties in the written safety plan. The controlling safety interventions may include the parent arranging informal temporary care of the child. • The implementation of the safety interventions offset the need to take more restrictive actions at this time. Failure to follow the safety interventions or a change in circumstances may result in the need to take more formal actions to assure child safety in the future. **Note:** The safety plan must identify who will participate to assure safety of the child, who will monitor the safety plan, and duration of the safety plan. Document the actions taken or services initiated to address each identified sign of present or impending danger. Address how behaviors, conditions, and circumstances associated with the sign of present or impending danger will be controlled.

DHS worker signature:	Date and time completed:
Supervisor consulted and manner of consultation:	Date and time:

Present danger: Immediate, significant, and clearly observed maltreatment which is occurring to a child in the present or there is an immediate threat of maltreatment requiring immediate action to protect the child.

Impending danger: A foreseeable state of danger in which family behaviors, attitudes, motives, emotions, or the child's physical environment pose a threat of maltreatment.

Department of HUMAN SERVICES

Family Risk Assessment

Family Name: _____ Incident Number: _____

Worker Name: _____ Date Completed: _____

NEGLECT

N1 Current allegation is for neglect
- ☐ a. No ..... -1
- ☐ b. Yes 1

N2 Prior neglect assessments
- ☐ a. None ..... -1
- ☐ b. Assessment only 1
- ☐ c. One confirmed or founded 2
- ☐ d. Two or more confirmed or founded 3

N3 Household has previously received DHS child welfare services
- ☐ a. No 0
- ☐ b. Yes, previously received services 1
- ☐ c. Yes, prior child removal from household 3

N4 Number of children in household
- ☐ a. Two or fewer ..... -1
- ☐ b. Three or more 1

N5 Age of youngest child in household
- ☐ a. Three or older 0
- ☐ b. Two or younger 1

N6 Number of prior assessments
- ☐ a. None 0
- ☐ b. One 1
- ☐ c. Two or more 2

N7 Age of primary caregiver
- ☐ a. 26 or older ..... -1
- ☐ b. 25 or younger 0

N8 Primary caregiver has substance use problem
- ☐ a. No 0
- ☐ b. Yes 1

N9 Child in household has mental health/ behavioral problem
- ☐ a. No 0
- ☐ b. Yes 1

ABUSE

A1 Number of prior assessments
- ☐ a. None ..... -1
- ☐ b. 1 to 3 1
- ☐ c. 4 or more 3

A2 Household has previously received DHS child welfare services
- ☐ a. No 0
- ☐ b. Yes 2

A3 Primary caregiver has history of abuse or neglect as a child
- ☐ a. No 0
- ☐ b. Yes 2

A4 Primary caregiver was placed in protective services as a child
- ☐ a. No 0
- ☐ b. Yes 3

A5 Caregiver(s) provides supervision inconsistent with the child's needs
- ☐ a. No 0
- ☐ b. Yes 1

A6 Current allegation is for abuse
- ☐ a. No 0
- ☐ b. Yes 2

A7 Caregiver(s) involved in disruptive/volatile adult relationships
- ☐ a. No 0
- ☐ b. Yes 1

A8 Characteristics of children in the household
- ☐ a. Not applicable 0
- ☐ b. Mental health/behavioral problems 2
- ☐ c. Physical disability 2
- ☐ d. Both b. and c. 4

A9 Caregiver(s) has history of mental health treatment
- ☐ a. No, neither caregiver 0
- ☐ b. Either caregiver 1
- ☐ c. Both caregivers 2

N10 Recent or history of domestic violence in the household

- ☐ a. No.....0
- ☐ b. Yes.....1

N11 Caregiver(s) have history of homelessness

- ☐ a. No.....0
- ☐ b. Yes.....3

Total neglect score:

A10 Secondary caregiver has a substance use problem

- ☐ a. N/A - no secondary caregiver.....0
- ☐ b. No problem with drugs or alcohol ..... -1
- ☐ c. Alcohol only.....1
- ☐ d. Other drugs or drugs and alcohol combined..2

A11 Prior abuse assessments

- ☐ a. None.....0
- ☐ b. Abuse assessments (other than sex abuse)..1
- ☐ c. Sexual abuse assessments 2
- ☐ d. Both b. and c. 3

Total abuse risk score:

SCORED RISK LEVEL:

Assign family's scored risk level based on the highest score on either the neglect or abuse instrument using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
☐ -4 to -1	☐ -2 to 0	☐ LOW
☐ 0 to 4	☐ 1 to 6	☐ MODERATE
☐ 5+	☐ 7+	☐ HIGH

POLICY OVERRIDERS:

Mark the conditions shown below that are applicable in this case. If any condition is applicable, override final risk to HIGH.

- ☐ 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
- ☐ 2. Non-accidental injury to infant.
- ☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
- ☐ 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

Policy Override Risk Level: ☐ HIGH ☐ Not applicable

DISCRETIONARY OVERRIDE:

If a discretionary override is made, mark YES and indicate reason. Otherwise, mark NO.
(Risk level will be overridden one level HIGHER. Risk level may NOT be lowered.)

☐ NO ☐ YES, Override risk level to

DISCRETIONARY OVERRIDE REASON:

SUPERVISOR'S REVIEW/APPROVAL OF DISCRETIONARY OVERRIDE:

Signature:_____ Date:_____

FINAL RISK LEVEL:

Department of HUMAN SERVICES

Child Protective Services
Child Abuse Assessment Summary

Case Name or Names:		
Address:	Home Phone:	Other Phone:
Incident #:	Completion Date:	Addendum Date:
Intake Date:	Child Protection Worker:	County Name/County #:
Assessment Findings: ☐ Not confirmed ☐ Confirmed, not placed on registry ☐ Founded ☐ Addendum to previous summary	Safety Assessment Findings: ☐ Safe ☐ Conditionally safe ☐ Unsafe	If conditionally safe, date Safety Plan completed: If unsafe, date of removal: ☐ Removal request, court denied ☐ Voluntary ☐ Relative ☐ Non-relative ☐ Emergency custody

Household Composition

Sex: Male (M), Female (F)

Name	DOB	Sex	Role	FACS ID	Comments

Non-Custodial Parent

Name:	DOB:	Parent of:
Address:		Phone:

Others Involved in the Assessment – Not in Household

Name	DOB	Sex	Role	FACS #	Comments

Person Determined Responsible for the Abuse *(complete only if abuse is confirmed)*				
Name:	DOB:	Role:	FACS #:	Sex:
Address:	Home Phone:			
	Work Phone:			

Intake Allegation Type

☐ Physical abuse	☐ Mental injury	☐ Sexual abuse
☐ Denial of critical care	☐ Child prostitution	☐ Presence of illegal drugs
☐ Dangerous substances	☐ Bestiality in presence of a minor	☐ Allows access by a registered sex offender
☐ Allows access to obscene materials	☐ Child sex trafficking	

Concerns Reported

Summary of Previously Confirmed or Founded Reports Concerning Person Alleged Responsible

Date	Incident #	Person Responsible	Type	Victim	Finding

Summary of Assessment Process	**Date(s)**
Child(ren) observed Justification if child observed outside of timeframe:	
Custodial parent(s) interview	
Non-custodial parent interview (if applicable)	
Evaluation of home environment completed	
Safety Assessment completed	

Safety Plan completed (if applicable)	
Risk Assessment completed	

Additional process information:

ICWA/Native American heritage information:

Date/time contacts were attempted:

Supervisory approval of contact delay:

Date/time of supervisory safety decision check back:

In accordance with Iowa Code 232,71B, when conducting an assessment, the Department of Human Services completes an evaluation of the family which includes the identification of strengths and needs of the child, and of the child's parents, home, and family. This information is documented in the Family Risk Assessment (form 470-4133), Safety Assessment (form 470-4132), and when applicable, a Safety Plan (form 470-4461). The information is available only to the child, parents, and others with legal access to this information, and then only upon request.

Confidential access: ☐ Yes ☐ No

If Yes, give justification:

Summary of Contacts

Date of contact:

Summary of contact (including date and time of contact, observations, interviews, or other information gathered to determine if the allegations of abuse meet the definition of child abuse as defined by Iowa Code):

Date of contact:

NOTE: Last contact must include a determination of child death or serious injury (as defined by Iowa Code section 702.18 and Iowa Code section 235A.18): Based on the credible evidence available, it is determined that the abuse ☐ DID ☐ DID NOT result in the death or serious injury of a child.

Summary of Contacts Addendum *(shown only if in addendum status)*

Date of contact:

Summary of contact (including date and time of contact, observations, interviews, or other information gathered to determine if the allegations of abuse meet the definition of child abuse as defined by Iowa Code):

Date of contact:

NOTE: Last contact must include a determination of child death or serious injury (as defined by Iowa Code section 702.18 and Iowa Code section 235A.18): Based on the credible evidence available, it is determined that the abuse ☐ DID ☐ DID NOT result in the death or serious injury of a child.

Family Risk Assessment

This page will not print with the CPS Assessment Summary report!

Family Name:	Incident Number:
Worker Name:	Date Completed:

NEGLECT

N1 Current allegation is for neglect
- ☐ a. No ..... -1
- ☐ b. Yes 1

N2 Prior neglect assessments
- ☐ a. None ..... -1
- ☐ b. Assessment only 1
- ☐ c. One confirmed or founded 2
- ☐ d. Two or more confirmed or founded 3

N3 Household has previously received DHS child welfare services
- ☐ a. No 0
- ☐ b. Yes, previously received services 1
- ☐ c. Yes, prior child removal from household 3

N4 Number of children in household
- ☐ a. Two or fewer ..... -1
- ☐ b. Three or more 1

N5 Age of youngest child in household
- ☐ a. Three or older 0
- ☐ b. Two or younger 1

N6 Number of prior assessments
- ☐ a. None 0
- ☐ b. One 1
- ☐ c. Two or more 2

N7 Age of primary caregiver
- ☐ a. 26 or older ..... -1
- ☐ b. 25 or younger 0

N8 Primary caregiver has substance use problem
- ☐ a. No 0
- ☐ b. Yes 1

N9 Child in household has mental health/ behavioral problem
- ☐ a. No 0
- ☐ b. Yes 1

ABUSE

A1 Number of prior assessments
- ☐ a. None ..... -1
- ☐ b. 1 to 3 1
- ☐ c. 4 or more 3

A2 Household has previously received DHS child welfare services
- ☐ a. No 0
- ☐ b. Yes 2

A3 Primary caregiver has history of abuse or neglect as a child
- ☐ a. No 0
- ☐ b. Yes 2

A4 Primary caregiver was placed in protective services as a child
- ☐ a. No 0
- ☐ b. Yes 3

A5 Caregiver(s) provides supervision inconsistent with the child's needs
- ☐ a. No 0
- ☐ b. Yes 1

A6 Current allegation is for abuse
- ☐ a. No 0
- ☐ b. Yes 2

A7 Caregiver(s) involved in disruptive/volatile adult relationships
- ☐ a. No 0
- ☐ b. Yes 1

A8 Characteristics of children in the household
- ☐ a. Not applicable 0
- ☐ b. Mental health/behavioral problems 2
- ☐ c. Physical disability 2
- ☐ d. Both b. and c. 4

A9 Caregiver(s) has history of mental health treatment
- ☐ a. No, neither caregiver 0
- ☐ b. Either caregiver 1
- ☐ c. Both caregivers 2

N10 Recent or history of domestic violence in the household ☐ a. No ..... 0 ☐ b. Yes 1	A10 Secondary caregiver has a substance use problem ☐ a. N/A - no secondary caregiver ..... 0 ☐ b. No problem with drugs or alcohol ..... -1 ☐ c. Alcohol only ..... 1 ☐ d. Other drugs or drugs and alcohol combined .2
N11 Caregiver(s) have history of homelessness ☐ a. No ..... 0 ☐ b. Yes 3	A11 Prior abuse assessments ☐ a. None ..... 0 ☐ b. Abuse assessments (other than sex abuse) .1 ☐ c. Sexual abuse assessments ..... 2 ☐ d. Both b. and c. 3

Total neglect score:	Total abuse risk score:

SCORED RISK LEVEL:

Assign family's scored risk level based on the highest score on either the neglect or abuse instrument using the following chart.

Neglect Score	Abuse Score	Scored Risk Level
☐ -4 to -1	☐ -2 to 0	☐ LOW
☐ 0 to 4	☐ 1 to 6	☐ MODERATE
☐ 5+	☐ 7+	☐ HIGH

POLICY OVERRIDES:

Mark the conditions shown below that are applicable in this case. If <u>any</u> condition is applicable, override final risk to HIGH.

- ☐ 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.
- ☐ 2. Non-accidental injury to infant.
- ☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment.
- ☐ 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

Policy Override Risk Level: ☐ HIGH ☐ Not applicable

DISCRETIONARY OVERRIDE:

If a discretionary override is made, mark YES and indicate reason. Otherwise, mark NO.
(Risk level will be overridden one level HIGHER. Risk level may NOT be lowered.)

☐ NO YES, Override risk level to

DISCRETIONARY OVERRIDE REASON:

SUPERVISOR'S REVIEW/APPROVAL OF DISCRETIONARY OVERRIDE:

Signature:	Date:

FINAL RISK LEVEL:

Iowa Department of Human Services

Safety Assessment

This page will not print with the CPS Assessment Summary report!

Case name:	Incident number/FACS number: /
Worker name: County:	Date *Safety Assessment* completed: Time:

Safety Assessments:

- ☐ Initial CPS safety assessment (*Completed at first visit with child/supervisory consultation within 24 hours)*
- ☐ CPS safety assessment (At the end of the child protection assessment on all assessments)
- ☐ Unsafe situations safety assessments (Whenever circumstances suggest the child is in an unsafe situation. *Completed by worker with supervisory consultation.*)
- ☐ Unsupervised visitation safety assessment *(Prior to decision, with supervisory consultation)*
- ☐ Reunification safety assessment (*Prior to decision, with supervisory consultation)*
- ☐ Case closure safety assessments *(Prior to decision, with supervisory consultation)*

Signs of Present or Impending Danger:

Yes	No	Current Child Well-Being
☐	☐	1. Caretaker is unwilling or unable to provide for the child's medical or mental health care needs.
☐	☐	2. Child is fearful of the caretaker, other family member, or other people living in or having access to the home.
☐	☐	3. Child is unable to self-protect, prevent maltreatment, or access protective relationships to assure safety; and at least one other concern exists.
Narrative:		

Yes	No	Current Parent (Caretaker) Capabilities
☐	☐	1. Caretaker alleged or observed substance use affects the caretaker's ability to supervise, protect, or care for the child.
☐	☐	2. Caretaker is unable to provide sufficient supervision to protect the child from potential maltreatment.
☐	☐	3. Caretaker's alleged or observed emotional instability or developmental delay affects the caretaker's ability to supervise, protect, or provide care for the child.
Narrative:		

Yes	No	Current Family Safety
☐	☐	1. Child has nonaccidental injuries or history is at variance with injury.
☐	☐	2. Caretaker in the home is violent or out of control. Domestic violence exists in the home and poses an imminent danger of physical or emotional maltreatment to the child.
☐	☐	3. Caretaker is causing maltreatment to the child or has made recent credible threats.
☐	☐	4. Child sexual abuse is suspected and circumstances suggest that the child's safety is of immediate concern.

☐	☐	5. Caretaker previously abused or neglected a child (or is suspected of such) and the severity of the past maltreatment or caretaker's response to previous intervention, along with at least one other safety concern, suggest imminent danger to the child. Such circumstances include, but are not limited to: • Bodily injury to a child due to assault • Death of a child due to maltreatment • Prior placement of any child due to maltreatment • Prior termination or relinquishment of parental rights due to maltreatment
☐	☐	6. The family refuses access to the child or there is reason to believe the family might flee.
Narrative:		
Yes	**No**	**Current Family Interactions**
☐	☐	1. Caretaker describes or acts toward the child in predominantly negative terms or has unrealistic expectations likely to cause maltreatment.
Narrative:		
Yes	**No**	**Current Home Environment**
☐	☐	1. Caretaker is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and physical living conditions, which may result in maltreatment to the child.
Narrative:		

Describe the threats of maltreatment that are present at this time (aggravating factors that combine to produce a potentially dangerous situation):

Describe the child's vulnerability to maltreatment (the degree to which a child cannot, on the child's own, avoid, negate, or minimize the impact of present or impending danger):

Describe the caretaker's protective capacities (family strengths and resources that reduce, control, or prevent threats of maltreatment from arising, as well as factors and deficiencies that have a negative impact on child safety):

Safety Decision:

☐ Safe	• No signs of present or impending danger identified OR one or more signs of present or impending danger identified and child vulnerability or caregiver's protective capacity offset the current danger. The child is not likely to be in imminent danger of maltreatment.
☐ Unsafe	• One or more signs of present or impending danger identified. Child vulnerability or protective capacities do not offset the impending danger of maltreatment, or caretaker has refused access to the child. Removal sanctioned by court order or *Voluntary Placement Agreement* for placement into foster care is the only controlling safety intervention possible.

☐ Conditionally Safe (Safety Plan needed; develop jointly with the family)	• One or more signs of present or impending danger identified. Child's vulnerability or protective capacities do not offset the present or impending danger of maltreatment. Controlling safety interventions have been initiated as identified and agreed upon by all necessary parties in the written safety plan. The controlling safety interventions may include the parent arranging informal temporary care of the child. • The implementation of the safety interventions offset the need to take more restrictive actions at this time. Failure to follow the safety interventions or a change in circumstances may result in the need to take more formal actions to assure child safety in the future. **Note:** The safety plan must identify who will participate to assure safety of the child, who will monitor the safety plan, and duration of the safety plan. Document the actions taken or services initiated to address each identified sign of present or impending danger. Address how behaviors, conditions, and circumstances associated with the sign of present or impending danger will be controlled.

DHS worker signature:	Date and time completed:
Supervisor consulted and manner of consultation:	Date and time:

Present danger: Immediate, significant, and clearly observed maltreatment which is occurring to a child in the present or there is an immediate threat of maltreatment requiring immediate action to protect the child.

Impending danger: A foreseeable state of danger in which family behaviors, attitudes, motives, emotions, or the child's physical environment pose a threat of maltreatment.

Assessment of Family Functioning and Safety

This page will not print with the CPS Assessment Summary report!

Yes	No	Current Child Well-Being
☐	☐	1. Caretaker is unwilling or unable to provide for the child's medical or mental health care needs.
☐	☐	2. Child is fearful of the caretaker, other family member, or other people living in or having access to the home.
☐	☐	3. Child is unable to self-protect, prevent maltreatment, or access protective relationships to assure safety; and at least one other concern exists.

Analysis of Child Well-Being:

* This message and prompts indicated with a * below will not print with the CPS Assessment Summary report!

*** Provide general narrative below documenting worker observations of strengths and challenges to child's well-being. Be sure to address how/if the allegations that prompted this assessment were or were not found to be a threat to the child's well-being. As you describe your assessment of the child's well-being, give consideration to the following:**

- **Child's mental health** (emotional stability, ability to handle stress, involvement in any needed mental treatment/medication)
- **Child's behavior** (in accordance with child's development level, is child well-behaved, following rules, accepting responsibilities, oppositional/delinquent)
- **School performance** (attendance patterns, does/does not do well academically, behaviors at school)
- **Relationship with parents/caregivers** (accepts discipline/supervision, open vs. hostile communication)
- **Relationship with siblings** (do siblings get along, is there serious fighting or rivalry, are siblings supportive of each other)
- **Relationship with peers** (able to form positive peer relationships vs. avoidance of peers or involvement with peers who have a negative influence; engagement in activities via school, religious, social or recreational outlets)
- **Motivation/cooperation to maintain the family** (child motivated to change, is cooperative with family members, wants to stay with family/caregivers, accepting of services/supports vs. resistant to change, not wanting to be part of family, not accepting of supports)

*** Child-specific statements will be kept in separate paragraphs to allow for redaction if needed in dissemination of the report.**

C1

C2

C3

Protected information regarding parent's physical health, mental health, or substance abuse:

Yes	No	Current Parent (Caretaker) Capabilities
☐	☐	1. Caretaker alleged or observed substance use affects the caretaker's ability to supervise, protect, or care for the child.
☐	☐	2. Caretaker is unable to provide sufficient supervision to protect the child from potential maltreatment.
☐	☐	3. Caretaker's alleged or observed emotional instability or developmental delay affects the caretaker's ability to supervise, protect, or provide care for the child.

Analysis of Parental Capabilities:

* **Provide general narrative below documenting worker observations of strengths and challenges to <u>current parent or caretaker capabilities</u>. Be sure to address how/if the allegations that prompted this assessment were or were not found to relate to the parent/caretaker's capabilities. As you describe your assessment of the parent/caretaker's capabilities, give consideration to the following:**

- **<u>Supervision of child</u>** (is supervision age-appropriate, is parent able to set age-appropriate limits, are substitute caregivers chosen carefully and with consideration to child's safety/comfort, is parent knowledgeable regarding where and with whom the child is located)
- **<u>Disciplinary practice</u>** (is discipline age-appropriate, non-punitive, and consistent; are parents good models for the children; do parents agree on parenting style and support each other; is discipline physically or emotionally abusive, excessive, punitive, inconsistent, or age-inappropriate)
- **<u>Development/enrichment opportunities</u>** (children are provided with social, recreational, musical, or other enrichment activities and parents are appropriately involved, or is child discouraged from such activities, or participates without active parental support)
- **<u>Parent/caregiver's physical health</u>** (does parent's physical health or medical needs impair the parent's ability to provide for the child's well-being)
- **<u>Parent/caregiver's mental health</u>** (does the parent have mental health issues that negatively impact the parent's ability to provide for the child's well-being; if parental mental health issues exist, is the parent getting help as needed)
- **<u>Parent/caregiver's use of drugs/alcohol</u>** (does parent use drugs or alcohol and if so, is/how is this impacting the parent's ability to provide for the well-being of the child)

* **Child-specific statements will be kept in separate paragraphs to allow for redaction if needed in dissemination of the report.**

C1

C2

C3

Protected information regarding parent's physical health, mental health, or substance abuse:

Yes	No	Current Family Safety
☐	☐	1. Child has non-accidental injuries or history is at variance with injury.
☐	☐	2. Caretaker in the home is violent or out of control. Domestic violence exists in the home and poses an imminent danger of physical or emotional maltreatment to the child.
☐	☐	3. Caretaker is causing maltreatment to the child or has made recent credible threats.
☐	☐	4. Child sexual abuse is suspected and circumstances suggest that the child's safety is of immediate concern.
☐	☐	5. Caretaker previously abused or neglected a child (or is suspected of such) and the severity of the past maltreatment or caretaker's response to previous intervention, along with at least one other safety concern, suggests imminent danger to the child. Such circumstances include, but are not limited to: • Bodily injury to a child due to assault • Death of a child due to maltreatment • Prior placement of any child due to maltreatment • Prior termination or relinquishment of parental rights due to maltreatment

Yes	No	Current Family Safety
☐	☐	6. The family refuses access to the child or there is reason to believe the family might flee.

Analysis of Family Safety:

*** Provide general narrative below documenting worker observations of strengths and challenges to <u>current family safety</u>. Be sure to address how/if the allegations that prompted this assessment were or were not found to relate to current family safety. As you describe your assessment of current family safety, give consideration to the following:**

- **<u>Absence/presence of physical abuse of children</u>** (have there been issues related to the physical abuse of the children and if so, how have these been resolved; has family been accepting of any needed help to resolve issues related to physical abuse)
- **<u>Absence/presence of sexual abuse of children</u>** (do there appear to be good boundaries; do children understand good and bad touch; have there been issues related to the sexual abuse of children and if so, how have these been resolved; are there issues related to a child in the household acting in a sexualized or sexually aggressive manner and if so, how is this being addressed; has family been accepting of any needed help to resolve issues relating to sexual abuse)
- **<u>Absence/presence of emotional abuse of children</u>** (do caregivers appear to meet child's emotional needs; do children appear to be secure and possessing sense of self-worth; have there been issues related to the emotional abuse of the children and if so, how have these been resolved; has family been accepting of any needed help to resolve issues related to emotional abuse)
- **<u>Absence/presence of neglect of children</u>** (have there been issues related to the neglect of children and if so, how have these been resolved; has the family been accepting of any needed help to resolve issues related to neglect)
- **<u>Absence/presence of domestic violence between parents/caregivers</u>** (how are family disputes resolved; does this family have a positive approach to resolving disputes; do family disputes ever erupt in violence; if there have been issues related to violence, how have these been resolved; has the family been accepting of any needed help to resolve issues related to domestic violence)

*** Child-specific statements will be kept in separate paragraphs to allow for redaction if needed in dissemination of the report.**

C1

C2

C3

Protected information regarding parent's physical health, mental health, or substance abuse:

Yes	No	Current Family Interactions
☐	☐	1. Caretaker describes or acts toward the child in predominantly negative terms or has unrealistic expectations likely to cause maltreatment.

Analysis of Family Interactions:

*** Provide general narrative below documenting worker observations of strengths and challenges to <u>current family interactions</u>. Be sure to address how/if the allegations that prompted this assessment were or were not found to relate to current family interactions. As you describe your assessment of current family interactions, give consideration to the following:**

- **<u>Bonding with children</u>** (parents create positive opportunities for interacting with children and establishing a

strong attachment; parents show high levels of positive stimulation, affection, and nurturing toward the child; appropriate independence is encouraged; or does parent not appear attached and is resentful, rejecting, detached, and unresponsive to the basic needs of the child)

- **Expectations of the children** (does parent understand child development stages, including cognitive, physical, social, and emotional; are expectations age-appropriate; or is parent's understanding of child development limited and/or not age-appropriate; or parent unable to successfully communicate expectations to child)
- **Mutual support within the family** (is there strong support within family and from extended family; is family able/not able to identify and access other resources and supports; do family members help each other willingly; or is there a lack of support from family members or a tendency for family members to undermine one another)
- **Relationship between parents/caregivers** (relationship between parents/caregivers is stable, consistent, affectionate, and loving; communication between parents/caregivers is clear and encouraging; the parents/caregivers have a relationship separate from the children; parent/caregiver conflicts are resolved successfully; or is there a lack of common parent/caregiver goals and cohesion, with an atmosphere of conflict; are issues of divorce, separation, and abandonment a constant challenge for parent/caregivers)

*** Child-specific statements will be kept in separate paragraphs to allow for redaction if needed in dissemination of the report.**

C1

C2

C3

Protected information regarding parent's physical health, mental health, or substance abuse:

Yes	No	Current Home Environment
☐	☐	1. Caretaker is unwilling or unable to meet the child's immediate needs for food, clothing, shelter, and physical living conditions, which may result in maltreatment to the child.

Analysis of Home Environment:

*** Provide general narrative below documenting worker observations of strengths and challenges to current home environment. Be sure to address how/if the allegations that prompted this assessment were or were not found to relate to current home environment. As you describe your assessment of current home environment, give consideration to the following:**

- **Housing stability** (does family have stable housing or are they at risk of eviction, dependent on others for housing, homeless, constantly moving)
- **Safety in community** (is the neighborhood safe or unsafe, are neighbors supportive, can children play outside)
- **Habitability of housing** (is/isn't home clean, neat, with no safety or health hazards; is home infested; are there unsafe items such as guns, knives, legal or illegal drugs, or poisons within reach of children; are there interior or exterior issues that need addressed to ensure safety)
- **Income/employment** (is/isn't there stable employment/income; is/isn't there sufficient income from legal sources to meet the family's needs)
- **Financial management** (financial resources are/not used in a way that addresses family's basic needs; debts are/not small and manageable)
- **Food/nutrition** (children's nutritional needs including any special needs are/not met; meals are/not provided regularly and meet basic nutritional needs)
- **Personal hygiene** (family members do/not appear clean, well-groomed, with awareness of hygiene and grooming; clothes are/not clean and appropriate to the season)
- **Transportation** (family has/not a car, or access to public transportation; transportation is/isn't sufficient to meet

obligations such as school, medical, employment; is a lack of transportation increasing social isolation)

- **Learning environment** (learning environment at home supports child development; parent is/isn't involved with child's educational development at home; parent is/isn't engaged with child's school)

*** Child-specific statements will be kept in separate paragraphs to allow for redaction if needed in dissemination of the report.**

C1

C2

C3

Protected information regarding parent's physical health, mental health, or substance abuse:

Findings and Determination of Abuse Allegations

NOTE: The end of this section must include a determination of child death or serious injury (as defined by Iowa Code section 702.18 and Iowa Code section 235A.18): The abuse ☐ DID ☐ DID NOT result in the death or serious injury of a child. [Iowa Code sections 235A.18 and 702.18]

Addendum Findings and Determination of Abuse Allegations

(shown only in addendum status)

NOTE: The end of this section must include a determination of child death or serious injury (as defined by Iowa Code section 702.18 and Iowa Code section 235A.18): The abuse ☐ DID ☐ DID NOT result in the death or serious injury of a child. [Iowa Code sections 235A.18 and 702.18]

Placement on Registry

Child's Name:	Person Responsible:	Abuse Type:	Assessment Finding:

Justification:

Summary and Analysis of Safety/Risk Assessments Identified

Describe the threats of maltreatment that are present at this time (aggravating factors that combine to produce a potentially dangerous situation):

Describe the child's vulnerability to maltreatment (the degree to which a child cannot, on the child's own, avoid, negate, or minimize the impact of present or impending danger):

Describe the caretaker's protective capacities (family strengths and resources that reduce, control, or prevent threats of maltreatment from arising, as well as factors and deficiencies that have a negative impact on child safety):

Protected information regarding parent's physical health, mental health, or substance abuse:

Addendum Summary and Analysis of Safety/Risk Assessments Identified

(shown only in addendum status)

Addendum Date:

Describe the threats of maltreatment that are present at this time (aggravating factors that combine to produce a potentially dangerous situation):

Describe the child's vulnerability to maltreatment (the degree to which a child cannot, on the child's own, avoid, negate, or minimize the impact of present or impending danger):

Describe the caretaker's protective capacities (family strengths and resources that reduce, control, or prevent threats of maltreatment from arising, as well as factors and deficiencies that have a negative impact on child safety):

Protected information regarding parent's physical health, mental health, or substance abuse:

Final Risk Level (based upon completion of the standardized risk assessment): ☐ Low ☐ Moderate ☐ High

Recommendation for Service

☐ Information or Information and Referral – no additional services recommended

☐ Voluntary Services

☐ Service recommendations were discussed with the family and a service plan is appropriate to address the following:

☐ No referral to Voluntary Services was made due to the following exception reason:
- ☐ Already engaged in DHS services
- ☐ Court action by DHS or already engaged in JCS services
- ☐ Abuse occurred in out of home setting
- ☐ Parent not willing to accept Voluntary Services
- ☐ Already engaged in Voluntary Services
- ☐ Family does not need additional supports beyond current formal/informal systems
- ☐ Resides out of state

☐ Department Services Referral date:

Prevention services identified to meet the foster care prevention strategy include (select all that apply):

☐ Solution Based Casework
☐ SafeCare
☐ Mental Health Evaluation/Treatment
☐ Substance Use/Abuse Evaluation/Treatment
☐ Treatment Court
☐ Behavioral Health Intervention Services (BHIS)
☐ Integrated Health Homes (IHH)
☐ Domestic Violence Advocacy/Education
☐ Early ACCESS
☐ Other (specify):
☐ Other (specify):
☐ Other (specify):

The foster care prevention strategy identified for this family is:

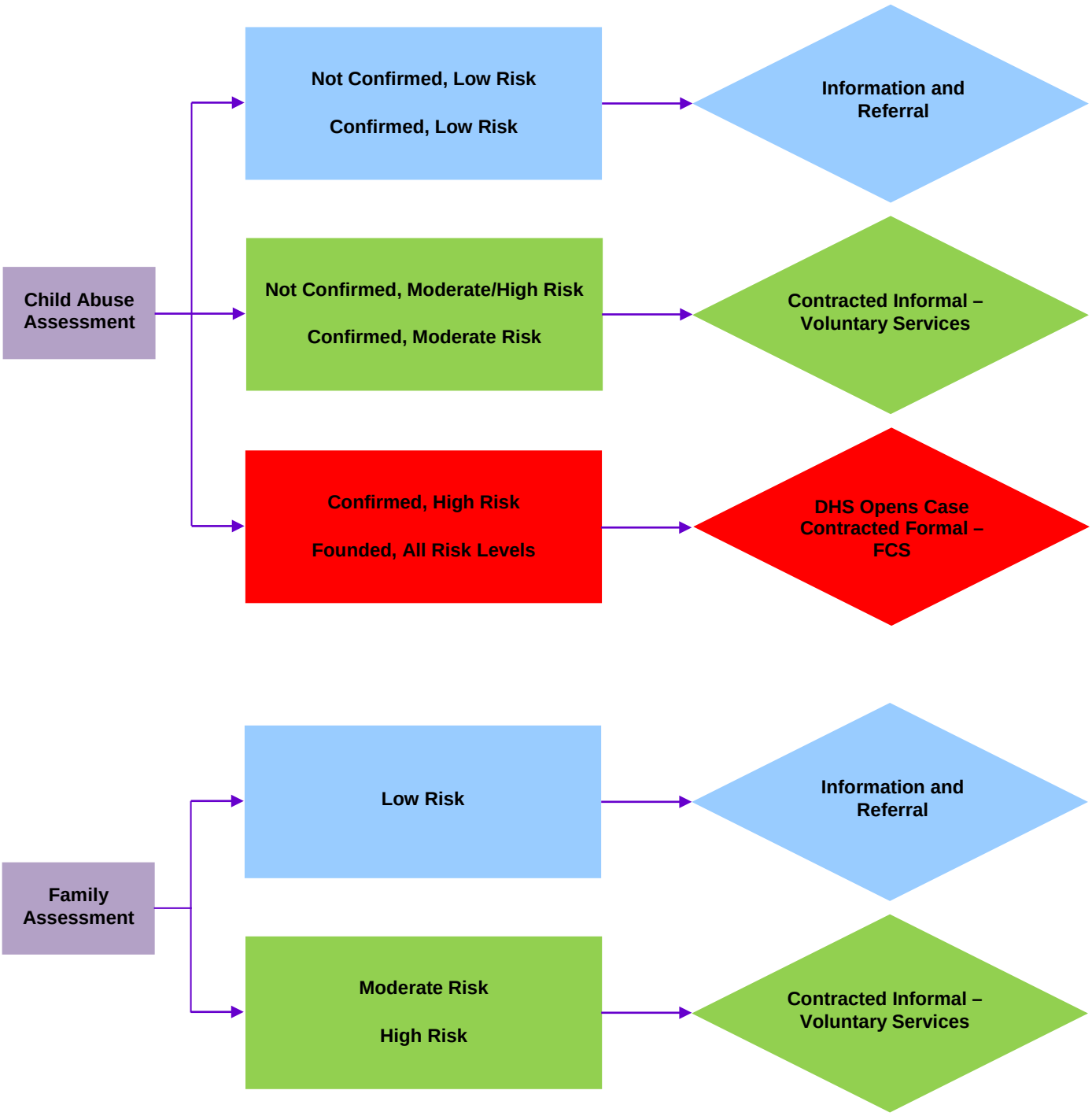
☐ Case transferred to Social Work Case Manager or Supervisor:

Recommendations for Court Involvement

Jurisdiction	Date	Type of Action Requested
Juvenile		
Criminal		

Case Disposition Decision Support Tree

This page will not print with the CPS Assessment Summary report!



Approval	
CPW Signature:	Date:
Supervisor Signature:	Date:

CC: County Attorney Date Sent:
Juvenile Court Date Sent:

Iowa Department of Human Services

CINA Services Assessment Summary

Client Name:		
Address:		Home Phone: Other Phone:
Intake Date:	CINA Assessment Worker:	County

Household Composition

Sex: Male (M), Female (F)

Name	DOB	Sex	Role	Comments

Non-Custodial Parent

Name:	DOB:	Parent of:
Address:		Phone:

CINA Issue Reported *(Give brief description of CINA Intake Issues)*

Summary of Previously Confirmed or Founded Reports concerning Family Members

Date	Incident #	Person Responsible	Type:	Victim	Finding

Summary of Previously Confirmed or Founded Reports concerning Subjects as found in ACAN

Date	Incident #	Person Responsible	Type:	Victim	Finding

Summary of Contacts

Date of Contact	Time of Contact	Type of Contact	Contact (Name, Location/Affiliation, Phone)
Summary of Contact			
Date of Contact	**Time of Contact**	**Type of Contact**	**Contact (Name, Location/Affiliation, Phone)**
Summary of Contact			

Summary of Observations, Findings and Determination of CINA Criteria

(See Intake Form and CINA Guidance Tool)

Iowa Department of Human Services
CINA Services Assessment Summary

Final Risk Level (based upon completion of the standardized risk assessment): ☐ Low ☐ Moderate ☐ High

CINA Assessment Summary

(Note assessment of family strengths /needs and recommendations for CINA and services)

In the event CINA adjudication occurs, prevention services identified to meet the foster care prevention strategy include (select all that apply):

- ☐ Solution Based Casework
- ☐ SafeCare
- ☐ Mental Health Evaluation/Treatment
- ☐ Substance Use/Abuse Evaluation/Treatment
- ☐ Treatment Court
- ☐ Behavioral Health Intervention Services (BHIS)
- ☐ Integrated Health Homes (IHH)
- ☐ Domestic Violence Advocacy/Education
- ☐ Early ACCESS
- ☐ Other (specify):
- ☐ Other (specify):
- ☐ Other (specify):

In the event CINA adjudication occurs, the foster care prevention strategy identified for this family is:

If Recommended for CINA Action, Complete the Following Family Assessment:

Family Functioning Domain	Assessment Findings – Strengths, Needs and Issues Linked to Family Functioning Domains
☐ Child Well-being	• Child´s mental health • Child´s behavior • Relationship with peers • School performance • Motivation/Cooperation to stay with family • Relationship with Caregiver(s) • Relationship with siblings
☐ Parental Capabilities	• Supervision of children • Mental health • Disciplinary practices • Physical health • Development/enrichment • Use of Drugs/Alcohol
☐ Family Safety	• Physical abuse of child • Neglect of child • Sexual abuse of child • Domestic violence • Emotional abuse of child
☐ Family Interactions	• Bonding with child • Relationship between parent/caregivers • Expectations of child • Mutual support within the family
☐ Home Environment	• Housing stability • Financial management • Income/Employment • Safety in community • Personal hygiene • Habitability • Transportation

Iowa Department of Human Services
CINA Services Assessment Summary

Case Disposition	Referral Date:
☐ To:_____ for CINA and Case Management	Date:
☐ To CPW for Assessment	Date:
☐ Information & Referral: To:	Date:
☐ Information Only: To:	Date:

Approval	
Worker Signature:	Date:
Supervisor Signature:	Date:

Department of
HUMAN SERVICES

Attachment A:
Iowa Evaluation of SafeCare®

Revised January 2021

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INTRODUCTION

Purpose

The Iowa Department of Human Services (DHS) identified SafeCare® as an in-home parent skill-based prevention service in Iowa's FFY 2020-2024, Title IV-E Prevention Services and Programs Plan (IV-E Prevention Plan). On July 1, 2020, DHS implemented SafeCare statewide through contracts with service providers as part of our family-centered services (FCS). The purpose of DHS' statewide implementation of SafeCare is to serve the parenting needs of families with children ages 0-5 where child abuse or neglect occurred. In accordance with the requirements of the Family First Prevention Services Act (Family First), the Children's Bureau (CB), housed within the federal Administration for Children, Youth and Families (ACYF), requires evaluation of all programs and services included in Iowa's IV-E Prevention Plan that do not have a well-supported rating determined by the Title IV-E Prevention Services Clearinghouse (IV-E Clearinghouse). The IV-E Clearinghouse completed an initial review of SafeCare and rated it as "supported". The IV-E Clearinghouse re-reviewed SafeCare and gave it again a rating of "supported" in August 2020. DHS selected Georgia State University Research Foundation, Inc. (GSU) to assist in conducting an evaluation of this program. The evaluation will contribute to the broad goals of accountability and program improvement, with a primary purpose of evaluating:

- whether SafeCare is implemented and delivered as intended, i.e. the effectiveness of implementation and fidelity to the SafeCare model, and
- whether SafeCare improves child safety and permanency and child and adult well-being outcomes for DHS families receiving in-home services in Iowa.

Stakeholders

DHS staff worked with the evaluation team at GSU, experts in SafeCare implementation, service provision, and certification at the National SafeCare Training and Research Center (NSTRC), to identify desired outcomes, potential barriers to evaluation, and to develop an evaluation strategy (see Table 1). DHS involvement in decision-making was around target population and key indicators of process and outcome designs. DHS and the service providers will also contribute to the data collection efforts for the process and outcome evaluations, and in helping to interpret evaluation findings. During implementation of SafeCare, the NSTRC will provide training, observation, and guidance of service providers to ensure initial and/or annual certification attainment and to ensure ongoing fidelity monitoring.

Table 1. Primary Stakeholders and Roles		
Stakeholder	**Primary Interest**	**Primary Role**
DHS	Implementing SafeCare statewide	Evaluation development, data collection, and assistance with interpretation of findings
FCS Contractors	Two new contractors trained and implement SafeCare; existing trained contractors continue to provide SafeCare	Provide services to be evaluated
NSTRC Trainers and Coaches	Training and fidelity monitoring for SafeCare providers across the state according to SafeCare guidelines	Assistance with identifying key indicators of success for process and outcome evaluations; Provide implementation quality technical assistance to DHS and SafeCare providers; Help to interpret evaluation findings
Local Trainers and Coaches	Training and fidelity monitoring for SafeCare providers across the state according to SafeCare guidelines	Provide training and coaching according to SafeCare guidelines; assistance with interpretation of evaluation findings
GSU	SafeCare Evaluation	Evaluation development, data collection, interpretation of findings, and evaluation report

EVALUATION DESCRIPTION

Service Need

Child maltreatment has the potential to affect negatively the quality of life for children and youth in both the short and long term. Child maltreatment affects the physical, mental, and emotional health of the victim, according to the Centers for Disease Control and Prevention (CDC), and the shared economic burden on the population in the United States (U.S.) is anywhere from $428 billion to $2.0 trillion depending on the data source for incidents of non-fatal child maltreatment (Peterson, Florence, & Klevens, 2018). Young children ages 0-5 experience maltreatment at higher rates than older children (U.S. Department of Health & Human Services Administration for Children and Families Administration on Children Youth and Families Children's Bureau, 2018), which emphasizes the need for evidence-based programs aimed at serving those impacted by early childhood maltreatment. Iowa data shows that almost half of child maltreatment victims are five or under (Table 2), with Denial of Critical Care (Neglect) as the primary type of child maltreatment occurring in Iowa (Table 3). Furthermore, children five or younger represent almost half of children experiencing re-abuse in Iowa (Table 4).

Table 2: Age of Child by Categories for Confirmed and Founded Assessments				
Calendar Year (CY)	**5 or <**	**6-10**	**11+**	**Total**
2019	46%	27%	27%	100%
2018	47%	28%	25%	100%
2017	47%	28%	25%	100%
2016	51%	27%	22%	100%
2015	49%	28%	23%	100%

Source: SACWIS

Table 3: Percentage of Child Maltreatment By Category for Confirmed or Founded Assessments											
Calendar Year (CY)	Denial of Critical Care (Neglect)	Exposure to Manufacturing Meth	Dangerous Substance	Mental Injury	Physical Abuse	PID	Sexual Abuse	Child Sex Trafficking[1]	Allowing Access to Sex Offender	Other	Total
2019	54%	-	27%	<1%	7%	7%	4%	<1%	<1%	<1%	100%
2018	55%	-	25%	0.1%	7%	8%	4%	<1%	1%	<1%	100%
2017	65%	-	11%	<1%	9%	9%	5%	<1%	<1%	<1%	100%
2016	71%	<1%	-	<1%	10%	11%	6%	-	1%	<1%	100%
2015	72%	1%	-	<1%	11%	9%	5%	-	1%	<1%	100%

Source: SACWIS PID = Presence of Illegal Drugs; Other = Child Prostitution, Bestiality in Presence of Minor, and Allowing Access to Obscene Material

[1] Please see definition of Child Sex Trafficking at http://dhs.iowa.gov/child-abuse/what-is-child-abuse/child-sex-trafficking.

Table 4: Observed Performance on Recurrence of Maltreatment National Safety Data Indicator by Age Group				
Federal Fiscal Year (FFY)	**Age at Initial Victimization**			
	5 or <	**6-10**	**11+**	**Total**
2018-2019	48%	29%	23%	100%
2017-2018	49%	28%	23%	100%
2016-2017	52%	27%	21%	100%

Source: Children's Bureau - Iowa Supplemental Context Data – September 2020 Update

Program Description

SafeCare is an evidenced-based, manualized (version 4.1.1) parenting program developed for families with children (age 0-5) at risk or with a history of child abuse or neglect. A SafeCare certified provider delivers the program in the home in 1-1.5 hour weekly sessions over the course of 18 to 20 weeks. The goals of SafeCare are to decrease incidents of child maltreatment, increase positive parent-child/parent-infant interaction, improve the way parents care for their child(ren)'s health, and enhance safety in the home, including parent supervision. There are three modules comprising SafeCare:

- Health Module
- Home Safety Module
- Parent-Infant/Parent-Child Interactions (PII/PCI) Module

In session one of the module, the certified provider completes a baseline assessment of the parents' skills. During sessions two through five, the certified provider teaches parents necessary parental skills, with parents encouraged to practice their skills between sessions with the development of a practice plan. In session six, the certified provider completes a final assessment to confirm the parent's skills mastery in that module.

A recent study assessing caregiver perspectives on the SafeCare program found that a majority of the caregivers indicated having a positive experience with the program and attributed this to the simplicity of the language, the skills-based approach, and the quality of the relationship with the SafeCare provider (Gallitto, Romano, & Drolet, 2018).

Program Effectiveness

A large number of publications have shown the effectiveness of SafeCare at both reducing and preventing child maltreatment as well as improving parenting skills. Over 30 years of evaluation and numerous studies occurred to develop and validate the program, with all three modules validated using single-case design studies (About SafeCare, n.d.). For example, one study assessed the extent to which SafeCare improved parenting skills and reduced further incidents of child abuse and neglect. In this study, the group assigned to SafeCare had significantly lower rates of re-abuse in

the two-year follow-up period, and no further reports of child abuse at a three-year follow-up period compared to the control group (Gershater-Molko, Lutzker, & Wesch, 2002). Another study evaluating SafeCare's three core components found that each were highly effective in improving parent scores for role-play situations about home safety, parent-child interactions, and child health care (Gershater-Molko, Lutzker, & Wesch, 2003).

Training and Certification

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

Target Population

The SafeCare curriculum is for families who have at least one child (age 0-5). SafeCare can be used as a primary prevention service for families at risk of child maltreatment, but is also a secondary or tertiary prevention service for those who already have a history of child maltreatment. Risk factors for child maltreatment that SafeCare seeks to target can range from young parents, parents with a history of domestic or intimate partner violence, parents of children with developmental and/or physical disabilities, as well as children with emotional and/or behavioral issues. DHS child protective workers (assessment phase of the case) or social work case managers (ongoing case management phase of the case) refer participants to a FCS contractor through our child welfare information system (CWIS).

Stage of Development

Iowa began implementing SafeCare in 2017 as part of a study conducted with GSU. At that time, due to the study design, implementation did not occur in all of Iowa's 99 counties. However, effective July 1, 2020, DHS contracted with its family-centered services (FCS) providers to implement SafeCare statewide.

Theory of Change & Logic Model

SafeCare is an evidence-based program aiming to provide parent-training curriculum in the home for families with children (age 0-5) who have a history of or risk factors for maltreatment (National SafeCare Training and Research Center (NSTRC), 2016). The goal of working with these families is to improve parenting skills in three main areas:

- Parent-infant/Parent-child interaction skills
- Health care skills
- Home safety

SafeCare's certification system serves to ensure quality service delivery with fidelity over time. SafeCare draws from tenants of social learning and deliberate practice theories across all levels of implementation. Social learning theory identifies four requirements for learning: observation (environmental), retention (cognitive), reproduction (cognitive), and motivation (both) (Bandura,1977). Deliberate practice is a theoretical framework that details how purposeful, systematic, and focused practice leads to improvements in performance and the attainment of expertise (Ericsson, Krampe, & Tesch-Römer, 1993).

Figure 1. SafeCare Logic Model

1. Inputs	2. Activities	3. Outputs	4. Short to Intermediate Outcomes	5. Long-term Outcomes
• Contracted Providers • DHS funding • Families • Referrals • Office space • Materials • SafeCare manuals • Fidelity monitoring instruments and personnel • Technical assistance • Screening tools/ assessments • 4-day workshop training, for those contracted providers not already certified in SafeCare	• Parent-Infant/Parent-Child (PII/PCI) Module • Health Module • Home Safety Module • Family Engagement Skills	• Number of sessions held per module • Number/proportion of parents/caregivers who complete the PII/PCI Module • Number/proportion of parents/caregivers who complete and graduate from all 3 Modules	• Improved Parent-Infant/Parent-Child interactions (e.g. Increase in parenting skills demonstrated during planned activities) • Improved parent knowledge/skill of Child Health (e.g. Increased ability to safely plan around illness and injury scenarios) • Improved home safety (e.g. Decreased number of hazards in the home)	• Reduced recurrence of maltreatment (maltreatment: confirmed/founded abuse/unfounded) • Improved permanency outcomes (prevent removal; decreased re-entry into foster care)

EVALUATION DESIGN

Stakeholder Needs

The intended audience for this evaluation are those involved with child welfare who hold research, clinical, federal, and/or state agency positions. The findings from this evaluation will serve to inform DHS on whether the statewide implementation of SafeCare® is effective for reducing recurrence of child maltreatment and preventing foster care entry and/or re-entry in Iowa. Specifically, DHS aims to learn whether SafeCare increases parenting skills related to parent-infant/parent-child interactions, the child's health, and home safety among caregivers receiving SafeCare through DHS.

Evaluation Questions

Process Evaluation

The evaluation team will conduct a process evaluation to determine if contractors are implementing and delivering SafeCare as intended. The process evaluation will serve to answer the following questions:

- Are providers adequately trained and delivering SafeCare with fidelity?
- Are parents/caregivers receiving an adequate dose of SafeCare?
- Is the dose of SafeCare received related to family outcomes?
- What family characteristics, including caregiver and child, are associated with:
  - completion of the parent-infant/parent-child interactions (PII/PCI) module, and
  - completion of and graduation from all three SafeCare modules?

Outcome Evaluation

The primary outcomes targeted by SafeCare are decreasing recurrence of child maltreatment, increasing positive parent-infant/parent-child interactions, improving the way parents care for their child(ren)'s health, and enhancing both parent supervision and safety in the home. For the purpose of this evaluation, short-term outcomes will focus on increasing child safety, home safety, and increasing parent-infant/parent-child interactions. Long-term outcomes focus on recurrence of maltreatment and entry or re-entry into out-of-home care. As such, this outcome evaluation will serve to answer the following questions:

- Did parents/caregivers receiving SafeCare experience behavior change targeted by SafeCare (i.e. improved parent-infant/parent-child interactions, improved knowledge/skill of child's health, and improved home safety)?
- Did parents/caregivers who received SafeCare have subsequent confirmed and founded child maltreatment reports 12 months after SafeCare completion?
- Did parents/caregivers who received SafeCare have their children enter foster care 12 months after SafeCare completion?
- If parents/caregivers received SafeCare while the child(ren) was in foster care, did these child(ren) re-enter foster care 12 months after SafeCare completion?
- Are parents who complete SafeCare, compared to those who do not, more likely to avoid future maltreatment and child removal, and more likely to be re-unified?

Evaluation Design

Setting and Study Population

Parents/caregivers receiving services through DHS are eligible for the study when they:

- have children age 0-5 who experienced child abuse or neglect,
- identified as needing knowledge and skills related to child health, home safety, and/or parent-infant/parent-child interactions, and

- referred by the DHS caseworker to a family-centered services (FCS) contractor for SafeCare. Contractors deliver SafeCare in an in-home setting.

Process Evaluation Design

The process evaluation will focus on utilization and will draw from a variety of quantitative data sources including administrative data collected by DHS, NSTRC, and FCS contractors providing SafeCare. The process evaluation will focus on documenting implementation of and fidelity to the SafeCare model. Similar to the outcome evaluation design, we will use a single-group design, evaluating all families who receive SafeCare across the state. See Table 5 for a detailed description of data sources and measures by each evaluation objective.

Outcome Evaluation Design

The outcome evaluation will be primarily summative and objectives-based, serving to determine whether desired program outcomes occurred. Specifically, we seek to evaluate the effectiveness of SafeCare as a parent educational program for caregivers receiving services through DHS. The evaluation will use a single-group design, evaluating all families who receive SafeCare and comparing those that receive full vs. less than full doses of the program. This is the only viable design, as implementation of SafeCare is statewide in Iowa and thus there is not a credible comparison group to SafeCare families that receive other (or no) services.

DATA SOURCES AND COLLECTION METHODS

Process Evaluation

DHS and GSU will collect most of the data. DHS administrative data, collected through our child welfare information system (CWIS), will be used for the process evaluation including information regarding family and case characteristics, family demographics, and assessments (e.g. safety, risk, and risk reassessment).

Data collected by the GSU through their online portal system and accompanying smartphone app will serve to provide data regarding:

- parent/caregivers receiving SafeCare®, e.g. frequency of SafeCare visits, module and program completion, and parent/caregiver satisfaction surveys, and
- provider and coach activities, including provider training and certification completion dates, coach training and certification completion dates, and provider session fidelity. Please see Table 5 for a detailed description of data sources collected in the NSTRC online portal.

FCS contractors providing SafeCare will add any information needed but not provided by GSU through their online portal system, e.g. staff education, training, and experience, contractor's parent/caregiver satisfaction surveys.

DHS has the following contract performance measures for SafeCare:

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

Outcome Evaluation

Administrative Data from DHS and GSU

For the purpose of this evaluation, outcome data will come from DHS' CWIS. The information to be collected includes family characteristics, demographics, assessments (e.g. safety, risk, and risk re-assessment), and long-term outcomes (recurrence of maltreatment and entry and/or re-entry into foster care). In addition to fidelity measures, any data collected regarding parent/caregiver sessions and outcomes will be accessible by DHS. DHS and/or GSU may collect SafeCare providers' progress and outcomes information reported through the NSTRC online portal.

Instruments

The SafeCare module assessments (see Table 5 and Attachment A) will serve as a data collection instrument for those receiving services. In addition to the NSTRC's online portal, SafeCare providers use NSTRC's mobile app during their in-home visitation to help facilitate and track progress with the program. Once the mobile app is ready for widespread use, it also will be a method of data collection in conjunction with any manual data entry required. DHS' child protective assessment summaries, both child abuse and child in need of assistance (CINA), and the referral form for SafeCare will also be used to collect data. Information will help to identify and describe parent, child, and family characteristics.

Outcome Measures

Maltreatment and Permanency

The overarching goals of child welfare is to ensure the safety, permanency, and well-being of children and to strengthen parental capacity to care for their children safely. In an effort to target these goals, Family First focuses on measures that intend to a) reduce the number of children entering foster care, b) reduce the length of stay in foster care, and c) promote permanency of those who entered foster care. For the purpose of this evaluation, DHS will collect administrative data on recurrence of maltreatment, entry into foster care, and re-entry to foster care.

Home Safety and Parent-Child Interactions
The goals of SafeCare are to decrease incidents of child maltreatment, to increase positive parent-child/infant interaction, improve the way parents care for their child(ren)'s health, and to enhance safety in the home and parent supervision. The SafeCare module assessments will measure these overarching goals (see Attachment A).

Safety will be measured using scores on the Home Accident Prevention Inventory (HAPI), which measures the presence of 10 categories of hazard items in the home (e.g., poison, suffocation, fire/electrical, sharp object, allergen). Contractors will assess three rooms in the caregiver's home during baseline, training, and at the end of the module, providing a count of the number of hazards in the home.

Measurement of parent-infant/parent-child interaction for children will occur through assessments, administered during baseline, training, and at the end of the module: the Child Planned Activities Training (cPAT) checklist and the Child Planned Activities Independent Play (cPAT IP) checklist. The cPAT scores parent's behaviors before, during, and after planned activities, measuring behaviors such as preparing for the activity in advance, praising desired behavior during the activity, and giving the child a warning that the activity is ending. The cPAT IP measures parent's behaviors before, during, and after a time period where the child needs to play independently, scoring behaviors such as explaining the time period for the activity, checking on the child often, and spending individual time with the child after the independent play. A version of the cPAT is available for parent-infant interactions (Infant Planned Activities Training; iPAT), whereas the cPAT IP is not administered with parents of infants.

Table 5. Data sources and measures by evaluation objective

Measure	Data Source	Purpose
Safety (HAPI), Parent-child/infant interaction (cPAT, iPAT, and cPAT IP)	NSTRC administrative data or data collected directly from contractors and manually entered	Short-term outcome
Recurrence of maltreatment, Foster care entry, and Re-entry into foster care	DHS administrative data	Long-term outcomes
Family and case characteristics (case type, family demographics, referral information, assessments)	DHS administrative data	Control measures, data quality, detailed analysis, potential moderators
Fidelity, adherence measures, feedback forms	NSTRC administrative data or evaluation data collected by GSU	Control measures, data quality, analysis

Provider credentials (education, training, certifications, experience)	NSTRC and contractors administrative data	Control measures, data quality, analysis

Data Security

To ensure protection of confidential information, the collection of information about families and contractors is limited to the amount necessary to achieve the aims of the evaluation so that unneeded information is not collected. Encryption of all information collected during the evaluation period will occur during transfer and stored on a secure, password-protected server within DHS, which includes data provided by GSU and contractors.

DATA ANALYSIS

Process Evaluation

The evaluation will be a prospective observational assessment of all families enrolling in the SafeCare program. Analyses will primarily be descriptive, and include frequencies, means and other appropriate descriptive measures. See Table 6 for a detailed description of process measures and methods of interpretation for each evaluation objective.

Table 6: Process evaluation analysis measures and methods

Evaluation Question	Process Measure	Methods
Are contractors adequately trained and delivering SafeCare with fidelity?	• Training completion/certification • Number of sessions • Percent of providers reaching fidelity benchmark • Number of days between training and first session • Length of time as active provider	Descriptive statistics • Mean, median • Standard deviations • Percentages • Subgroup descriptions
Are parents/caregivers receiving an adequate dose of SafeCare?	• Number of parents/caregivers that started, completed, declined, and dropped out • Number of SafeCare sessions completed • Number/percent of parents/caregivers who completed the PII/PCI module • Number/percent of	Descriptive statistics • Mean, median • Standard deviations • Percentages • Subgroup descriptions • Distribution over time

Table 6: Process evaluation analysis measures and methods		
Evaluation Question	**Process Measure**	**Methods**
	parents/caregivers who completed all three modules	
What family characteristics, including caregiver and child, are associated with: • completion of the parent-infant/parent-child interactions (PII/PCI) module and • completion of and graduation from all three SafeCare modules.	• Demographics • DHS Referral form • DHS safety, risk, and risk re-assessment tools • DHS child protective assessment summaries with child maltreatment and case information	Descriptive statistics • Mean, median • Standard deviations • Percentages • Subgroup descriptions and differences via chi-square and t-tests/analysis of variance

Sampling and Procedures

The evaluation will collect and analyze data on the entire population, i.e. families receiving SafeCare across the state, which is the rationale for not drawing a sample and using associated sampling methods and procedures.

Limitations

A limitation of this process evaluation is that the use of administrative data limits the amount of observable data to those variables collected by DHS and NSTRC. For example, neither DHS nor NSTRC collect variables related to socioeconomic status (SES) such as income and occupation.

Outcome Evaluation

The evaluation will be a prospective assessment of families receiving SafeCare, which will examine outcomes for all families receiving SafeCare, and variation according to family characteristics and SafeCare completion. We will examine short-term behavioral outcomes for families completing each SafeCare module (changes in parenting, home safety, and health skills), and longer-term outcomes for all families (maltreatment, removal, and permanence of reunification for families receiving SafeCare). We also will examine whether there are differences in the means/frequency of those outcomes by

family characteristics, and SafeCare completion. See Table 7 for a detailed description of measures and methods of interpretation for each evaluation objective.

Iowa began implementing SafeCare in 2017 as part of a study conducted with GSU. At that time, due to the study design, implementation did not occur in all of Iowa's 99 counties. However, effective July 1, 2020, DHS contracted with its family-centered services (FCS) providers to implement SafeCare statewide. Because of the statewide implementation of SafeCare, there are challenges in having a meaningful and credible comparison group, as described below:

- There is no comparison group in the present timeframe as referral to and receipt of SafeCare is occurring across the state.
- A comparison group who received services as usual prior to the statewide expansion of SafeCare is a possibility but we do not think it adds value to the current program evaluation as historical events present a strong confound for interpreting differences between current SafeCare cases and prior non-SafeCare cases. Additionally, under the previous services' contracts, there was no documentation provision of SafeCare independently in DHS' child welfare information system (CWIS) as it is now. Therefore, ensuring parents/caregivers only received services as usual is difficult to ascertain.
- The statewide implementation of SafeCare came at the same time as statewide implementation of Solution Based Casework for all cases. Services prior to July 1, 2020 did not include Solution Based Casework. This presents another important confound for comparing new versus old cases as new cases receive both SafeCare and SBC, whereas old cases received only SafeCare.

Therefore, there will be no credible comparison group to evaluate long-term child welfare outcomes, i.e. recurrence of maltreatment, foster care entry, and re-entry into foster care. The evaluation will comprise determining performance for the long-term outcomes and then delving deeper into the data to examine SafeCare families who achieved positive outcomes and those who did not. Evaluation of the data may include but not be limited to the following:

- Child's age and whether the child had special needs, e.g. disabilities, chronic physical illnesses, and mental health issues
- Parent(s) age, education level, presence of substance abuse and/or mental health issues, and intimate partner violence
- Family composition (e.g., presence of a spouse/partner, or living with a parent)
- Presence or absence of parental engagement in other services and supports
- Racial disproportionality or disparity

For short-term outcomes, SafeCare specific outcomes, e.g. pre- and post-measures of home safety, parent-child/infant interactions, and child health, there also will be no comparison group, i.e. parents/caregivers will be compared to themselves across time. Paired t-tests will be used to examine changes in SafeCare's behavior indices over time, and regression models will be used to understand differences in behavior change over time by client characteristics. Multiple testing will occur if necessary. See Table 7

for a detailed description of outcome measures and methods of interpretation for each evaluation objective.

Table 7. Outcome evaluation analysis measures and methods

Evaluation Question	Outcome	Measure	Methods
What percentage of families receiving SafeCare experience a recurrence of maltreatment?	Child safety	DHS child protective and case information	• Percentage of families with repeat maltreatment. • Comparison of maltreatment recidivism by SafeCare completion via chi-square.
What percentage of families receiving SafeCare experience their child(ren)'s entry or re-entry into foster care?	Child permanency	Ongoing DHS case information	• Percentage of families with children removed from home. • Comparison of removals by SafeCare completion via chi-square.
Does SafeCare improve parent-child/infant interactions?	Child and Adult well-being	SafeCare modules	Paired t-tests comparing pre- and post- SafeCare behavior metrics.
Does SafeCare improve home safety?	Child and Adult well-being	SafeCare modules	Paired t-tests comparing pre- and post- SafeCare home hazards.
Does SafeCare improve parent health skills?	Child and Adult well-being	SafeCare modules	Paired t-tests comparing pre- and post- SafeCare health skills.

Sampling and Procedures

The evaluation will collect and analyze data on the entire population, i.e. families receiving SafeCare across the state, which is the rationale for not drawing a sample and using associated sampling methods and procedures.

Limitations

The primary limitation of the outcome evaluation is the lack of a credible comparison group. SafeCare completers will be compared to non-completers, but those comparisons are not considered methodologically strong.

A second limitation is that behavioral outcomes will be collected by service providers, not independent evaluators. The behavioral outcomes to be used in the evaluation are

part of SafeCare delivery (and require training to complete them), and thus they are a convenient way to capture parent behavior change. A strength of these outcomes is that they are observation measures, not simple self-reports of behavior change. Another limitation related to this is that no behavior change metrics will be available for families who do not complete a module as the behavior change measures are collected on the last session of the module.

Finally, families receiving SafeCare also receive concomitantly Solution Based Casework (SBC), and may receive other services as needed. It may be difficult to isolate whether results of the evaluation are due to receipt of SafeCare alone, a combination of SafeCare and SBC, or SBC. Furthermore, the evaluation does not utilize a comparison group for evaluation of short- and long-term outcomes.

COMMUNICATION AND REPORTING

GSU will develop a report of findings in consultation with DHS. DHS will use the report to inform program implementation, fidelity, adherence measures, data collection systems, training, program policies, and/or future research. Dissemination of the evaluation findings will occur to include but not be limited to statewide stakeholders, including DHS, families, contracted providers, and others through presentations and published reports.

EVALUATION MANAGEMENT

Evaluation Team

The evaluation team will consist of GSU faculty, staff, and researchers who work within child welfare, as well as various stakeholders including DHS administration and staff, service providers, and program developers. Table 8 below further demonstrates the agency roles and responsibilities of the evaluation team.

Table 8. Evaluation team roles and responsibilities

Agency	Title or Role	Responsibilities
GSU	Project Lead	• Fiscal management and policy oversight • Protocol and regulatory compliance • Oversight of evaluation activities and staff
GSU	Project Administrator	• Protocol development, drafting, and review • Oversight of evaluation activities and staff • Implementation monitoring/consult
DHS, program developers, service providers	Stakeholders and advisors	• Support and evaluation guidance • Subject matter expertise
GSU, DHS	Data coordinator	• Data collection, review, and management • Quality assurance of data collected
GSU	Faculty affiliates	• Guidance and coordination with stakeholders • Subject matter expertise
GSU	Research analysts	• Data analysis • Interpretation and dissemination of findings

Data Collection and Evaluation Timeline

DHS and GSU anticipate this evaluation to span a timeframe of roughly five years to ensure adequate time for collection of all measures (such as recurrence of maltreatment within one year). Immediate collection of process data will occur as providers serve families, and family level data (enrollment, completion, behavior change) collection will occur on an ongoing basis, and summarized annually in an aggregate manner (i.e., each year will be cumulative). Short-term outcomes will also be summarized annually in an aggregate manner. Long-term outcomes (maltreatment cases, removals, and permanence of reunifications) will be extracted from the Iowa CWIS annually, and examined at the midpoint of the project (30 months in) and at the end of the project (60 months in). In the first 3 months of the project, we will establish data collection protocols, IRB approvals, and quality assurance processes. GSU will

deliver an interim report annually. The reports at the end of Year 3 and at the end of Year 5 will include summaries of the long-term outcomes data.

See Tables 9 and 10 below for a more detailed timeline of data collection and evaluation activities, respectively.

Table 9. Timeline of data collection activities

Activity	Timeline
Fidelity adherence, surveys	Ongoing throughout the life of the project ; all providers have fidelity assessed periodically via SafeCare® coaches • Fidelity and adherence measures must be met and sustained before data collection begins
Outcomes, short- and long-term (Safety and Permanency)	Parental improvement demonstrated through pre- and post-tests within SafeCare session modules on an ongoing basis 1-2 years post SafeCare • Recurrence of maltreatment, entry and/or re-entry into foster care are long term measures with follow-up periods at 12 months post-SafeCare completion

Table 10. Illustrative timeline of evaluation activities

			Timing		
Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Implementation	X				
IRB approval	X				
Planning and coordination	X	X	X		
Fidelity monitoring	X	X	X	X	X
Data collection	X	X	X	X	X
Data analysis	X	X	X	X	X
Interpretation of findings	X	X	X	X	X
Dissemination and written report	X	X	X	X	X

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Home Accident Prevention Inventory—HAPI

Assessment Form

Parent _____ **Child** _____ **Provider** _____

Child's Reach _____ **Child's Eye-level** _____

Room _____ **Session #** _____ **Date** _____

Assessment Baseline Training End of Module **Assessment Type** Formal Informal

POISON	Hazard item (count)	Total
Beauty products		
Medications		
Cleaning products		
Paints, solvents, etc.		
Pesticides, herbicide, etc.		
Poisonous plants		
Alcoholic beverages		
Tobacco, THC, or nicotine		

CHOKE	Hazard item (count)	Total
Small objects (e.g., toys, candies, push pins, etc.)		

SUFFOCATION	Hazard item (count)	Total
Cords		
Plastics		
Sleep hazards [infant homes]		

DROWNING	Hazard item (count)	Total
Standing water in basins		
Unsecured toilet		

Parent _____ Room _____ Date _____

FIRE/ELECTRICAL	Hazard item (count)	Total
Combustibles		
Fireplaces without screens		
Outlet/switch without plate/safety cover		
Appliances without covers		
Damaged electrical cords/plugs		

FALL/ACTIVITY RESTRICTION	Hazard item (count)	Total
Balcony/porch/loft		
Steps		
Windows		
Objects in walkway		
Activity restriction		

SHARP OBJECT	Hazard item (count)	Total
Knives, scissors, corkscrews, vegetable peelers, etc.		

FIREARM	Hazard item (count)	Total
Guns, rifles, BB guns, etc.		

CRUSH	Hazard item (count)	Total
Objects over 10 pounds (e.g., TV, bookshelf, boxes, etc.)		

ALLERGEN/ORGANIC	Hazard item (count)	Total
Air allergens (e.g., smoke, dust)		
Decaying food/dirty dishes		
Evidence of infestation		

TOTAL HAZARDS: _____ **Progress** Circle one *In Progress* *Success* *Mastery*

Notes

Child Planned Activities Training—cPAT

Assessment Form

Parent _____ **Child** _____ **Provider** _____

Activity _____ **Session #** _____ **Date** _____

Assessment Baseline Training End of Module **Assessment Type** Formal Informal

Scoring

✓+	Demonstrated the behavior consistently and with ease *Parent must perform all bulleted items to receive this score*
✓	Needs improvement in ease and/or consistency of the behavior *Parent must perform at least one bulleted item to receive this score* *(For behaviors with a single bullet, parent must perform at least 1 skill noted in the bullet)*
—	Did not demonstrate behavior at all

	Parent Behavior	Score	Notes
BEFORE	**Prepare in advance** • Gets supplies/toys ready in advance (includes items already present) • Informs child activity is going to happen		
BEFORE	**Explain activity** • Gets the child's attention • Explains the activity		
BEFORE	**Say what you expect and what will happen** • Gives 1+ positively stated expectation • Gives 1+ positive consequence		
DURING	**Talk about what you and your child are doing** • Talks warmly about activity • Uses incidental teaching		
DURING	**Use good physical interaction skills** • Gets on child's level • Uses good eye-contact		
DURING	**Give choices** • Lets child have 2+ choices during activity		
DURING	**Praise desired behaviors** • Uses 2+ labeled praises		
DURING	**Redirect misbehavior** • Redirects child when misbehaving • Score *N/A* if no misbehavior • Score ignoring if done appropriately		
DURING	**Follow through** • Follows through with positive and/or negative consequences as appropriate		
END	**Wrap-up and transition** • Informs child activity is ending • Describes what child did well and what to do better next time (if applicable) • Transition to next activity		

Number of (✓+) _____
Number of (✓) _____
Number of (—) _____

Progress Circle one
In Progress
Success
Mastery

Parent Negative Behaviors:

Child Planned Activities Training
Independent Play—cPAT IP
Assessment Form

Parent _____ **Child** _____ **Provider** _____

Activity _____ **Date** _____ **Session #** _____

Scoring

✓+	Demonstrated the behavior consistently and with ease *Parent must perform all bulleted items to receive this score*
✓	Needs improvement in ease and/or consistency of the behavior *Parent must perform at least one bulleted item to receive this score*
—	Did not demonstrate behavior at all

	Parent Behavior	Score	Notes
BEFORE	**Prepare in advance** • Selects engaging activity (If child is less than 3 years, keeps in same room) • Gets supplies/toys ready in advance (includes items already present) • Informs child activity is going to happen		
BEFORE	**Explain activity** • Gets the child's attention • Explains activity in an exciting way • Tells child when parent will finish		
BEFORE	**Say what you expect and what will happen** • Gives 1+ positively stated rule • Gives 1+ positive consequence		
BEFORE	**Select short time period for activity** • Under 15 minutes if child 3-5 years • Under 5 minutes if child 1-2 years		
DURING	**Checks on child often** • Checks on child as needed for activity • Shows approval for positive behavior		
DURING	**Redirect misbehavior** • Ignores minor misbehavior • Score *N/A* if no misbehavior		
DURING	**Handle disruptions** • Engages child to the same or new activity if needed • Reminds child of expectations • Score *N/A* if no disruptions		
DURING	**Follow through** • Follows through with stated positive and/or negative consequences as appropriate		
END	**Wrap-up and transition** • Returns to child when time is up • Describes what child did well • Transition to next activity		
END	**Spends individual time** • Spends positive time with child		

Number of (✓+) _____

Number of (✓) _____

Number of (—) _____

Parent Negative Behaviors:

Infant Planned Activities Training—iPAT

Assessment Form

Parent _____ **Infant** _____ **Provider** _____

Activity _____ **Session #** _____ **Date** _____

Assessment Baseline Training End of Module **Assessment Type** Formal Informal

Scoring

✓+	Demonstrated the behavior consistently and with ease *Parent must perform all bulleted items to receive this score*
✓	Needs improvement in ease and/or consistency of the behavior *Parent must perform at least one bulleted item to receive this score* *(For behaviors with a single bullet, parent must perform at least 1 skill noted in the bullet)*
—	Did not demonstrate behavior at all

	Parent Behavior	Score	Notes
BEFORE	**Prepare in advance** • Gets supplies/toys ready in advance (includes items already present) • Informs infant activity is going to happen		
BEFORE	**Explain activity and what is expected** • Explains the activity • Gives 1 simple expectation for activity *Score if child is older than 6 months		
DURING	**Talk about what you and your infant are doing** • Talks warmly about activity • Uses 1 incidental teaching moment		
DURING	**Use good physical interaction skills** • Positively touches infant (e.g., patting, holding, rocking, kissing, etc.)		
DURING	**Look and smile at your infant** • Uses good eye contact • Smiles or looks pleasantly at infant		
DURING	**Imitate your infant** • Imitates 1 sound or behavior *Score *N/A* if imitation not appropriate		
DURING	**Praise and use loving words** • Says 2+ praises or love words		
DURING	**Give choices** • Gives infant 1 choice * Score N/A if infant is younger than 6 months and no choices given		
DURING	**Redirect** • Redirects infant when unsafe or doing something parent/infant does not like *Score N/A if no redirection needed		
END	**Wrap-up** • Informs infant activity is ending		

Number of (✓+) _____
Number of (✓) _____
Number of (—) _____

Progress Circle one
In Progress
Success
Mastery

Parent Negative Behaviors:

Iowa Department of Human Services
Family Risk Reassessment

Family Name: FACS ID:

Worker Name: Date:

R1 New Confirmed or Founded assessment(s) since the initial Risk Assessment or the last Risk Reassessment

- ☐ a. No 0
- ☐ b. Yes, Confirmed 1
- ☐ c. Yes, Founded 2

R2 Number of children in Primary Household

- ☐ a. 2 or fewer -1
- ☐ b. 3 or more 1

R3 Age of the youngest child in Primary Household

- ☐ a. 3 years or older 0
- ☐ b. 2 years or younger 1

R4 Characteristics of any child in the Primary Household

- ☐ a. None 0
- ☐ b. Diagnosed mental health and/or behavioral problem 2
- ☐ c. Physical Disability 2
- ☐ d. Both B and C 4

R5 Age of Primary Caregiver

- ☐ a. 26 years or older -1
- ☐ b. 25 years or younger 0

R6 Primary Caregiver has substance use that impacts functioning

- ☐ a. No 0
- ☐ b. Yes, Primary Caregiver is effectively addressing the substance use need(s) 1
- ☐ c. Yes, Primary Caregiver is not effectively addressing the substance use need(s) 2

R7 Secondary Caregiver has substance use that impacts functioning

- ☐ a. Not applicable, only 1 Caregiver in the Primary Household 0
- ☐ b. No 0
- ☐ c. Yes, Secondary Caregiver is effectively addressing the substance use need(s) 1
- ☐ d. Yes, Secondary Caregiver is not effectively addressing substance use need(s) 2

R8 Primary Caregiver has mental health need(s) that impacts functioning

- ☐ a. No 0
- ☐ b. Yes, Primary Caregiver is effectively addressing the identified mental health need(s) 1
- ☐ c. Yes, Primary Caregiver is not effectively addressing the identified mental health need(s) 2

R9 Secondary Caregiver has mental health need(s) that impacts functioning

- ☐ a. Not applicable, only 1 Caregiver in the Primary Household 0
- ☐ b. No 0
- ☐ c. Yes, Secondary Caregiver is effectively addressing the identified mental health need(s) 1
- ☐ d. Yes, Secondary Caregiver is not effectively addressing the identified mental health need(s) 2

R10 Incident(s) of domestic violence in Primary Household since the last Risk Assessment or Risk Reassessment.

- ☐ a. No 0
- ☐ b. Yes 1

R11 Caregiver(s) in the Primary Household involved in a disruptive/ volatile adult relationship since the last Risk Assessment or Risk Reassessment. (If R10 above is scored "Yes," select "No" for R11.)

- ☐ a. No 0
- ☐ b. Yes 1

R12 Housing instability in the Primary Household since the last Risk Assessment or Risk Reassessment.

- ☐ a. No 0
- ☐ b. Yes 2

R13 Primary Household has identified informal and/or formal supports. (This excludes DHS and DHS child welfare contracted services such as Family-Centered Services, Shelter Services, etc.)

- ☐ a. 3 or more -1
- ☐ b. 1-2 0
- ☐ c. None 1

R14 Caregiver(s) in the Primary Household provide supervision inconsistent with the child's needs since the last Risk Assessment or Risk Reassessment.

- ☐ a. Not Applicable, child is in an out of home placement 0
- ☐ b. No 0
- ☐ c. Yes 1

Total Reassessment Score:

SCORED RISK LEVEL:

Risk Score	Scored Risk Level
☐ -3 to 3	☐ LOW
☐ 4 to 8	☐ MODERATE
☐ 9+	☐ HIGH

POLICY OVERRIDES:
Mark the conditions shown below that are applicable in this case. If any condition is applicable, override final Risk Level to **HIGH**.

☐ 1. Sexual abuse case AND the perpetrator is likely to have access to the child victim.

☐ 2. Non-accidental injury to an infant.

☐ 3. Serious non-accidental physical injury requiring hospital or medical treatment.

☐ 4. Parent/Caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

Override Risk Level: ☐ HIGH ☐ Not Applicable

DISCRETIONARY OVERRIDE:
If a discretionary override is made, mark YES and indicate reason. Otherwise, mark NO. (Risk level will be overridden one level HIGHER. Risk level may NOT be lowered.)

☐ **NO** ☐ **YES, Override risk level to:**

Discretionary Override Reason:

Supervisor's Review/Approval of Discretionary Override:

Signature: Date:

Based on the risk factors identified, describe how the services and supports are offsetting and/or controlling the risk factors.

If progress is not being made, describe what changes need to made to offset and/or control the risk factors.

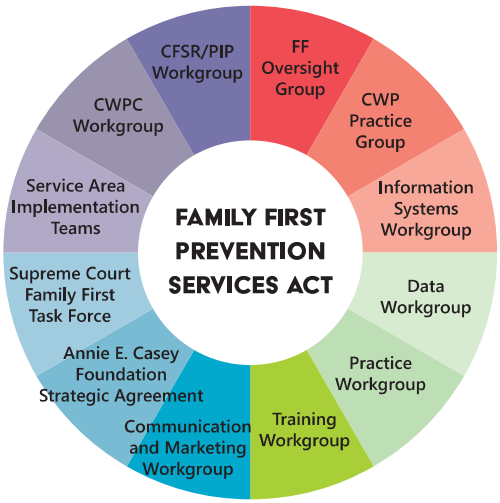
Department of HUMAN SERVICES

FAMILY FIRST

IMPLEMENTATION WORKGROUPS AND TEAMS

Family First Oversight Group

Workgroup type: Department of Human Services
Workgroup purpose: Primarily responsible for the research and design of Iowa's child welfare system
Lead(s): Matt Haynes, Doug Wolfe, Lori Lipscomb, Lori Frick and Janee Harvey



The following work in collaboration with Family First Oversight Group

Service Area Implementation Teams

Workgroup type: DHS
Workgroup purpose: These teams will serve as local leaders of change and will be responsible for promoting quality and consistency in practice related to Family First. The teams will work with Family First Oversight Group ensuring bi-directional communication related to Family First implementation in Iowa.
Leads: Social Work Administrators

Information Systems Workgroup

Workgroup type: DHS
Workgroup purpose: Develop and assist with the implementation of Family First, as it pertains to system changes. This may include, but is not limited to FACS, Jarvis (Foster Care/Child Welfare Reports, Child Services, STAR, IVE Tracking), WISE.
Lead: Doug Wolfe, Program Manager, Child Welfare Bureau, DHS

Data Workgroup

Workgroup type: DHS
Workgroup Purpose: Place a concentrated focus on necessary practice enhancements and changes that will be required under Family First.
Lead: Lori Lipscomb, Centralized Service Area Manager, DHS

Practice Workgroup

Workgroup type: Public/Private partnership: DHS and Child Welfare Providers
Workgroup purpose: Place a concentrated focus on necessary practice enhancements and changes that will be required under Family First.

Lead: Lori Frick, Service Area Manager, Eastern Service Area 3, DHS

Training Workgroup

Workgroup type: Public/Private partnership: DHS and Child Welfare Providers
Workgroup purpose: Plan and coordinate training on assessment tools and pertinent practice shifts related to the rollout of Family First and associated procurements for DHS staff and contracted providers.
Lead: Matt Haynes, Bureau Chief for Support and Training, DHS

Comm. 535 (05/19)

Communication and Marketing Workgroup

Workgroup type: Public/Private partnership between DHS and Child Welfare Providers
Workgroup Purpose: Develop and assist with the implementation of a communication and marketing plan for the implementation of Family First system transformation to include what information should be shared, when, how, by whom, and to what audiences.
Lead: Janee Harvey, Child Welfare Bureau Chief, DHS

Annie E. Casey Foundation – Strategic Agreement

Workgroup type: Public/Private partnership between DHS and Annie E. Casey Foundation
Workgroup purpose: Assessment of preventive service needs and gaps, recommendation of preventive service models, financial analysis and implementation strategies related to Family First
Lead: Kerri Smith (Senior Associate at AECF) and G5

Child Welfare Policy and Practice Group (CWPPG)

Workgroup type: Public/Private partnership: DHS,
Child Welfare Providers and CWPPG
Workgroup purpose: DHS is sponsoring Provider Partnership Forums across the state which are being facilitated by CWPPG. These forums serve as a vehicle for collecting the voice of future child welfare in Iowa. Forums include open conversation in a safe space designated for providers. These conversations will be an opportunity for small group conversations to share cross-area perspectives with the guidance of a neutral facilitator, sharing of successes and themes of concern, and an initial discussion of the Families First legislation.
Lead: Freida Baker (Program Coordinator at CWPPG).

Child and Family Services Review/Program Improvement Plan (CFSR/PIP) Workgroup

Workgroup type: Public/Private partnership between DHS, Child Welfare Providers and numerous key external stakeholders
Workgroup purpose: Serve as representative of stakeholder communities and provide feedback via root cause analysis of systemic challenges pertaining to the following 3 goals: Children abused or neglected shall be safe from re-abuse in their homes; children achieve permanence in their living situation; and children experience optimal well-being through their families' enhanced capacity to provide for their needs.
Lead(s): Jeff Terrell, Matt Haynes, Lori Lipscomb, Kara Lynn Regula and Janee Harvey

Child Welfare Partners Committee (CWPC) Workgroup

Workgroup type: Public/Private partnership between DHS and Child Welfare providers
Workgroup purpose: The CWPC sets the tone for the collaborative public-private work groups and ensures coordination of messages, activities, and products with those of other stakeholder groups.
Lead(s): Theresa Lewis (Four Oaks), Emily Blomme (Foundation 2), Susan Smalley (MIFTC), Rick Venega (Families First), Debbie Orduna (Boys Town), Theresa Burke (Decat), Chris Koepplin (YHMA), Dawn Turner (DHS), Tom Bouska (DHS), Jana Rhoads (DHS), Janee Harvey (DHS), Leta Hosier (DHS)

Supreme Court Family First Task Force

Workgroup type: Juvenile Judges, Court Improvement Project, DHS and Juvenile Court Services
Workgroup purpose: Review Family First impact on the role of the judicial branch in the child welfare and juvenile justice systems. Submit a report by July 1, 2019 that identifies rule and/or policy changes needed to comply with Family First.
Lead(s): Susan Christensen, Supreme Court Justice

SW2s and SW2 Supervisors – New Worker Training Plan FY21

Required Coursework				
Completion Timeframe	#	Course	Modality	Hours
Within the 1st month		How to Take Training and Navigate this System – LearnSoft Tutorial	Online	-
	CC 364	Confidentiality and Dissemination	Recording	1.75
Within the first 3 months	CC 368	ICWA Update	Recording	1
	CC 588	WellnessCheck TOP Enhancements	Recording	1
	CC 590	WellnessCheck TOP Training	Recording	1
	CC 595	Family Risk Reassessment Tool	Recording	.5
	CC 873	Court 101	Recording	.5
	CC 877	FCS/QRTP Contract Fundamentals	Recording	2
	DS 168	Mandatory Dependent Adult Abuse Reporter Training	Online	2
	DS 169	Mandatory Child Abuse Reporter Training	Online	2
	HS 001	Confidentiality is Key	Online	1
	HS 003	Confidentiality: HIPAA Privacy & Security	Online	1.25
	SW 020	Foundations of Social Worker 2 Practice	Classroom	42
	SW 705	Danger vs. Risk	Recording	1
Within the first 6 months	CC 377	Worker Webinar - Initial Case Permanency Plan & Action Plan	Recording	1
	CC 379	Transition Planning Worker Webinar	Recording	1
	CC 382	Safety Session 2 Training	Recording	.5
	CC 384	In-Depth Care Match Training	Recording	.5
	CC 591	SafeCare Overview for Iowa DHS	Recording	.5
	CC 592	Building a Foundation for Adulthood - 4 Part Video Series	Recording	1
	SP 100	Overview of Child Welfare eLearning	Online	2
	SP 105	Substance Abuse eLearning	Online	4.5
	SP 107	Impact of Abuse on Child Development eLearning	Online	2
	SP 150	Child Welfare in Iowa	Webinar	4.5
	SP 270	Mental Health Fundamentals	Classroom	6
	SP 309	Domestic Violence Fundamentals	Classroom	6
	SP 310	Substance Abuse Fundamentals	Classroom	6
	SP 311	Trauma Fundamentals	Classroom	6
	SP 312	Medical Fundamentals	Classroom	12
	SP 812	CFSR Fundamentals	Classroom	6
	SW 071	Legal Aspects of Social Work	Classroom	12

	SW 072	Testifying in Juvenile Court	Classroom	6
	SW 073	Permanency & Termination of Parental Rights	Classroom	6
	SW 500	Social Work Ethics	Recording	3
Within 12 Months	SP 335	CSC and SFM Fundamentals	Classroom	6
	SP 535	Assessing throughout the Case	Classroom	6
	SP 542	Motivational Interviewing	Classroom	6
	SW 507	Race: The Power of an Illusion	Classroom	5.5
	SW 508	Understanding Implicit Bias	Classroom	6
	SW 712	Solution Based Casework – Case Permanency Planning	Classroom	4
	SW 713	Engagement	Classroom	6
	SW 714	Safety Assessment and Planning	Classroom	6
			Total Hours	**189**

SW3s and SW3 Supervisor - New Worker Training Plan

Required Coursework				
Completion Timeframe	#	Course	Modality	Hours
Within the 1st month		How to Take Training and Navigate this System – LearnSoft Tutorial	Online	-
	CC 364	Confidentiality and Dissemination	Recording	1.75
	CC 370	Interview of Alleged Perpetrators During Protective Assessments	Recording	.5
Within the first 3 months	CC 360	Authoring Domestic Violence-Informed Allegations	Recording	1
	CC 368	ICWA Update	Recording	1
	CC 373	Updates to the Risk Assessment	Recording	.5
	CC 588	WellnessCheck TOP Enhancements	Recording	1
	CC 595	Family Risk Reassessment Tool	Recording	.5
	CC 590	WellnessCheck TOP Training	Recording	1
	CC 873	Court 101	Recording	.5
	CC 877	FCS/QRTP Contract Fundamentals	Recording	2
	CP 200	Basic Training for Child Protective Workers	Classroom	40
	DA 202	Fundamentals of Dependent Adult Assessments	Classroom	12
	DS 168	Dependent Adult Abuse Mandatory Reporter Training	Online	2
	DS 169	Child Abuse Mandatory Reporter Training	Online	2
	HS 001	Confidentiality is Key	Online	1
	HS 003	Confidentiality: HIPAA Privacy & Security	Online	1.25
	SW 705	Danger vs. Risk	Recording	1
First Six Months	CC 367	Making a Case for Sexual Abuse: Choosing the Proper Offense	Recording	1
	CC 369	Making a Case for Sexual Abuse: Corroborating Evidence	Recording	1
	CC 376	Court Involvement to Compel Home Visits	Recording	1
	CC 382	Safety Session 2 Training	Recording	.5
	CC 384	In-Depth Care Match Training	Recording	.5
	CC 591	SafeCare Overview for Iowa DHS	Recording	.5
	SP 100	Overview of Child Welfare eLearning	Online	2
	SP 105	Substance Abuse eLearning	Online	4.5
	SP 107	Impact of Abuse on Child Development eLearning	Online	2
	SP 150	Child Welfare in Iowa	Online	4.5
	SP 270	Mental Health Fundamentals	Classroom	6
	SP 309	Domestic Violence Fundamentals	Classroom	6
	SP 310	Substance Abuse Fundamentals	Classroom	6
	SP 311	Trauma Fundamentals	Classroom	6
	SP 312	Medical Fundamentals	Classroom	12

	SP 313	Legal Fundamentals for Child Protective Workers	Classroom	6
	SP 812	CFSR Fundamentals	Classroom	6
	SW 074	Testifying Fundamentals for Child Protective Workers	Classroom	6
	SW 500	Social Work Ethics	Recording	3
Within 12 Months	SP 335	CSC and SFM Fundamentals	Classroom	6
	SP 535	Assessing throughout the Case	Classroom	6
	SP 542	Motivational Interviewing	Classroom	6
	SW 507	Race: The Power of an Illusion	Classroom	5.5
	SW 508	Understanding Implicit Bias	Classroom	6
	SW 712	Solution Based Casework – Child Protective Assessment	Classroom	4
	SW 713	Engagement	Classroom	6
	SW 714	Safety Assessment and Planning	Classroom	6
			Total Hours	**189**

FFY 2020-2024
CHILD AND FAMILY SERVICES PLAN
TRAINING PLAN

June 2020

FFY 2020-2024
Child and Family Services Plan (CFSP)
Training Plan

State of Iowa
Iowa Department of Human Services
Division of Field Operations

Contact Person:

Name: Michelle Tyrell

Title: Training Specialist II

Address: Iowa Department of Human Services
Division of Field Operations
Hoover State Office Building – 5th Floor
1305 E. Walnut Street
Des Moines, IA 50319

Phone: (515) 242-5215

E-Mail: mtyrrel@dhs.state.ia.us

New Worker Training Requirements

The DHS requires newly hired social work staff to complete the New Worker Training Plans by the timeframes specified for each course (Attachment 8D-A for SW2/SW2 Supervisors and Attachment 8D-B for SW3/SW3 Supervisors). The New Worker Training Plans serve as a roadmap of the training requirements within the first year of hire. These documents also detail the learning modality and number of credit hours associated with each course. The DHS contracts with the Child Welfare Research and Training Project at Iowa State University (ISU) to perform many of the necessary day-to-day activities related to the coordination of training. One of ISU's responsibilities is to review the New Worker Training Plan with learners during their New Worker Orientation phone call.

SW2 training prior to caseload assignments is as follows: New Social Worker 2s must complete the initial four days of *SW 020 Foundations of Social Worker 2 Practice* before assignment to any cases. Following this classroom time, learners participate in the month-long field learning experience before they return to class for the final 3.5 days of SW 020. Newly hired staff will work with their mentors on no more than 10 cases during their field learning experience prior to the completion of SW 020. Suggested types of cases to avoid assigning during the field learning experience timeframe include:

- Sexual abuse cases
- Severe physical abuse
- Previous terminations
- Medical neglect cases
- Child death
- Cases that has multiple CPS substantiation
- Severe domestic violence in the home

CPW training prior to caseload assignments is as follows: New Social Worker 3s must complete the initial three days of *CP 200 Basic Training for Child Protective Workers* before assignment to any cases. Following this classroom time, learners participate in the month-long field learning experience before they return to class for the final 3.5 days of CP 200. Newly hired staff receive no more than six Family Assessment or Child in Need of Assistance (CINA) cases during their field learning experience prior to the completion of CP 200. Additionally, new Social Worker 3s must complete *DA 202 Dependent Adult Abuse Fundamentals* before assignment to any dependent adult abuse cases.

Supports provided during the in-service training period: Within the CFSP reporting period, the DHS developed a formalized mentoring program with the goal of supporting new workers as they transition into their role. Attachment 8D-C documents the framework for this program, along with Attachment 8D-C(1), the Mentoring Agreement . The Field Learning Experience Guides are Attachments 8D-C(2) for SW2 and 8D-C(3) for SW3, which detail tasks performed to both support and supplement classroom learning.

Another level of support provided to new staff is access to the DHS Help Desks. During the orientation coursework, new staff receive an introduction to these specialized teams of personnel. The Service Help Desk answers more complicated practice and policy related questions, and the CWIS Help Desk answers information system questions and technical questions that arise.

ISU plays a role in providing support during the initial service training period by conducting a training orientation call with each new worker to discuss the training requirements, walk-through the Learning Management System (LMS), and help new staff acclimate to the mentoring program.

Ongoing Worker Training Requirements

DHS requires social work staff to complete a minimum of 24 training hours each state fiscal year (e.g., July 1, 2019 – June 30, 2020).

Training Hour Reminder Emails: One of ISU's contracted services is to send out a bi-annual email to all staff to reiterate the 24-hours training requirement.

Learning Needs Surveys: DHS distributes a bi-annual statewide Learning Needs Survey to SW2s, SW3s, Supervisors, as well as to Policy and Service Help Desk staff. The purpose of the survey is to identify the ongoing training needs of staff. These results serve as a basis for the DHS Training Committee to select and align training initiatives for the upcoming fiscal year with the learning needs of staff.

DHS Training Committee Feedback: The DHS Training Committee members include a Supervisor, SW3, and SW2 from each of the five Service Areas; as well as DHS leadership, Service Help Desk staff, Policy Program Managers, and contracted training personnel. Incorporating feedback from the DHS Training Committee helps to ensure that ongoing training addresses skills and knowledge needed by staff to carry out their duties.

Focus Group Feedback: Focus groups occur for newly developed or significantly updated ongoing courses. The focus groups are comprised of DHS Training Committee members as well as additional key stakeholders and staff. These focus groups assist in refining the course objectives and reviewing the curriculum during development prior to the pilot offering.

Pilot Offerings for Newly Developed/Revised Ongoing Coursework: Any newly developed or significantly updated course includes a pilot offering before introduction to frontline staff. This practice ensures course content meets the needs of ongoing workers before implementing training.

Levels of Proficiency: Structuring coursework by levels of proficiency is one method to better target staff's ongoing training needs. The design of the fundamentals-level coursework is for acquiring basic skills and knowledge, while the intermediate-level trainings focus on building advanced skills for more tenured staff.

Post-Training Electronic Surveys and Analysis: ISU staff conducts post-training surveys 60 days after training for newly developed coursework. In previous years, ISU surveyed learners by phone. A change to that process this year was to survey learners electronically.

Table 1: 60 Day Post-Training Surveys		
Course Title	**I will be able to apply on the job what I learned during this session. (AVERAGE)**	**How likely is it that you would recommend this training to another person in your position? (0 being the lowest and 10 being the highest) (AVERAGE)**
200	4.11	7.5
020	3.80	8.29
SP 812	3.10	6.60

Source: ISU

Post-Training Evaluation of Ongoing Training: Learners complete a standardized electronic post-training evaluation after attending training. This 16-question evaluation includes a number of questions designed to measure how well the training addresses skills and knowledge needed by staff to carry out their duties.

Collaboration

The Bureau of Service Support and Training implemented a number of practices to collaborate with external partners (e.g., courts, provider community, etc.). For the past year, DHS staff met on a regular basis with Kathy Thompson, Iowa Children's Justice Director, Iowa's Court Improvement Program (CIP), and Kristie Oliver, liaison for our provider community. During the meeting, each leader provides updates on their respective training efforts, looking as well for opportunities to partner, share, and align the trainings we offer.

Over the past months, the focus was on Family First related trainings. Most noteworthy is the Danger vs Risk training that DHS recorded for its staff, as well as to share with provider staff, court personnel, and legal partners across the state. Danger vs Risk is the initial training related to the new Safety Assessment and Safety Plan tools. DHS contracted with the National Council on Crime and Delinquency (NCCD) to develop these tools. This collaboration has promoted a more standardized understanding of danger and risk in our collective work with children and families of Iowa.

Another example of a successful collaboration between DHS, providers, court, and legal partners was the coordination of the Family First context setting presentation by Amelia Franck-Meyer, CEO of Alia Innovations and a well-known advocate for the significant redesign of America's foster care system.

Training announcements about all DHS-sponsored learning opportunities, including those unrelated to Family First, go statewide to providers, tribal representatives, and various other partners.

Training to Support the FFY 2020-2024 Child and Family Services Plan (CFSP) Goals and Objectives

Because of Iowa's continued work on its Child and Family Services Review (CFSR), Program Improvement Plan (PIP) development, DHS updated the training plans for FY 2020 and FY 2021. Details regarding these trainings are in the Updates to Training Plan spreadsheet, Attachment 8D(1). In addition, DHS incorporates the Child Welfare Provider Training Academy (CWPTA) training plan and the Juvenile Court Services (JCS) Training Plan as part of the state's training plan (see Attachments 8D(2) and 8D(3) respectively).

DHS trained on the Family First implementation in FY 2020. With Iowa's Family First implementation effective October 1, 2020, DHS will continue this training into FY 2021. The training will prepare staff for the resulting changes in practice and services.

- Family First Related Coursework Offered in FY 2020:
  - Mentoring for Supervisors (online learning)
  - DHS Alia Seminar (online learning)
  - How to Achieve Best Practice – CFSR Training
  - Solution Based Casework for Supervisors (online learning)
  - Danger versus Risk (online learning)
  - Revised Risk Re-Assessment (online learning)
  - FCS/QRTP Contract Fundamentals (online learning)

- Family First Related Coursework Planned for FY 2021:
  - Safety Assessment and Planning
  - CFSR Fundamentals for New Workers
  - Solution Based Casework - Protective Assessment
  - Solution Based Casework - Case Permanency Planning
  - Family Engagement
  - CSC and SFM Fundamentals

Table 2: Training Descriptions	
Name of Training	**Description**
CFSR Training	Understand the basic content of the CFSR and develop best practice commitment plan.
Danger Versus Risk	Assure all child welfare stakeholders (court, providers, etc.) are trained on, and able to apply, definitions of "danger" versus "risk" as they pertain to decision-making (including removal and reunification) when working with families, youth, and children.

Table 2: Training Descriptions	
Name of Training	**Description**
Engagement	Train DHS staff on the new practice skills to assure demonstrated understanding of what it means to "actively engage" parents and children in case planning during routine visits.
Advanced Micro-aggressions	Because DHS social workers and supervisors deal with the community on a regular basis, secondary trauma can settle in and lessen tolerance for certain groups. By addressing field exhaustion and the level of compassion toward the work, supervisors can assess the following: • what their staff needs, • use assertiveness* to clarify and rectify issues in their department, and • ask for the necessary supports to increase staff morale and personal self-care practices.
Problematic Sexual Behavior in Children	1. Increase knowledge of best practices in addressing problematic sexual behavior in children & adolescents for families 2. Increase knowledge of child welfare workers role in addressing problematic sexual behavior in youth 3. Increase knowledge of effective treatment components
Safety Assessment and Planning	Train DHS staff on the new practice skills for evidence-based tools and how they inform decision-making, including initial and on-going safety assessment, removal, and writing actionable safety plans consistent with safety expectations.

Progress on Goals

Item 26: Initial Staff Training

Goal 1: Improve new staff completing training within the required timeframes

Strategies to reach this goal are:

- New Worker Training Timeframes Data: Starting FY 2020, DHS developed quarterly reporting that tracks the average length of time between new worker hire dates and the start of new worker training (SW 020/CP 200). The tracking enables DHS to better assess the length of time it takes to initiate core training for new workers in their first three months of employment (see Table 3 below for this data).

Table 3: Completion Timeframes for New Worker Training (SW 020/CP 200)				
	Average Days to 020/200	**#/% within 30 Days of Hire**	**#/% within 60 Days of Hire**	**#/% within 90 Days of Hire**
New SWCMs	24	48 (59%)	34 (41%)	0
New CPWs	27	22 (63%)	9 (26%)	4 (11%)

- Transitioning to a Statewide Learning Management System: DHS is excited to be part of a statewide inter-departmental initiative to transition to the LearnSoft Learning Management System (LMS). This new system will greatly benefit learners by providing an enhanced online learning experience. Planning for this migration has occurred throughout this reporting period with an anticipated go live date of July 1, 2020. What this new LMS means for the DHS:
  - Significantly enhanced reporting capabilities
  - Intuitive navigation
  - Coursework is pushed out to learners instead of putting the responsibility on the learner to register for coursework
  - Technical support provided by specialists at LearnSoft
  - Enhanced collaboration between state agencies about course offerings open to all state employees
- Strategic Scheduling: In past fiscal years, DHS scheduled SW 020 and CP 200 around influxes of newly hired staff. Upon reflection, that method was ineffective as hiring patterns fluctuate between Service Areas.

  This fiscal year DHS intentionally offered SW 020/CP 200 on a bi-annual basis. This strategy ensures that a new worker training session is always on the horizon for newly hired staff. Additionally this scheduling method better allows for advanced planning by Social Work Administrators and DHS trainers.
- Increased Training Capacity: DHS implemented an enhanced facilitator model this year, structured around having two full-time DHS internal trainers with significant DHS background in the field. These trainers are responsible for providing SW 020/ CP 200 facilitation for new DHS staff. With two internal trainers on board instead of just the one trainer we had in the past, DHS now has the capacity to offer these courses on a regular bi-monthly basis.

Goal 2: Improve the perceived effectiveness of the trainings

Strategies to reach this goal include:

- Training Effectiveness Report Conducted by ISU: As planned for this fiscal year, ISU conducted an in-depth analysis of SW 020 and CP 200. The analysis identified barriers in learning/practice and proposed modifications based on the findings (see Attachment 8D-D). The basis of these evaluations on the new worker trainings (SW 020 and CP 200) are on the work of California Social Work Education Center (SWEC).
- Post-Training Evaluation of New Worker Training: Learners complete a standardized electronic post-training evaluation after attending training. This

evaluation includes a number of questions designed to measure how well the training addresses basic skills and knowledge needed by staff to carry out their duties. Table 4 reflects data for the reporting period that measures perceived effectiveness of new worker training.

Table 4: Post-Training Evaluation Data for APSR 2020

	I will be able to apply on the job what I learned during this session. (AVERAGE)	**How likely is it that you would recommend this training to another person in your position? (0 being the lowest and 10 being the highest) (AVERAGE)**
CPW New Worker	4.37	8.20
SWCM New Worker	4.66	9.13
CPW Ongoing (includes all courses except 200, 202, 020)	3.99	7.58
SWCM Ongoing (includes all courses except 200, 202, 020)	4.29	8.34

- Subject Matter Expert Trainers: As mentioned previously, the enhanced facilitator model consists of pairing an internal DHS trainer with a carefully selected subject matter expert (SME) co-facilitator. In the past, ISU facilitators who lacked direct DHS field experience trained DHS staff. Under the new model, DHS now employs two full-time internal trainers with significant DHS background in the field.

  A second component of this model is that DHS is more selective in finding qualified subject matter experts, seeking to collaborate with leaders across disciplines to keep training relevant and fresh. A great example is the partnership with Dana Christianson, model developer for Solution Based Casework® (SBC). This evidence-based model will serve as the foundation for our new Family-Centered Services, aligning well with Family First. Dana Christianson directly facilitated training for DHS supervisors, establishing credibility in the facilitator and the model for the field. Dana will likewise be training our trainers in the model as a means to build ongoing internal training capacity on this front.
- Summative Evaluations for Fundamentals Training: Establishing post-tests for Fundamentals-level training is an ongoing objective planned for FY 2021. These summative evaluations will measure if the learning objectives of the training were met.
- Annie E. Casey Feedback Partnership Update: The Annie E. Casey Foundation selected Iowa to provide readiness assessment and consultation to DHS. The assessment and consultation related to DHS' rollout of Family First, e.g. helping DHS think through its selection of evidence-based models, approach to service funding, development of performance measures and ongoing contract monitoring plans, contract development, training considerations, and how to further enhance

collaboration and engagement with our provider community. The foundation's work with Iowa concluded recently, but their depth of knowledge, experience, and insight proved critical in the development of our Family First related strategies.

- Child Welfare Policy and Practice Group (CWPPG) Recommendations & Implemented Measures: DHS invited a representative from Child Welfare Practice and Policy Group (CWPPG) to attend both of the new worker orientation courses SW 020 and CP 200 to provide recommendations for enhancing training. These recommendations and the response measures DHS implemented are in Attachment 8D-E.

Goal 3: Establish or improve support and education in non-classroom settings

Strategies to reach this goal include:

- Mentoring Program: A multidisciplinary focus group convened to develop a standardized mentoring program for new Child Protection Workers (CPW/SW3s) and Social Work Case Managers (SWCM/SW2s) during their first six months of employment. This framework formalized an informal system that was already in place in an effort to improve statewide consistency. The Mentoring Program aims to build the confidence level of a new worker as well as their competency in doing casework in the counties they serve. With this goal in mind, the design of the program is around experiential learning opportunities in the field that reinforce classroom learning. The desired outcome of the program is increased employee satisfaction and retention.

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

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

  The next step in the process in the coming fiscal year is to survey folks who participated in the mentoring program. The results will serve as feedback for evaluating and enhancing the Mentoring Program.
- Masters of Social Work Stipend Program: DHS explored drawing down title IV-E funding and collaborating with state universities to provide financial assistance to current DHS staff interested in earning a Masters of Social Work. We continue to work with the University of Northern Iowa to explore the development of a stipend program. Currently DHS, ISU, and UNI are working with an IV-E consultant to enhance our approach to evaluating training curriculum and corresponding administrative activities as they relate to IV-E funding. This enhanced understanding will assist UNI with conducting an IV-E funding analysis of its Social Work

coursework and administrative activities, allowing DHS to make informed decisions about the scope of a stipend pilot.

Item 27 – Ongoing Staff Training

Goal 1: Address staff not completing the required ongoing training hours within our established timeframes

Quarterly Reporting in FY 2021: The intent during this reporting period was to develop a quarterly report for Social Work Administrators and Service Area Managers detailing which of their workers have or have not met the minimum 24 hours of training each fiscal year. Due to technical limitations, DHS did not develop the report as planned, but DHS plans to develop the report in FY 2021.

The training team encountered technical obstacles for reaching this goal. The CWRTP through an annually renewed Service Training contract between the DHS and ISU has hosted and supported the Moodle-based DHS Training Management System website since 2010. The current Moodle-based LMS utilizes Moodle 3.2, which is outdated and no longer fully supports needed functions. In FY 2020, issues with the current LMS affected the quality of training experience for end-users. Some of the issues included:

- Outdated PHP code caused barriers for those creating new accounts. The system did not send out password reset and new account confirmation emails.
- The package of current content is in SCORM 1.2, which uses Flash. As of December 31, 2020, Adobe will no longer support Flash.
- Automatic certification generation did not occur in the manner expected throughout FY 2020.
- Inability to secure a video server in FY 2020 due to DHS security restrictions. Some learners were unable to access their trainings due to the barrier.

Mitigation Steps Taken:

- ISU Service Training team trained all members of the team to trouble-shoot common issues on Moodle and answer service training email requests.
- ISU Service Training Team posted on Moodle LMS the work around for watching videos not supported by Flash player and led users through steps to do this on their DHS computers.
- CHS-IT created a duplicate Moodle site for handling the high-volume non-DHS Mandatory Reporter training requests.
- ISU is currently reviewing all certificate generation for FY 2020 to ensure the accuracy of reports.
- In FY 2021, DHS will transition to the LearnSoft LMS.

The strategy to reach this goal is:

Transitioning to a Statewide Learning Management System: As noted previously, DHS will migrate to the LearnSoft Learning Management System (LMS), which has a much more robust reporting capacity. DHS will evaluate the need for a quarterly report for

SWAs and SAMs after DHS transitions to the new LMS when it is able to better assess all reports available to supervisors and administrators to track compliance with training expectations.

Goal 2: Address the need for supervisory training that promotes the development of child welfare supervisory and management skills.

Strategies to reach this goal include:

- Provide supervisory specific webinars: DHS will develop topic-specific webinars specifically targeted for supervisors. These webinars will often be co-facilitated by a field supervisor and will be recorded for on-demand access. The topics will vary to include trending issues as well as overall best management practices. This strategy allows supervisors to enhance their management skills in short and simple increments of time.

  DHS assembled a DHS supervisory workgroup to inform quarterly supervisory webinars (seminars). The first Supervisory Seminar will occur in September of 2020, focused on Team-Building in the Virtual Environment. The mentoring program is just one of the items that will be covered during this seminar as it relates to supporting supervisors with new staff during the pandemic.

- Additional face-to-face coursework offerings specifically designed for supervisors: The plan over the next five years is to offer additional courses designed specifically for supervisors. A good example of this type of training is the recently developed trauma course for supervisors. Participants of SP 810 Trauma Stewardship for Supervisors learn supervisory approaches to address worker secondary trauma, dealing with the aftermath of a critical incident, and create a plan of action to implement with their team.

  Due to the COVID pandemic, this strategy is on hold for this fiscal year until we can safely resume in-person training on a regular basis.

- Advanced level course offerings: A strategy to engage supervisors in training is to provide the field with more advanced- level curriculum. Most supervisors are tenured staff who are beyond the fundamentals level of curriculum. By offering additional training that incorporates complex case studies and takes a deeper dive into trending issues, the intent is to reinvigorate and challenge senior staff members with new information and tools.

  DHS is contracting with Safe and Together again this fiscal year to provide supervisors and tenured staff with more advanced-level domestic violence training. These trainings serve as the next step for those who already have a solid working knowledge of domestic violence fundamentals.

- Provide Supervisors with "The Essential Handbook for Highly Effective Human Service Managers": All supervisors and Social Work Administrators received literature that promotes the development of child welfare supervisory and management skills. "The Essential Handbook for Highly Effective Human Service Managers" emphasizes an innovative approach to equip managers at all levels with the strategies and tools necessary to maximize employee commitment, performance and client care. Social Work Administrators in each service area determined how to build effectively upon the best practices outlined in the book with supervisors in their area.

  At present, Social Work Administrators in every service area are reviewing key chapters of the handbook with supervisors. A standardized plan is concurrently being developed to ensure that the most pertinent material/chapters from the handbook are covered during supervisory discussions in every service area. It's intended that this plan will also outline a means for tracking supervisory participation.

- Promoting External Training Opportunities for Supervisors: Many external organizations that collaborate with DHS offer supervisory specific training that is open to DHS supervisors. These courses allow DHS supervisors to earn credit for trainings on topics other than internal trainings offered. The Department of Administrative Services, who offers training on supervisory and management topic areas, will be just one of the agencies DHS will collaborate with in the transition to the LearnSoft LMS. This singular platform will enhance communication between state agencies about course offerings open to all state employees.

  In July of 2020, Iowa Department of Human Services participated in a statewide initiative to enhance training delivery through implementation of Learnsoft, our new Learning Management System (LMS). Supervisors now have streamlined access to the Department of Administrative Services course offerings.

  Supervisors are also being asked to participate in a number of NCWWI supervisory virtual courses before the end of the September 2020 in preparation for the required Supervisory Seminar - Team-Building in the Virtual Environment. They will also be provided a number of NCWWI resources to support their daily practice, including:

  - Session One: Virtual Supervision
    - Webinar Recording (https://vimeo.com/405792283)
    - PowerPoint Slides (https://ncwwi.org/files/--Documents/Supporting_the_Virtual_Workforce_Supervision_April_2020.pdf)
    - Supervision During Physical Distancing: Tools and Guidance (https://ncwwi.org/index.php/resourcemenu/resource-library/supervision/1493-supervision-during-physical-distancing-tools-and-guidance/file)
    - Tip Sheet: Productively Working from Home (https://ncwwi.org/index.php/resourcemenu/resource-library/practice-supports/1495-tip-sheet-productively-working-from-home/file)

        - Caring for the Workforce (https://ncwwi.org/index.php/resourcemenu/resource-library/work-conditions-and-benefits/1577-caring-for-the-workforce-webinar-chatlog-summary/file)
        - Virtually Supervising Child Welfare Professionals During a Pandemic (https://ncwwi.org/index.php/resourcemenu/resource-library/supervision/1494-virtually-supervising-child-welfare-professionals-during-a-pandemic/file)

    - Session Five: Coaching Remotely
        - Webinar Recording (https://vimeo.com/416893991)
        - PowerPoint Slides (https://ncwwi.org/files/--Documents/LE.5.Remote.Coaching.pdf
        - Tips for Coaching Someone Remotely (https://ncwwi.org/index.php/resourcemenu/resource-library/education-professional-development/coaching/1505-tips-for-coaching-remotely/file)
        - Facing the Pandemic with Emotional Agility (https://ncwwi.org/index.php/resourcemenu/resource-library/trauma-informed-practice/1506-facing-the-pandemic-with-emotional-agility/file)

- Phased Training for New Initiatives: A training model effective for DHS is initially train supervisors on new initiatives/practices, followed by a second wave of training for frontline staff. This method allows supervisors to ask management-specific questions and creates buy-in for the initiative. By providing supervisors with knowledge in advance of their staff, they are better able to plan and anticipate the questions they may receive from frontline staff, e.g. updates to standardized tools and corresponding technical system changes.

  This method of introducing training on new initiatives to supervisors before frontline staff is a strategy we hope to carry forward within this fiscal year, specifically when in-person training resumes.

SFY 2020 CHILD WELFARE PROVIDER TRAINING ACADEMY PLAN

Submitted: September 19, 2019
Revised: November 8, 2019

- **FL - Front-line child welfare providers**
- **FLS - Front-line child welfare supervisors**
- **LP - Live Presentation (In-person)**
- **WC - Web Course and/or webinar**
- **RL - Access only to Relias Users**
- **B - Basic/New Worker**
- **I - Intermediate/More Experienced Worker**
- **A - Advanced/Supervisory Level Worker**
- **R - Regions (Western, Central, Eastern)**

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW 1001 Family Team Decision-Making (FTDM) Meeting Facilitation Lori Mozena, Katie Obert, Katie Henniges, Ashley Hopkins or Jessica Eash Thomas	This training assists child welfare workers with understanding the Family Team Decision-Making (FTDM) meeting process so potential facilitators can evaluate and utilize in daily practice and be coached in FTDM meeting facilitation which develops the family's plan.	All Child Welfare	FL & FLS: B & I	LP	R	4
CW 1002 Youth Transition Decision-Making (YTDM) Meeting Facilitation Katie Henniges, Ashley Hopkins, or Jessica Eash Thomas	This training assists child welfare workers with understanding the youth driven family team decision-making meeting process so potential facilitators can be coached in YTDM meeting facilitation to utilize in guiding and developing the youth's plan.	All Child Welfare	FL & FLS: I & A	LP	R	2
CW 1003 Facilitating Family Team Decision-Making (FTDM) Meetings with Domestic Violence Leah Vejzovic and Ashley Hopkins	This training reviews the dynamics of battering and allows child welfare workers to learn how those dynamics may sabotage the efficacy and safety of a FTDM meeting. This course utilizes family team decision-making meeting facilitation skills to develop the family's plan when domestic violence is involved and provides an understanding of what facilitators need to know to determine the best method to facilitate a family team decision-making meeting.	All Child Welfare	FL & FLS: B & I	LP	R	2

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW 1004 Coaching for Family Team Decision-Making (FTDM) Meeting Facilitators and Youth Transition Decision-Making (YTDM) Meeting Facilitators Katie Henniges, or Jessica Eash Thomas	This training allows approved and active facilitators to work towards becoming an approved coach for Family Team Decision-Making Meeting Facilitators and Youth Transition Decision-Making Meeting Facilitators. The attendees will gain an understanding of the concepts and practice of becoming a coach and how to evaluate the facilitator's process.	All Child Welfare	FL & FLS: B & I	LP	R	1
CW 1005 FTDM Meeting Fundamentals Training Lori Mozena, Katie Obert, Katie Henniges, Ashley Hopkins, or Jessica Eash Thomas	This training assists child welfare workers with understanding of the Family Team Decision-Making (FTDM) meeting process in an overview. This training will help those participants who are not facilitators, evaluate their families that they work with and utilize the information learned in this training with their daily practice.	All Child Welfare	FL & FLS: B & I & A	LP	R	2
CW 1006 Foundation of Understanding Trauma Frank Grijalva, Matthew Vasquez and Facilitators in Training	Level 1. This training will discuss the broad spectrum of major contributors to a child's behavior, what needs to be addressed first and what short/long term reasonable outcomes are. The lifespan consequences of trauma on an individual/community and worker's role as protectors and educators. They will also learn how to engage in and explore concrete processes to stabilize attachment, develop safe relationships and effective emotional management.	All Child Welfare	FL & FLS: B & I & A	LP	R	18
CW 1007 Self-Care of Trauma Frank Grijalva, Matthew Vasquez and Facilitators in Training	Level 2. This course will review lifespan consequences of trauma on an individual/community and worker's role as protectors and educators. Participants will learn what can happen to them as they operate in highly stressful environments and how to take care of themselves. They will also learn how to engage in and explore concrete processes to stabilize attachment, develop safe relationships and effective emotional management.	All Child Welfare	FL & FLS: B & I & A	LP	R	10

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW 1008 KINNECT Module - Safety Frank Grijalva and Facilitators in Training	Level 3. Safety may be perceived differently by each child and because of his or her history. This training is based on a trauma informed multimodal multidisciplinary curriculum designed for stabilization of system-involved youth. This training will explore a child's view of what is meant by physically safe, socially safe, safety in flight, fight and freeze, and how one's self begins with safety.	All Child Welfare	FL & FLS: B & I & A	LP	R	0
CW 1009 KINNECT Module - Emotional Frank Grijalva and Facilitators in Training	Level 4. This training helps educate the attendees on how to work with the major implications kids in care have on demonstrating their feelings of emotion and how to help them in their socialization. The training is structured to provide general description of effective practice for working with the kids in care so that they have consistent, persistent opportunities to practice emotional management skills.	All Child Welfare	FL & FLS: B & I & A	LP	R	6
CW 1010 KINNECT Module – Loss Frank Grijalva and Facilitators in Training	Level 5. This training will allow participants to explore loss and ways individuals may show signs of grief and unresolved grief. Participants will learn about evidence-based practices for effective interventions and strategies based on multi-modal treatment structures.	All Child Welfare	FL & FLS: B & I & A	LP	R	0
CW1015 KINNECT Module – Future Frank Grijalva and Facilitators in Training	Level 6. System involved children and families are often conditioned to live in the moment at the expense of planning for the future. Environments of poverty, dangerous neighborhoods, and dangerous homes all create a demand on the human to be acutely aware to what is going on right now because the brain is designed to address current threat first. The final module of KINNECT acknowledges that too often our children in need are unable to see or feel a future that is hopeful and masterful for them. Participants will learn about evidence-based practices for effective interventions and strategies based on multi-modal treatment structures.	All Child Welfare	FL & FLS: B & I & A	LP	R	12

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW1016 Level 3: Family Home Training Frank Grijalva and Facilitators in Training	Given what has been learned in Levels 1 and 2, this training will focus on how to execute trauma informed care with children placed in family home settings, including family foster care families working towards reunification. The course will cover topics, such as, the logistics of working with children in a family home environment, how to best prepare, how to alleviate and respond to stressors in the family home environment, and how to identify and guide expectations. Participants will engage in practical activities from a foundation of understanding the scientific and sociological processes that facilitate pro-social connection and guidance to build resilience.	All Child Welfare	FL & FLS: B & I & A	LP	R	20
CW1017 Domestic Violence Fundamentals Leah Vejzovic	This course is an introduction to domestic violence concepts and how they relate to family and child welfare. Participants will learn about what domestic violence is, how to identify various tactics of abuse, and how domestic violence impacts children from birth through their adolescent years. The training will also explore how domestic violence impacts parenting and how professionals can help promote resilience and healing in families experiencing this type of trauma.	All Child Welfare	FL & FLS: B & I & A	LP	R	4
CW1018 Domestic Violence Intermediate Leah Vejzovic	This session builds on the Fundamental course material by exploring how to screen for domestic violence and effectively engage both adult survivors of abuse and their perpetrators while working towards child safety and well-being. Participants will be given tools to help them partner with survivors and engage perpetrators in a change effort, as well as receive introduction to a variety of strategies for planning for child safety and evaluating effective change. Participants will also explore how to explain the services available to survivors of domestic violence and how to appropriately refer to local domestic violence service agencies.	All Child Welfare	FL & FLS: B & I & A	LP	R	4

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW1019 Mental Health Fundamentals Billy Claywell	In-home workers face many difficulties, including working with clients with mental health conditions. Mental Health Fundamentals explores five common mental health conditions and gives workers practical guidance on how to communicate with clients without getting caught up in their drama. Participants will learn about the connection between genetics, environments, and lifestyles in the development of a mental health condition; communication techniques to assist clients to replace maladaptive behaviors with positive ones; and skills to de-escalate clients experiencing a mental health crisis. Upon completion of this course participants will be able to understand how personal experiences impact relationships with clients experiencing mental health conditions, be able to identify the diagnostic criteria for five common mental health diagnoses, and able to recognize how adverse childhood experiences affect mental health.	All Child Welfare	FL & FLS: B & I & A	LP	R	4
CW1020 Substance Abuse Fundamentals (Dangerous Playgrounds 3.0) Mike McGuire	Dangerous Playgrounds 3.0 will provide an interactive learning approach designed to increase participant awareness about current trends related to substances of abuse - both legal as well as illicit. Participants in this training can expect to learn what substances of abuse are, what they look like, how they are used, terminology, and various associated paraphernalia. In addition, participants will learn the behavioral indicators (physical, psychological, emotional) of specific substances of abuse. The class will likewise connect behavioral indicators, environmental concerns, and physical symptoms of use to their impact on safety, risk, and protective factors in child welfare. This course will provide a broad overview of substances of abuse with an emphasis on current trends and those most likely to be encountered by those working with youth and families. Participants will leave this training better equipped to understand and navigate the often complex world of substances of abuse encountered in your work.	All Child Welfare	FL & FLS: B & I & A	LP	R	3

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
CW1021 Testifying in Court Judge Constance Cohen, Cole Mayer, and Annie von Gillern	More and more often, child welfare professionals are having to take the stand and be questioned in open court. Remembering everything that has happened in a case, while trying to make sure you accurately recite facts while questions are being hurled at you can feel like you've drifted into oncoming traffic. This training will focus on best practices for professionals testifying in court, common problems to avoid, and how to keep a good working relationship with your families while answering questions that might make them feel uncomfortable.	All Child Welfare	FL & FLS: B & I & A	LP	R	1
CW1022 Motivational Interviewing (MI) Brian Lowery	Counselors and social workers are frequently challenged by parent's lack of motivation to change negative behaviors, which are causing distress in a client's family. This is particularly true in the case of caregivers who are struggling with substance use disorders. *Motivational Interviewing* is an evidence-based counseling style which adopts a brief intervention format, using critical elements that serve as catalysts for motivation and change. MI addresses how to strengthen client intrinsic motivation to change and reduce ambivalence. This course serves as an introduction to MI and gives participants the basic tools necessary to incorporate this intervention into their practice.	All Child Welfare	FL & FLS: B & I & A	LP	R	3
WEBINAR – "Attachment – the difference between coming from an environment with trauma vs. reactive attachment disorder" Frank Grijalva	Reactive Attachment Disorder (RAD) is often a behavioral and wiring response to trauma exposure in early childhood. The symptoms associated with RAD, when looked at through the lens of what works for Attachment issues, are still very relevant. When thinking about this from the example of a brain injury and the type of therapy that traumatic brain injury (TBI) patients go through to rehab the brain, the training will provide information on useful interventions, the importance of intervention frequency, and the process for service referrals.	All Child Welfare	FL & FLS: B & I & A	WC	R	1

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
WEBINAR – Neglect Frank Grijalva	The rehabilitation for victims of neglect is multi-faceted. This webinar will identify the different developmental phases and how they play out in the behavior of children and adults. Information on selected interventions and their utility will be presented to understand response and sequencing to address early neglect.	All Child Welfare	FL & FLS: B & I & A	WC	R	1
WEBINAR – Compassion Fatigue/Self-Care Frank Grijalva	This webinar will provide information that outlines the physiological conditioning process, how individual temperament may play into compassion fatigue and how workers can create solid self-care plans to protect themselves and their quality of life now and into the future.	All Child Welfare	FL & FLS: B & I & A	WC	R	1
RL 001 REL-HHS-0-AS-V3 Suicide in Adolescents and Transition Age Youth Monique Kahn, Psy.D. Kimberly Roaten, Ph.D., CRC *Created: 11/29/18* *Last Modified: 2/2/19*	This course will provide a foundation on how widespread adolescent suicide is and the prevailing theories about what impels individuals to commit suicide. The course will describe suicide behaviors and warning signs to watch for and ways to effectively work with adolescents to better refer to services and work toward the goals in the client's case plan.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 002 REL-HHS-0-AMI Motivational Interviewing in Clinical Practice Christopher de Beer, LCSW, LCASA *Created: 8/17/18* *Last Modified: 11/3/18*	Motivational Interviewing (MI) is an evidence-based, client-centered approach to engaging people in conversations about change. Shown to be effective in a variety of settings, MI is increasingly being adopted by therapists, substance use disorder counselors, and health care workers as a tool to help clients make important behavioral changes. This course is for social workers who are already familiar with the four processes of and the core skills used in MI and would like to improve their ability to use MI more effectively with a broad range of clients. Examples from both a medical and mental health setting will provide illustrations of effective MI techniques.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 003 REL-BH-0-BHWEB1 Assessing Opioid Abuse in Families Karl Haake, MD Nellie Galindo, MSW, MSPH *Created: 06/13/18* *Last Modified: 10/18/18*	Opioid abuse in the United States has been declared an epidemic by the Centers for Disease Control and Prevention. Awareness has never been higher. An important tool to address the opioid crisis in America is to perform better assessment. This webinar will provide information regarding the background issues related to the opioid epidemic and provide listeners with the tools to perform better assessments of opioid risks in families.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning User	Daily
RL 004 REL-HHS-0-ADTTI2-V2 Attachment Disorders: Assessment, Diagnosis, and Treatment Tracey N. Turner-Keyser, MA, BC-DMT, LPCS, IDME David O. Keyser, Ph.D. *Created: 04/26/18* *Last Modified: 09/01/18*	This course looks to discover what happens when the infant-caregiver relationship is not healthy. In this course we are discussing Attachment Disorder (AD), a condition that occurs in many children who experience abuse, neglect, and chaos at the hands of their caregivers during infancy and early childhood. In this course, you will learn about assessment strategies, diagnostic tools of attachment disorder and evidenced-based emerging interventions for attachment problems, plus suggestions for effective ways of communicating with parents who are raising a child with AD and information on parenting practices to share with them. The term Attachment = Relationship and the information provided will help you to understand child and adult relationship potential.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 005 REL-HHS-0-ADTTI1-V2 Attachment Disorders: Attachment and Trauma David O. Keyser, Ph.D. *Created: 01/26/18* *Last Modified: 04/07/18*	In this course, you will receive an overview of past and current research and theories on the process of attachment, an understanding of the impact of early exposure to trauma on brain development and the attachment process, a symptoms checklist of attachment problems, and a description of some long-term consequences for a child with attachment disorder. You will learn that an attachment disorder is a condition that occurs in many children who experience abuse, neglect, and chaos at the hands of their caregivers during infancy and early childhood. Learners will be able to review some of the pioneering	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
	literature on this topic and explore the issue from the perspective of case vignettes.					
RL 006 REL-HHS-0-BRD-V2 Bipolar and Related Disorders Joshua D Feder MD Naju Madra, MA Monique Kahn, Psy.D. Sarah Clavell Storer, PhD Patricia Scheifler *Created: 06/08/16* *Last Modified: 12/01/16*	The diagnosis of bipolar and related disorders can be difficult. Treatment is often challenging. This course will help you recognize the symptoms, differentiate between the types of bipolar and related disorders, and give you up-to-date information on medications and psychosocial interventions. You will review research to help you understand the role of genetics in this disorder. You will be able to better understand client behavior and improve your ability to work with this population. A series of interactive vignettes will help guide you through this course. While children and adolescents have symptoms that are like bipolar disorder and in fact may have the disorder, the average age of onset is in late adolescence or young adulthood. This course does not present information on clinical practice for children and adolescents with bipolar disorder but instead provides information on adult onset diagnosis, clinical pathways, and treatment.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 007 REL-HHS-CWLA-CCC Calming Children in Crisis Donna Petras PhD., MSW *Created: 03/18/15* *Last Modified: 02/01/16*	A major challenge in working with children who have experienced trauma is helping them manage the strong emotions often experienced as a result. Feelings of emotional pain resulting from maltreatment and loss often present as anger. Children may feel overwhelmed by their feelings and express anger in a way that places themselves and others at risk. This course provides skills for helpers to assist children in identifying and managing their feelings in a healthy manner. Specific skills taught include helping children identify and label their feelings, cope with feelings of anger, develop a Safety Plan; and learn how and when to use the plan. The skills taught in this course are helpful for persons working with children in a wide variety of settings including family foster care, and residential and educational facilities.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 008 REL-HHS-0-COOD Co-Occurring Disorders Jeremy King, LCSW, CASAC *Created: 06/13/16* *Last Modified: 10/01/16*	Co-occurring substance use and mental health disorders often present difficulties for even well trained behavioral health professionals. The treatment of such individuals is further complicated by the fact that many professionals are poorly trained in assessing and treating co-occurring disorders. This course is designed to provide you with an overview of the basic concepts associated with co-occurring substance use and mental health disorders. The information included in this training includes prevalence data, strategies for identifying co-occurring disorders, and an introduction for effective engagement and treatment strategies for individuals with co-occurring disorders. Throughout the course, you will be guided through interactive learning exercises and activities that are meant to enhance the learning experience and reinforce the material that you have learned. This course is intended for entry- and intermediate-level licensed clinicians across a variety of professions and industries.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 09 REL-HHS-0-DDCA-V2 Depressive Disorders in Children and Adolescents Bridgett Ross, Psy.D. Monique Kahn, Psy.D. David Patzer, MD *Created: 05/18/18* *Last Modified: 08/04/18*	This course offers a basic understanding of the different types of depressive disorders and how they affect children and adolescents. What are the signs and symptoms and how they manifest differently in children of different ages? Discussion will include various causes and specific attention to risk factors for suicide and suicidal behavior. This course provides staff with an understanding to better refer to services and work toward the goals in the client's case plan.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 010 REL-HHS-0-DV-V2 Domestic and Intimate Partner Violence Debi Ash, MS Joseph Murphy, PhD *Created: 10/23/17* *Last Modified: 01/06/18*	This is a course about causes, effects, and consequences of violence among intimate partners, sometimes called domestic violence. Intimate partner violence (IPV) accounts for 15% of all violent crimes, although frequency and severity of DV, or IPV, can be often underreported. The constant in all IPV relationships is one partner's sustained effort to maintain power and control over the other.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 011 REL-ALL-0-HSOCM HIPAA Dos and Don'ts: Electronic Communication and Social Media Linda Weaver, PhD, JD *Created: 02/18/15* *Last Modified: 01/31/16*	The use of electronic communications and social media allows users to instantly share pictures and personal messages with anyone, anywhere. But as the opportunities to share information online have increased, so have the challenges for keeping information private. Assuring client confidentiality is key to providing ethical practice and important to engaging and maintaining working relationships with clients. The goal of this course is to make attendees aware of social media and privacy pitfalls that could violate client confidentiality.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 012 REL-ALL-0-HTSE Human Trafficking: Sexual Exploitation Catie Hart *Created: 07/25/17* *Last Modified: NA*	Human trafficking is a significant issue in the United States and worldwide. Professionals working with in the field are in a unique position to be able to recognize victims of human trafficking and take steps to report their suspicions. Therefore, it is critical to understand human trafficking, recognize the signs and risk factors of human trafficking, and the steps to take if they suspect a person may be a victim of human trafficking. This course will focus on the sexual exploitation of human trafficking in adults and children.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 013 REL-HHS-0-INTTIC Introduction to Trauma-Informed Care Cheryl Sharp, MSW, ALWF Joseph Murphy, Ph.D. *Created: 10/10/18* *Last Modified: 5/1/19*	Over 90% of people receiving behavioral healthcare have a history of trauma. In this course, you will learn about the various types of trauma, the long-lasting consequences of trauma, and what it means to provide care through a trauma-informed lens. Through interactive practice scenarios and detailed examples, you will learn the scope of your role and responsibilities when you are serving individuals with histories of trauma. You will examine best practices to implement, as well as how to avoid harmful ones that can further perpetuate the suffering and silence of trauma. As you complete this course, you will gain a deeper understanding of how your personal history can impact your work with trauma survivors. Importantly, you will learn what it means to provide trauma-informed care, and why this approach is a multi-faceted one that you should consider for the individuals you serve. This training is designed for behavioral healthcare professionals who interact with individuals in a variety of behavioral healthcare settings, including those with basic to intermediate levels of experience with trauma.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning users	Daily
RL 014 REL-HHS-0-BH3 Overview of Psychiatric Medications for Children/Adolescents David Patzer, MD *Created: 06/19/17* *Last Modified: NA*	Over the past 20 years, there has been a significant increase in the frequency with which children and adolescents receive prescription medication to manage their behavioral and psychological symptoms. As a person who works with children and families who seek psychiatric help, it is important for you to know about the types of medications used, common side effects, and ways that these medications help those who take them. This course will teach you key information about how medications are used to treat children and adolescents who have psychiatric disorders.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 015 REL-HHS-0-MI-V2 Motivational Interviewing Christopher de Beer, LCSW, LCASA *Created: 8/17/18* *Last Modified: 11/3/18*	In this course, you will learn about the Motivational Interviewing approach to helping people discover their own desire and ability to make difficult changes. Motivational Interviewing (MI) is a way of communicating that draws out people's own thoughts and beliefs in order to help them resolve ambivalence about change. In addition to examining the underlying spirit of MI, you will learn specific skills and techniques that will support the MI processes of engaging, focusing, evoking, and planning with clients as they discover their own reasons for change. You will also learn about the varied settings in which MI is currently being practiced. Licensed clinicians in a helping profession will benefit from this course, whether it is used to learn about MI for the first time or to reinforce your knowledge of MI's important principles. The course uses a blend of instructive information and interactive exercises to help you understand and apply its core concepts.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 016 REL-HHS-0-OSUDPART1 Overview of Substance Use Disorders: Part 1 Dr. Steve Jenkins, PhD Naju Madra, MA *Created: 10/15/14* *Last Modified: 12/07/15*	As someone who works with individuals who have substance use disorders, you know how difficult it can be to understand why people continue to use drugs despite extremely adverse consequences. In Part 1 of this training, you will explore the process of substance use disorders and how they develop, as well as an understanding of why some individuals develop them while others do not. Throughout this course, you will learn about the stages of "addiction" and deepen your understanding of how "normal" behaviors can develop into dangerous ones. Drawing upon guidelines from the National Institutes of Health as well as the National Institute on Drug Abuse, this training offers you a comprehensive look at these sometimes-fatal disorders, including their effects on others. The material in this course is designed for	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
	paraprofessionals working with individuals who have substance use disorders. Detailed examples and interactive exercises will help you to apply these competencies in your own setting. After completing this training, you will be ready to demonstrate best practices for the individuals you serve who struggle with substance use disorders.					
RL 017 REL-HHS-0-OSUDPART2 Overview of Substance Use Disorders: Part 2 Dr. Steve Jenkins, PhD Naju Madra, MA *Created: 10/10/14* *Last Modified: 12/07/15*	In Part 1 of this course, you learned about how substance use disorders develop, as well as their various stages including when substance use becomes unhealthy and problematic. In this course, you will build upon that knowledge and explore in detail four commonly used drugs, which will help you to understand the short-term and long-term effects of substance use disorders, along with the symptoms of withdrawal. The material in this course is designed for paraprofessionals working with individuals who have substance use disorders. Drawing upon guidelines from the National Institutes of Health and the National Institute on Drug Abuse, Part 2 of this training offers you a more detailed look at specific substance use disorders, including their effects on others. Descriptive scenarios and practice exercises will help you to solidify your application of the knowledge you acquire to better apply these tools in your own setting. After completing Part 2 of this training, you will be better prepared to help the individuals you serve who struggle with substance use disorders.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 018 REL-HHS-0-WYSBP-V2 Strengths Based Approach in Working with At-Risk Youth Robin Whisnant, MS Naju Madra, M.A. *Created: 2/12/19* *Last Modified: 5/4/19*	Vulnerable youth have characteristics and experiences that put them at risk of developing problem behaviors and outcomes that have the potential to hurt their community, themselves, or both (Fernandes-Alcantara, 2018). This means that helping families understand the inner and external strengths that each family member holds could help them to better understand one another. In this course, you will learn how to help families identify the expert in their lives to help them begin to learn the parts of their emotional health that are in their control. You will discover the importance of your job as a professional who educates youth and their family on this perspective, helping them understand the tools available to them so they can further strengthen their family.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 019 REL-HHS-0-IPSUD-V2 The Impact of Parental Substance Use Disorders Stacy Agosto, MA, LCSW Naju Madra, MA Nellie Galindo, MSW, MSPH *Created: 07/06/18* *Last Modified: 09/01/18*	This course will provide insight and information about the ways in which children and families are affected by substance use disorders in the parents. You will explore the ways alcohol and drug use impact a person who is using, and how, as their use progresses, it impacts their ability to care for their children. You will understand how parental substance use affects children's neurobiological, emotional, and social development from pre-birth to adolescence. In addition, you will explore the family dynamics that can develop when one or both parents are abusing alcohol and drugs. Finally, you also will gain a basic understanding of the various treatment models for children living in these circumstances, as well as a basic understanding of treatment options for parents with substance use disorders. At the end of this course, you will have a better understanding of how to help families of children living with parents with substance use disorders.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 020 REL-HHS-0-OTSRD-V2 Traumatic Stress Disorders in Children and Adolescents Naju Madra, MA Bridgett Ross, PsyD *Created: 01/26/18* *Last Modified: 10/6/18*	Nearly 35 million children in the United States experience one or more traumatic events in their lives (National Survey of Children's Health, 2012). These events include abuse, natural disasters, and community violence that can lead to mental disorders. In this course, you will learn about the different mental disorders that often develop in children and adolescents who have been exposed to trauma. You also will gain a basic understanding of the most effective treatments for these disorders. With a blend of interactive exercises, this course offers a number of practical strategies that you can apply in working with children exposed to trauma and other stressors.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 021 REL-HHS-0-WPCES Working with Parents: Communication, Education, and Support Nikiyah Gill Anne Collins-Castillo, BA, BCaBA *Created: 03/26/15* *Last Modified: 09/10/18*	In this course, you will learn that working closely with families requires communicating effectively and building a respectful and trusting relationship. Focus will be on learning ways to communicate and support families even when you encounter resistance. It is important to understand your own personal biases and how these might affect your interactions with families. It is also helpful to identify why families may be resistant, and how to use specific techniques to communicate effectively and support the families of the young children you serve.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 022 REL-ALL-0-CDIV Cultural Competence Benjamin Reese, Jr., Psy.D. *Created: 12/28/18* *Last Modified: 2/2/19*	As workplaces become more diverse, effective and successful employees must become more knowledgeable of other cultural norms, be respectful of the wide range of cultural behaviors, and effectively communicate with people of various backgrounds. This course provides important information about becoming more respectful and culturally competent.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 024 REL-ALL-0-BOUND Boundaries Kevin Fawcett, Ph.D. *Created: 4/23/15* *Last Modified: 1/18/19*	As a working professional, you may find yourself in situations where you or the people you work with blur professional boundaries (a line in the working relationship between staff and persons who receive services from their organization). Some boundary violations can be dangerous for you and the people with whom you work. For this reason, it is important for you to be aware of these risks, avoid them, and know when to step back and ask a supervisor for help in managing the situation. This course focuses on exploring the concept of boundaries. You will learn about what to look for in order to avoid harmful issues and how to make sure your relationship remains professional. This course is appropriate for all working professionals.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 025 REL-HHS-0-AS-V3 Suicide in Adolescents and Transition Age Youth Monique Kahn, Psy.D. Kimberly Roaten, Ph.D., CRC *Created: 11/29/18* *Last Modified: 2/2/19*	In 2017, suicide was the second leading cause of death for young people ages 15-24. Rates of suicide among youth continue to increase, making it essential for mental health clinicians and other professionals working with adolescents to understand the dynamics of suicide among young people. After providing a foundation on how widespread the problem is and the prevailing theories about the drivers of suicidal behaviors, this course will teach you about how to effectively screen potentially suicidal youth and ways you can intervene to lower their risk. Working with suicidal youth can be anxiety-provoking even for experienced clinicians. However, it is important to bear in mind that **suicide is preventable**. With knowledge of risk factors and warning signs, along with tools you can use to effectively mitigate risk, you may be the critical factor standing between life and death for a vulnerable, at risk teen.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
RL 026 REL-HSS-0-GL Grief and Loss Steve Jenkins, Ph.D. *Created: 6/13/16* *Last Modified: 9/1/16*	As a health care provider, you are bound to encounter grief and grieving individuals on a fairly regular basis. Grieving the loss of a loved one is always unique to the individual who is experiencing the loss. Hence, there is no correct way to deal with loss, and no set amount of time that an individual is expected to grieve. How a person grieves is dependent upon many factors, including how the person dies. Loss of a loved one through a sudden, unexpected death is often dealt with very differently than a long, drawn out dying process through cancer or AIDS. Other factors that can affect the grieving process include, coping skills, the nature of the relationship to the person who died, spiritual or religious beliefs, a personal support system, psychological and physical health, culture, and financial resources. Depending upon the situation, the grieving process for some, although intensely difficult, can provide a sense of personal growth, or even relief. Others may experience a significantly extended grieving period. By understanding the grieving process, and how to best interact with grieving individuals, you can make this process as positive as possible for individuals dealing with loss.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily
RL 027 REL-HHS-0-PBSC Positive Behavior Support for Children Larry Lipsitz, M.Ed. *Created: 11/14/14* *Last Modified: 12/7/15*	The children you work with will come from different backgrounds and upbringings and might spend more time with you than they do with anyone else outside of their families. They might be from a broken home, or from a home that is nicer than your own. They might live with their birth parents, adoptive parents, grandparents, or in a foster home. Sadly, some children will have gone through several different "family" environments, sometimes forced to leave each, and typically for reasons completely out of their control. Regardless of their background, they all have at least one thing in common: they are now in the system you are a part of and have likely experienced some form of abuse (e.g., sexual, physical, or verbal). Do not	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

Course # and Title	Brief Course Syllabus	Funding Source	Audience	Style	Location	# of Offerings
	automatically assume the child's abuser was a family member; it could have been someone outside the family. Each child and each situation are different. Growing research has exhibited progressive findings that indicate success with positive behavioral supports. Positive behavioral supports deemphasize punishment, and instead focus on replacing challenging behaviors with more appropriate behaviors. You will use positive behavior supports to help the child understand that failures can provide opportunities for improvement and growth. Your goal is to teach the child valuable techniques that will help them live a positive life. Your job is not to be the expert – doctors and other specialists have already determined the child's medical and personal needs. Your job is to help make the child feel comfortable and safe. You, not experts, will get to know the child.					
RL 028 REL-HHS-0-AB-V2 Abuse and Neglect: What to Look for and How to Respond Naju Madra, M.A. Bridgett Ross, Psy.D. *Created: 3/12/18* *Last Modified: 6/2/18*	This course provides the most current and relevant information on child, elder, and dependent adult abuse, as well as intimate partner violence. You will learn about these various types of abuse as they relate to your role as a behavioral healthcare service worker. Upon completion of this course, you will be able to recognize the various signs of abuse among all these groups, as well as clearly understand your reporting responsibilities and procedures. Most importantly, you will have the key competencies you need to assist victims of violence and help others to avoid victimization. This course is designed for all Human Service personnel for entry level training or compliance reviews.	All Child Welfare	FL & FLS: B & I & A	RL	Access to Relias Learning Users	Daily

CONTRACT DECLARATIONS AND EXECUTION

Procurement Type/Number	Contract #
RFP #ACFS 20-006	ACFS 20-XXX

Title of Contract
Family-Centered Services

This Contract must be signed by all parties before the Contractor provides any Deliverables. The Agency is not obligated to make payment for any Deliverables provided by or on behalf of the Contractor before the Contract is signed by all parties. This Contract is entered into by the following parties:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Human Services 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Billing Contact Name / Address:** **Phone:**
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Mindy Norwood 1305 E. Walnut Street Des Moines, Iowa 50319-0114 **Phone:** (515) 281-4212 **E-Mail:** mnorwoo@dhs.state.ia.us	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Janee Harvey 1305 E. Walnut Street Des Moines, Iowa 50319-0114 Department of Human Services **E-Mail:** jharvey1@dhs.state.ia.us

Contractor: (hereafter "Contractor")	
Legal Name: **Doing Business As Name(s):**	**Contractor's Principal Address:**
Tax ID #:	**Organized under the laws of:** Iowa
Contractor's Contract Manager Name/Address ("Notice Address"): **Phone:** **E-Mail:**	**Contractor's Billing Contact Name/Address:** **Phone:**

Contract Information	
Start Date: 06/01/20	**End Date of Base Term of Contract:** 06/30/22
Possible Extension(s): The Agency shall have the option to extend this Contract up to 4 additional 1-year extensions.	
Contract Contingent on Approval of Another Agency: No	**ISPO Number:** ISPO-20-1
Contract Include Sharing SSA Data? No	

Contract Execution

This Contract consists of this Contract Declarations and Execution Section, the Special Terms, any Special Contract Attachments, the General Terms for Services Contracts, and the Contingent Terms for Service Contracts.

In consideration of the mutual covenants in this Contract and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into this Contract and have caused their duly authorized representatives to execute this Contract.

Contractor,	**Agency, Iowa Department of Human Services**
Signature of Authorized Representative:	Signature of Authorized Representative:
Printed Name:	Printed Name: Kelly Garcia
Title:	Title: Director
Date:	Date:

Iowa Code Chapter 8F

As a condition of entering into this Contract with the Agency, the Contractor certifies that: 1) it has the information required by Iowa Code Chapter 8F and referenced in Section 3.4, Certification Regarding Iowa Code Chapter 8F available for inspection by the Agency and the Iowa Legislative Services Agency; and 2) the Contractor is in full compliance with all laws, rules, regulations, and contractual agreements applicable to the Contractor and the requirements of Iowa Code Chapter 8F.

[Per Iowa Code § 8F.3 (2), certification shall be signed by: 1) An officer AND director; OR 2) Two directors; OR 3) The sole proprietor of the Contractor, whichever is applicable]

Contractor, by:	**Contractor, by:**
Signature of Authorized Representative:	Signature of Authorized Representative:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.

Special Contract Definitions applicable to this Contract are set forth in Special Contract Attachment A.

1.2 Contract Purpose.

Pursuant to this Contract, the Contractor will deliver Family-Centered Services (FCS) that align with the Family First Prevention Services Act (Family First), which was signed into law as part of the Bipartisan Budget Act on February 9, 2018.

FCS to be delivered under this Contract encompasses Solution Based Casework® (SBC), Family Team Decision-Making (FTDM) Meeting Facilitation, Youth Transition Decision-Making (YTDM) Meeting Facilitation, Child Safety Conference (CSC) Facilitation, SafeCare®, and Family Preservation Services.

1.3 Scope of Work.
1.3.1 Deliverables.

The Contractor shall provide services as directed by the Agency, including but not limited to the following:

1) **Transition and Implementation.**
   - **A.** The Contractor shall:
     - **a.** Hire staff in accordance with the staff qualifications as set forth in Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.
     - **b.** Train staff in accordance with the training obligation as set forth in Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.
     - **c.** Work directly with the SBC® model developer to arrange and secure training for staff to be trained no later than December 1, 2020.
     - **d.** Meet with the Agency as directed during the transition period to address transition of open Cases as set forth in Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.
2) **Operations.**
   - **A.** During Operations, the Contractor shall provide services as directed by the Agency, including, but not limited to, the following:
     - **a.** *Core Obligations*: The Contractor shall:
       - **i.** Comply at all times with the General Obligations as set forth in Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.
       - **ii.** Maintain accreditation at all times in accordance with their respective accrediting body.
       - **iii.** Comply at all times with the Agency approved documentation and reporting requirements as set forth in Special Contract Attachments B through F.
       - **iv.** Train new and ongoing staff in accordance with Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.
       - **v.** Comply at all times with any Program Improvement Plan as set forth in Special Contract Attachment B - Contractor Scope of Work Obligations for General Family-Centered Services Delivery.

b. *Service Delivery:* The Contractor shall:

i. Provide SBC® as directed by the Agency and in accordance with Special Contract Attachment C - Contractor Scope of Work Obligations for SBC®.

ii. Provide FTDM/YTDM Meeting Facilitation as directed by the Agency and in accordance with Special Contract Attachment D - Contractor Scope of Work Obligations for FTDM and YTDM Meeting Facilitation.

iii. Provide SafeCare® as directed by the Agency and in accordance with Special Contract Attachment E - Contractor Scope of Work Obligations for Provision of SafeCare®.

iv. Provide Family Preservation Services as directed by the Agency and in accordance with Special Contract Attachment F - Contractor Scope of Work Obligations for Family Preservation Services and CSC Facilitation.

1.3.2 Performance Measures.

Performance measures and targets are included as a part of this Contract and used to assess performance of the Contractor. The performance measures and targets included are the minimum performance requirements. The Agency reserves the right to modify performance measures if the Agency determines that modification of performance measures is necessary to effectively assess and/or promote accomplishment of goals under this Contract.

1.3.2.1 SBC® on Agency Child Welfare Service Cases and Non-Agency Cases

A. Performance Measure 1: Children served by the Contractor are safe from abuse for 12 consecutive months following the conclusion of their Case. The target is to achieve 90% on all Cases served to receive payment.

B. Performance Measure 2: Children served by the Contractor are safely maintained in their own homes or with Kin/Fictive Kin Caregivers during the Case. The target is to achieve 90% on all Cases served to receive payment.

C. Performance Measure 3: Children served by the Contractor who are reunified or exit foster care do not experience reentry into care within 12 consecutive months of their reunification date. The target is to achieve 90% on all Cases served to receive payment.

1.3.2.2 SafeCare® on Agency Child Welfare Service Cases

A. Performance Measure 1: 65% of parents in Contractor's Cases receiving SafeCare® will complete and graduate from all three modules.

B. Performance Measure 2: 85% of parents in Contractor's Cases receiving SafeCare® will complete the parent-Child/parent-infant interactions module.

1.3.2.3 Family Preservation Services on Agency Child Welfare Service Cases

A. Performance Measure 1: Children served by the Contractor during a CPS Child Abuse Assessment will not be removed from their homes and placed in foster care during provision of Family Preservation Services and for three months following the end date of this service. The target is to achieve 90% on all Cases served to receive payment.

B. Performance Measure 2: 80% of Children served by the Contractor during the CPS Child Abuse Assessment will not suffer maltreatment during provision of Family Preservation Services and for three months following the end date of this service.

1.3.3 Agency Responsibilities.

The Agency will:

- **A.** Provide recommendations for Motivational Interviewing (MI) training resources to Contractor staff and any subcontractor staff.
- **B.** Meet with Contractor to transition existing Cases from prior contracts to this Contract.
- **C.** Refer Cases to Contractor to provide FCS as needed.
- **D.** Participate in a Case transition meeting (handoff) with the assigned FSS.

1.3.4 Monitoring, Review, and Problem Reporting.

1.3.4.1 Agency Monitoring Clause. The Contract Manager or designee will:

- Verify Invoices and supporting documentation itemizing work performed prior to payment;
- Determine compliance with general contract terms, conditions, and requirements; and
- Assess compliance with Deliverables, performance measures, or other associated requirements based on the following:

The Agency will assign a Service Contract Specialist to the Contract. The Service Contract Specialist, or designee, will be responsible for the following contract management responsibilities:

- **A.** Responding to day-to-day questions from the Contractor.
- **B.** Resolving Contract issues and disputes between the Agency and the Contractor to the extent possible.
- **C.** Monitoring the Agency's data on a monthly basis regarding any incentive payments the Contractor is eligible to obtain.
- **D.** Conducting onsite reviews of Contractor records, including the records of subcontractors as necessary, to validate the Contractor's monthly service reporting and compliance with the service requirements. The Agency reserves the right to set the frequency of onsite reviews.
    - **a.** For SBC®, the Service Contract Specialist will read a minimum of 10 randomly selected records on open Agency Child Welfare Service Cases and a minimum of 3 randomly selected records on Non-Agency Cases for a total of 13 records quarterly. The records will be selected through a random sampling methodology to be reviewed as part of the Contractor's Quality Assurance review. If there is a significant error rate observed of more than 10%, the Agency reserves the right to increase the sample size.
        - **i.** If the randomly selected SBC records also include provision of SafeCare® and/or Family Preservation Services, the Service Contract Specialist will read for these service requirements as well.
- **E.** Monitoring Program Improvement Plans (PIP) that the Contractor is required to develop to improve their performance in meeting the service requirements.
- **F.** Reviewing data regarding Contractor performance to make a recommendation to the Contract Manager and Contract Owner regarding contract renewal and any necessary contract amendments.
- **G.** Developing a quarterly Contract Compliance Review Report for review by the Contract Owner and Service Area Manager. At a minimum, the report will summarize information on SBC®, SafeCare®, and Family Preservation Services.
- **H.** Conducting onsite reviews of the Contractor's overall Quality Assurance system to validate that the Contractor is implementing a Quality Assurance system as described in their proposal.

a. Quality Assurance reviews by the Service Contract Specialist will occur periodically throughout the contract period. The first review will take place within the first nine (9) months of the Contract. Further review, as needed, will ensure that the Service Contract Specialist maintains an understanding of the Contractor's Quality Assurance processes. During the subsequent reviews, the Service Contract Specialist will review 10 staff files including newly hired staff and on-going staff, and five subcontractor staff if there are any subcontractors, to check on the compliance with records checks and qualifications. Based on Service Contract Specialist's or Contractor's preference, these reviews may be scheduled prior to or concurrent with the Contract Compliance Review.

1.3.4.2 Agency Review Clause. The Contract Manager or designee will use the results of monitoring activities and other relevant data to assess the Contractor's overall performance and compliance with the Contract. At a minimum, the Agency will conduct a review quarterly; however, reviews may occur more frequently at the Agency's discretion. As part of the review(s), the Agency may require the Contractor to provide additional data, may perform on-site reviews, and may consider information from other sources.

The Agency may require one or more meetings to discuss the outcome of a review. Meetings may be held in person. During the review meetings, the parties will discuss the Deliverables that have been provided or are in process under this Contract, achievement of the performance measures, and any concerns identified through the Agency's contract monitoring activities.

1.3.4.3 Problem Reporting. As stipulated by the Agency, the Contractor and/or Agency shall provide a report listing any problem or concern encountered. Records of such reports and other related communications issued in writing during the course of Contract performance shall be maintained by the parties. At the next scheduled meeting after a problem has been identified in writing, the party responsible for resolving the problem shall provide a report setting forth activities taken or to be taken to resolve the problem together with the anticipated completion dates of such activities. Any party may recommend alternative courses of action or changes that will facilitate problem resolution. The Contract Owner has final authority to approve problem-resolution activities.

The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

1.3.4.4 Addressing Deficiencies. To the extent that Deficiencies are identified in the Contractor's performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a PIP acceptable to the Agency to resolve the Deficiencies. See Special Contract Attachment B.

The Agency reserves the right to impose a PIP under this Contract based on Contractor's performance under any predecessor Contract.

1.3.5 Contract Payment Clause.
1.3.5.1 Pricing. In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Contractor will be compensated as follows:

Payment is contingent on the Contractor accepting each Case on a No Reject, No Eject basis, providing services in accordance with the provisions of this Contract, achieving the Contract performance targets, and submitting Invoices for each month of the Contract.

1.3.5.1.1 Start-Up Funding. If approved by the Agency, the Contractor may Invoice the Agency a maximum of $100,000 in start-up funding for training and implementation of approved EBIs specified under this Contract. Start-up funding is only available within 60 days of the initial Contract start date and will not be available during renewal periods. A detailed budget for start-up activities is required for this payment to be considered.

1.3.5.1.2 Billable Unit of Service and Payments for SBC®

The Contractor may Invoice the Agency in the month following the month of service in an amount of **$705.00** per Case for each full month of SBC® on open Agency Child Welfare Service Cases or an amount of **$501.00** per Case for each full month of SBC® on Non-Agency Cases. The service start date begins on the date of the Agency referral, which is the effective date of the 3055.

Payment for services for partial calendar months will be prorated, using a daily rate calculated based on a 30-day month, based on the number of days of services approved during the month. Payments will be made for both the beginning and ending days of service. The prorated daily amount will equal the monthly rate divided by thirty days.

1.3.5.1.3 Billable Unit of Service and Payments for SafeCare®

The Contractor may Invoice the Agency in the month following the month of service in an amount of **$300.00** per Case for each full month of SafeCare® on open Agency Child Welfare Service Cases receiving this additional service.

Payment for services for partial calendar months will be prorated, using a daily rate calculated based on a 30-day month, based on the number of days of services approved during the month. Payments will be made for both the beginning and ending days of service. The prorated daily amount will equal the monthly rate divided by thirty days.

1.3.5.1.4 Billable Unit of Service and Payments for Family Preservation Services

The Agency purchases Family Preservation Services using the following unit of service methodology:

A. One unit of service (10 calendar days) with a defined unit rate. The Agency Worker may purchase a unit of service as needed to provide Family Preservation Services for a Case, with the option of purchasing up to two additional units of service if the Agency Worker determines that safety concerns continue in a Case after the first unit of service. The unit of service begins with the date of referral.

B. The Contractor may Invoice the Agency following the unit of service in an amount of $**475.00** for each unit of service.

1.3.5.1.5 Incentive Payments

The Contractor may receive a performance-based payment for achieving targets for each applicable performance measure included in the Contract in addition to the monthly base or unit rate. Performance-based pay is contingent on performance results achieved and are paid out after review of the performance.

Incentive payments are only payable on Cases that are closed at the end of the service period and are not payable on Cases that are reopened or transferred within 30 days of the end of the Contract service period.

1.3.5.1.5.1 The Contractor may submit monthly Invoices for performance incentive payments after the Agency Service Contract Specialist or Contract Manager reviews system reports and approves the amount specified on the Invoice.

SBC® on Agency Child Welfare Service Cases and Non-Agency involved Cases

A. **Performance Measure 1**- Performance-based payments made in the amount of $250 per Case if achieved. Eligibility to receive payment for this performance measure begins 12 months after Case closure.
B. **Performance Measure 2** - Performance-based payments made in the amount of $200 per Case if achieved. Eligibility to receive payment for this performance measure begins after Case closure.
C. **Performance Measure 3** - Performance-based payments made in the amount of $150 per Case if achieved. Eligibility to receive payment for this performance measure begins within 12 months of the reunification date.

Family Preservation Services on Agency Child Welfare Service Cases

A. **Performance Measure 1 -** Performance-based payments made in the amount of $300 per Case if achieved. Eligibility to receive payment for this performance measure begins three months after completion of Family Preservation Services.

1.3.5.1.6 If approved by the Agency, the Contractor may Invoice the Agency a maximum of $9,000 annually per Service Area Contract for licensing fees associated with SBC®.

1.3.5.1.7 If approved by the Agency, the Contractor may Invoice the Agency a maximum of $1,000 annually for accreditation fees associated with SafeCare®.

1.3.5.1.7.1 If approved by the Agency, the Contractor may Invoice the Agency a maximum of $1,000 annually per trainer per Contractor for trainer recertification fees associated with SafeCare®.

1.3.5.2 Reserved. (*Payment Methodology*)

1.3.5.3 Timeframes for Regular Submission of Initial and Adjusted Invoices. The Contractor shall submit an Invoice for services rendered in accordance with this Contract. Invoice(s) shall be submitted monthly. Unless a longer timeframe is provided by federal law, and in the absence of the express written consent of the Agency, all Invoices shall be submitted within six months from the last day of the month in which the services were rendered. All adjustments made to Invoices shall be submitted to the Agency within ninety (90) days from the date of the Invoice being adjusted. Invoices shall comply with all applicable rules concerning payment of such claims.

1.3.5.4 Submission of Invoices at the End of State Fiscal Year. Notwithstanding the timeframes above, and absent (1) longer timeframes established in federal law or (2) the express written consent of the Agency, the Contractor shall submit all Invoices to the Agency for payment by August 1st for all services performed in the preceding state fiscal year (the State fiscal year ends June 30).

1.3.5.5 Payment of Invoices. The Agency shall verify the Contractor's performance of the Deliverables and timeliness of Invoices before making payment. The Agency will not pay Invoices that are not considered timely as defined in this Contract. If the Contractor wishes for untimely Invoice(s) to be considered for payment, the Contractor may submit the Invoice(s) in accordance with instructions for the Long Appeal Board Process to the State Appeal Board for consideration. Instructions for this process may be found at: http://www.dom.state.ia.us/appeals/general_claims.html.

The Agency shall pay all approved Invoices in arrears and in conformance with Iowa Code 8A.514. The Agency may pay in less than sixty (60) days, but an election to pay in less than sixty (60) days shall not act as an implied waiver of Iowa law.

1.3.5.6 Reimbursable Expenses. Unless otherwise agreed to by the parties in an amendment to the Contract that is executed by the parties, the Contractor shall not be entitled to receive any other payment or compensation from the State for any Deliverables provided by or on behalf of the Contractor pursuant to this Contract. The Contractor shall be solely responsible for paying all costs, expenses, and charges it incurs in connection with its performance under this Contract.

1.4 Insurance Coverage.
The Contractor and any subcontractor shall obtain the following types of insurance for at least the minimum amounts listed below:

Type of Insurance	**Limit**	**Amount**
General Liability (including contractual liability) written on occurrence basis	General Aggregate Product/Completed Operations Aggregate Personal Injury Each Occurrence	$2 Million $1 Million $1 Million $1 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	$1 Million
Excess Liability, Umbrella Form	Each Occurrence Aggregate	$1 Million $1 Million
Workers' Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law
Property Damage	Each Occurrence Aggregate	$1 Million $1 Million
Professional Liability	Each Occurrence Aggregate	$2 Million $2 Million

1.5 Data and Security. If this Contract involves Confidential Information, the following terms apply:

1.5.1 Data and Security System Framework. The Contractor shall comply with either of the following:

- Provide certification of compliance with a minimum of one of the following security frameworks, if the Contractor is storing Confidential Information electronically: NIST SP 800-53, HITRUST version 9, SOC 2, COBIT 5, CSA STAR Level 2 or greater, ISO 27001 or PCI-DSS version 3.2 prior to implementation of the system and again when the certification(s) expire, or
- Provide attestation of a passed information security Risk assessment, passed network penetration scans, and passed web application scans (when applicable) prior to implementation of the system and again annually thereafter. For purposes of this section, "passed" means no unresolved high or critical findings.

1.5.2 Vendor Security Questionnaire. If not previously provided to the Agency through a procurement process specifically related to this Contract, the Contractor shall provide a fully completed copy of the Agency's Vendor Security Questionnaire (VSQ).

1.5.3 Cloud Services. If using cloud services to store Agency Information, the Contractor shall comply with either of the following:

- Provide written designation of FedRAMP authorization with impact level moderate prior to implementation of the system, or
- Provide certification of compliance with a minimum of one of the following security frameworks: HITRUST version 9, SOC 2, COBIT 5, CSA STAR Level 2 or greater or PCI-DSS version 3.2 prior to implementation of the system and again when the certification(s) expire.

1.5.4 Addressing Concerns. The Contractor shall timely resolve any outstanding concerns identified by the Agency regarding the Contractor's submissions required in this section.

1.6* Reserved. *(Labor Standards Provisions.)
1.7* Reserved. *(Performance Security.)

1.8 Incorporation of General and Contingent Terms.
1.8.1 General Terms for Service Contracts ("Section 2"). The version of the General Terms for Services Contracts Section posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference. The General Terms for Service Contracts may be referred to as Section 2.

The contract warranty period (hereafter "Warranty Period") referenced within the General Terms for Services Contracts is as follows: The term of this Contract, including any extensions.

1.8.2 Contingent Terms for Service Contracts ("Section 3"). The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference. The Contingent Terms for Service Contracts may be referred to as Section 3.

All of the terms set forth in the Contingent Terms for Service Contracts apply to this Contract unless indicated otherwise in the table below:

<table>
<tr><td>Contractor a Business Associate? Yes</td><td>Contractor a Qualified Service Organization? Yes</td></tr>
<tr><td>Contractor subject to Iowa Code Chapter 8F? Yes</td><td>Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)? No</td></tr>
<tr><td colspan="2">Contract Payments include Federal Funds? Yes
The Contractor for federal reporting purposes under this Contract is a: Subrecipient
Federal Funds Include Food and Nutrition Service (FNS) funds? No
DUNS #:
The Name of the Pass-Through Entity: Iowa Department of Human Services</td></tr>
<tr><td>CFDA #: 93.558
Grant Name: Temporary Assistance for Needy Families</td><td>Federal Awarding Agency Name: Department of Health and Human Services/Administration for Children and Families</td></tr>
</table>

SPECIAL CONTRACT ATTACHMENTS

Special Contract Attachment A – Special Terms Definitions
Special Contract Attachment B – General Scope
Special Contract Attachment C – Solution Based Casework
Special Contract Attachment D – FTDM/YTDM Meeting Facilitation
Special Contract Attachment E – SafeCare
Special Contract Attachment F – Family Preservation Services

Attachment A
Special Terms Definitions

"Agency Child Welfare Service Case" means at least one Child in a Household is involved in Agency services with an Agency assigned social work case manager.

"Agency Worker" means the Agency Child welfare worker that has been assigned responsibility for a Child and Family's Case, either to perform a CPS Child Abuse Assessment, CPS Family Assessment, or CPS CINA Assessment or assume Case management responsibility for ongoing Agency Child Welfare Service Cases.

"Business Day" means any day other than a Saturday, Sunday, or State holiday as specified by Iowa Code § 1C.2.

"Case" means the following:

For SBC®, "Case" means:

- the Children who are victims of abuse and meet the Agency's criteria for opening ongoing services, or Children who are subject to a court order based on Child in Need of Assistance (CINA) proceedings; and
- any whole, half, or step siblings of these Children who reside in the same Household at the time of service referral or move into the Household during the service delivery period, or are in placement under the care and supervision of the Agency; and
- the parents, stepparents, adoptive parents, or Kin/Fictive Kin Caregivers of the Children.

For SafeCare®, "Case" means

- the parents and Children ages zero to five in at-Risk Families.

For Family Preservation Services, "Case" means:

- intact Families or Kin/Fictive Kin Caregivers who have Children at Imminent Risk of Removal and placement in foster care as assessed by the Agency Worker and completion of the Agency Family Risk assessment.

"Casework Contact" means contact such as SafeCare® or other necessary Family supportive activities. A Casework Contact shall, at a minimum, be 45 minutes in length and include interventions and assessment of parent/Child interactions for danger and Risk.

"CHEA" means Council for Higher Education Accreditation.

"Child", "Children," or "Youth" means a person or persons who meets the definition of a Child in Iowa Code § 234.1(2).

"Child Abuse" means one or more of the categories of Child Abuse defined in Iowa Code § 232.68.

"Child Abuse Assessment" means an assessment process by which the Agency responds to all accepted reports of Child abuse which allege Child Abuse as defined in Iowa Code section 232.68(2) *"a"* (1) through (3) and (5) through (10); or which allege Child Abuse as defined in Iowa Code section 232.68(2) *"a"* (4) that also allege imminent danger, death, or injury to a Child. A Child Abuse Assessment results in a disposition and a determination of whether a Case meets the definition of Child Abuse and a determination of whether criteria for placement on the registry are met.

"Child's Home Of Origin" means the primary Household from which the Child was residing prior to Removal (i.e. parents, caretaker, and guardian).

"Child in Need of Assistance (CINA)" means a Child adjudicated by juvenile court to be a Child in Need of Assistance pursuant to Iowa Code § 232.2.

"Child Protective Services (CPS) Child Abuse Assessment Summary" means the report form completed by the Agency Worker that documents information obtained during the Child Abuse Assessment process.

"Child Protective Services (CPS) CINA Assessment Summary" means the report form completed by the Agency Worker that documents information obtained during the CINA Assessment process.

"Child Protective Services (CPS) Family Assessment Summary" means the report completed by the Agency's Child Protective Worker that documents information obtained during the Family Assessment process.

"Child Safety Conferences" or "CSC" means a conference facilitated for Children at Imminent Risk of Removal and placement in foster care. CSCs are held within three Business Days from the date of referral and again 10 calendar days from the date of the initial CSC, unless this date falls on a Saturday, Sunday, or State holiday.

"Child Vulnerability" means the degree that a Child cannot on the Child's own avoid, negate, or minimize the impact of Present or Impending Danger.

"Combined Cost Report" means a report that allows the Agency to determine allowable costs for each service across various Agency programs.

"Contractor(s)" means the organization that has executed a Contract with the Agency to provide Family-Centered Services. This term refers to the organization that is named as the responsible party in the Contract and whose authorized representative has signed the Contract.

"Contract Manager" means the Agency person or persons accountable to the Contract Owner, acting under the direction and guidance of the Contract Owner for a specific RFP and Contract.

"Contract Owner" means the Agency administrative official who has the authority to make decisions related to the Contract on behalf of the Agency.

"Crisis Intervention Response" means activities and interventions undertaken by a Contractor, or their subcontractors, to respond, both during and after normal business hours, to crisis situations, as defined by the Family, Agency Worker, or Contractor, that present significant threats to the safety, Permanency, or well-being of a Child(ren) in Cases for which the Contractor is responsible.

"Cultural Competence/Responsiveness" means the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, Families, tribes, and communities, and protects and preserves the dignity of each.

"Evidence-Based Interventions" or "EBIs" means practices or programs that have peer-reviewed, documented empirical evidence of effectiveness. EBIs use a continuum of integrated policies, strategies, activities, and services whose effectiveness has been proven or informed by research and evaluation.

"Face-to-Face Contact" or "F-F" means in person or by videoconferencing. Videoconferencing will be on a limited basis in appropriate circumstances with prior Agency approval.

"Family" or "Families" means the person or persons comprising the Household where the alleged victim of Child Abuse resides.

"Family Assessment" means an Assessment process by which the Agency responds to all accepted reports of Child Abuse that allege Child Abuse as defined in Iowa Code section 232.68(2)"a"(4), but do not allege imminent danger, death, or injury to a Child. A Family Assessment does not include a determination of whether a Case meets the definition of Child Abuse and does not include a determination of whether criteria for placement on the registry are met.

"Family Support Specialist" or "FSS" means the individual primarily responsible for Case management support, which is provided using the Solution-Based Casework (SBC) practice model. The FSS is responsible for providing general service delivery, Family Preservation Services, and Motivational Interviewing.

"Facilitator" means an approved person who organizes, prepares for, conducts, and reports on all activities involved in a Family Team and/or Youth Transition Decision-Making Meeting.

"Family Case Plan" means the official record of the Agency's involvement with the Family.

"Family-Centered Services" or "FCS" means the services and supports provided under this Contract.

"Family Interaction" means the philosophy to maintain relationships with siblings, parents, Family, and other individuals and to reduce the sense of abandonment and loss that Children experience at placement.

"Family Interaction Plan" means the plan guiding Family Interactions that encourages progressive increase in a parent's responsibility and premised on Case goals and on an assessment of a Family functioning and safety concerns for the Children.

"Family Team Decision-Making (FTDM)" means both a philosophy and a practice strategy for delivering Child Welfare Services.

"Family Team Decision-Making (FTDM) Family Plan" means a collaborative plan between the Family system and the Child welfare system developed with the Family during a FTDM Meeting that identifies the strategies and agreements made during the FTDM Meeting.

"Family Team Decision-Making (FTDM) Meeting" means a gathering of Family members and extended Family, friends, the Agency Case manager, Contractor Family Support Specialist (FSS), Contractor Intervention Specialist (IS), service providers, community professionals, and other interested people who, with the assistance of a FTDM Meeting Facilitator who meets the Agency's Facilitator standards, plan to enhance the safety,

Permanency, and well-being of Children and Family through development and review of an individualized Family Case Plan.

"Fictive Kin" means an individual who is unrelated by either birth or marriage but who has an emotionally significant relationship with another individual who would take on the characteristics of a Family relationship.

"Household" means parents and their Children living in the same residence with at least one of the Children being the subject of a Child Abuse Assessment, Family Assessment, or CINA Assessment.

"Immediate Threat" means conditions that, if no response were made, would be more likely than not to result in sexual abuse, injury, or death to a Child. (Iowa Administrative Code 441 IAC-175.21)

"Impending Danger" means a foreseeable state of danger in which Family behaviors, attitudes, motives, emotions, or the Child's physical environment poses a threat of maltreatment.

"In-Home" means residing in one's home.

"Intervention Specialist" or "IS" means an individual responsible for providing Evidence Based Interventions.

"Kin" means one's Family and relations.

"Kinship Caregiver" means relative (e.g. grandparent, sibling, etc.) and Fictive Kin (e.g. godparents, close Family friends, etc.) providing care for a Child.

"Non-Agency Case" means nobody in the Household is involved with an Agency assigned social work Case manager. Case management and decision making responsibility is assigned to the Contractor.

"No Reject, No Eject" means that the Contractor shall accept and serve all Cases referred to FCS by the Agency.

"Out-of-Home Care" means that the Agency has placement and care responsibility of the Child.

"Permanency" means a Child has a safe, stable custodial environment in which to grow up, a life-long relationship with a nurturing caregiver, and is able to explore and retain significant connections to Family members to the greatest extent possible.

"Practice Standards" means a document that includes expectations around core service delivery requirements under the FCS Contract.

"Protective Capacities" means Family strengths or resources that reduce, control, and/or prevent Threats of Maltreatment.

"Quality Assurance" means the procedures established and activities undertaken by Contractor for FCS to ensure that service is delivered in accordance with requirements established by the Agency and to improve the quality of services to achieve safety, Permanency, and well-being.

"Referral and Authorization for Child Welfare Services, Form #470-3055" or "3055" means the authorization for service provision.

"Removal" means the placement of a Child from the setting in which they were living by order of the Court or Voluntary Placement Agreement.

"Risk" means the probability or likelihood that a Child in the future will experience maltreatment.

"SafeCare®" means an evidence-based training curriculum for parents who are at-Risk or have been reported for Child maltreatment. Parents receive weekly home visits to improve skills in several areas, including home safety, health care, and parent-Child interaction.

"Safety Constructs" means elements to explore in assessing safety that include Threats of Maltreatment, Child Vulnerability, and caretaker's Protective Capacities.

"Service Area" means the 99 counties grouped together by the Agency to provide for improved, localized administration of programs.

"Service Area Manager" or "SAM" means the Agency official responsible for managing the Agency's programs, operations, and Child welfare budget within one of the Agency Service Areas.

"Service Contract Specialist" means the Agency worker assigned to provide review and oversight for an Agency Contract with a Contractor.

"**Solution Based Casework®**" or "**SBC**" means an evidence-based Family centered model of Child welfare assessment, Case planning, and ongoing Casework. The goal is to work in partnership with the Family to help identify their strengths, focus on everyday life events, and help them build the skills necessary to manage situations that are difficult for them.

"Staffing Report" means a report that outlines costs associated with the number and positions of personnel providing services under this Contract, including salaries and other direct costs.

"Support Worker" means the person assigned by the Contractor to provide assistance and support to the Family Support Specialist providing FCS to achieve identified family goals for safety, Permanency, and well-being as specified in the service plan. The Support Worker may provide assistance by scheduling appointments and meetings, providing transportation assistance, supervising Family Interactions and sibling interactions, escorting parents and adults in the Case, advocating for Children and Families, and conduct telephone contacts with parents and adults in the Case. The Support Worker shall not be involved with Children/Youth or solely responsible for Family contact within the first 30 days of service delivery.

"Threats of Maltreatment" means the aggravating factors that combine to produce a potentially dangerous situation.

"Youth Transition Decision-Making (YTDM) Meeting" means a Youth-centered practice model and teaming approach that follows standards similar to that of FTDM Meetings and is offered to Youth 16 years of age and older. This model has two key components: Engagement/Stabilization and the Dream Path process to promote self-sufficiency and to empower Youth to take control of their lives and dreams. Supportive adults and peers create a team to help the Youth make connections to resources, education, employment, health care, housing and supportive personal and community relationships.

"**Youth Transition Decision-Making (YTDM) Meeting Dream Path**" means a Youth-friendly collaborative plan completed for all YTDM Meetings covering the five Fostering Connections categories. The main focus is accomplishing steps toward achieving the Youth's goals for age 18 and older.

"Youth Transition Decision-Making (YTDM) Meeting Youth Plan" means a collaborative plan between the Youth and the Child welfare system developed with the Youth during a YTDM Meeting. The plan states the strategies and agreements made during the YTDM Meeting.

Attachment B
Contractor Scope of Work Obligations for General Family-Centered Services Delivery

General Obligations for Provision of FCS Delivery.
The Contractor shall:

- **A.** Participate in a Case transition process for existing Agency Child Welfare Service Cases transitioning over July 1, 2020, under this Contract. Assignment of Cases is based on Family need as well as the Contractor capability to provide the service.
- **B.** Participate in Face-to-Face Case transition meetings with Agency staff in June 2020 on all Cases transferring to the Contractor.
- **C.** Work in collaboration with the Agency to develop Practice Standards to be utilized under this Contract.
- **D.** Assess Child safety throughout provision of FCS by identifying, documenting, and reporting the three elements of Safety Constructs: Threats of Maltreatment, Child Vulnerability, and caretaker's Protective Capacities.
- **E.** Provide FCS to all Families referred by the Agency on a No Reject, No Eject basis in rural and urban areas throughout the Service Area.
    - **a.** If a Family should move from one Service Area to another Service Area during FCS and juvenile court has jurisdiction in that Service Area, the current Contractor shall be responsible for providing services to the Children and Family regardless of where the Family moves in Iowa until the Court jurisdiction changes. The Contractor shall deliver services in other Service Areas of Iowa either directly or through subcontracts with other organizations. Once Court jurisdiction changes, the Case will close and a new Case will open in the new Service Area.
    - **b.** If there is no juvenile court jurisdiction, the Case will close in that Service Area and a new Case will open in the new Service Area. If the current Contractor has a Contract in the Service Area where the Family moved, the Case will be assigned to that Contractor. If the current Contractor does not have a Contract in the Service Area, the Case will be assigned based on Family need as well as Contractor capability to provide the service unless there is only one Contractor.
    - **c.** Use encrypted email in any correspondence containing Family information.
- **F.** Participate in Service Area and/or state level meetings, to be held at least quarterly, with the Service Area Manager (SAM) or their designees, and other Agency staff upon Agency request to review and resolve any service delivery issues.
- **G.** Participate in service implementation training with Agency staff beginning in June 2020 and in the service transition process so that most existing Cases can be transitioned to Contractors for delivery of the services as of July 1, 2020.
- **H.** Provide transportation assistance, either directly or by providing funding for transportation supports, or arranging transportation through a community resource or through the Family's support network when necessary for the Family to access services and/or supports, attend interactions, and participate in other activities identified as essential needs stated in the Agency Safety Plan or Agency Case Plan.
- **I.** Develop a training plan and tailor such plan to the needs of workers and target populations for the services and submit to the Agency for review within 30 days after the contract start date. A final training plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within 30 days after the first submission of the plan. The Contractor shall execute, adhere to, and provide training set forth in the Agency-approved training plan. The Contractor shall resubmit updated training plans to the Agency whenever changes are made. The training plan shall include initial and ongoing training provided for all Contractor or subcontractor staff on Children and Family identified needs, including but not limited to:
    - **a.** Domestic Violence,
    - **b.** Mental health,
    - **c.** Substance use/abuse,
    - **d.** Cultural responsiveness, and
    - **e.** Trauma informed care.

Staff Qualifications.
The Contractor shall:

- **A.** Adhere to the following minimum staff qualifications for all Contractor, or subcontractor staff providing FCS:
  - **a.** Any Contractor or subcontractor staff delivering a service intervention for which a professional licensure is required by state statutes shall possess the current appropriate professional licensure.
  - **b.** The FSS shall possess a bachelor degree or master's degree from an accredited four year college recognized by the Council for Higher Education Accreditation (CHEA); or an associate of arts degree in human services or related field from an accredited college or university plus the equivalent of two years of full time experience in human services or related field.
    - **i.** The FSS providing SBC® shall be trained and certified in SBC or working towards training and certification.
      - **1.** The FSS shall not have more than 14 Families assigned to their caseload at one time.
    - **ii.** The FSS providing Family Preservation Services shall be trained and certified in Motivational Interviewing or working towards training and certification.
      - **1.** The FSS shall not have more than four Families assigned for this service to their caseload at one time.
  - **c.** The IS shall meet requirements in accordance with model fidelity for the EBI utilized and by which they are trained.
    - **i.** The IS providing SafeCare® shall be trained and certified or working toward certification.
      - **1.** The IS shall not have more than 15 Families assigned to their caseload at one time.
  - **d.** The FSS and the IS assigned to the same Case shall work collaboratively as a team and provide necessary interventions and/or supports to address Family needs.
  - **e.** The Support Worker shall possess a high school degree with minimum of one year of full time experience in human services; or an associate of arts degree in human services or related field from an accredited college or university with a minimum of six months of full time experience in human services; or a bachelor degree in human services or a related field from an accredited four year college recognized by the Council for Higher Education Accreditation (CHEA).
- **B.** Conduct, at their own expense, criminal, Child and dependent adult abuse, and sex offender record checks in the state of Iowa on all of Contractor and subcontractor staff who will have contact with Children and Families served under this Contract prior to their delivery of services as well as periodically, at a minimum annually throughout employment. The Contractor shall maintain copies of these record checks in the personnel file and make them available for review as requested by the Agency. The Contractor shall check the program exclusion status of individuals and entities prior to entering into and continuing employment or contractual relationships. In order to do this, the Contractor shall check the System for Award Management (SAM) and HHS - Office of Inspector General (OIG) by name of each individual or entity for their exclusion status before the Contractor hires or enters into any contractual relationship with the person or entity. The Contractor will, at a minimum annually, check the website for exclusions for the employees and subcontractors involved with this Contract. These checks cannot be more than 12 months apart year to year. SAM is the official U.S. Government system that consolidated the capabilities of CCR/Fed Reg, ORCA, and EPLS. The website is: https://www.sam.gov/portal/public/SAM/. The website for the Office of Inspector General is: http://exclusions.oig.hhs.gov/
- **C.** Establish, maintain, and adhere to a record check evaluation process that ensures the Contractor is in compliance with the following requirements:
  - **a.** Persons listed on the sex offender registry shall not work with Children and Families.
  - **b.** Persons who have been convicted of a felony offense as specified in Iowa Code § 237.8(2) that precludes their licensure as a foster parent shall not be employed by the Contractor, or any of

their subcontractors, to work with Children and/or Families. These felony offenses are as follows:

- **i.** Drug-related offenses within the five-year period preceding their employment;
- **ii.** Child endangerment or neglect or abandonment of a dependent person;
- **iii.** Domestic abuse;
- **iv.** Crimes against a Children, including but not limited to sexual exploitation of a minor; or
- **v.** A forcible felony.

D. Implement, maintain, and adhere to a procedure to be used by the Contractor and subcontractors to conduct record check evaluations and make hiring decisions for persons who have founded Child Abuse records or have criminal convictions that do not automatically prohibit them from employment under B. above. These procedures shall include a description of how the Contractor and subcontractors will evaluate the types of Child Abuse or criminal offenses potential staff may have committed and how they will monitor and supervise persons they employ with any Child Abuse or criminal histories. The Contractor shall provide documentation of this procedure to the Agency.

Iowa statutes allow for persons with founded Child Abuse reports or criminal convictions to be considered for employment in Child serving settings when the nature of their offenses does not preclude them from work in these capacities as defined in B, above.

Quality Assurance and Improvement Reporting.
The Contractor shall:

A. Have an established Quality Assurance and Improvement System for tracking and evaluating the effectiveness of service delivery under this Contract.

B. Have a Quality Assurance and Improvement System that prepares and submits Monthly Service Performance Summary Reports to their Agency Service Contract Specialist that describe the aggregate performance of the Contractor in meeting key service requirements for all Cases in which they provided FCS during each month.

C. Use the Agency-developed format for these Monthly Service Performance Summary Reports. This report is due by 3:00 p.m. 15 days from the last day of the month. If the 15th day falls on a Saturday, Sunday, or holiday observed by the State of Iowa, the report is due by 8:30 a.m. on the next Business Day.

- **a. SBC® -** The minimum service elements the Contractor shall track and include in these reports are described below:
  - **i.** # and % of Cases in which the Contractor made F-F Casework Contact with the Children who reside out of the home one time per month in the home where the Child currently resides; and
  - **ii.** # and % of Cases in which the FSS attended FTDM meetings, YTDM meetings, and CSCs held on the Child/youth and Family while the Case is open.
- **b. FTDM and YTDM Meeting Facilitation -** The minimum service elements the Contractor shall track and include in these reports are described below:
  - **i.** Results of the satisfaction surveys compiled from the FTDM Meeting and/or YTDM Meeting.
- **c. Family Preservation Services -** The minimum elements that the Contractor shall track and include in these reports are described below:
  - **i.** # and % of Cases in which the Contractor FSS achieved a one-hour return response time to the Agency Worker after the initial referral call is received.

D. Complete an Agency-developed quarterly Staffing Report to the Service Contract Specialist by the 15th of the following month.

E. Complete and submit an Agency-developed Combined Cost Report annually to the Service Contract Specialist within 90 days after the end of the Contractor's fiscal year.

The Contractor will be held to 95% on accuracy in reporting for FCS of the elements listed above. If the Contractor falls below the 95%, a Program Improvement Plan (PIP) shall be required.

The Contractor shall transmit reports to the Agency by the method determined by the Agency.

Program Improvement Plans.
This section describes the Agency procedures for requiring the Contractor to develop PIPs.

If the Contractor does not achieve 85% of Case compliance with the service elements for any consecutive three-month period of time for FCS, the Contractor shall be required to have a PIP. The PIP for Case compliance must be approved and in place within 60 days from the end of the three month period giving rise to a PIP. If the Contractor does not achieve 95% on accuracy in reporting for FCS, the Contractor shall be required to have a PIIP. The PIP for accuracy must be in place within 45 days of notice that a PIP is required.

The Contractor shall implement the described action steps and appropriate improvement benchmarks in order to meet contractual minimum compliance expectations. Case compliance PIPs shall continue for a minimum of six months and shall contain measurable improvement goals that will be achieved by the Contractor during the six-month period. FCS accuracy of reporting PIPs shall continue until the Contractor reaches 95% accuracy as determined by the results of the Contract Compliance Review. The Agency Contract Owner must approve all PIPs.

Once a PIP is approved, the Contractor shall submit required documentation, including monthly reports, concerning progress on their plan to the Agency Service Contract Specialist. The Service Contract Specialist will monitor implementation of the plan throughout its duration. The Contractor shall satisfactorily provide the services described in this Contract and any PIP in order to meet the desired outcomes throughout the duration of the Contract.

In the event that the Contractor fails to successfully complete any PIP within a reasonable timeframe, the Agency reserves the right, in its sole discretion, to cease assignment of Cases until such time as Contractor remedies, to the Agency's satisfaction, any concerns regarding performance. In addition, the Agency reserves the right to cease assignment at any point that the Agency determines that the best interests of those served are not met by placing additional Cases with Contractor.

Service Provision Dispute Protocol.
If the Contractor is directed by an Agency Worker to provide a level of interventions or supports beyond what they believe is required or reasonable, the Contractor, or their subcontractor, shall provide services to the Family at the level directed by the Agency while the matter is being resolved. The Contractor can communicate the basis of their belief in writing or via electronic communication to the Agency Worker and their supervisor. Every effort shall be made to resolve the Case service provision dispute at the lowest level possible, through discussions between the Agency Worker and their supervisor and the Contractor and/or subcontractor worker and supervisor, generally within five Business Days of receipt of the review request.

If the Contractor is not satisfied with the dispute resolution decision of the Agency Worker and their supervisor, the Contractor may refer the Case situation in writing or via electronic communication to the respective Agency Service Area Manager (SAM) or designee for review. This review shall be generally completed within seven Business Days after receipt of the request for review. After completion of this review, the Agency SAM or designee will communicate the Agency's decision in writing to the Contractor.

If a dispute over Contract terms is identified, the social work administrator (SWA) reviews the Contract dispute and refers to the Agency Service Contract Specialist. The Service Contract Specialist reviews the dispute and

attempts to resolve the issue. If the issue is not resolved, the dispute is elevated to the Contract Owner where the dispute is addressed with the Contractor.

Attachment C
Contractor Scope of Work Obligations for Solution Based Casework®

General Obligations for Provision of SBC®.
The Contractor shall:

- **A.** Provide a monthly service package using the SBC® practice model with Children and Families with an open Agency Child Welfare Service Case. This includes intact Families on In-Home Cases, when Children are in Kin/Fictive Kin Caregiver placements, or when in foster care placements.
- **B.** Provide a monthly service package using the SBC® practice model with Children and Families during In-Home Cases with no Agency involvement up to a maximum of three (3) months.
    - **a.** The Contractor shall have Case management and decision making responsibility on Non-Agency involved Cases.
    - **b.** The Contractor shall ensure minimum Casework Contacts are met.
- **C.** Provide SBC® in accordance with model fidelity.
    - **a.** Provide documentation relating to successful implementation of the model and certification of FSSs.
- **D.** Receive Agency referrals with available Case-specific information, including:
    - **a.** Referral and Authorization for Child Welfare Services (Agency Form #470-3055) authorizing service provision and service duration,
    - **b.** CPS Child Abuse Assessment which led to referral,
    - **c.** Safety Assessment at the end of the CPS Child Abuse Assessment Summary that led to referral, and
    - **d.** Other available referral information, including information on results from previous FTDM Meetings, YTDM Meetings, or CSCs concerning the Family and their Children and/or Youth.
- **E.** Assign a FSS trained and certified, or actively working toward training and certification, in SBC for each Case receiving FCS. This person shall be responsible for delivering and/or coordinating all services and supports provided for the Case and preparing and submitting required reports on the Case to the Agency Worker throughout the service delivery period. The assigned FSS shall not be in a supervisory or project manager position providing SBC. **Exceptions:**
        - **i.** A Contractor supervisor or project manager may carry a caseload when they are completing the process to become certified upon notice to and approval from the Agency.
        - **ii.** A FSS who promotes into a supervisory or project manager position may continue to carry Cases when determined to be beneficial to the Family and upon notice and approval from the Agency. Some Families may require additional time to transition to another FSS or may be near closing, which would impact the decision to transfer to another worker. The transition period on these Cases will not exceed three months. If near the end of three months, the Contractor believes additional time is warranted, the Contractor may request approval from the Agency Service Area Manager (SAM) or designee for an extension by providing supporting justification. Upon review of the justification, the Agency SAM or designee has the option to approve or deny the request. No new Cases shall be assigned to the promoted supervisor or project manager.
    - **a.** The FSS and the IS assigned to the same Case shall work collaboratively as a team and provide necessary interventions and/or supports to address Family needs.
    - **b.** The FSS, at a minimum, shall make four Face-to-Face Casework Contacts within each full calendar month of service delivery. Additional Casework Contacts shall be considered based upon Family need. **Exception:** If SafeCare® is provided to the Family in addition to SBC, the FSS shall make two Face-to-Face Casework Contacts rather than the four.
        - **i.** At a minimum, three of the four Casework Contacts shall take place in the parental home.

1. If one or more Children reside out of the home, at least one of the four Casework Contacts must occur in the home where the Child(ren) currently resides.

ii. At a minimum, the Casework Contacts shall be 45 minutes in length and include interventions and assessment of parent/Child interactions for danger and Risk.

1. If one or more Children reside out of the home, at least one of the four Casework Contacts must occur in the home where the Child(ren) currently resides.

c. The FSS shall participate in a Case transition meeting (handoff) with the assigned Agency Worker.

d. The FSS shall identify and address any concerns relating to Immediate Threat during service delivery and report concerns of Immediate Threat immediately and directly to the Agency Worker or their supervisor by telephone or electronic communication.

e. The FSS shall utilize individualized Case needs and results of the FTDM Meeting, YTDM Meeting, and/or CSC to direct the blend of services and supports provided to address the Safety, Risk, and Permanency issues.

This is not an exhaustive list but describes the range of core activities that may be necessary to achieve desired outcomes in the types of Cases referred for these services:

i. **Family Interaction planning and supervision of interaction between parents and Children and between siblings –** Schedule, plan, arrange, provide transportation assistance for, provide interaction supervision, provide parenting instruction during interaction, and provide reports on parent/Child and/or sibling interaction, as specified in the Family Interaction Plan. This may also include, but is not limited to training, preparing, and monitoring informal supports to assist with supervising and/or facilitating Family Interactions once approved by the Agency Worker and other members of the team.

The Support Worker can be incorporated into Family Interactions after at least four interactions or visits have been completed by the FSS. The Support Worker shall have at least three interactions or visits with the FSS and Family before the Support Worker can supervise Family Interactions on his or her own.

ii. Coordinate transportation planning for parent/Child or sibling interaction with the Child's Kin/Fictive Kin Caregivers, foster parents, Agency Worker, or others.

The Support Worker can be incorporated into sibling interactions after at least two interactions or visits have been completed by the FSS. The Support Worker shall have at least one interaction or visit with the FSS and siblings before the Support Worker can supervise sibling interactions on his or her own.

iii. **Family functioning interventions** - Provide service activities that improve and enhance a Family's and/or Children's functioning skills and Protective Capacities. These activities include, but are not limited to, the following:

1. Communication and social interaction functioning, which includes promoting effective communication skills, enhancing productive means of expressing feelings, and effective anger management techniques.
2. Family relationship enhancement, which means activities with one or more members to improve Family relationships, build and strengthen parent/Child relationships, and/or address issues that jeopardize the safety, Permanency, or well-being of the Child.
3. Supporting Family involvement in substance abuse, mental health, or domestic violence treatment programs.

4. Advocacy training including providing one or more Family members instruction on how to advocate for, access, and utilize services/supports from systems such as mental health, substance abuse treatment, domestic violence programs, education, public housing, public, and private benefit programs, etc. This will help the Family successfully access community services and supports within their communities to promote Family self-reliance.

iv. Concurrent and Permanency Planning service activities - Provide services that support Concurrent Planning practice and help the Agency identify and achieve alternative permanent Family connections for Child(ren) who cannot be reunified. Examples of service activities include, but are not limited to:

1. Supporting parents to accept movement to other Permanency plans for their Children;
2. Identifying potential Kin/Fictive Kin Caregivers for Children and supporting transition of the Children to this placement;
3. Supporting and maintaining the placement of Children in settings such as with Kin/Fictive Kin Caregivers and foster Family care; and
4. Providing transition planning and support as a Child/Youth moves toward adulthood.

v. Activities or provision of funding – Assist Children and their Families to secure necessary concrete supports, such as emergency groceries, Household supplies, diapers, etc. essential to Family safety, Permanency, or well-being and efforts to connect the Children and Family to community resources and informal supports and promote greater self-reliance.

f. The FSS and/or the IS shall attend all FTDM Meetings, YTDM Meetings, and CSCs held on the Child/Youth and Family while the Case is open. If neither the FSS or IS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.

g. The FSS and/or the IS shall attend court hearings and other meetings on the Child and Family while the Case is open when their attendance is requested either by the Court or Agency Worker and when provided at least 24-hour notice. If neither the FSS or IS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.

h. The FSS shall promptly notify the Agency Worker concerning any Children or adults exiting the Household or new Children or adults entering the Household, while the Case is open.

i. The FSS shall provide Culturally Responsive services to Families referred to the Contractor to meet the needs of the Child and Family including but not limited to:

i. Provision of interpreter and translation services as necessary, including sign language to meet the needs of the Children and Family.

ii. Collaboration with community organizations that reflect the ethnic and cultural diversity of the community within the Service Area and tailor services to serve Families of different race/ethnicity and cultural background.

Service Documentation and Reporting Deliverables on open Agency Child Welfare Service Cases.

The Contractor shall:

A. Maintain a system of individual files on each Case referred by the Agency and maintain these files in an organized and confidential fashion, in compliance with Agency information security and privacy standards, for a minimum of seven years beyond the end of the Contract.

B. Ensure completion and submission of the following original and updated documentation, at a minimum, to the Agency Worker:

a. Casework Contact Note - The Contractor shall complete an Agency-developed Casework Contact note prepared by the FSS after each Casework Contact with the Family. The Casework Contact note shall be submitted to the Agency Worker within 10 calendar days from the date of the contact.

b. Service Plan - The Contractor shall complete an Agency-developed service plan prepared by the FSS that aligns with the current Agency Family Case Plan. The service plan shall be developed and submitted within 45 calendar days of the initial referral for services. The Support Worker shall provide contact narratives for all Casework Contacts to the FSS but shall not author the service plan. The Contractor shall outline the role of the Support Worker in the service plan.

i. The Contractor shall also provide a copy of the service plan to the parents, unless their parental rights have been terminated, within five Business Days from submission to the Agency Worker. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

c. Case Progress Report - The Contractor shall complete an Agency-developed quarterly Case progress report prepared by the FSS for the Case. Due dates for the Case progress report are calculated from the effective date of the 3055. These reports shall be provided each quarter within five Business Days from the end of the quarter of service provision.

i. The Contractor shall also provide a copy of the quarterly Case progress report to the parents, unless their parental rights have been terminated. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

d. Service Termination Summary - The Contractor shall complete an Agency-developed service termination summary prepared by the FSS within 10 Business Days from Case closure.

i. The Contractor shall also provide a copy of the service termination summary to the parents, unless their parental rights are terminated, within 10 Business Days from Case closure. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

e. Other Reports - Upon Agency Worker request, the Contractor shall provide other reports such as a special progress letter for Court, etc.

Service Documentation and Reporting Deliverables on Non-Agency Cases.

The Contractor shall:

A. Maintain a system of individual files on each Case referred by the Agency and maintain these files in an organized and confidential fashion, in compliance with Agency information security and privacy standards, for a minimum of seven years beyond the end of the Contract.

B. Ensure completion and submission of the following original and updated documentation, at a minimum, to the Agency:

a. Casework Contact Note - The Contractor shall complete an Agency-developed Casework Contact note prepared by the FSS after each Casework Contact with the Family. The Casework Contact note shall be submitted to the Agency within 10 calendar days from the date of the contact.

b. Service Plan - The Contractor shall complete an Agency-developed service plan prepared by the FSS. The service plan shall be developed and submitted within 30 calendar days of the initial referral for services.

i. The Contractor shall also provide a copy of the service plan to the parents within five Business Days from submission to the Agency. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

c. Service Termination Summary - The Contractor shall complete an Agency-developed service termination summary prepared by the FSS within 10 Business Days from Case closure.

i. The Contractor shall also provide a copy of the service termination summary to the parents within 10 Business Days from Case closure. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

Attachment D
Contractor Scope of Work Obligations for FTDM and YTDM Meeting Facilitation

General Obligations for Provision of FTDM and YTDM Meeting Facilitation.
The Contractor shall:

- **A.** Provide trained FTDM Meeting and YTDM Meeting Facilitators with Agency-assigned approval numbers to facilitate meetings.
- **B.** Facilitate FTDM Meetings or YTDM Meetings at the following junctures during the life of the Case on open Agency Child Welfare Service Cases:

  For FTDM Meetings
  - **a)** Initial (within 45 calendar days from the date of referral).
  - **b)** Six months from the date of referral to services.
  - **c)** 12 months from the date of referral to services and every six months the Case remains open.
  - **d)** Prior to Case closure if referred.

  For YTDM Meetings
  - **a)** On or after the Youth's 16th birthday.
  - **b)** Within 90 days prior to the Youth's 18th birthday.
- **C.** Facilitate FTDM or YTDM Meetings in accordance with the established statewide FTDM/YTDM Meeting standards. The FTDM/YTDM Meeting standards are available at the following: http://www.iatrainingsource.org/ftdm-ytdm-documents
- **D.** Accept all completed referrals from the Agency.
- **E.** Provide the following activities, at a minimum, upon receipt of the completed referral:
  - **a.** Initiate FTDM or YTDM planning with the Family or Youth upon receipt of the completed referral.
  - **b.** Contact the Agency Worker for background information on the Family or Youth.
  - **c.** Schedule all FTDM or YTDM Meetings.
  - **d.** Facilitate the initial FTDM Meeting within 45 calendar days from the date of referral.
  - **e.** Coordinate and conduct all preparatory work for the FTDM or YTDM Meeting.

Service Documentation and Reporting Deliverables.
The Contractor shall:

- **A.** Ensure completion and submission of the FTDM Meeting Notes, form #470-4126, or the YTDM Meeting Notes, form #470-5161 depending upon the type of meeting, and submit to the referring Agency Worker within five Business Days from the date of the meeting.
  - **a.** Complete the Youth's Dream Path, form #470-5176 in addition to or in lieu of the YTDM Meeting Notes if preferred by the Youth with all fields completed, and submit to the referring Agency Worker within five Business Days from the date of the meeting.
- **B.** Provide an Agency-approved satisfaction survey to all FTDM Meeting and YTDM Meeting participants. The results of the survey shall be compiled into a dated report and maintained by the Contractor within two weeks of the meeting. The Contractor shall make the results of the surveys available to Agency staff when requested.
- **C.** Provide all supplies, interpreters, equipment, access to conference calls/phone lines, and any materials necessary to conduct a FTDM Meeting or YTDM Meeting.

Attachment E
Contractor Scope of Work Obligations for Provision of SafeCare®

General Obligations for Provision of SafeCare®.
The Contractor shall:

- **A.** Provide a monthly service package of SafeCare® when referred on an open Agency Child Welfare Service Case. This includes intact Families on In-Home Cases, when Children are in Kin/Fictive Kin Caregiver placements, or when in foster care placements.
- **B.** Receive Agency referrals with available Case-specific information, including:
  - **a.** Referral and Authorization for Child Welfare Services (Agency Form #470-3055) authorizing service provision and service duration.
- **C.** Assign an IS for each Case receiving SafeCare®.
  - **a.** The IS shall provide weekly sessions of SafeCare® in accordance to model fidelity.
    - **i.** The IS, at a minimum, shall make four Face-to-Face Casework Contacts within each full calendar month delivering SafeCare®. Additional Casework Contacts shall be considered based upon Family need.
      - **1.** At a minimum, if the Children reside in the parental home, two of the four Casework Contacts shall take place in the parental home.
      - **2.** If one or more Child resides out of the home, at least one of the four Casework Contacts must occur in the home where the Children currently reside.
  - **b.** The IS and FSS assigned to the same Case shall work collaboratively as a team and provide necessary interventions and/or supports to address Family needs.
  - **c.** The IS and/or the FSS shall attend all FTDM Meetings, YTDM Meetings, and CSCs held on the Child/Youth and Family while the Case is open. If neither the IS or FSS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.
  - **d.** The IS and/or the FSS shall attend court hearings and other meetings on the Child and Family while the Case is open when their attendance is requested either by the Court or Agency Worker and when provided at least 24 hour notice. If neither the IS or FSS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.

Service Documentation and Reporting Deliverables.
The Contractor shall:

A. Ensure completion and submission of the following original and updated documentation, at a minimum, to the Agency Worker:

- **a. Casework Contact Note** - The Contractor shall complete an Agency-developed Casework Contact note prepared by the IS after each SafeCare® Casework Contact with the Family. The Casework Contact note shall be submitted to the Agency Worker within 10 calendar days from the date of the contact.
- **b. Service Termination Summary** - The Contractor shall complete an Agency-developed service termination summary prepared by the IS within 10 Business Days from closure of SafeCare®.
  - i. The Contractor shall also provide a copy of the service termination summary to the parents, unless their parental rights have been terminated, within 10 Business Days from closure SafeCare®. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

Attachment F
Contractor Scope of Work Obligations for Family Preservation Services and Child Safety Conference Facilitation

General Obligations for Provision of Family Preservation Services, CSC Facilitation, and Motivational Interviewing.
The Contractor shall:

- **A.** Provide a Family Preservation Services package of one, 10-calendar day unit of service, or at direction of the Agency, a maximum of three consecutive, 10-calendar day units of service. Although the unit of service is 10 calendar days, the actual number of days of service delivery may be less than 10 days as determined by the Agency.
- **B.** Receive Agency referrals and begin providing services according to the Agency's referral. All Agency referrals will be made by phone to the Contractor. The Contractor shall receive the written Safety Plan, referral face sheet, and 3055 within 24 hours of the Agency referral.
- **C.** Ensure a one-hour return response time to the Agency Worker after the initial referral call is received.
- **D.** The Contractor shall schedule a CSC upon receipt of the Agency referral.
    - **a.** The Contractor shall facilitate the initial CSC within three Business Days of the Agency referral.
    - **b.** The Contractor shall facilitate a follow up CSC within 10 calendar days from the date of the initial CSC.
        - i. If a FTDM Meeting is scheduled during this timeframe, the FTDM Meeting shall occur in lieu of the follow up CSC as long as the FTDM Meeting addresses the plan developed during the initial CSC.
- **E.** Ensure availability of the FSS and services 24 hours a day, seven days per week.
- **F.** Assign a FSS trained in Motivational Interviewing (MI) or in process of being trained for each Case receiving Family Preservation Services. This person shall be responsible for delivering and/or coordinating all Family Preservation Services provided for the Case and preparing and submitting required reports on the Case to the Agency Worker throughout the service delivery period. The assigned FSS shall not be in a supervisory or project manager position providing Family Preservation Services. The FSS supervisor can be involved in activities provided during Family Preservation Services activities when coordinated with the FSS.
    - **a.** The FSS shall utilize Motivational Interviewing to engage and support the Family.
    - **b.** The FSS shall meet with the Family within 24 hours of the Agency Worker's referral to assess initial criteria and explain the service to the Family.
    - **c.** The FSS shall identify and address any concerns relating to Immediate Threat during the provision of the Family Preservation Services and report any concerns immediately and directly as they arise to the Agency Worker or their supervisor via telephone with a follow up electronic communication.
    - **d.** The FSS, at a minimum, shall make at least eight Face-to-Face Casework Contacts within each unit of service with one of the eight Face-to-Face Casework Contacts to include the CSC. Additional Casework Contacts shall be considered based upon Family need.
        - **i.** At a minimum, six of the Casework Contacts shall take place in the Child's Home Of Origin.
        - **ii.** At a minimum, all Casework Contacts shall be 60 minutes in length and include interventions and assessment of parent/Child interactions and all other situations that could constitute danger and Risk to the Children.
        - **iii.** If a FSS providing SBC meets with the Family and the Face-to-Face Casework Contact is at least 60 minutes in length, this Casework Contact shall count toward one of the eight Face-to-Face Casework Contacts required in this service.

e. The FSS shall ensure a two-hour response time, either Face-to-Face or by telephone depending on the situation, to any crisis, as defined by the Family, Agency Worker, or Contractor, that threatens the safety of the Children. The Support Worker shall not be a substitute for managing crisis or situations that could impact safety.
  i. The FSS shall directly notify the Agency Worker or their supervisor via telephone or electronic communication.

f. The FSS shall utilize individualized Case needs and results of the CSC to direct the blend of services and supports provided to each Case in order to maintain Children safely In the Home or with Kin/Fictive Kin Caregivers.
  i. The CSC plan guides the Family Preservation Services intervention. The focus is development of solutions that will remove the Risks placing the Children in imminent Risk of Removal.

g. The FSS shall help Children and Families with concrete advocacy and service coordination needs.

h. The FSS shall deliver services uniquely designed within the CSC plan to address the identified needs of the Family, such as, but not limited to:
  i. Provide necessary information and skill building opportunities to Family members.
  ii. Teach problem solving and other life skills, focusing on assisting in crisis management and the specific issues placing the Children at imminent Risk of Removal from the home.
  iii. Provide funding or activities to help the Family secure necessary concrete supports.
  iv. Assist the Family in establishing social connections with formal and informal supports and community services.
  v. Evaluate the safety of Children to carry out the CSC plan. The focus is on regular assessment of the Protective Capacities of the caregivers, Child Vulnerability, and Threats of Maltreatment to the Children throughout the provision of Family Preservation Services.
  vi. Provide assistance and basic education to Families regarding Household management skills and capacities related to issues of Immediate Threat identified in the CSC plan.
  vii. Provide activities to ensure that a parent is keeping medical, mental health and substance abuse appointments as appropriate to the Case situation.

i. The FSS and/or the IS shall attend all FTDM Meetings, YTDM Meetings, or CSCs held on a Case receiving Family Preservation Services. If neither the FSS or IS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.

j. The FSS and/or IS shall attend court hearings and other meetings on Cases receiving Family Preservation Services when requested by the Court or requested by the Agency Worker and when provided at least 24-hour notice. If neither the FSS or IS is able to attend due to a scheduling conflict, the direct supervisor may attend on their behalf.

Service Documentation and Reporting Deliverables.

The Contractor shall:

A. Maintain a system of individual files on each Case from the Agency and maintain these files in an organized and confidential fashion, in compliance with Agency information security and privacy standards, for a minimum of seven years beyond the end of the Contract.

B. Ensure completion and submission of the following original and updated documentation, at a minimum, to the Agency Worker:
  a. CSC Plan - The Contractor shall complete an Agency-developed CSC Plan and provide by end of the next calendar day. If the CSC is held on a Friday, the CSC Plan shall be provided by the end of the next Business Day.
  b. Casework Contact Note - The Contractor shall complete an Agency-developed Casework Contact note prepared by the FSS after each Casework Contact with the Family. The Casework Contact note shall be submitted to the Agency Worker by end of the next calendar day. If

contact is made on Thursday, Friday, Saturday, or a holiday observed by the State of Iowa, the Casework Contact Note shall be submitted by the end of the next Business Day.

c. Service Summary Report - The Contractor shall complete an Agency-developed service summary report prepared by the FSS for each unit of service. The unit of service begins on the effective date on the 3055. The Contractor shall provide the summary report by end of the next calendar day of the final day of service for the respective unit.

i. The Contractor shall also provide a copy of the service summary report to the parents, unless their parental rights have been terminated, by end of the next calendar day of the final day of service for the respective unit. The Contractor shall maintain a copy in the Case file for review by the Agency. The date of completion and provision shall be included within the report.

d. Other Reports – Upon Agency Worker request, the Contractor shall provide other reports such as a special progress letter for Court, etc.

SafeCare

SafeCare is an evidence-based behavioral parenting model shown to prevent and reduce child maltreatment and improve health, development, and welfare of children ages zero to five in at-risk families.

SafeCare is a home visitation-based parent training program conducted over 18 sessions. Parents who are at-risk for neglect are taught how to have positive parent-child and parent-infant interactions, keep homes safe, and improve child health. This program targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas:

- How to interact in a positive manner with their children, plan activities, and respond appropriately to challenging child behaviors,
- How to recognize hazards in the home in order to improve the home environment, and
- How to recognize and respond to symptoms of illness and injury, in addition to keeping good health records.

The goals of SafeCare include:

- Reduce future incidents of child maltreatment.
- Increase positive parent-child interaction.
- Improve how parents care for their children's health.
- Enhance home safety and parent supervision.

Eligibility

SafeCare is not a standalone intervention. SafeCare can be purchased as an additional service package under family-centered services. SafeCare is designed for all parents and caregivers of children ages 5 and under.

Making a Referral for SafeCare

Before making a referral for SafeCare, consider. Am I concerned about the parent/caregiver's ability to:

- Engage/bond with their infant?
- Structure daily activities that stimulate their child?
- Manage their toddler's behavior?
- Maintain a safe home?
- Make good health decisions for their child?

If there are concerns about the parent/caregiver's ability to complete any of these points, then a referral for SafeCare may be warranted. If warranted, issue the 3055 authorization.

- Complete the required entries in FACS and generate the 3055 authorization in JARVIS. Refer to the JARVIS/FACS System Guidance Documents for steps in accurately making system entries in FACS and JARVIS. Authorize SafeCare through the end of the month regardless of the date services are initiated (For example, a 4 month authorization with a 3055 effective date of 7.25.20, the final day of eligibility should be 11.30.20, not 11.25.20).
- Once system entries are completed, complete form 470-5150, *Child Welfare Services Referral Face Sheet* if SafeCare is not referred at the same time as family-centered services with SBC.
- Ensure that all information contained in the 3055 and child welfare services referral face sheet is accurate.
- Send the 3055 and child welfare services referral face sheet to the assigned family-centered services contractor so an intervention specialist can be assigned to provide SafeCare to the family.
- Complete a termination 3055 IF the final date of eligibility is greater than the identified date of completion of SafeCare and provide to the intervention specialist.
- Prorate payment for services for partial calendar months using a daily rate based on the number of days of SafeCare approved during a partial month.

Once the referral is made to the family-centered services contractor, the SafeCare provider will take into consideration the parent/caregiver's readiness for SafeCare sessions. A parent/caregiver must be able to participate in weekly or bi-weekly sessions of SafeCare.

NOTE: SafeCare has been delivered to families with a range of risk levels, in both non-court and court-mandated situations. But there are sometimes urgent situations or crises which limit caregivers' ability to fully focus on a session. Keep in mind that once a referral is made to the contractor, there may be reasons why a family would be excused from SafeCare. Possible reasons for excusing families from SafeCare:

- Incarceration, treatment, geographical or facility restrictions;
- If the case is projected to close within two months
- Significant impairment due to drugs or alcohol

The SafeCare provider will always review the case with their SafeCare coach and seek their guidance. If one or more reasons apply for exclusion, the SafeCare provider will notify the SWCM for further discussion. If the issue/issues are remedied, it may be possible that another referral be made later. In addition, there might be times when a family begins SafeCare and is unable to complete the modules. If a family cancels or no shows for more than two consecutive sessions (more than two weeks pass without provision of SafeCare), the SafeCare provider will decide whether to reengage or discharge the family based on guidance from their SafeCare coach.

Families cannot concurrently receive SafeCare and family preservation services. If a family receiving SafeCare is referred for family preservation services, the authorization for SafeCare must end. If the family is excused or discharged from SafeCare after completion of the referral and 3055 authorization, close the SafeCare service by issuing a termination 3055 and send to the intervention specialist. Once family preservation services are completed and the family is stabilized, re-authorize SafeCare services to be provided if warranted at that time.

Payment for SafeCare

The monthly rate is the same for all contractors providing this service. If there is not a full month of service delivery, the monthly rate is prorated to a daily rate for the number of days the SafeCare referral is open during the calendar month. Contractors are paid for both the beginning and ending dates of SafeCare service authorization. The contractor may invoice the Department in the month following the month of service at the specified case rate for each full month of SafeCare on open Department service cases receiving this additional service package. Refer to the JARVIS/FACS System Guidance Documents for steps in making payment for SafeCare.

234.1 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Administrator"* means the administrator of the division.

2. *a.* *"Child"* means either a person less than eighteen years of age or a person eighteen or nineteen years of age who meets any of the following conditions:

(1) Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma.

(2) Is attending an instructional program leading to a high school equivalency diploma.

(3) Has been identified by the director of special education of the area education agency as a child requiring special education as defined in section 256B.2, subsection 1.

b. A person over eighteen years of age who has received a high school diploma or a high school equivalency diploma is not a "child" within the definition in this subsection.

3. *"Division"* or *"state division"* means that division of the department of human services to which the director has assigned responsibility for income and service programs.

4. *"Food assistance program"* means the benefits provided through the United States department of agriculture program administered by the department of human services in accordance with 7 C.F.R. pts. 270 – 283.

5. *"Food programs"* means the food stamp and donated foods programs authorized by federal law under the United States department of agriculture.

[C71, 73, 75, 77, 79, 81, S81, §234.1; 81 Acts, ch 7, §11]

83 Acts, ch 96, §160; 86 Acts, ch 1245, §1419; 92 Acts, ch 1229, §20; 93 Acts, ch 54, §3; 2008 Acts, ch 1073, §1; 2009 Acts, ch 41, §263

Referred to in §217.36, 235.1, 237.1, 237.15, 238.1, 252.14, 425.15

1. Criminal History

Item	Factoid	Response Category	Static		Dynamic	
			Risk	Protective	Risk	Protective
1. Age at first offense:	*Number* years old at first offense	Over 16		0		
		16	1			
		15	2			
		13 to 14	3			
		Under 13	4			
2. Misdemeanor complaints:	*Number* misdemeanors (Use *No* when the number is zero)	None or one		0		
		Two	1			
		Three or four	2			
		Five or more	3			
3. Felony complaints:	*Number* felonies (Use *No* when the number is zero)	None		0		
		One	2			
		Two	4			
		Three or more	6			
4. Weapon complaints:	*Number* weapons/ firearms complaints (Use *No* when the number is zero)	None		0		
		One or more	1			
5. Against-person misdemeanor complaints:	*Number* against-person misdemeanors (Use *No* when the number is zero)	None		0		
		One	1			
		Two or more	2			
6. Against-person felony complaints:	*Number* against-person felonies. (Use *No* when the number is zero)	None		0		
		One or two	2			
		Three or more	4			
7. Number of times where youth served at least 24 hours confined in detention:	*Number* detentions (Use *No* when the number is zero)	None		0		
		One	1			
		Two	2			
		Three or more	3			
8. Number of times where youth served at least 30 days confined in a State Training School or in Residential Treatment through delinquency action:	*Number* placments at STS or Res. TX (Use *No* when the number is zero)	None		0		
		One	2			
		Two or more	4			

Item	Factoid	Response Category	Static		Dynamic	
			Risk	Protective	Risk	Protective
9. Escapes:	*Number* escapes (Use *No* when the number is zero)	None		0		
		One	1			
		Two or more	2			
10. Failure-to-appear in court warrants:	*Number* failure to appears (Use *No* when the number is zero)	None		0		
		One	1			
		Two or more	2			
Maximum Score			31	0	0	0
Lower 33%			0 to 4	0	0	0
Middle			5 to 7	0	0	0
Upper 33%			8 to 31	0	0	0

Note: *Number of complaints that resulted in an adjudication, consent decree, diversion, informal, held open, warn and dismiss, deferred disposition, or deferred adjudication (*regardless *of whether successfully completed).*

2. Demographics

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Gender	Male	1	0		
	Female	0	1		
Maximum Score		**1**	**1**	**0**	**0**

3A. School History

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Youth is a special education student or has a formal diagnosis of a special education need: *(One point for each, maximum score of one)*	Not a Special Education Student		0		
	Special Ed: *Learning, Behavior, Mental Retardation, ADHD/ADD (list all checked)*	1			
2. History of expulsions and suspensions since the first grade:	No expulsions/suspensions		1		
	1 expulsion/suspension	1			
	2 or 3 expulsions/suspensions	2			
	4 or 5 expulsions/suspensions	2			
	6 or 7 expulsions/suspensions	2			
	More than 7 expulsions/suspensions	2			
3. Age at first expulsion or suspension:	No expulsions		1		
	First expelled: 5 to 9 years old	2			
	First expelled: 10 to 13 years old	2			
	First expelled: 14 to 15 years old	1			
	First expelled: 16 to 18 years old	1			
4. Youth has been enrolled in a community school during the last 6 months, regardless of attendance: *(If Yes is checked, must complete Section 3B)*	Not enrolled last 6 months, graduated/GED and not attending				2
	Not enrolled last 6 months, dropped-out or expelled			2	
	Enrolled last 6 months				2
Maximum		**5**	**2**	**2**	**2**
Lower 33%		**0-3**			
Middle		**4-4**			
Upper 33%		**5-5**			

3B. Current School Status

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
List items in the following section only if the youth has been enrolled in school during the last six months.					
1. Youth's current school enrollment status, regardless of attendance: If in home school because of expulsion, check dropped or expelled, otherwise check enrolled full-time.	Graduated/GED				2
	Enrolled full-time				2
	Enrolled part-time				1
	Suspended			3	
	Dropped out			3	
	Expelled			3	
2. Type of school in which youth is enrolled:	Enrolled at *School Name*, *school type* *Not an ICIS question*				0
3. Youth believes there is value in getting an education:	Believes getting education of value				1
	Somewhat believes education of value			1	
	Does not believe education of value			2	
4. Environment: Youth believes school provides an encouraging environment for him or her:	Believes school is encouraging				1
	Somewhat believes school is encouraging			1	
	Does not believe school is encouraging			2	
5. School Staff: Teachers, staff, or coaches the youth likes or feels comfortable talking with:	Not close to any adult at school			0	
	Close to 1 adult at school				1
	Close to 2 adults at school				2
	Close to 3 adults at school				2
	Close to 4 or more adults at school				2
6. School Activities: Youth's involvement in school activities during most recent term:	Involved in 2 or more school activities				2
	Involved in 1 school activity				1
	Not involved in any school activities			1	
	Not interested in school activities			2	
7. Youth's conduct in the most recent term:	Recognition for good school behavior				2
	No problems with school conduct				1
	School problems reported by teachers			1	
	School problem calls to parents			2	
	School problem calls to police			3	
8. Number of expulsions and suspensions in the most recent term:	No recent expel/suspend				1
	1 recent expel/suspend			1	
	2 or 3 recent expel/suspend			2	
	Over 3 recent expel/suspend			3	
9. Youth's attendance in the most recent term:	Good attendance; few excused absences				2
	No unexcused absences				1
	Some partial-day unexcused absences			1	
	Some full-day unexcused absences			2	
	Truancy petition/equivalent or withdrawn See page 30, more info			3	

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
10. Youth's academic performance in the most recent school term:	Grades: mostly As				3
	Grades: mostly As and Bs				2
	Grades: mostly Bs and Cs, no Fs				1
	Grades: mostly Cs and Ds, some Fs			1	
	Grades: Some Ds and mostly Fs			2	
11. Interviewer's assessment of likelihood the youth will stay in and graduate from high school or an equivalent vocational school:	Very likely to graduate				1
	Uncertain if will stay and graduate			1	
	Not very likely to graduate			2	
Maximum		**0**	**0**	**22**	**17**
Lower 33%				**0-3**	
Middle				**4-6**	
Upper 33%				**7-22**	

4A. Historic Use of Free Time

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of pro-social structured recreational activities within the past 5 years:	Has been involved in 2 or more structured activities		2		
	Has been involved in one structured activity		1		
	Never involved in structured activities		0		
2. History of unstructured pro-social recreational activities within the past 5 years:	Has been involved in 2 or more pro-social unstructured activities		2		
	Has been involved in 1 pro-social unstructured activity		1		
	Never involved in unstructured pro-social activities		0		
Maximum		**0**	**4**	**0**	**0**
Lower 33%		**n/a**			
Middle		**n/a**			
Upper 33%		**n/a**			

4B. Current Use of Free Time

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Current interest and involvement in supervised, structured pro-social recreational activities:	Currently in 2 or more structured activities				3
	Currently in 1 structured activity				2
	Currently interested in structured activity, but not involved.				1
	Currently not interested in any structured activities			0	
2.Types of pro-social, structured recreational activities in which youth currently participates: *(No score but accounted for in Question 1, until further research)*	Currently no structured recreational activities			0	
	Currently in athletics				0
	Currently in community/cultural group				0
	Currently in hobby group/club				0
	Currently in religious group/church				0
	Currently in volunteer organization				0
3. Current interest and involvement in pro-social unstructured recreational activities:	Currently in 2 or more unstructured activities				3
	Currently in 1 unstructured activity				2
	Currently interested in unstructured activity				1
	Currently not interested in unstructured activities			1	
Maximum		**0**	**0**	**1**	**6**
Lower 33%				**n/a**	
Middle				**n/a**	
Upper 33%				**n/a**	

5A. Employment History

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of employment:	Too young for employment or NA		0		
	Never been employed	0			
	Has been employed		1		
2. History of successful employment:	Never successfully employed or NA	0			
	Has been successfully employed		1		
3. History of problems while employed:	Never fired or quit: problems or NA		0		
	Fired or quit: poor performance	1			
	Fired or quit: not getting along	2			
4. History of positive personal relationship(s) with past employer(s) or adult coworker(s):	Never had positive employment relationships or NA	0			
	Had 1 positive employment relationship		1		
	Had 2 or more positive employment relationships		2		
Maximum		**2**	**4**	**0**	**0**
Lower 33%		**n/a**			
Middle		**n/a**			
Upper 33%		**n/a**			

5B. Current Employment

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Understanding of what is required to maintain a job:	Lacks knowledge to maintain job			0	
	Has knowledge to maintain job				1
	Has demonstrated maintaining job				2
2. Current interest in employment:	Currently employed				3
	Highly interested in employment				2
	Somewhat interested in employment				1
	Not interested in employment			0	
	Too young for employment				0
3. Current employment status:	Not currently employed			0	
	Employment currently going well				1
	Problems with current employment			1	
4. Current positive personal relationship(s) with employer(s) or adult coworker(s):	Not currently employed			0	
	Currently employed: no positive relationships				0
	At least 1 current positive job relationship				1
Maximum		**0**	**0**	**1**	**7**
Lower 33%				**n/a**	
Middle				**n/a**	
Upper 33%				**n/a**	

6A. History of Relationships

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of positive adult non-family relationships not connected to school or employment:	No positive adult relationships	0			
	1 positive past adult relationship		1		
	2 positive past adult relationships		2		
	3 or more positive past adult relationships		3		
2. History of anti-social friends/companions:	Never had consistent friends or companions	1			
	Had only pro-social friends		1		
	Had pro-social and anti-social friends	1			
	Had only anti-social friends	2			
	Been gang member/associate	3			
Maximum		**3**	**4**	**0**	**0**
Lower 33%		**0-0**			
Middle		**1-1**			
Upper 33%		**2-3**			

6B. Current Relationships

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Current positive adult non-family relationships not connected to school or employment:	No current positive adult relationships			0	
	1 positive current adult relationship				1
	2 positive current adult relationships				2
	3 or more current positive adult relationships				3
2. Current pro-social community ties:	No pro-social community ties			0	
	Some pro-social community ties				1
	Strong pro-social community ties				2
3. Current friends/ companions youth actually spends time with:	No consistent friends or companions			1	
	Only pro-social friends				1
	Pro-social and anti-social friends			1	
	Only anti-social friends			2	
	Gang member/associate			3	
4. Currently in a "romantic," intimate, or sexual relationship:	Not romantically involved			0	
	Romantically involved: pro-social person				1
	Romantically involved: anti-social person/criminal			1	
5. Currently admires/ emulates anti-social peers:	Does not admire anti-social peers				1
	Somewhat admires anti-social peers			1	
	Admires, emulates anti-social peers			2	
6. Current resistance to anti-social peer influence:	Does not associate with anti-social peers				2
	Usually resists anti-social peer influence				1
	Rarely resists anti-social peer influence			1	
	Leads anti-social peers			2	
Maximum		**0**	**0**	**8**	**10**
Lower 33%				**0-0**	
Middle				**1-2**	
Upper 33%				**3-8**	

7A. Family History

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of JCS/ DHS, or Voluntary out-of-home and shelter care placements and DHS/Voluntary Residential Treatment exceeding 30 days:	No out-of-home placements		1		
	1 out-of-home placement	1			
	2 out-of-home placements	2			
	3 or more out-of-home placements	3			
2. History of running away or getting kicked out of home:	No history of running away/kicked out		1		
	1 instance of running away/kicked out	1			
	2 to 3 instances of running away/kicked out	2			
	4 to 5 instances of running away/kicked out	3			
	Over 5 instances of running away/kicked out	4			
3. History of petitions filed: *One point for each type of petition for a maximum of 3 points*	No dependency petitions		1		
	FINA	1			
	CINA	1			
	Mental Health Commitment(s)	1			
	Substance Abuse Commitment(s)	1			
4. History of jail/imprisonment of persons who were ever involved in the household for at least 3 months: *One point for each for a maximum of 3 points*	No family history jail/imprisonment		1		
	Mother/female caretaker history jail/imprisonment	1			
	Father/male caretaker history jail/imprisonment	1			
	Older sibling history jail/imprisonment	1			
	Younger sibling history jail/imprisonment	1			
	Other family member history jail/imprisonment	1			
5. Youth has been living under any "adult supervision":	Living with peers, no adult supervision			1	
	Living alone, no adult supervision			1	
	Transient no adult supervision			1	
	Living under adult supervision				1
Maximum		**13**	**4**	**1**	**1**
Lower 33%		**0-0**			
Middle		**1-2**			
Upper 33%		**3-13**			

7B. Current Living Arrangements

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Youth is currently living with: *Sum protective factors for a maximum of 4 points.*	Living Alone			0	
	Transient living			1	
	Biological mother				2
	Biological father				2
	Non-biological mother				1
	Non-biological father				1
	Older sibling(s)				0
	Younger sibling(s)				0
	Grandparent(s)				0
	Other relative(s)				0
	Long-term parental partner(s)				0
	Short-term parental partner(s)				0
	Youth's romantic partner				0
	Youth's child				0
	Foster/group home				0
	Youth's friends				0
2. Annual combined income of youth and family:	Annual income under $15,000			2	
	Annual income $15,000 to $34,999			1	
	Annual income $35,000 to $49,999				1
	Annual income $50,000 to $74,999				2
	Annual income $75,000 to $99,999				2
	Annual income $100,000 and over				2
3. Jail/imprisonment history of persons who are currently involved with the household: *One point for a maximum of 3 points*	No jail/imprisonment in current family				1
	Current mother/female caretaker jail/imprisonment			1	
	Current father/male caretaker jail/imprisonment			1	
	Current older sibling jail/imprisonment			1	
	Current younger sibling jail/imprisonment			1	
	Current other family member jail/imprisonment			1	
4. Problem history of parents who are currently involved with the household: *Score one point per problem up to a maximum of 3 points, but print all problems checked.*	No current parent problems				1
	Current parent alcohol problem			1	
	Current parent drugs problem			1	
	Current parent mental health problem			1	
	Current parent physical health problem			1	
	Current parent employment problem			1	
5. Problem history of siblings who are currently involved with the household: *Score one point per problem up to a maximum of 3 points, but print all problems checked.*	No siblings in household			0	
	No current sibling problems				1
	Current sibling alcohol problem			1	
	Current sibling drug problem			1	
	Current sibling mental health problem			1	
	Current sibling physical health problem			1	
	Current sibling employment problem			1	
6. Support network for family:	No family support network			0	
	Some family support network				1
	Strong family support network				2

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
7. Family willingness to help support of youth:	Consistently willing to support youth				1
	Inconsistently supports youth			1	
	Little or no willingness to support youth			2	
	Hostile, berating, or belittling of youth			3	
8. Family provides opportunities for youth to participate in family activities and decisions affecting youth:	No opportunities for family involvement			2	
	Some opportunities for family involvement			1	
	Opportunities for family involvement				1
9. Youth has run away or been kicked out of home: See Page 60	No run away/kicked out				1
	Run away/kicked out			1	
	Currently a runaway/kicked out			2	
10. Family member(s) youth feels close to or has good relationship with: *Score one point per member up to a maximum of 3 points*	Not close to family members			1	
	Close to mother/female caretaker				1
	Close to father/male caretaker				1
	Close to male sibling				1
	Close to female sibling				1
	Close to extended family				1
11. Level of conflict between parents, between youth and parents, among siblings:	Some family conflict: well managed				1
	Family verbal intimidation, arguments			1	
	Family threats of physical abuse			2	
	Domestic violence: physical/sexual abuse			3	
12. Parental supervision: See Page 61	Consistent good parental supervision				1
	Sporadic parental supervision			1	
	Inadequate parental supervision			2	
13. Parental authority and control:	Usually follows family rules				1
	Sometimes follows family rules			1	
	Consistently disobeys family/is hostile No pro-social parental rules present.			2 2	
14. Consistent appropriate consequences for bad behavior:	Consistently appropriate consequences				1
	Consistently overly severe consequences			1	
	Consistently insufficient consequences			1	
	Inconsistent or erratic consequences			2	
15. Consistent appropriate rewards for good behavior:	Consistently appropriate rewards				1
	Consistently overly indulgent/overly protective			1	
	Consistently insufficient rewards			1	
	Inconsistent or erratic rewards			2	
16. Parental characterization of youth's anti-social behavior:	Parents disapprove of youth's anti-social behavior				1
	Parents minimize/excuse/denies youth's anti-social behavior/Blames others			1	
	Youth's anti-social behavior ok with parents			2	
	Parents proud of youth's anti-social behavior			3	
Maximum		**0**	**0**	**34**	**23**
Lower 33%				**0-4**	
Middle				**5-8**	
Upper 33%				**9-34**	

8A. Alcohol and Drug History

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of alcohol use: *Sum points for a maximum of 6 points. List all factoids that are checked.*	No past alcohol use		2		
	Past alcohol use	0			
	Past alcohol use disrupted education	1			
	Past alcohol use caused family conflict	1			
	Past alcohol use interfered with pro-social friendships	1			
	Past alcohol use caused health problems	1			
	Past alcohol use contributed to criminal behavior	2			
2. History of drug use: *Sum points for a maximum of 13 points. List all factoids that are checked.*	No past drug use		2		
	Past drug use	1			
	Past drug use disrupted education	2			
	Past drug use caused family conflict	2			
	Past drug use interfered with pro-social friendships	2			
	Past drug use caused health problems	2			
	Past drug use contributed to criminal behavior	4			
3. History of complaints for drug/alcohol assessment:	Never referred for drug/alcohol assessment		0		
	Diagnosed: no drug/alcohol problem		0		
	Referred but not assessed for drug/alcohol	1			
	Diagnosed drug/alcohol abuse	2			
	Diagnosed drug/alcohol dependency	3			
4. History of attending alcohol/drug education classes for an alcohol/drug problem:	Never attended drug/alcohol education		0		
	Voluntarily attended drug/alcohol education		3		
	Parent, school directed drug/alcohol education		2		
	Court directed drug/alcohol education		1		
5. History of participating in alcohol/drug treatment program:	Never participated in drug/alcohol treatment		0		
	Participated once in drug/alcohol treatment		1		
	Participated several times drug/alcohol treatment		1		
6. Youth using alcohol/drugs:	No alcohol/drug use				3
	Alcohol/drug use (must complete 8b)			1	
Maximum		**22**	**8**	**1**	**3**
Lower 33%		**0-2**			
Middle		**3-5**			
Upper 33%		**6-22**			

8B. Current Alcohol and Drugs

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Alcohol use: *Sum points for a maximum of 11 points.*	No current alcohol use		0		
	Current alcohol use not disrupting functioning			1	
	Alcohol disrupts education			2	
	Alcohol causes family conflict			2	
	Alcohol interferes with keeping pro-social friendships			2	
	Alcohol causes health problems			2	
	Alcohol contributes criminal behavior			3	
2. Current drug use: *Sum points for a maximum of 12 points.*	No current drug use		0		
	Current drug use not disrupting functioning			2	
	Drug use disrupts education			2	
	Drug use causes family conflict			2	
	Drug use interferes with keeping pro-social friendships			2	
	Drug use causes health problems last			2	
	Drug contributes criminal behavior			4	
3. Type of drugs currently used. *(Not scored, information only)*	Current drug use: *List all yes's*				
	Marijuana/Hashish			0	
	Amphetamines			0	
	Cocaine (coke)			0	
	Cocaine (crack/rock)			0	
	Heroine			0	
	Inhalants			0	
	Barbiturates			0	
	Tranquilizers/sedatives			0	
	Hallucinogens			0	
	Phencyclidine			0	
	Other opiates			0	
	Other Drugs			0	
4. Alcohol/drug treatment program participation:	Alcohol/drug treatment not warranted				0
	Not currently attending needed alcohol/drug treatment			1	
	Currently attending alcohol/drug treatment				1
	Successfully completed alcohol/drug treatment				2
Maximum		**0**	**0**	**24**	**2**
Lower 33%				**0-2**	
Middle				**3-5**	
Upper 33%				**6-24**	

9A. Mental Health History

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. History of suicidal ideation:	Has never thought of suicide		0		
	Has had serious thoughts of suicide	0			
	Has made a plan to commit suicide	0			
	Has attempted to commit suicide	0			
2. History of physical abuse: *Maximum score one point*	Not a victim of physical abuse		1		
	Physically abused by family member	1			
	Physically abused: outside the family	1			
3. History of sexual abuse: *Maximum score of one point.*	Not a victim of sexual abuse		1		
	Sexually abused by family member	1			
	Sexually abused: outside the family	1			
4. History of being a victim of neglect:	Not a victim of neglect		1		
	Victim of neglect	3			
5. History of ADD/ADHD:	No history of ADD/ADHD		1		
	Diagnosed with ADD/ADHD	1			
	Only ADD/ADHD medication prescribed	1			
	Only ADD/ADHD treatment prescribed	1			
	ADD/ADHD medication and treatment prescribed	2			
6. History of mental health problems:	No history of mental health problem(s)		1		
	Diagnosed with mental health problem(s)	1			
	Only mental health medication prescribed	1			
	Only mental health treatment prescribed	1			
	Mental health medication and treatment prescribed	2			
7. Health insurance:	No health insurance			1	
	Public insurance (Medicaid)				1
	Private insurance				1
8. Current mental health problem status:	No current mental health problem(s)				4
	Current mental health problem(s)			1	
Maximum		**9**	**5**	**2**	**5**
Lower 33%			**0-0**		
Middle			**1-1**		
Upper 33%			**2-5**		

9B. Current Mental Health

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Current suicide ideation:	No recent thoughts of suicide				0
	Has recent serious thoughts of suicide			0	
	Has recently planned suicide			0	
	Has recently attempted suicide			0	
2. Currently diagnosed with ADD/ADHD:	No ADD/ADHD diagnosis				0
	No ADD/ADHD medication currently prescribed			0	
	Currently taking ADD/ADHD medication				1
	ADD/ADHD medication currently prescribed, but not taking			1	
3. Mental health treatment currently prescribed, excluding ADD/ADHD treatment:	No current mental health problem				0
	No mental health treatment currently prescribed			0	
	Attending mental health treatment				1
	Mental health treatment prescribed but not attending			1	
4. Mental health medication currently prescribed excluding ADD/ADHD medication:	No current mental health problem				0
	No mental health medication currently prescribed			0	
	Currently taking mental health medication				1
	Mental health medication currently prescribed, but not taking			1	
5. Mental health problems currently interfere with working with the youth:	No current mental health problem				0
	Mental health does not interfere in work with youth			0	
	Mental health interferes in work with youth			1	
Maximum		**0**	**0**	**4**	**3**
Lower 33%				**0-0**	
Middle				**1-1**	
Upper 33%				**2-4**	

10. Attitudes/Behaviors

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Primary emotion when committing last crime(s) within the last 6 months:	During crime: nervous, afraid, worried, uncertain				1
	During crime: excited, or stimulated			1	
	During crime: unconcerned or indifferent			1	
	During crime: confident/bragging			1	
2. Primary purpose for committing crime(s) within the last 6 months: *(Item not scored, is for information only)*	Anger			0	
	Revenge			0	
	Impulse			0	
	Sexual desire			0	
	Money, material gain, drugs			0	
	Excitement, amusement			0	
	Peer status, acceptance, attention			0	
3. Impulsive; acts before thinking:	Uses self-control: usually thinks before acting				2
	Uses some self-control: sometimes thinks before acting				1
	Impulsive: often acts before thinking			1	
	Highly impulsive: usually acts before thinking			2	
4. Belief in control over anti-social behavior:	Believes can stop anti-social behavior				2
	Somewhat believes anti-social behavior is controllable			1	
	Believes anti-social behavior is out of their control			2	
5. Empathy, remorse, sympathy, or feelings for the victim(s) of criminal behavior:	Has empathy for his or her victim(s)				2
	Has some empathy for victim(s)				1
	Does not have empathy for victim(s)			2	
6. Respect for property of others:	Respects property of others				2
	Respects personal, not publicly accessible, property			1	
	Conditional respect for personal property:			2	
	No respect for personal/public property			3	

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
7. Respect for authority figures:	Respects most authority figures				2
	Does not respect authority figures			1	
	Resents most authority figures			2	
	Defies/hostile toward most authority figures			3	
8. Attitude toward pro-social rules/conventions in society:	Believes pro-social rules apply				2
	Believes some pro-social rules apply			1	
	Does not believe pro-social rules apply			2	
	Resents or is defiant toward rules			3	
9. Accepts responsibility for anti-social behavior:	Accepts responsibility for behavior				2
	Minimizes, denies, justifies, excuses, or blames others for own behavior			1	
	Accepts own anti-social behavior as okay			2	
	Proud of their anti-social behavior			3	
10. Youth's belief in successfully meeting conditions of court supervision:	Believes will be successful				1
	Unsure of success			1	
	Does not believe will be successful under supervision			2	
11. Optimism:	High aspirations: sense of purpose, commitment to better life				2
	Normal aspirations: some sense of purpose				1
	Low aspirations: little sense of purpose or plans for better life			1	
	Believe nothing matters: he or she will be dead before long			2	
Maximum		**0**	**0**	**23**	**18**
Lower 33%				**0-1**	
Middle				**2-3**	
Upper 33%				**4-23**	

11. Aggression

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Tolerance for frustration:	Rarely gets upset/temper tantrums				2
	Sometimes gets upset/temper tantrums			1	
	Often gets upset/temper tantrums			2	
2. Hostile interpretation of actions and intentions of others in a common non-confrontational setting:	Primarily positive view of intentions of others				2
	Primarily negative view of intentions of others			1	
	Primarily hostile view of intentions of others			2	
3. Belief in yelling and verbal aggression to resolve a disagreement or conflict:	Believes verbal aggression is rarely appropriate				2
	Believes verbal aggression is sometimes appropriate			1	
	Believes verbal aggression is often appropriate			2	
4. Belief in fighting and physical aggression to resolve a disagreement or conflict:	Believes physical aggression is never appropriate				2
	Believes physical aggression is rarely appropriate				1
	Believes physical aggression is sometimes appropriate			2	
	Believes physical aggression is often appropriate			3	
5. Reports/evidence of violence not included in criminal history (Maximum of 2 points)	No reports of violence outside of criminal history				0
	Violent destruction of property			1	
	Violent outbursts, displays of temper, uncontrolled anger indicating potential for harm			1	
	Deliberately inflicted physical pain			1	
	Used/threatened with a weapon			1	
	Fire starting reports			1	
	Animal cruelty reports			1	
6. Reports/evidence of sexual aggression not included in criminal history (Maximum of 2 points)	No reports of sexual aggression outside of criminal history				0
	Reports of aggressive sex			1	
	Reports of sex for power			1	
	Reports of young sex partners			1	
	Reports of child sex			1	
	Reports of voyeurism			1	
	Reports of exposure			1	
Maximum		**0**	**0**	**13**	**8**
Lower 33%				**0-0**	
Middle				**1-2**	
Upper 33%				**3-13**	

12. Skills

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
1. Consequential thinking:	Does not understand about consequences of actions			1	
	Understands about consequences to actions				1
	Identifies consequences of actions				2
	Good consequential thinking and acting				3
2. Problem-solving:	Cannot identify problem behaviors			1	
	Identifies problem behaviors				1
	Thinks of solutions for problem behaviors				2
	Applies appropriate solutions to problem behaviors				3
3. Monitoring of internal triggers (distorted thoughts) that can lead to trouble:	Cannot identify internal triggers			2	
	Identifies internal triggers				1
	Actively monitors/controls internal triggers				2
	Cannot identify internal triggers			2	
4. Monitoring of external triggers (events or situations) that can lead to trouble:	Cannot identify external triggers			2	
	Identifies external triggers				1
	Actively monitors/controls external triggers				2
	Cannot identify external triggers			2	
5. Control of impulsive behaviors that get youth into trouble:	Never a problem with impulsive behavior				3
	Lacks techniques to control impulsive behavior			2	
	Knows techniques to control impulsive behavior				1
	Uses techniques to control impulsive behavior				2
6. Control of aggression:	Never a problem with aggression				3
	Lacks alternatives to aggression			2	
	Rarely uses alternatives to aggression			1	
	Sometimes uses alternatives to aggression				1
7. Goal setting:	Does not set any goals			2	
	Sets unrealistic goals			1	
	Sets somewhat realistic goals				1
	Sets realistic goals				2
8. Situational perception:	Cannot analyze the situation for use of a pro-social skill			1	
	Does not choose the best pro-social skill				1
	Chooses best skill but not best time and place				2
	Selects the best time and place for best skill				3

Item	Factoid	Static		Dynamic	
		Risk	Protective	Risk	Protective
9. Dealing with others:	Lacks basic social skills in dealing with others			1	
	Lacks advanced skills in dealing with others				1
	Sometimes uses advanced social skills in dealing with others				2
	Often uses advanced social skills in dealing with others				3
10. Dealing with difficult situations:	Lacks skills in dealing with difficult situations			2	
	Rarely uses skills in dealing with difficult situations			1	
	Sometimes uses skills in dealing with difficult situations				1
	Often uses skills in dealing with difficult situations				2
11. Dealing with feelings/emotions:	Lacks skills in dealing with feelings/emotions			2	
	Rarely uses skills in dealing with feelings/emotions			1	
	Sometimes uses skills in dealing with feelings/emotions				1
	Often uses skills in dealing with feelings/emotions				2
Maximum		**0**	**0**	**18**	**28**
Lower 33%				**0-0**	
Middle				**1-2**	
Upper 33%				**3-18**	

Domain 1: Delinquency History	
Complaints, rather than offenses, are used to assess the persistence of re-offending by the youth. Include only complaints that resulted in a Warn and Dismiss, Held Open, Diversion, Informal, Consent Decree, Adjudication, or other disposition, (regardless of whether successfully completed). *A complaint is a report of a law violation by a juvenile. One complaint may contain one or more charges/allegations.*	
1. **Age at first complaint:** The youth's age at the time of the first complaint for a public offense referred to juvenile court where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O Over 16 O 16 O 15 O 13 to 14 O Under 13
Felony and misdemeanor complaints:	
2. **Misdemeanor complaints:** Total number of complaints for which the most serious allegation was a misdemeanor which was within the jurisdiction of juvenile court and where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O None or one O Two O Three or four O Five or more
3. **Felony complaints:** Total number of complaints for which the most serious allegation was a felony and where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O None O One O Two O Three or more
Against-person or weapon complaints: *Include all complaints not dismissed for lack of legal sufficiency.*	
4. **Weapon complaints:** Number of complaints for which the most serious allegation was a firearm/weapon charge.	O None O One or more
5. **Against-person misdemeanor complaints:** Number of complaints for which the most serious allegation was an against-person misdemeanor – a misdemeanor involving threats, force, or physical harm to another person or sexual misconduct (assault, coercion, harassment, intimidation, etc.)	O None O One O Two or more
6. **Against-person felony complaints:** Number of complaints involving force or physical harm to another person including sexual misconduct (homicide, manslaughter, assault, robbery, kidnapping, rape, domestic violence, harassment, criminal mistreatment, intimidation, coercion, etc.)	O None O One or two O Three or more
Detention/State Training School/Warrants:	O
7. **Number of time a youth served at 24 consecutive hours confined in detention:** Total number of times a youth served at least 24 hours physically confined in a detention facility.	O None O One O Two O Three or more
8. **Number of times where youth was placed at least 30 days in a State Training School or Residential Treatment through a delinquency action:** Number of times placed at either the Boy's or Girls State Training School, not including 30-day evaluations or residential treatment and not including CINA placements of commitments to the State Children's Home.	O None O One O Two or more
9. **Escapes:** Total number of attempted or actual escapes from a locked setting or escapes from custody of law enforcement officers that resulted in adjudication.	O None O One O Two or more
10. **Failure-to-appear in court warrants:** Total number of in-court failures-to-appear that resulted in warrants/pick-up/wanted order(s) being issued. Exclude failure-to-appear warrants/orders for non-criminal matters.	O None O One O Two or more

Social History		
For Initial Assessments, current is the most recent term in last 6 months; for Re-assessments and Final Assessments current is the last 4 weeks in the most recent term.		
1. **Youth's Gender**	O Male O Female	
2a. **Youth's current school enrollment status, regardless of attendance:** If the youth is in home school as a result of being expelled or dropping out, check the expelled or dropped out box, otherwise check enrolled.	O Graduated, GED O Enrolled full-time O Enrolled part-time	O Suspended O Dropped out O Expelled
2b. **Youth's conduct in the most recent term:** Fighting or threatening students; threatening teachers/staff; overly disruptive behavior; drug/alcohol use; crimes, e.g., theft, vandalism; lying, cheating, dishonesty.	O Recognition for good behavior O No problems with school conduct O Problems reported by teachers O Problem calls to parents O Calls to police	
2c. **Youth's attendance in the most recent term:** Full-day absence means missing majority of classes. Partial-day absence means attending the majority of classes and missing the minority. A truancy petition is equal to 7 unexcused absences in a month or 10 in a year.	O Good attendance with few absences O No unexcused absences O Some partial-day unexcused absences O Some full-day unexcused absences O Truancy petition/equivalent or withdrawn	
2d. **Youth's academic performance in the most recent school term:**	O Honor student (mostly As) O Above 3.0 (mostly As and Bs) O 2.0 to 3.0 (mostly Bs and Cs, no Fs) O 1.0 to 2.0 (mostly Cs and Ds, some Fs) O Below 1.0 (some Ds and mostly Fs)	
3a. **History of anti-social friends/companions:** Anti-social peers are youths hostile to or disruptive of the legal social order; youths who violate the law and the rights of others. *(Check all that apply.)*	☐ Never had consistent friends or companions ☐ Had pro-social friends ☐ Had anti-social friends ☐ Been a gang member/associate	
3b. **Current friends/companions youth actually spends time with:** *(Check all that apply.)*	☐ No consistent friends or companions ☐ Pro-social friends ☐ Anti-social friends ☐ Gang member/associate	
4. **JCS, DHS or voluntary out-of-home and shelter care placements or DHS/Voluntary Residential Treatment; any of which exceeded 30 days:** Exclude State Training School commitments.	O No out-of-home placements exceeding 30 days O 1 out-of-home placement O 2 out-of-home placements O 3 or more out-of-home placements	
5. **History of runaways or times kicked out of home:** Include times the youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.	O No history of running away/being kicked out O 1 instance of running away/kicked out O 2 to 3 instances of running away/kicked out O 4 to 5 instances of running away/kicked out O Over 5 instances of running away/kicked out	
6a. **History of jail/imprisonment of persons who were involved in the household for at least 3 months, no matter what the age of the youth at the time the person resided in the youth's home:** *(Check all that apply.)*	☐ No jail/imprisonment history in family ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member	
6b. **History of jail/imprisonment of persons who are currently involved with the household:** *(Check all that apply.)*	☐ No jail/imprisonment history of persons currently in household ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member	

6c. **Problem history of parents who are currently involved with the household:** *(Check all that apply).* Include any problems the parents or caregivers currently involved in the household have ever experienced.	☐ No problem history of parents in household ☐ Parental alcohol problem history ☐ Parental drug problem history ☐ Parental physical health problem history ☐ Parental mental health problem history ☐ Parental employment problem history
7. **Current parental authority and control:**	O Youth usually obeys and follows rules O Sometimes obeys or obeys some rules O Consistently disobeys, and/or is hostile
8a. **History of alcohol use:** *(Check all that apply.)*	☐ No past alcohol use ☐ Past alcohol use ☐ Alcohol caused family conflict ☐ Alcohol disrupted education ☐ Alcohol caused health problems ☐ Alcohol interfered with keeping pro-social friends ☐ Past alcohol contributed to criminal behavior
8b. **History of drug use:** *(Check all that apply.)*	☐ No past drug use ☐ Past drug use ☐ Drugs caused family conflict ☐ Drugs disrupted education ☐ Drugs caused health problems ☐ Drugs interfered with keeping pro-social friends ☐ Drugs contributed to criminal behavior
8c. **Current alcohol use:** *(Check all that apply.)*	☐ No current alcohol use ☐ Current alcohol use ☐ Alcohol causing family conflict ☐ Alcohol disrupting education ☐ Alcohol causing health problems ☐ Alcohol interfering with keeping pro-social friends ☐ Alcohol contributing to criminal behavior
8d. **Current drug use:** *(Check all that apply.)*	☐ No current drug use ☐ Current drug use ☐ Drugs causing family conflict ☐ Drugs disrupting education ☐ Drugs causing health problems ☐ Drugs interfering with keeping pro-social friends ☐ Drugs contributing to criminal behavior
9a. **History of physical abuse:** Include suspected incidents of abuse, whether or not substantiated, but exclude reports proven to be false. *(Check all that apply.)*	☐ Not a victim of physical abuse ☐ Physically abused by family member ☐ Physically abused by someone outside the family
9b. **History of sexual abuse:** Include suspected incidents of abuse, whether or not substantiated, but exclude reports proven to be false. *(Check all that apply.)*	☐ Not a victim of sexual abuse ☐ Sexually abused by family member ☐ Sexually abused by someone outside the family
10. **History of being a victim of neglect:** Include suspected incidents of neglect, whether or not substantiated, but exclude reports proven to be false.	O Not victim of neglect O Victim of neglect
11. **History of mental health problems:** Such as schizophrenia, bi-polar, mood, thought, personality, and adjustment disorders. Exclude substance abuse and special education since those issues are considered elsewhere. Confirm by a professional in the social service/healthcare field. *(Check one)*	O No history of mental health problem(s) O Diagnosed with mental health problem(s) O Only mental health medication prescribed O Only mental health treatment prescribed O Mental health medication and treatment prescribed

Attitude/Behavior Indicators	
1. Attitude toward responsible law abiding behavior:	O Abides by conventions/values O Believes conventions/values sometime apply to him or her O Does not believe conventions/values apply to him or her O Resents or is hostile toward responsible behavior
2. Accepts responsibility for anti-social behavior:	O Accepts responsibility for anti-social behavior O Minimizes, denies, justifies, excuses, or blames others O Accepts anti-social behavior as okay O Proud of anti-social behavior
3. Belief in yelling and verbal aggression to resolve a disagreement or conflict:	O Believes verbal aggression is rarely appropriate O Believes verbal aggression is sometimes appropriate O Believes verbal aggression is often appropriate
4. Belief in fighting and physical aggression to resolve a disagreement or conflict:	O Believes physical aggression is never appropriate O Believes physical aggression is rarely appropriate O Believes physical aggression is sometimes appropriate O Believes physical aggression is often appropriate
5. Reports/evidence of violence not included in criminal history: (Check all that apply.)	☐ No reports/evidence of violence ☐ Violent outbursts, displays of temper, uncontrolled anger indicating potential for harm ☐ Deliberately inflicting physical pain ☐ Using/threatening with a weapon ☐ Fire starting ☐ Violent destruction of property ☐ Animal cruelty
6. Reports of problem with sexual aggression not included in criminal history: *(Check all that apply.)*	☐ No reports/evidence of sexual aggression ☐ Aggressive sex ☐ Sex for power ☐ Young sex partners ☐ Child sex ☐ Voyeurism ☐ Exposure

Domain 1: Record of Complaints Resulting in Conviction, Diversion, or Deferred Adjudication/Disposition	
Complaints, rather than offenses, are used to assess the persistence of re-offending by the youth. Include only complaints that resulted in a Warn and Dismiss, Held Open, Diversion, Informal, Consent Decree, Adjudication, or other disposition, (regardless of whether successfully completed). *A complaint is a report of a law violation by a juvenile. One complaint may contain one or more charges/allegations.*	
1. **Age at first complaint:** The youth's age at the time of the first complaint for a public offense referred to juvenile court where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O Over 16 O 16 O 15 O 13 to 14 O Under 13
Felony and misdemeanor complaints	
2. **Misdemeanor complaints:** Total number of complaints for which the most serious allegation was a misdemeanor which was within the jurisdiction of juvenile court and where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O None or one O Two O Three or four O Five or more
3. **Felony complaints:** Total number of complaints for which the most serious allegation was a felony and where the complaint resulted in a disposition other than dismissed for lack of legal sufficiency.	O None O One O Two O Three or more
Against-person or weapon complaints: *Include all complaints not dismissed for lack of legal sufficiency.*	
4. **Weapon complaints:** Number of complaints for which the most serious allegation was a firearm/weapon charge.	O None O One or more
5. **Against-person misdemeanor complaints:** Number of complaints for which the most serious allegation was an against-person misdemeanor – a misdemeanor involving threats, force, or physical harm to another person or sexual misconduct (assault, coercion, harassment, intimidation, etc.).	O None O One O Two or more
6. **Against-person felony complaints:** Number of complaints involving force or physical harm to another person including sexual misconduct (homicide, manslaughter, assault, robbery, kidnapping, rape, domestic violence, harassment, criminal mistreatment, intimidation, coercion, etc.)	O None O One or two O Three or more
Detention/State Training School/Warrants:	O
7. **Number of times where youth served at least 24 hours day confined in detention:** Total number of times for which the youth served at least 24 consecutive hours physically confined in a detention facility.	O None O One O Two O Three or more
8. **Number of times where youth was placed for at least 30 day in Residential Treatment or the State Training School :** Number of times placed at either the Boy's or Girls State Training School, not including 30-day evaluations or residential treatment for more than 30 days and not including CINA placement or DHS commitments to the State Children's Home.	O None O One O Two or more
9. **Escapes:** Total number of attempted or actual escapes from a locked setting or escapes from custody of law enforcement officers that resulted in a conviction.	O None O One O Two or more
10. **Failure-to-appear in court warrants:** Total number of in-court failures-to-appear that resulted in warrants/pick-up/wanted order(s) being issued. Exclude failure-to-appear warrants/orders for non-criminal matters.	O None O One O Two or more

DOMAIN 2: Demographics	
1. **Gender:**	O Male O Female

DOMAIN 3A: School History	
1. **Youth is a special education student or has a formal diagnosis of a special education need:** *(Check all that apply.)*	☐ No special education need ☐ Learning ☐ Mental retardation ☐ Behavioral ☐ ADHD/ADD
2. **History of expulsions and suspensions since the first grade:**	O No expel/suspend O 4 or 5 O 1 expel/suspend O 6 or 7 O 2 or 3 O More than 7
3. **Age at first expulsion or suspension:**	O No expulsions O 14 to 15 years old O 5 to 9 years old O 16 to 18 years old O 10 to 13 years old
4. **Youth has been enrolled in a community school during the last 6 months, regardless of attendance:**	O No, graduated/GED and not attending school, do not complete Domain 3B O No, dropped-out or expelled for more than six months, do not complete Domain 3B O Yes, must complete Domain 3B
DOMAIN 3B: Current School Status	
For Initial Assessments, current is the most recent term in last 6 months; for Re-assessments and Final Assessments current is the last 4 weeks in the most recent term.	
1. **Youth's current school enrollment status, regardless of attendance:** *If the youth is in home school as a result of being expelled or dropping out, check the expelled or dropped out box; otherwise check enrolled, if in home school.*	O Graduated/GED O Suspended O Enrolled full-time O Dropped out O Enrolled part-time O Expelled
2. **Type of school in which youth is enrolled:** **Name of School** _____	O Public academic O Private academic O Vocational O Home school O Alternative O College O GED program O Other _____
3. **Youth believes there is value in getting an education:**	O Believes getting an education is of value O Somewhat believes education is of value O Does not believe education is of value
4. **Youth believes school provides an encouraging environment for him or her:** from the youth's perspective	O Believes school is encouraging O Somewhat believes school is encouraging O Does not believe school is encouraging
5. **Teachers, staff, or coaches the youth likes or feels comfortable talking with:**	O Not close to any teachers, staff, or coaches O Close to 1 O Close to 3 O Close to 2 O Close to 4 or more
6. **Youth's involvement in school activities during most recent term:** *School leadership; social service clubs; music, dance, drama, art; athletics; other extracurricular activities.*	O Involved in 2 or more activities O Involved in 1 activity O Interested but not involved in any activities O Not interested in school activities
7. **Youth's conduct in the most recent term:** *Fighting or threatening students; threatening teachers/staff; overly disruptive behavior; drug/alcohol use; crimes (e.g., theft, vandalism); lying, cheating, dishonesty.*	O Recognition for good behavior O No problems with school conduct O Problems reported by teachers O Problem calls to parents O Calls to police
8. **Number of expulsions and suspensions in the most recent term:**	O No expel/suspend O 2 or 3 O 1 expel/suspend O Over 3
9. **Youth's attendance in the most recent term:** *Partial-day absence means attending majority of classes and missing minority. Full-day absence means missing majority of classes. A truancy petition is equal to 7 unexcused absences in a month or 10 in a year.*	O Good attendance; few excused absences O No unexcused absences O Some partial-day unexcused absences O Some full-day unexcused absences O Truancy petition/equivalent or withdrawn

10. **Youth's academic performance in the most recent school term:**	O Honor student (mostly As) O Above 3.0 (mostly As and Bs) O 2.0 to 3.0 (mostly Bs and Cs, no Fs) O 1.0 to 2.0 (mostly Cs and Ds, some Fs) O Below 1.0 (some Ds and mostly Fs)

11. **Interviewer's assessment of likelihood the youth will stay in and graduate from high school or an equivalent vocational school:**	O Very likely to stay in school and graduate O Uncertain if youth will stay and graduate O Not very likely to stay and graduate

DOMAIN 4A: Historic Use of Free Time	
1. **History of structured pro-social recreational activities within the past 5 years:** *Youth has participated in structured and supervised pro-social community activities, such as religious group/church, community group, cultural group, club, athletics, or other community activities.*	O Involved in 2 or more structured activities O Involved in 1 structured activity O Never involved in structured activities
2. **History of unstructured pro-social recreational activities within the past 5 years:** *Youth has engaged in activities that positively occupy the youth's time, such as reading, hobbies, etc.*	O Involved in 2 or more pro-social unstructured activities O Involved in 1 pro-social unstructured activity O Never involved in pro-social unstructured activities
DOMAIN 4B: Current Use of Free Time (For Initial Assessments, current means behaviors during the last six-month, for Re-assessments and Final Assessments, current means behaviors during the last four-weeks)	
1. **Current interest and involvement in pro-social structured recreational activities:** *Youth participates in structured and supervised pro-social community activities, such as religious group/church, community group, cultural group, club, athletics, or other community activity.*	O Currently involved in 2 or more structured activities O Currently involved in 1 structured activity O Currently interested but not involved O Currently not interested in any structured activities
2. **Types of structured recreational activities in which youth currently participates:** *(Check all that apply.*)	☐ No structured recreational activities ☐ Athletics ☐ Community/cultural group ☐ Hobby group or club ☐ Religious group/church ☐ Volunteer organization
3. **Current interest and involvement in pro-social unstructured recreational activities:** *Youth engages in activities that positively occupy his or her time, such as reading, hobbies, etc.*	O Currently involved in 2 or more unstructured activities O Currently involved in 1 unstructured activity O Currently interested but not involved O Currently not interested in any unstructured activities

DOMAIN 5A: Employment History	
1. **Child's History of employment:**	O Too young for employment consideration or NA O Never been employed O Has been employed
2. **Child's History of successful employment:**	O Never successfully employed or NA O Has been successfully employed
3. **Child's History of problems while employed:**	O Never fired or quit because of problems or NA O Fired or quit because of poor performance O Fired or quit because he or she could not get along with employer or coworkers
4. **Child's History of positive personal relationship(s) with past employer(s) or adult coworker(s):**	O Never had any positive relationships or NA O Had 1 positive relationship O Had 2 or more positive relationships
DOMAIN 5B: Current Employment (For Initial Assessments, current means behaviors during the last six-month, for Re-assessments and Final Assessments, current means behaviors during the last four-weeks)	
1. **Child understanding of what is required to maintain a job:**	O Lacks knowledge of what it takes to maintain a job O Has knowledge of abilities to maintain a job O Has demonstrated ability to maintain a job
2. **Child's current interest in employment:**	O Currently employed O Highly interested in employment O Somewhat interested O Not interested in employment O Too young for employment consideration
3. **Child's current employment status:**	O Not currently employed O Employment currently going well O Having problems with current employment
4. **Child's current positive personal relationship(s) with employer(s) or adult coworker(s):**	O Not currently employed O Currently employed but no positive relationships O At least 1 current positive relationship

DOMAIN 6A: History of Relationships	
1. **History of positive adult non-family relationships not connected to school or employment:** *Adults, who are not teachers and not part of the youth's family, who can provide support and model pro-social behavior, such as religious leader, club member, community person, etc.*	O No positive adult relationships O 1 positive adult relationship O 2 positive adult relationships O 3 or more positive adults relationships
2. **History of anti-social friends/companions:** *Anti-social peers are youths hostile to or disruptive of the legal social order; youths who violate the law and the rights of others. (Check all that apply.)*	☐ Never had consistent friends or companions ☐ Had pro-social friends ☐ Had anti-social friends ☐ Had both pro-social and anti-social friends ☐ Been a gang member/associate
DOMAIN 6B: Current Relationships (For Initial Assessments, current means behaviors during the last six-month, for Re-assessments and Final Assessments, current means behaviors during the last four-weeks)	
1. **Current positive adult non-family relationships not connected to school or employment:** *Adults, who are not teachers and not part of the youth's family, who can provide support and model pro-social behavior, such as religious leader, club member, community person, etc.*	O No positive adult relationships O 1 positive adult relationship O 2 positive adult relationships O 3 or more positive adults relationships
2. **Current pro-social community ties:** *Youth feels there are people in his or her community who discourage him or her from getting into trouble or are willing to help the youth.*	O No pro-social community ties O Some pro-social community ties O Has strong pro-social community ties
3. **Current friends/companions youth actually spends time with:** (*Check all that apply.)*	☐ No consistent friends or companions ☐ Pro-social friends ☐ Anti-social friends ☐ Pro-social and Anti-Social friends ☐ Gang member/associate
4. **Currently in a "romantic," intimate, or sexual relationship:**	O Not romantically involved with anyone O Romantically involved with a pro-social person O Romantically involved with an anti-social person/criminal
5. **Currently admires/emulates anti-social peers:**	O Does not admire, emulate anti-social peers O Somewhat admires, emulates anti-social peers O Admires, emulates anti-social peers
6. **Current resistance to anti-social peer influence:**	O Does not associate with anti-social peers O Usually resists going along with anti-social peers O Rarely resists goes along with anti-social peers O Leads anti-social peers

DOMAIN 7A: Family History	
1. **JCS/DHS or voluntary out-of-home and shelter care placements or DHS/Voluntary Residential Treatment; any of which exceeded 30 days:** Exclude State Training School Commitments.	O No out-of-home placements exceeding 30 days O 1 out-of-home placement O 2 out-of-home placements O 3 or more out-of-home placements
2. **History of running away or getting kicked out of home:** *Include times the youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.*	O No history of running away or being kicked out O 1 instance of running away/kicked out O 2 to 3 instances of running away/kicked out O 4 to 5 instances of running away/kicked out O Over 5 instances of running away/kicked out
3. **History of petitions filed:** *Include all petitions regardless of whether the petition was granted.* **Only non-delenquency petitions***(Check all that apply.)*	☐ No petitions filed ☐ CINA ☐ Mental health Commitment(s) ☐ Substance Abuse Commitment(s)
4. **History of jail/imprisonment of persons who were involved in the household for at least 3 months, no matter what the age of the youth at the time the person resided in the youth's home:** *(Check all that apply.)*	☐ No jail/imprisonment history in family ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member
5. **Youth currently living under any "adult supervision":** *Adult supervision must be someone who is responsible for the youth's welfare, either legally or with parental consent. For Initial Assessments, current means within the last six-months, for Re-assessments and Final Assessments, current means within the last four weeks.*	O No, living with peers without adult supervision, do not complete Domain 7B O No, living alone without adult supervision, do not complete Domain 7B O No, transient without adult supervision, do not complete Domain 7B O Yes, living under adult supervision, must complete Domain 7B

DOMAIN 7B: Current Living Arrangements

(For Initial Assessments, current means behaviors during the last six-month, for Re-assessments and Final Assessments, current means behaviors during the last four-weeks)

1. **All persons with whom youth is currently living:** *(Check all that apply.)*	☐ Living alone	☐ Transient (street, moving around)
	☐ Biological mother	☐ Biological father
	☐ Non-biological mother	☐ Non-biological father
	☐ Older sibling(s)	☐ Younger sibling(s)
	☐ Grandparent(s)	☐ Other relative(s)
	☐ Long-term parental partner(s)	☐ Short-term parental partner(s)
	☐ Youth's romantic partner	☐ Youth's child
	☐ Foster/group home	☐ Youth's friends

2. **Annual family income:**	O Under $15,000 O $15,000 to $34,999 O $35,000 to $49,999 O $50,000 to $74,999 O $75,000 to $99,999 O $100,000 and over
3. **Jail/imprisonment history of persons who are currently involved with the household:** *(Check all that apply.)*	☐ No jail/imprisonment history of persons currently in household ☐ Mother/female caretaker ☐ Father/male caretaker ☐ Older sibling ☐ Younger sibling ☐ Other member
4. **Problem history of parents who are currently involved with the household:** *(Check all that apply.)* Include any problems the parents or caregivers currently involved in the household have ever experienced.	☐ No problem history of parents in household ☐ Parental alcohol problem history ☐ Parental drug problem history ☐ Parental physical health problem history ☐ Parental mental health problem history ☐ Parental employment problem history

5. **Problem history of siblings who are currently involved with the household:** *(Check all that apply.)*	☐ No siblings currently in household ☐ No problem history of siblings in household ☐ Sibling alcohol problem history ☐ Sibling drug problem history ☐ Sibling physical health problem history ☐ Sibling mental health problem history ☐ Sibling employment problem history
6. **Support network for family:** *Extended family and/or family friends who can provide additional support to the family.*	O No support network O Some support network O Strong support network
7. **Family willingness to help support youth:**	O Consistently willing to support youth O Inconsistently willing to support youth O Little or no willingness to support youth O Hostile, berating, and/or belittling of youth
8. **Family provides opportunities for youth to participate in family activities and decisions affecting the youth:**	O No opportunities for involvement provided O Some opportunities for involvement provided O Opportunities for involvement provided
9. **Youth has run away or been kicked out of home:** *Include times youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.*	O Has not run away/kicked out of home O Has run away/kicked out O Is currently kicked out of home or is a runaway
10. **Family member(s) youth feels close to or has good relationship with:** *(Check all that apply.)*	☐ Does not feel close to any family member ☐ Feels close to mother/female caretaker ☐ Feels close to father/male caretaker ☐ Feels close to male sibling ☐ Feels close to female sibling ☐ Feels close to extended family
11. **Level of conflict between parents, between youth and parents, among siblings:**	O Some conflict that is well managed O Verbal intimidation, yelling, heated arguments O Threats of physical abuse O Domestic violence: physical/sexual abuse
12. **Parental supervision:** *Parents know whom youth is with, when youth will return, where youth is going, and what youth is doing.*	O Consistent good supervision O Sporadic supervision O Inadequate supervision
13. **Current parental authority and control:**	O Youth usually obeys and follows rules O Youth sometimes obeys or obeys some rules O Youth consistently disobeys and/or is hostile O No pro-social parental rules present.
14. **Consistent appropriate consequences for bad behavior:** *Appropriate means clear communication, timely response, and response proportionate to conduct.*	O Consistently appropriate consequences O Consistently overly severe consequences O Consistently insufficient consequences O Inconsistent or erratic consequences
15. **Consistent appropriate rewards for good behavior:** *Appropriate means clear communication, timely response, and response proportionate to conduct; rewards mean affection, praise, etc.*	O Consistently appropriate rewards O Consistently overly indulgent/overly protective O Consistently insufficient rewards O Inconsistent or erratic rewards
16. **Parental characterization of youth's anti-social behavior:**	O Disapproves of youth's anti-social behavior O Minimizes, denies, justifies, excuses behavior, or blames others/circumstances O Accepts youth's anti-social behavior as okay O Proud of youth's anti-social behavior

DOMAIN 8A: Alcohol and Drug History	
Disrupted functioning involves having a problem in any of these five life areas: education, family conflict, peer relationships, crime, or health, and usually indicates treatment is warranted. Use that contributes to criminal behavior typically precipitates the commission of a crime: there is evidence or reason to believe the youth's criminal activity is	
1. **History of alcohol use:** *(Check all that apply.)*	☐ Past alcohol use ☐ No alcohol use ☐ Alcohol caused family conflict ☐ Alcohol disrupted education ☐ Alcohol caused health problems ☐ Alcohol interfered with keeping pro-social friends ☐ Alcohol contributed to criminal behavior
2. **History of drug use:** *(Check all that apply.)*	☐ Past drug use ☐ No past drug use ☐ Drugs caused family conflict ☐ Drugs disrupted education ☐ Drugs caused health problems ☐ Drugs interfered with keeping pro-social friends ☐ Drugs contributed to criminal behavior
3. **History of referrals for alcohol/drug assessment:**	O Never referred for drug/alcohol assessment O Diagnosed as no problem O Referred but never assessed O Diagnosed as abuse O Diagnosed as dependent/addicted
4. **History of attending alcohol/drug <u>education classes</u> for an alcohol/drug problem:**	O Never attended drug/alcohol education classes O Voluntarily attended drug/alcohol education classes O Attended classes by parent, school, or other agency request O Attended classes at court direction
5. **History of participating in alcohol/drug <u>treatment program</u>:**	O Never participated in treatment program O Participated once in treatment program O Participated several times in treatment programs
Youth currently using alcohol or drugs: *For Initial Assessments, current is the last six-months; for Re-assessments/Final Assessments, it's 4 weeks.*	O No current use, do not compete Domain 8B O Current use, must complete domain 8B
DOMAIN 8B: Current Alcohol and Drugs (For Initial Assessments, current is the last six-months, for Re-assessments/Final Assessments, it's the last four-weeks).	
1. **Current alcohol use:** Indicate if there is evidence or reason to believe the youth's criminal activity is related to alcohol use. Answering yes means the youth may need alcohol treatment. If a youth is a minor in possession with no indication of dependence on alcohol, then answer no. (Check all that apply.)	☐ No current alcohol use ☐ Current alcohol use ☐ Alcohol causing family conflict ☐ Alcohol disrupting education ☐ Alcohol causing health problems ☐ Alcohol interfering with keeping pro-social friends ☐ Alcohol contributing to criminal behavior
2. **Current drug use:** Indicate if there is evidence or reason to believe the youth's criminal activity is related to drug use. Answering yes means the youth may need drug treatment. If a youth is a minor in possession with no indication of dependence on drugs, then answer no. (Check all that apply.)	☐ No current drug use ☐ Current drug use ☐ Drugs causing family conflict ☐ Drugs disrupting education ☐ Drugs causing health problems ☐ Drugs interfering with keeping pro-social friends ☐ Drugs contributing to criminal behavior

3. **Type of drugs currently used:** *(Check all that apply.)*	☐ No current drug use ☐ Amphetamines (uppers/speed/ecstacy) ☐ Barbiturates (Tuinal/Seconal/downers) ☐ Cocaine (coke) ☐ Cocaine (crack/rock) ☐ Hallucinogens (LSD/acid/mushrooms/GHB) ☐ Heroine ☐ Inhalants (glue/gasoline) ☐ Marijuana/hashish ☐ Other opiates (Dilaudid/Demerol/Percodan/Codeine/Oxycontin) ☐ Phencyclidine (PCP/angel dust) ☐ Tranquilizers/sedatives (Valium/Libnum/Dalmane/ Ketamine) ☐ Other drugs (List in comment)
4. **Current alcohol/drug treatment program participation:**	O Alcohol/drug treatment not warranted O Not currently attending needed alcohol/drug treatment program O Currently attending alcohol/drug treatment program O Successfully completed alcohol/drug treatment program

DOMAIN 9A: Mental Health History	
1. **History of suicidal ideation:**	O Has never thought about suicide O Has had serious thoughts about suicide O Has made a plan to commit suicide O Has attempted to commit suicide
Include suspected incidents of abuse, whether or not substantiated, but exclude reports proven to be false.	
2. **History of physical abuse:** *(Check all that apply.)*	☐ Not a victim of physical abuse ☐ Physically abused by family member ☐ Physically abused by someone outside the family
3. **History of sexual abuse:** *(Check all that apply.)*	☐ Not a victim of sexual abuse ☐ Sexually abused by family member ☐ Sexually abused by someone outside the family
4. **History of being a victim of neglect:**	O Not a victim of neglect O Victim of neglect
5. **History of ADD/ADHD:** *Confirmed by a professional in the social service/healthcare field.*	O No history of ADD/ADHD O Diagnosed with ADD/ADHD O Only ADD/ADHD medication prescribed O Only ADD/ADHD treatment prescribed O ADD/ADHD medication and treatment prescribed
6. **History of mental health problems:** *Such as schizophrenia, bi-polar, mood, thought, personality, and adjustment disorders. Exclude conduct disorder, oppositional defiant disorder, substance abuse, and ADD/ADHD. Confirmed by a professional in the social service/healthcare field.* (Check one)	O No history of mental health problem(s) O Diagnosed with mental health problem(s) O Only mental health medication prescribed O Only mental health treatment prescribed O Mental health medication and treatment prescribed
7. **Currently has health insurance:**	O No health insurance O Public insurance (Medicaid) O Private insurance
8. **Current mental health problem status:** *For Initial Assessments, current is the last 6 months; for Re-assessments and Final Assessment it is the last 4 weeks.*	O No current mental health problem(s), do not complete Domain 9B O Current mental health problem(s), must complete Domain 9B

DOMAIN 9B: Current Mental Health	
(For Initial Assessments, current means behaviors during the last six-month, for Re-assessments and Final Assessments, current means behaviors during the last 4 weeks.)	
1. **Current suicidal ideation:**	O Does not have thoughts about suicide O Has serious thoughts about suicide O Has recently made a plan to commit suicide O Has recently attempted to commit suicide
2. **Currently diagnosed with ADD/ADHD:** *Confirmed by a professional in the social service/healthcare field.* **Type of medication:** _____	O No ADD/ADHD diagnosis O No ADD/ADHD medication currently prescribed O Currently taking ADD/ADHD medication O ADD/ADHD medication currently prescribed, but not taking
3. **Mental health treatment currently prescribed excluding ADD/ADHD treatment:**	O No current mental health problem O No mental health treatment currently prescribed O Attending mental health treatment O Treatment currently prescribed, but not attending
4. **Mental health medication currently prescribed excluding ADD/ADHD medication:** **Type of medication:** _____	O No current mental health problem O No mental health medication currently prescribed O Currently taking mental health medication O Mental health medication currently prescribed, but not taking
5. **Mental health problems currently interfere in working with the youth:**	O No current mental health problem O Mental health problem(s) do not interfere in work with youth O Mental health problem(s) interfere in work with youth

1	O
	O
2	O
3	O
4	O
5	O
6	O
7	O
8	O
9	O

DOMAIN 10: Attitudes/Behaviors	
(For Initial Assessments, current is within the last 6 months; for Re-assessments and Final Assessments current is within the last 4 weeks.)	
10. **Primary emotion when committing crime(s) within the last 6 months:**	O Nervous, afraid, worried, ambivalent, uncertain, or indecisive O Hyper, excited, or stimulated O Unconcerned or indifferent O Confident or brags about not getting caught
11. **Primary purpose for committing crime(s) within the last 6 months:**	O Anger O Revenge O Impulse O Sexual desire O Money or material gain, including drugs O Excitement, amusement, or fun O Peer status, acceptance, or attention
12. **Impulsive; acts before thinking:**	O Uses self-control; usually thinks before acting O Some self-control; sometimes thinks before acting O Impulsive; often acts before thinking O Highly Impulsive; usually acts before thinking
13. **Belief in control over anti-social behavior:**	O Believes he or she can avoid/stop anti-social behavior O Somewhat believes anti-social behavior is controllable O Believes his or her anti-social behavior is out of his or her control
14. **Empathy, remorse, sympathy, or feelings for the victim(s) of criminal behavior:**	O Has empathy for his or her victim(s) O Has some empathy for his or her victim(s) O Does not have empathy for his or her victim(s)
15. **Respect for property of others:**	O Respects property of others O Respects personal property but not publicly accessible property: "It's not hurting anybody." O Conditional respect for personal property: "If they are stupid enough to leave it out, they deserve losing it." O No respect for property: "If I want something, it should be mine."
16. **Respect for authority figures:**	O Respects most authority figures O Does not respect authority figures, and may resent some O Resents most authority figures O Defies or is hostile toward most authority figures
17. **Attitude toward pro-social rules/conventions in society:**	O Believes pro-social rules/conventions apply to him or her O Believes some pro-social rules/conventions sometimes apply to him or her O Does not believe pro-social rules/conventions apply to him or her O Resents or is defiant toward pro-social rules/conventions
18. **Accepts responsibility for anti-social behavior:**	O Accepts responsibility for anti-social behavior O Minimizes, denies, justifies, excuses, or blames others O Accepts anti-social behavior as okay O Proud of anti-social behavior
19. **Youth's Belief in successfully meeting the conditions of Court Supervision:**	O Believes he or she will be successful O Unsure if he or she will be successful O Does not believe he or she will be successful
20. **Optimism:** *Youth talks about future in positive way with plans or aspirations of a better life that could include employment, education, raising a family, travel, or other pro-social life goals.*	O High aspirations, sense of purpose, commitment to better life O Normal aspirations: some sense of purpose O Low aspirations, little sense of purpose or plans for better life O Believes nothing matters; he or she will be dead before long

DOMAIN 11: Aggression	
(For Initial Assessments, rate items 1 to 4 based on the last 6 months; for Re-assessments and Final Assessments use the last 4 weeks.)	
1. **Tolerance for frustration:**	O Rarely gets upset over small things or has temper tantrums O Sometimes gets upset over small things or has temper tantrums O Often gets upset over small things or has temper tantrums
2. **Hostile interpretation of actions and intentions of others in a common non-confrontational setting:**	O Primarily positive view of intentions of others O Primarily negative view of intentions of others O Primarily hostile view of intentions of others
3. **Belief in yelling and verbal aggression to resolve a disagreement or conflict:**	O Believes verbal aggression is rarely appropriate O Believes verbal aggression is sometimes appropriate O Believes verbal aggression is often appropriate
4. **Belief in fighting and physical aggression to resolve a disagreement or conflict:**	O Believes physical aggression is never appropriate O Believes physical aggression is rarely appropriate O Believes physical aggression is sometimes appropriate O Believes physical aggression is often appropriate
For Initial Assessments, include the entire history of reports; for Re-assessments and Final Assessment include reports within the last 4 weeks.	
5. **Reports/evidence of violence not included in criminal history:** *(Check all that apply.)*	☐ No reports/evidence of violence ☐ Violent outbursts, displays of temper, uncontrolled anger indicating potential for harm ☐ Deliberately inflicting physical pain ☐ Using/threatening with a weapon ☐ Fire starting ☐ Violent destruction of property ☐ Animal cruelty
6. **Reports of problem with sexual aggression not included in criminal history:** *(Check all that apply.)*	☐ No reports/evidence of sexual aggression ☐ Aggressive sex ☐ Sex for power ☐ Young sex partners ☐ Child sex ☐ Voyeurism ☐ Exposure

DOMAIN 12: Skills	
(Use a general pattern of current behavior and not a single instance.)	
1. **Consequential thinking:**	O Does not understand there are consequences to actions O Understands there are consequences to actions O Identifies consequences of actions O Acts to obtain desired consequences - good consequential thinkin
2. **Problem Solving**	O Cannot identify problem behaviors O Identifies problem behaviors O Thinks of solutions for problem behaviors O Applies appropriate solutions to problem behaviors
3. **Monitoring of Internal Triggers:** (distorted thoughts that can lead to trouble)	O Cannot identify internal triggers O Identifies internal triggers O Actively monitors/controls internal triggers
4. **Monitoring of external triggers:** (events or situations, that can lead to trouble)	O Cannot identify external triggers O Identifies external triggers O Actively monitors/controls external triggers
5. **Control of impulsive behaviors that get youth into trouble:** *Reframing, replacing anti-social thoughts with pro-social thoughts, diversion, relaxation, problem solving, negotiation, relapse prevention.*	O Never had a problem with impulsive behavior O Does not know techniques to control impulsive behavior O Knows techniques to control impulsive behavior O Uses techniques to control impulsive behavior
6. **Control of aggression:** *Includes asking permission, sharing thoughts, helping others, negotiating, using self control, standing up for one's rights, responding to teasing, avoiding trouble with others, and keeping out of fights*.	O Never had a problem with aggression O Lacks alternatives to aggression O Rarely uses alternatives to aggression O Sometimes uses alternatives to aggression O Often uses alternatives to aggression
7. **Goal Setting:**	O Does not set goals O Sets unrealistic goals O Sets somewhat realistic goals O Sets realistic goals
8. **Situational perception:** *Ability to analyze the situation, choose the best pro-social skill, and select the best time and place to use the pro-social skill.*	O Cannot analyze the situation for use of a pro-social skill O Can analyze but not choose the best pro-social skill O Can choose the best skill but cannot select the best time and plac O Can select the best time and place to use the best pro-social skill
9. **Dealing with others:** *Basic social skills include listening, starting a conversation, having a conversation, asking a question, saying thank you, introducing yourself, introducing other people, and giving a compliment. Advanced social skills include asking for help, joining in, giving instructions, following instructions, apologizing, and convincing others.*	O Lacks basic social skills in dealing with others O Has basic social skills, lacks advanced skills in dealing with others O Sometimes uses advanced social skills in dealing with others O Often uses advanced social skills in dealing with others
10. **Dealing with difficult situations:** *Includes making a complaint, answering a complaint, dealing with embarrassment, dealing with being left out, standing up for a friend, responding to frustration, responding to failure, dealing with contradictory messages, dealing with accusation, getting ready for a difficult conversation, and dealing with group pressure.*	O Lacks skills in dealing with difficult situations O Rarely uses skills in dealing with difficult situations O Sometimes uses skills in dealing with difficult situations O Often uses skills in dealing with difficult situations

11. **Dealing with feelings/emotions:** *Includes knowing his or her feelings, expressing feelings, understanding the feelings of others, dealing with someone else's anger, expressing affection, dealing with fear, and rewarding oneself.*	O Lacks skills in dealing with feelings/emotions O Rarely uses skills in dealing with feelings/emotions O Sometimes uses skills in dealing with feelings/emotions O Often uses skills in dealing with feelings/emotions

JUVENILE COURT SERVICES
IV-E CANDIDACY FOR FOSTER CARE ELIGIBILITY SCREENING

(For Office Use Only)

A child who is candidate for foster care is a child who is at imminent risk for placement in foster care but who can remain safely at home or in a kinship placement with the provision of appropriate services. This screening tool is a structured approach for JCOs to determine if a child is a candidate for foster care and therefore eligible for Title IV-E prevention services.

Client Name		**JI#**	

Pre-Screening Questions		
1.	Is child under the age of 18?	☐ Yes. Continue to question #2.
		☐ No. Stop. Child is not an eligible candidate
2.	Is child discharging from a foster care placement?	☐ Yes. Child is eligible candidate.
		☐ No. Continue to question #3
3.	Have you petitioned the court for removal of the child from his/her home?	☐ Yes. Child is eligible candidate.
		☐ No. Continue to question #4
4.	Is the child in foster care pregnant or parenting foster youth?	☐ Yes. Child is eligible candidate.
		☐ No. Continue to Child Screening #1

Child Screening			
Please check all boxes that apply to the child			**Score** (No=0 Yes=1)
1.	Previous out-of-home placements	Select	0
2.	Developmental delays	Select	
3.	Social or emotional deficits	Select	
4.	Physical or cognitive disabilities	Select	
5.	Victim of physical, emotional or sexual abuse	Select	
6.	Victim of neglect	Select	
7.	Increasing pattern of delinquent behavior	Select	
8.	History of or current substance abuse problem	Select	
9.	Exhibits sexually problematic behavior	Select	
10.	Based on the child's offense is the child a risk to self or others?	Select	
11.	Child's IDA risk level	Select	
Total Score			0

Parent/Caregiver Screening Questions *Please check all boxes that apply, past or present, to parent(s)/caregiver(s)*			**Score** (No=0 Yes=1)
1.	Substance abuse problem	Select	
2.	Mental illness	Select	
3.	Lack of social supports or connections	Select	
4.	History of child maltreatment	Select	
5.	Involvement in criminal conduct/activity	Select	
6.	Home environment is characterized by violence and/or conflict	Select	
7.	Deficits in parenting skills (behavior management, communication, supervision, positive interaction/engagement)	Select	
Total Score			0

Score Totals	**Possible**	**Actual**
Child	12	0
Parent/Caregiver	7	0
Comprehensive Score Total	19	0
Candidacy Scoring Threshold 0-5 Not at imminent risk for foster care placement. 6-18 At risk of foster care placement		

Candidate for Foster Care Determination:	
☐	NOT a candidate for foster care placement
	☐ Comprehensive Total Score of 5 or less
	☐ Currently in a foster care placement
☐	Candidate for foster care (must have at least 1 of the 4 below checked)
	☐ Comprehensive Total Score of 6 or more
	☐ Discharging from a foster care placement
	☐ JCO has petitioned court for removal of youth from his/her home
	☐ Child is in foster care and pregnant or parenting foster youth.

A comprehensive assessment and prevention plan will be completed by the Juvenile Court Officer to further clarify the child and family strengths and needs and identify the appropriate prevention services necessary for the child to remain safely in his/her home.

Screening Supportive Documentation

☐ Child Delinquency Records
☐ Child Welfare Records
☐ Child Interview
☐ Collateral Contacts
☐ Parent/Caregiver Criminal Records
☐ Child School Records
☐ Parent/Caregiver Interview

_____ _____

Juvenile Court Officer Date

FFPSA Juvenile Court Services Staff Training Plan

Purpose: Integrate and coordinate FFPSA activities across all eight judicial districts

Topic	Goal	Objective	Delivery	Description
FFPSA Overview	Foster an understanding of FFPSA and how its implementation in Iowa will impact JCS's organizational policies, practices and outcomes	• Identify the key components of FFPSA • Demonstrate understanding of the opportunities and challenges associated with JCS participating in FFPSA	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	An overview of FFPSA that includes its purpose, goals and key concepts. The training also examines the impact on practic, policy, and funding that FFPSA will have on Iowa's juvenile justice system
Risk Assessment	Cultivate an understanding the risk assessment component of FFPSA and how the IDA, TOP and Candidacy for Foster Care Screening Tool (CFST) can be utlized to effectively assess the risk and protective factors of youth and families	• Identify FFPSA requirements for risk assessment • Describe how the IDA, TOP and CFST assess youth and family risk factors • Demonstrate ability to use risk assessment results to identify possible prevention service strategies.	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	An overview of the risk assessments used by JCS to assess the risk and protective factors of youth and their families. The course will include assessment (IDA, TOP and CFST) specific training related to FFPSA prevention service identification and prevention plan development.
Eligibility Tool and Screening	Develop the knowledge and skills needed to accurately complete the Candidacy for Foster Care Screening Tool (CFST) to identify youth who are eligible for Title IV-E prevention services	• Identify the CFST purpose and when it should be administered • Demonstrate ability to correctly use the CFST to identify youth who are candidates for out-of-home placement. • Successfully integrate the CST into case management practices	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	A summary of the ACF criteria and requirements for determining Title IV-E Candidacy for Foster Care. The training includes instruction and guidance on how to complete the JCS CFST tool and opportunities to apply knowledge using authentic case scenarios.
Prevention Case Plan Development	Develop the knowledge and skills required to accurately complete the Title IV-E Prevention Case Plan (TPCP)	• Identify the purpose of the TPCP and when it should be completed • Demonstrate ability to accurately complete the TPCP • Successfully integrate the TPCP into case management practices	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	A summary of the ACF criteria and requirements for Title IV-E Prevention Plans. The training includes instruction and guidance in how to complete the JCS TPCP and opportunities to apply knowledge using authentic case scenarios.
Prevention Services	Develop the knowledge and skills needed to effectively incorporate Title IV-E prevention services into case management practices	• Demonstrate understanding of what constitutes a Title IV-E prevention service (TPS) • Demonstrate the ability to identify a TPS • Demonstrate the ability to match TPS to youth and family needs. • Demonstrate the ability to monitor the effectiveness of TPS	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	An overview of what constitutes an ACF prevention service and the prevention services available specific to each district. Instruction and guidance will also be provided in how to identify, match, and monitor prevention services offered by JCS.

FFPSA Juvenile Court Services Staff Training Plan

Purpose: Integrate and coordinate FFPSA activities across all eight judicial districts

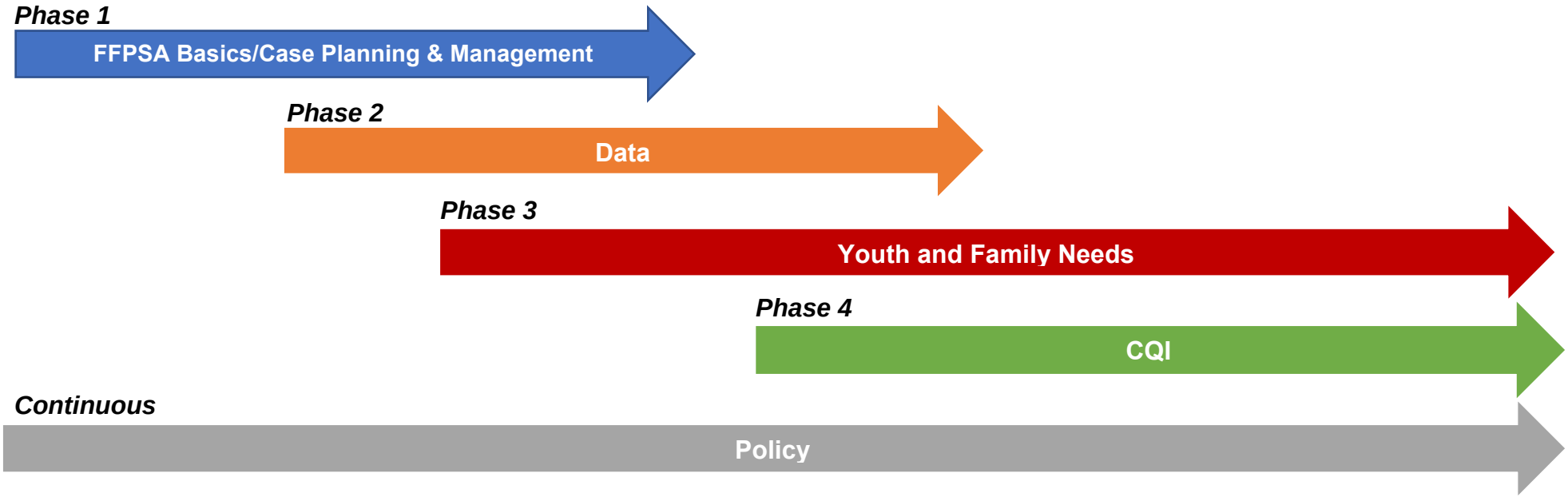
Safety Assessment & Planning	Develop the knowledge and skills required to effectively integrate safety assessment and planning into case management practices to ensure the safety and well-being of youth	• Identify and describe the key components of safety assessment • Identify the required timeframes for safety assessment • Describe the safety planning process • Apply safety assessment and planning principles to successfully complete a written safety plan	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	Introduce JCS staff to the components of formal safety assessment and planning. Instruct and guide JCS staff in the practical skills and knowledge required to complete safety assessments and plans for youth and their families.
QRTP	Foster an understanding of what a QRTP is and how it will impact placement policies and procedures for JCS	• Explain what a QRTP is and its purpose • Identify the criteria required for a QRTP placement • Explain the benefits and disadvantages of implementing a QRTP based placement system.	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	A summary of the ACF criteria for QRTPs, what QRTP implementation in Iowa will look like and how it will impact JCS.
Data Entry & Collection	Demonstrate proficiency in accurately recording required FFPSA data	• Identify FFPSA required data • Identify when and where FFPSA data should be recorded • Describe how accurate data collection supports the mission and goals of JCS	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	An overview of FFPSA reporting requirements that includes the type of data required for FFPSA, where the data will come from and who is responsible for entering the data.
CQI Process	Develop skills needed to participate in the CQI process, promote best practices, and identify opportunities for system improvement	• Define CQI and identify its key concepts and principles • Recognize the need to continually evalute services to ensure best practices are utilized • Decribe how the CQI process can improve JCS procedures, processess and quality of services	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	An introduction to the CQI process that covers the basics of CQI, benefits of CQI and how JCS intends to use CQI to improve practice.
FFPSA Related Policies	Demonstrate the knowledge, skills and support needed to promote the safety, permanency and well-being of youth	• Describe how FFPSA will impact JCS procedures and practices • Identify and implement changes in practice and procedures as they relate to FFPSA	• E-learning (webinar, self-paced course) • Direct Instruction • Coaching • Briefs	A series of policy related trainings that specifically addresses each of the policy areas impacted by FFPSA. The trainings address how, when and why each policy was developed or modified and the implications on JCS practices and procedures that will occur as a result.

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

JCS has identified six areas of training related to FFPSA – FFPSA basics, case planning and management, data, CQI, youth and family needs and policy. Training in these areas will be implemented in a phased approach. Phase one of the training will focus on providing JCS staff a context for learning through an overview of FFPSA and its requirements. This phase of training will cover case planning and management related to FFPSA requirements, inclusive of candidacy determination/eligibility screening tool, prevention plan development and implementation, identification, matching, monitoring and evaluation of services and family needs/safety assessment planning.

Phase two of training will introduce JCS staff to the data required for FFPSA. This will include data collection, reporting, entry and RMS. Phase three of training will focus on youth and family needs and address topics, such as trauma informed care, child development, cultural diversity and family engagement. Phase four of training will center on training specific JCS staff in the Continuous Quality Improvement (CQI) process. Training related to policy changes due to implementation FFPSA will be a continuous process that will occur simultaneously, as staff are trained on each of the FFPSA components that impact JCS processes and procedures. This training will serve to bring all the components related to FFPSA together in a comprehensive manner.

A blended learning approach will be used throughout the trainings. This approach will include direct and on-line instruction, discussion, demonstration and collaborative learning.



Confidential Document

Juvenile Court Services

Title IV-E Candidate for Foster Care Child Prevention Case Plan

Client Information						
Client Name				DOB	- - (mm/dd/yyyy)	
Gender	Choose item.	Race	Choose item.	Ethnicity	Choose an item.	
IV-E Candidacy Determination Date	- - (mm/dd/yyyy)			Candidate ID#		
Date Prevention Plan Completed	- - (mm/dd/yyyy)			IDA Risk Level	[Select]	
☐ Initial ☐ Review ☐ Change in Circumstances				6-month Review Date	- - (mm/dd/yyyy)	
Eligibility End/Case Closure Date	- - (mm/dd/yyyy)		Case Closure Reason	Select		

This child has been determined at imminent risk of foster care placement based on criteria identified in the IV-E Candidacy for Foster Care Eligibility Screening. In order for the child to safely remain in his/her home, prevention services are required. Absent the effectiveness of the services identified in this prevention plan, the plan is to remove the child from his/her home and place him/her in a suitable foster care placement.

Planned Placement Option(s) if Prevention Services are not effective:	
Placement Type	*Placement Description*
[Select]	
[Select]	
[Select]	

Specific Parent/Family Needs (identified from data obtained from IDA and IV-E Candidacy Eligibility Screening)		
Family Relationships	☐ Lack of social supports or connections ☐ Home environment characterized by violence and/or conflict ☐ Involvement in criminal conduct/activity ☐ History of child maltreatment	
Caregiver Status	☐ Deficits in parenting skills ☐ Mental illness ☐ Substance abuse	
Specific Child Needs (identified from data obtained from IDA and IV-E Candidacy Eligibility Screening)		
IV-E Candidacy Screening	☐ Previous out-of-home placements ☐ Developmental delays ☐ Social or emotional delays ☐ Physical or cognitive disabilities ☐ Risk to self or others	☐ Substance abuse problem ☐ Increasing pattern of delinquent behavior ☐ Victim of physical, emotional, or sexual abuse ☐ Victim of neglect

Identified Child Risk Factors (obtained from the IDA)	
IDA Risk Domains	*Dynamic Risk Item*
☐ Attitudes/Behaviors	
☐ Aggression	
☐ Skills	
☐ Current school status	
☐ Current relationships	
☐ Current living arrangements	
☐ Current drug and alcohol use	
☐ Current mental health	
☐ Current use of free time	
☐ Current employment	

Family Strengths/Protective Factors	
☐ Resilience ☐ Knowledge of parenting and child development ☐ Healthy family bonds ☐ Social connections/supports	☐ Communication ☐ Ability to cope with stress ☐ Pro-social attitudes/beliefs
Child Strengths/Protective Factors	
☐ School status ☐ Use of free time ☐ Employment ☐ Pro-social relationships	☐ Support system ☐ Pro-social attitudes/beliefs ☐ Skills ☐ Resilience/coping skills

Based on assessment data and input from the Juvenile Court Officer, child, parent/caregiver, and collateral contacts, the following case plan will be implemented.

Child Prevention Case Plan Strategies and Services					
Prevention Strategy	Objective	Service	Recipient	Date Initiated	Date Completed
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -
Choose an item.	Choose an item.	Choose an item.	Choose.	- -	- -

Juvenile Court Officer Responsibilities:

1. Utilize best practice, case, and collateral information to determine the level of contact required to provide the juvenile and his/her family the support needed to reach their goals.
2. Collaborate with providers to ensure supervision, support and monitoring of the youth and family is augmented through the provision of community-based services.
3. Monitor compliance with case plan objectives and services.
4. Other: _____

This prevention plan has been developed with my input. I have reviewed the plan and agree with the proposed services.

_____ _____
Child's Signature Date

_____ _____
Parent/Caregiver Signature Date

_____ _____
Juvenile Court Officer Date

_____ _____
Juvenile Court Officer Supervisor Date

1.3 Title IV-E Child Prevention Case Plan

Purpose

This policy outlines the criteria and process for developing a Title IV-E compliant child prevention case plan.

Policy Statement

A Title IV-E Child Prevention Case Plan (CPCP), shall be completed for all youth under Juvenile Court Services (JCS) supervision, who have been determined to be a Title IV-E Eligible Candidate using the Candidate for Foster Care Screening Tool (CFST).

Scope

All Juvenile Court Officers (JCOs) are to conform to the provisions of this policy

Definitions

ACF - Administration for Children and Families

CFST – Candidate for Foster Care Screening Tool

CM – Case Management

CPCP- Child Prevention Case Plan

FFPSA – Family First Prevention Service Act

FFP – Federal Financial Participation

Fictive Kin - means an individual who is unrelated by either birth or marriage but who has an emotionally significant relationship with another individual who would take on the characteristics of a family relationship.

IDA – Iowa Delinquency Assessment

Kin – One's family and relations.

Kinship Care - The care of Children by relatives or, in some jurisdictions, close family friends (often referred to as Fictive Kin).

Kinship Caregiver - Relative (e.g., grandparent, sibling, etc.) and Fictive Kin (e.g., godparents, close family friends, etc.) providing care for a child.

Procedures

Family First Prevention Services Act (FFPSA) Child Prevention Case Plan (CPCP)

FFPSA stipulates that for a state to be eligible for Federal Financial Participation (FFP) in administrative and prevention services funding, all children who have been identified as a Candidate for Foster Care must have a written Child Prevention Case Plan (CPCP) that identifies the following:

1) Whether the child is either a "child who is a candidate for foster care" or is a pregnant or parenting foster youth in need of prevention services in advance of the services being provided.
2) If the child is a "child who is a candidate for foster care," the child's prevention plan must:
   - Identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver;
   - List the services to be provided to or on behalf of the child to ensure the success of that prevention strategy.
3) The prevention plan for a pregnant or parenting foster youth must:
   - Be included in the youth's foster care case plan;
   - List the services to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent; and
   - Describe the foster care prevention strategy for any child born to the youth.[1]

[1] 115th Congress (2018). *P.L. 115-123.* https://www.congress.gov/bill/115th-congress/house-bill/1892/text?q=%7B%22search%22%3A%5B%22hr1892%22%5D%7D&r=1

Utilizing this federal guidance and information from the Administration for Children and Families (ACF) technical bulletins, the Iowa Department of Human Services (DHS), and related research, JCS developed a Title IV-E Child Prevention Case Plan (CPCP) that would meet federal requirements for FFP.

Targeted Candidates

All youth who have been identified by the Candidate for Foster Care Screening Tool (CFST) as a Title IV-E Candidate for Foster Care.

Required Documentation

- Iowa Delinquency Assessment (IDA)
- JCS Candidate for Foster Care Screening Tool (CFST)
- Child Prevention Case Plan (CPCP)

Child Prevention Case Plan (CPCP) Process

Federal guidelines stipulate that child specific administrative costs will not be eligible for reimbursement until a "child is identified in a prevention plan."[2] Reimbursement will continue "until the end of the 12th month, if services were provided for the entire 12-month period, or if the services are provided for less than the entire 12-month period, the end of the month the child's title IV-E prevention services ended."[3] Due to this, a written CPCP must be completed in Case Management (CM) within the same calendar month of the child being identified by the Candidate for Foster Care Screening Tool (CFST), as a Title IV-E Candidate for Foster Care.

Federal regulations mandate that CPCPs be written in collaboration with a youth and his/her parent(s)/caregiver(s). Therefore, it is necessary that the JCO make every attempt to elicit and utilize youth and parent(s)/caregiver(s) input to guide CPCP development.

To complete the CPCP, follow the below steps:

1. *IV-E Candidacy Determination Date* – enter date the most recent CFST was completed
2. *CPCP Status* – check to indicate initial plan, review, or change in circumstances.

[2] Administration of Children and Families – Children's Bureau (2018). PI-18-09: State Requirements for Electing Title IV-E Prevention and Family Services and Programs. https://www.acf.hhs.gov/cb/resource/pi1809
[3] IBID

3. *Planned Placement Option if Preventive Services are Not Effective*
    a. *"*Placement Type" select possible placement option from dropdown (family foster home, residential, etc.).
    b. "Placement Description" enter descriptor for placement (i.e. name of residential facility).
4. *Family Relationships*- check all applicable
5. *Caregiver Status* check – check all applicable
6. *Child Title IV-E Candidacy Screening* – check all applicable
7. *Identified Child Risk Factors* –
    a. "IDA Risk Domains" check all applicable
    b. "Dynamic Risk Item" enter description of Risk Domain
8. *Family Strengths/Protective Factors* – check all applicable(from CFST)
9. *Child Strengths/Protective Factors* – check all applicable(from CFST)
10. *Child Prevention Case Plan Strategies and Services*
    a. *Prevention Strategy* – select one. FFPSA allows for three types of strategies: Family Support Services (parent skill training, parent education, individual or family counseling), mental health services, and substance abuse treatment services
    b. Objective – select one that corresponds to prevention strategy. (There may be more than one objective, however, select the one that is deemed most important at that time).
    c. Service – select type of service to be used
    d. *Recipient* – select who will receive the service
    e. Date Initiated – enter date service begins
    f. *Date Completed* – enter date service ends

To finalize the CPCP, the following signatures are required:

- JCO responsible for developing plan
- Child
- Parent(s)/Caregiver(s)
- JCO Supervisor

Once the CPCP has been finalized, a copy must be given to the child and parent/caregiver.

Follow existing procedures to upload the CPCP to CM. Place a copy of the CPCP in the youth's file.

FFPSA requires that CPCP is reviewed:

- At a minimum of every six (6) months
- Anytime there is a change in the youth and/or parent(s)/caregiver(s) circumstances (i.e. substance abuse, imprisonment, new charges, etc.).

Required Training

All Juvenile Court Officers are required to complete the following trainings:

- Iowa Delinquency Assessment
- Title IV-E Candidate for Foster Care Determination and Screening
- Title IV-E Child Prevention Case Planning

References and related policies/forms

Administration of Children and Families – Children's Bureau (2020). *Title IV-E Prevention Program.* https://www.acf.hhs.gov/cb/title-iv-e-prevention-program

Administration of Children and Families – Children's Bureau (2018). PI-18-09: *State Requirements for Electing Title IV-E Prevention and Family Services and Programs.* https://www.acf.hhs.gov/cb/resource/pi1809

Juvenile Court Services CFST Policy 1.1

Appendices

Appendix A – Candidate for Foster Care Screening Tool (CFST)

Appendix B – Child Prevention Case Plan (CPCP)

SAMPLE

Please do not replicate.

KIDS INSIGHT

Child TOP Clinical Scales Form

	All	Most	A lot	Some	A little	None	N/A	Indicate how much of the time during the past two weeks the child has . .
1	○	○	○	○	○	○		had trouble falling a sleep.
2	○	○	○	○	○	○		had nightmares.
3	○	○	○	○	○	○		woke up during the night (excluding trips to bathroom).
4	○	○	○	○	○	○		had trouble getting back to sleep in the night.
5	○	○	○	○	○	○		needed someone (mother/caretaker) nearby in order to fall asleep.
6	○	○	○	○	○	○	○	been slow at completing homework.
7	○	○	○	○	○	○	○	had trouble paying attention in class.
8	○	○	○	○	○	○		physically hurt a person or animal.
9	○	○	○	○	○	○		had desires to seriously hurt someone.
10	○	○	○	○	○	○		had thoughts of killing someone else.
11	○	○	○	○	○	○		seriously hurt someone.
12	○	○	○	○	○	○		had trouble waiting.
13	○	○	○	○	○	○		done what was asked of him/her.
14	○	○	○	○	○	○		been able to complete something after complaining that it was boring.
15	○	○	○	○	○	○		had trouble standing up for himself/herself.
16	○	○	○	○	○	○		been too shy.
17	○	○	○	○	○	○		gotten along well with others.
18	○	○	○	○	○	○		seemed scared around people.
19	○	○	○	○	○	○		eaten a variety of foods (vegetables, fruit, grains, meat...) in the same meal.
20	○	○	○	○	○	○		eaten too little.
21	○	○	○	○	○	○		been a picky eater.
22	○	○	○	○	○	○		had trouble staying still.
23	○	○	○	○	○	○		been able to talk but refused to do so.
24	○	○	○	○	○	○		had trouble looking people in the eye when talking to them.
25	○	○	○	○	○	○		looked to share interests and exciting things with others.
26	○	○	○	○	○	○		not wanted to be touched.
27	○	○	○	○	○	○		been very distressed when away from mother/caretaker.
28	○	○	○	○	○	○		looked down or depressed.
29	○	○	○	○	○	○		had little or no interest in things that were enjoyable before.
30	○	○	○	○	○	○		been afraid of being alone or did not want to be alone.
31	○	○	○	○	○	○		become stuck in a certain mood and been unable to change.
32	○	○	○	○	○	○		shown little emotion when you expected some type of reaction.
33	○	○	○	○	○	○		thought about killing himself/herself or wished to be dead.
34	○	○	○	○	○	○		hurt himself/herself.
35	○	○	○	○	○	○		followed rules to your satisfaction.
36	○	○	○	○	○	○		done what he/she was asked to do.
37	○	○	○	○	○	○		run away.
38	○	○	○	○	○	○		had trouble with the police.
39	○	○	○	○	○	○		stolen or shoplifted.
40	○	○	○	○	○	○		had trouble finishing things.
41	○	○	○	○	○	○		lost things.
42	○	○	○	○	○	○		wet clothes or the bed.
43	○	○	○	○	○	○		soiled underwear.
44	○	○	○	○	○	○		been easy to live with.
45	○	○	○	○	○	○		seen things that were not there.
46	○	○	○	○	○	○		heard things that were not there.
47	○	○	○	○	○	○		made inappropriate sexual comments.
48	○	○	○	○	○	○		caused you to worry about his/her sexual activity.

SAMPLE

Please do not replicate.

KIDS INSIGHT

Adolescent TOP Clinical Scales Form

	All	Most	A lot	Some	A little	None	Indicate how much of the time during the past <u>two weeks</u> you have . . .
1	○	○	○	○	○	○	gone on an eating binge
2	○	○	○	○	○	○	thought you were too fat even though others said your weight is fine
3	○	○	○	○	○	○	purged after eating by using laxatives, water pills, or throwing up
4	○	○	○	○	○	○	been too shy
5	○	○	○	○	○	○	felt too much conflict with someone
6	○	○	○	○	○	○	been emotionally hurt by someone
7	○	○	○	○	○	○	felt someone else had too much control over your life
8	○	○	○	○	○	○	had trouble falling asleep
9	○	○	○	○	○	○	had nightmares
10	○	○	○	○	○	○	awakened frequently during the night
11	○	○	○	○	○	○	had trouble returning to sleep after awakening in the night
12	○	○	○	○	○	○	had conflicts with others at work or school regardless of fault
13	○	○	○	○	○	○	missed work or school for any reason
14	○	○	○	○	○	○	not been acknowledged for your accomplishments at work or school
15	○	○	○	○	○	○	had your performance criticized at work or school
16	○	○	○	○	○	○	not been excited about your work or school work
17	○	○	○	○	○	○	physically hurt someone else or an animal
18	○	○	○	○	○	○	had desires to seriously hurt someone
19	○	○	○	○	○	○	had thoughts of killing someone else
20	○	○	○	○	○	○	felt that you were going to act on violent thoughts
21	○	○	○	○	○	○	had trouble staying still
22	○	○	○	○	○	○	had trouble finishing things
23	○	○	○	○	○	○	lost things
24	○	○	○	○	○	○	had trouble paying attention in class
25	○	○	○	○	○	○	been slow at completing homework
26	○	○	○	○	○	○	had trouble looking people in the eye when talking to them
27	○	○	○	○	○	○	run away
28	○	○	○	○	○	○	had trouble with the police
29	○	○	○	○	○	○	stolen or shoplifted
30	○	○	○	○	○	○	felt down or depressed
31	○	○	○	○	○	○	felt little or no interest in most things
32	○	○	○	○	○	○	felt guilty
33	○	○	○	○	○	○	felt restless
34	○	○	○	○	○	○	felt worthless
35	○	○	○	○	○	○	felt tired, slowed down, or had little energy
36	○	○	○	○	○	○	worried about things
37	○	○	○	○	○	○	had trouble concentrating or making decisions
38	○	○	○	○	○	○	noticed your thoughts racing ahead
39	○	○	○	○	○	○	inflicted pain on yourself
40	○	○	○	○	○	○	felt rested after only a few hours of sleep
41	○	○	○	○	○	○	thought about killing yourself or wished you were dead
42	○	○	○	○	○	○	planned or tried to kill yourself
43	○	○	○	○	○	○	felt you were better than other people
44	○	○	○	○	○	○	felt on top of the world
45	○	○	○	○	○	○	worried that someone might hurt you
46	○	○	○	○	○	○	had unwanted thoughts or images
47	○	○	○	○	○	○	seen or heard something that was not really there
48	○	○	○	○	○	○	felt someone or something was controlling your mind
49	○	○	○	○	○	○	spent more time drinking or using drugs than you intended
50	○	○	○	○	○	○	neglected school, work, or other responsibilities because of using alcohol or drugs
51	○	○	○	○	○	○	felt you wanted or needed to cut down on your drinking or drug use
52	○	○	○	○	○	○	had your family, a friend, or anyone else tell you they objected to your alcohol or drug use
53	○	○	○	○	○	○	found yourself thinking about a drink or getting high
54	○	○	○	○	○	○	used alcohol or drugs to relieve uncomfortable feelings, such as sadness, anger, or boredom
55	○	○	○	○	○	○	made inappropriate sexual comments
56	○	○	○	○	○	○	caused someone to worry about your sexual activity
57	○	○	○	○	○	○	In the past 2 months how often have you had sex or oral sex without a condom?
58	○	○	○	○	○	○	In the past 2 months how often have you felt forced to have sex?

Title IV-E Prevention and Family Services and Programs Plan
State of Iowa

ATTACHMENT I

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, the Iowa Department of Human Services, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

June 16, 2020
(Date)

K. Garcia, Director
(Signature and Title)

2/24/2021
(CB Approval Date)

Joseph Bock
Acting
(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Iowa Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Functional Family Therapy (FFT) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

June 16, 2020
(Date)

K. Gowin, Director
(Signature and Title)

2/24/2021
(CB Approval Date)

Joseph Bock
(Signature, Associate Commissioner, Children's Bureau)
Acting

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The Iowa Department of Human Services (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Multisystemic Therapy (MST) (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

Jun 16, 2020
(Date)

K Garcia, Director
(Signature and Title)

2/24/2021
(CB Approval Date)

Joseph Bock
(Signature, Associate Commissioner, Children's Bureau)
Acting

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The Iowa Department of Human Services (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

June 16, 2020
(Date)

K Garcia, Director
(Signature and Title)

2/24/2021
(CB Approval Date)

Joseph Bock
(Signature, Associate Commissioner, Children's Bureau)
Acting