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2020-2024 TITLE IV-E PREVENTION SERVICES AND PROGRAMS PLAN

Children and Family Services Division

Cory Pedersen, Director

An electronic version of this document can be obtained by visiting the following website:

http://www.nd.gov/dhs/info/pubs/family.html

The document will be available once final approval has been received by the federal Administration for Children and Families.

For additional information regarding North Dakota's Title IV-E Prevention Plan, please contact:

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May 22, 2020

Marilyn Kennerson
CB Regional Office Program Manager 1961 Stout Street, 8th Floor
Byron Rogers Federal Building
Denver, CO 80294-3538

Dear Ms. Kennerson:

As the Director of the North Dakota Department of Human Services' Children and Family Services Division, I am pleased to present the 2020-2024 Title IV-E Prevention Services and Programs Plan. The plan is the culmination of intensive collaborative planning efforts by children and family services, human services, juvenile justice, and behavioral health and is a testament to North Dakota's commitment to providing quality services to *keep children safe* while *strengthening families*.

We look forward to your review and approval of this plan.

Sincerely,

Cory Pedersen, Director
Enclosure

CHILDREN AND FAMILY SERVICES DIVISION

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TABLE OF CONTENTS

Introduction
- **Implementation of FFPSA**

Section 1: Service Description and Oversight
- **In-Home Parent Skill-based Programs**
- **Mental Health and/or Substance Abuse Prevention and Treatment Services**

Section 2: Evaluation Strategy and Waiver Request

Section 3: Monitoring Child Safety
- **Present Danger Assessment and Present Danger Plan**
- **Safety Assessment and Safety Plan**

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 Title IV-E Prevention Programs

Appendix A: State Title IV-E Prevention Program Reporting Assurance

Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Appendix C: State Assurance of Trauma-Informed Service Delivery

Appendix D: State Annual Maintenance of Effort (MOE) Report

Appendix E: Eligibility Referral

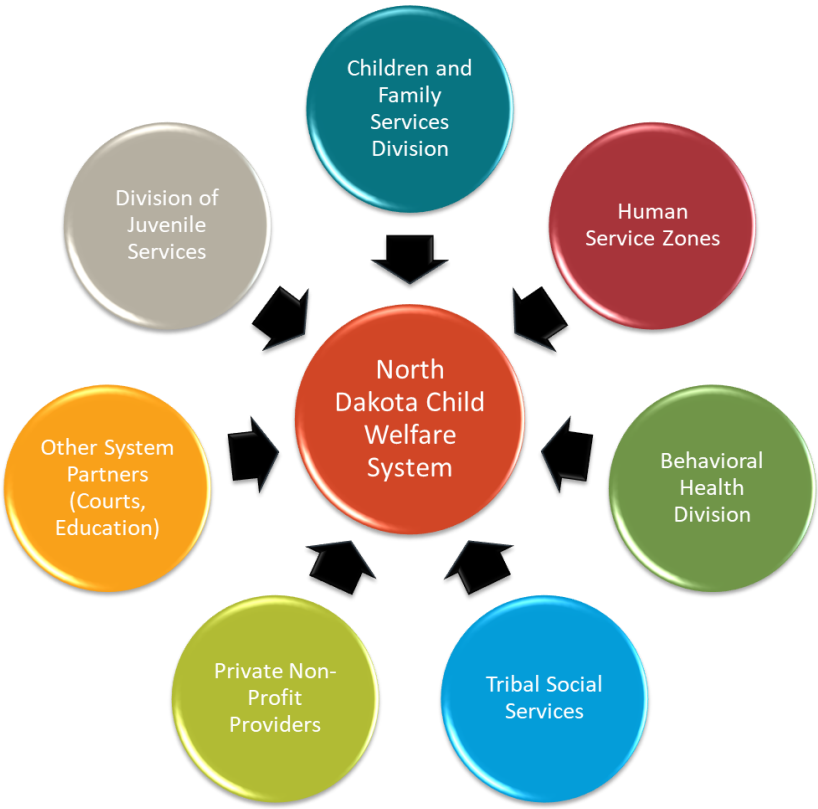
Appendix F: Title IV-E Process Flow

Appendix G: ND Candidate for Foster Care

INTRODUCTION

North Dakota's Child Welfare System is focusing on efforts to ensure availability and access to a broad, flexible array of effective, community-based services and supports for children and their families that address their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.

Figure 1. North Dakota's Child Welfare System



In 2018, the ND Behavioral Health System Study conducted by Human Services Research Institute (HSRI) combined several past studies and utilized qualitative and quantitative data to develop a report with 65 separate recommendations for improving the behavioral health system. Twenty-five of the recommendations were specific to children and families with overarching goals to invest in prevention and early intervention efforts; ensure all North Dakotans have timely access to behavioral health services; expand outpatient and community-based services; and enhance and streamline the system of care for children and youth.

In the implementation of the recommendations, the Department of Human Services is addressing the behavioral health needs by supporting the entire behavioral health continuum of care, increasing community-based services, and preventing criminal justice involvement for individuals with a behavioral health condition. These efforts include a Social Service Redesign, partnering with the Education System to develop cohesive strategies to address behavioral health in schools, expanding access to community-based behavioral health supports through 1915i Medicaid State Plan Amendment, the development of a voucher payment for substance use disorder treatment and recovery services with a recent expansion to

include adolescents, the creation of a community behavioral health program focusing on families utilizing outcome based payments, the development of a Children's Cabinet, the recent award of the System of Care Grant, expansion of targeted case management for youth with severe emotional disturbances, and the establishment of a Commission on Juvenile Justice.

Implementation of FFPSA

In August of 2018, North Dakota began efforts to engage partners and stakeholders to implement the Family First Prevention Services Act (PL 115-132). These efforts included a collaboration among multiple entities including county social services, law enforcement agencies, legislators, foster parents and residential service providers. Other key partners included the North Dakota Division of Juvenile Services, North Dakota tribes, juvenile court, states attorneys and team members from various divisions within the Department of Human Services. Changes were made to North Dakota Century Code during the 2019-2020 legislative session and North Dakota Administrative Code was enacted October 1, 2019. The North Dakota Department of Human Services held nine monthly informational meetings in 2019 on the Family First Prevention Services Act (PL 115-123) to provide implementation updates to stakeholders and to give them an opportunity to ask questions and offer suggestions. Meetings were held on-site at the State Capitol, and a conference call line was also available for those unable to attend in person.

- Limitation on placements that are not in foster family homes:
  - Legislative session updated North Dakota Century Code Chapter 50-11 to allow for licensing "on or near" an Indian reservation and increase the ND foster care bed capacity from four beds to six beds to be consistent with the national model standards.
  - North Dakota completed the revision to the North Dakota Administrative Code Chapter 75-03-14 to enhance family foster care licensing. The national model standards were implemented in compliance on October 1, 2019.
  - North Dakota Administrative Code Chapter 75-03-40 "Licensing of Qualified Residential Treatment Program (QRTP) providers was created to override and repeal the previous North Dakota Administrative Code Chapter 75-03-16 "Licensing of Residential Child Care and Group Homes (RCCF)". QRTP level of care was in federal compliance on October 1, 2019.
  - North Dakota Administrative Code Chapter 75-03-41 "Licensing of Supervised Independent Living (SIL) Programs" was created to offer the SIL level of care in state in federal compliance on October 1, 2019.

- Assessment and Documentation of the Need for Placement in a QRTP:
  - The Department of Human Services has contracted with a third-party vendor, Maximus - Ascend, Inc., to complete a formal assessment via a Qualified Individual to approve or deny a child placement for treatment in a QRTP.
  - ND Legislative session did have a law change (SB 2069) to e*xpand the role of Juvenile Court Directors to approve placement of foster children in Qualified Residential Treatment Programs.* CFS collaborated with ND Juvenile Court to align the Qualified Individual and Judicial Status Review Processes to be in compliance with FFPSA Federal Legislation, NDCC and NDAC (Juvenile Rule N.D.R.Proc.R. § 7). State court process and Tribal court processes are documented in foster care policy for QRTP. Court Improvement Project began efforts to train judges on the FFPSA regulations and the impact to the courts related to QRTP's; additional training will be offered ongoing.
  - The Ascend contract was signed in August 2019. The Department has met weekly with Ascend to assess, evaluate, review and discuss any concerns or procedural adjustments warranted. In addition, Ascend has provided webinars and face to face training to case managers, courts and QRTP providers.

A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health have been meeting regularly to review the current inventory of evidence-based

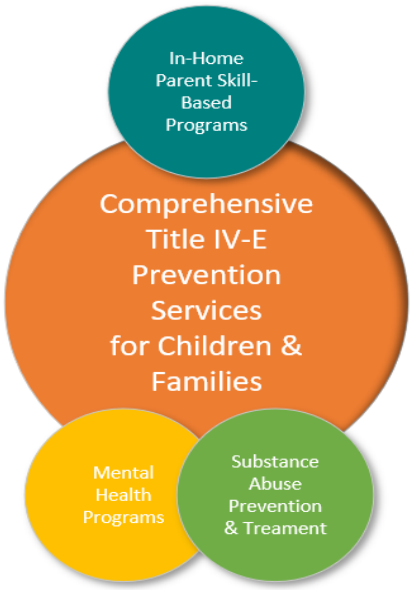
prevention programs. North Dakota plans to expand its services to include those approved as well-supported through the Title IV-E Prevention Services Clearinghouse with the exception of Motivational Interviewing. Motivational Interviewing is being addressed in a statewide effort to train the child welfare system including tribal social services, private non-profit providers, juvenile correctional systems, and education through the development of learning communities. The service array will be expanded through plan amendments as additional evidence-based services are reviewed and approved through the Title IV-E prevention services clearinghouse authorized by the Children's Bureau through ACYF-CB-PI-19-06.

SECTION 1: SERVICE DESCRIPTION AND OVERSIGHT

Comprehensive Title IV-E prevention services for children and families in North Dakota will consist of the three allowable services of the FFPSA:

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

Figure 2. Components of North Dakota's Comprehensive Title IV-E Prevention Services for Children and Families

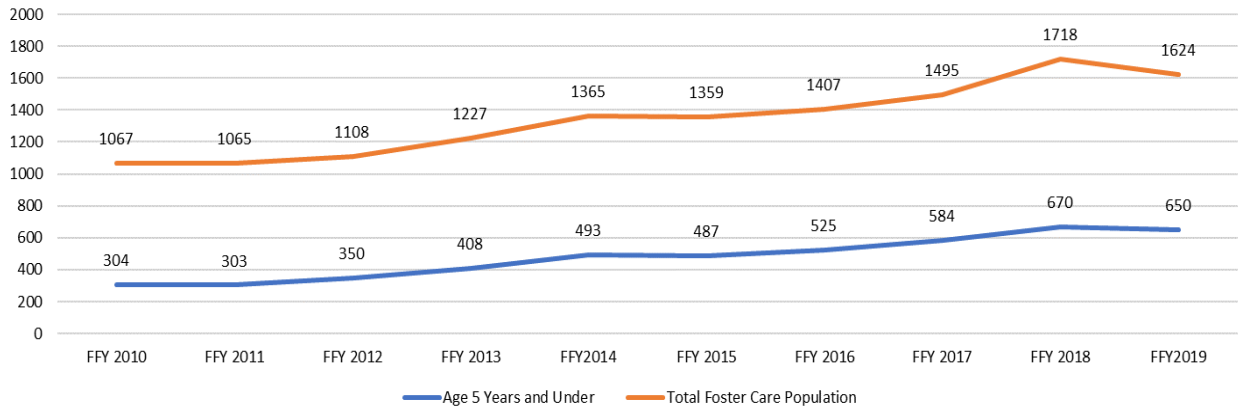


The North Dakota Department of Human Services (DHS) is in the process of developing a web-based portal. Through this portal, individuals, or other referral sources such as private and public agencies, treatment providers, juvenile court, parents or caregivers will be able to submit the eligibility referral to determine foster care candidacy for Title IV-E prevention services. The goal of the portal will be to connect and identify the most appropriate program(s) the child and/or family member(s) may be eligible for. Community and private providers can apply through the ND Department of Human Services to become an approved provider to receive reimbursement through Title IV-E. The agency must identify what approved service, as identified in this plan, they will provide and submit proof they are trained and qualified to offer that service. As agencies are approved, a Memorandum of Understanding (MOU) will be signed with the Department of Human Services. The MOU will assure the agency conducts all requirements set out by the Department of Human Services and Families First Prevention Services Act.

In-Home Parent Skill-Based Programs

North Dakota saw a 52% increase in the number of children in foster care over the last ten years. Of the children in foster care, the percentage under the age of 5 years has steadily risen from 28% to 40% during the same timeframe (Figure 3.) North Dakota will build the service array of the approved well-supported In-home parent skill-based programs to target this population.

Figure 3. North Dakota Foster Care Census and Those Age 5 Years and Under for Federal Fiscal Year 2010-2019



Through the Title IV-E Prevention Plan, North Dakota plans to expand/implement the following programs:

	Healthy Families
Service Description	Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Healthy Families North Dakota (HFND) offers services until the child is five years old. During the first six months following a child's birth or following enrollment (whichever is later), in-home visits are offered weekly. After six months, families receive visits less frequently depending on their needs and progress.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	Healthy Families North Dakota (HFND) has been approved by Healthy Families America (HFA) for adaptation. The adaptation allows for enrollment of a child up to age 2 years, when the family is involved with the child welfare system. This approved adaptation will also be implemented with this plan. The Healthy Families America Site Development Guide (rev. 2014) is a guidebook that provides information for sites on planning, developing, and implementing an HFA site. The HFA Best Practice Standards (rev. 2017) offer specific guidelines on HFA model implementation.
Plan to Implement	Healthy Families North Dakota is in 11 counties of the state. HFND has targeted at risk children through 20 years of providing services in the state. Through the expansion, HFND will engage families directly involved in the child welfare system that qualify as a prevention candidate. North Dakota's plan for implementation includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for HFA, North Dakota expects to see the following outcomes for children and families receiving this service: • Reduce child maltreatment • Improve parent-child interactions and children's social-emotional well-being • Increase school readiness • Promote child physical health and development • Promote positive parenting • Promote self-sufficiency • Increase access to primary care medical services and community services • Decrease child injuries and emergency department use

Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure HFND's fidelity to the model and progress measures meet the standards established. HFND must meet the threshold of national accreditation. Completion of this process is required to confirm fidelity to the Model as set forth by HFA. • Collect and analyze data for outcome and process measures and for required reporting. • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected HFA to be included in the state's prevention service array.
Target Population	Families are eligible to receive Healthy Families services beginning prenatally or within three months of birth; when referred from child welfare, families may be enrolled with a child up to twenty-four months of age. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences.
Assurance for Trauma Informed Service Deliver	See Appendix C: State Assurance of Trauma-Informed Service-Delivery. HFND requires that all staff participate in HFA Core Training, which is aligned with 3 major principles: 1) trauma-informed 2) attachment/relationship focused, and 3) grounded in reflective practice. Additionally, all staff receive intensive training on using the evidence-based curriculum, Growing Great Kids, and are required to participate in NEAR (Neuroscience, Epigenetics, Adverse Childhood Experience and Resilience) training, which supports the understanding of trauma and its impacts.
How Evaluated	HFND will include the required participation in a self-study, national peer-reviewed site visit, implement a quality assurance plan, and subsequent quality improvement efforts in order to continue to meet the threshold of accreditation. Completion of this process is required to confirm fidelity to the Model as set forth by HFA. North Dakota is requesting a waiver for evaluation of HFA, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

	Homebuilders
Service Description	Homebuilders provides intensive, in-home counseling and support services for families who have a child 0-17 years old at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services. Homebuilders uses behavioral assessments to determine outcome-based goals and help families identify strengths and problems associated with child safety and intervention maintenance of change. It aims to support families during crises using tailored intervention strategies and a diverse range of services, such as support with basic needs, service navigation, and psychotherapy. Providers use cognitive and behavioral practices to teach family members new skills and facilitate behavior change. Homebuilders services are concentrated during a period of four to six weeks with the goal of preventing out-of-home placements. Homebuilders therapists typically have small caseloads of two families at a time. Families typically receive 40 or more hours of direct face-to-face services. The family's therapist is available to family members 24 hours per day, 7 days per week. Treatment services primarily take place in the client's home. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	A manual is available for Homebuilders. **Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis.**
Plan to Implement	North Dakota's plan to implement includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for Homebuilders, North Dakota expects to see the following outcomes for children and families receiving this service: • Child safety • Child Permanency • Improved parent/caregiver mental/emotional health • Economic and housing stability
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure Homebuilders fidelity to the model and progress measures meet the standards established. Providers of Homebuilders implement fidelity monitoring and outcome measurement using the Homebuilders quality enhancement system, known as QUEST. QUEST is designed to assure quality through the development and continual improvement of the knowledge and skills necessary to obtain model fidelity and service outcomes. QUEST activities focus on providing training and creating an internal management system of on-going evaluation and feedback.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup, consisting of subject matter experts from child welfare, behavioral health, and juvenile justice, reviewed the current inventory of the approved well-supported

	evidence-based prevention programs in North Dakota and selected Homebuilders to be included in the state's prevention service array.
Target Population	Homebuilders serves families who have a child 0-17 years old at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	North Dakota is requesting a waiver for evaluation of Homebuilders, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

	Nurse- Family Partnership
Service Description	Nurse- Family Partnership (NFP) is a home-visiting program that has specially trained nurses regularly visit first-time moms-to-be, who are 28 weeks or less, meet income requirements and continuing through the child's second birthday. The primary outcomes of NFP are to improve the health, relationships, and economic well-being of mothers and their children. The content of the program can vary based on the needs and requests of the mother. Mothers, babies, families and communities all benefit. Through the partnership, the nurse provides new moms with the confidence and the tools they need not only to assure a healthy start for their babies, but to envision a life of stability and opportunities for success for both mom and child.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	https://www.nursefamilypartnership.org/wp-content/uploads/2018/12/NFP-Initial-Education-Policy-07.24.2018.pdf
Plan to Implement	NFP is a prevention service that is currently available in seven counties in North Dakota. To implement NFP as a service under the Title IV-E prevention program plan, ND's plans for implementation include: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse, North Dakota expects to see the following outcomes for children and families receiving this service: • Improved maternal health • Improved child health • Reduction in child maltreatment • Increased positive parenting practices • Improved family self-sufficiency
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement The NFP program will maintain fidelity to its model by using their web-based performance management system designed to collect and report characteristics, needs, services provided and progress towards goals. North Dakota will conduct ongoing contract monitoring to ensure NFP fidelity to the model and progress measures meet the standards established.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected NFP to be included in the state's prevention service array.
Target Population	NFP is intended for first-time moms-to-be, who are 28 weeks or less, meet income requirements and continuing through the child's second birthday. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	North Dakota is requesting a waiver for evaluation of NFP, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-

	Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice.

	Parents as Teachers
Service Description	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: • Personal home visits, • Supportive group connection events, • Child health and developmental screenings, and • Community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, child-care centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training. North Dakota participates in the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which funds the Parents as Teachers program at Turtle Mountain Nations in North Dakota, through Prevent Child Abuse North Dakota (PCAND).
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Version of Book or Manual	PAT will be implemented without adaptation. PAT has a Model Implementation Library with resources available to those who receive PAT training. Depending on the ages of the families served, the PAT Foundational Curriculum is available to support families with children prenatal to age 3, and the PAT Foundational 2 Curriculum is available to support families with children ages 3 through Kindergarten.
Plan to Implement	PAT program is a primary prevention service that is available in only one site in North Dakota. To implement PAT as a service under the Title IV-E prevention program plan, ND's plans for implementation include: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PAT, North Dakota expects to see the following outcomes for children and families receiving this service: • Increased child safety • Improved child behavioral and emotional functioning • Increased positive parenting practices • Improved parent/caregiver mental or emotional health
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement

	The PAT program will maintain fidelity to its model by implementing and replicating the 20 fundamental and essential requirements set out by the Parents as Teachers National Center. North Dakota will conduct ongoing contract monitoring to ensure PAT's fidelity to the model and progress measures meet the standards established.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected PAT to be included in the state's prevention service array.
Target Population	PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Pregnant and parenting foster youth may also be included as part of the target population.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	North Dakota is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Mental Health and/or Substance Abuse Prevention and Treatment Services

	Brief Strategic Family Therapy
Service Description	Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents 6 to 17 years old who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. There are three interventions components; (1) counselors establish relationships with family members to better understand and join the family system; (2) counselors observe how family members behave with one another in order to identify interactional patterns that are associated with problematic youth behavior; and (3) counselors work in the present, using reframes, assigning tasks and coaching family members to try new ways of relating to one another to promote more effective and adaptive family interactions. BSFT is delivered by trained therapists and are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral intervention and family systems theory. BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for Adolescent Drug Abuse*. NIH Pub. No. 03-4751. Bethesda, MD: National Institute on Drug Abuse. Developers proprietary manual: http://www.bsft.org/
Plan to Implement	North Dakota's plan to implement includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for BSFT, North Dakota expects to see the following outcomes for children and families receiving this service: • Improved child behavioral and emotional functioning • Decreased child substance use • Decreased parent/caregiver substance use • Decreased child delinquent behavior and substance use • Improved family functioning
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure BSFT's fidelity to the model and progress measures meet the standards established. BSFT training sites are initially required to demonstrate readiness for integrating the BSFT program, implementation trainings and supervision which meet certain fidelity requirements.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected BSFT to be included in the state's prevention service array.

Target Population	Families with children or adolescents 6 to 17 years who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	North Dakota is requesting a waiver for evaluation of BSFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

	Functional Family Therapy
Service Description	Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in five phases that consist of: (1) developing a positive relationship between therapist/program and family; (2) increasing hope for change and decrease blame/conflict; (3) identifying specific needs and characteristics of the family; (4) supporting individual skill-building of youth and family; and (5) generalizing changes to a broader context. Typically, therapists will meet with the family face-to-face for at least 90 minutes per week and for 30 minutes over the phone, over an average of three to five months. Master's level therapists provide FFT, are part of an FFT-supervised unit and receive ongoing support from their local unit and FFT LLC.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Functional Family Therapy for Adolescent Behavioral Problems. Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for Adolescent Behavioral Problems. Washington, D.C.: American Psychological Association.
Plan to Implement	North Dakota's plan to implement includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, North Dakota expects to see the following outcomes for children and families receiving this service: • Improved family functioning and skills • Reduced family conflict • Improved youth behavior • Reduced youth recidivism • Reduced alcohol and drug use
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure FFT's fidelity to the model and progress measures meet the standards established. Fidelity to the model and outcomes measures will be reviewed with FFT LLC as well as: • Evaluate the outcome measurement to identify strengths and weaknesses and incorporate this information into improvement plans, service design improvement process, quality monitoring and technical assistance.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected FFT to be included in the state's prevention service array.
Target Population	Justice involved youth with Emotional Disorders
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery

How Evaluated	Collaborate with FFT LLC to complete Fidelity Reviews annually and review Service Outcomes at least annually. North Dakota is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

	Multisystemic Therapy
Service Description	Multisystemic Therapy (MST) is an intensive family and community-based treatment program for youth 12 to 17 years old delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and substance use in youth. The MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Abuse Programs and Services
Version of Book or Manual	Multisystemic Therapy (MST) *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents, Second Edition* is intended for clinical psychologists, psychiatrists, social workers, counselors, researchers, and students. It describes the principles of MST and provides guidelines for implementing the program. **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.). New York: The Guilford Press.**
Plan to Implement	North Dakota's plan to implement includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for MST, North Dakota expects to see the following outcomes for children and families receiving this service: • Improve child behavioral and emotional functioning • Improve child social functioning • Improve child functions and abilities • Decrease child substance use • Decrease child delinquent behavior • Improve positive parenting practices • Improve parent mental/emotional health • Improve family functioning
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure MST's fidelity to the model and progress measures meet the standards established. MST is delivered by therapists who work for licensed MST teams and organizations. Clinically focused booster sessions aim to refresh MST skills and weekly consultations provided by MST experts. MST teams use a structured fidelity assessment approach to ensure clinical service delivery is consistent with the MST model.

How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup made up of subject matter experts from the child welfare system including children and family services, human services, juvenile justice, and behavioral health reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected MST to be included in the state's prevention service array.
Target Population	Families of youth 12-17 years old who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	It is recommended if MST is implemented to continue technical assistance from the creator of the program. North Dakota is requesting a waiver for evaluation of MST, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

	Parent Child Interaction Therapy
Service Description	Parent-Child Interaction Therapy (PCIT) is a program for two to seven-year old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach parents and caregivers in skills such as child centered play, communication, increasing child compliance, and problem-solving. Therapists use "bug-in-the-ear" technology to provide live coaching to parents and caregivers from behind a one way mirror or with same room coaching. Parents and caregivers progress through treatment as they master specific competencies, thus, there is no fixed length of treatment. Most families can achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and their parents or caregivers.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Version of Book or Manual	The Parent-Child Interaction Therapy Protocol. Eyberg, S. & Funderburk, B. (2011) Parent-Child Interaction Therapy Protocol: 2011. PCIT International, Inc PCIT will be implemented without adaptation
Plan to Implement	North Dakota's plan to implement includes: • Providers apply to be an approved IV-E prevention services provider. • Establish contracts with qualified provider, using billing codes to capture required client and payment data.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, North Dakota expects to see the following outcomes for children and families receiving this service: • Improved parenting knowledge • Increased positive parenting practices • Improved parent and child interactions • Decreased child behavior and attention problems • Improved parent/caregiver emotional health
Plan to Monitor for Fidelity	See Section 2. Continuous Quality Improvement North Dakota will conduct ongoing contract monitoring to ensure PCIT's fidelity to the model and progress measures meet the standards established. Providers of PCIT are required to implement fidelity monitoring and outcome measurement using these PCIT tools, which are available through PCIT International.
How Selected	A multi-disciplinary Title IV-E Prevention Services Planning Workgroup, made up of subject matter experts from child welfare, behavioral health, and juvenile justice, reviewed the current inventory of the approved well-supported evidence-based prevention programs in North Dakota and selected PCIT to be included in the state's prevention service array.
Target Population	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma Informed Service Delivery	See Appendix C: State Assurance of Trauma-Informed Service-Delivery

How Evaluated	North Dakota is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Appendix B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

SECTION 2: EVALUATION STRATEGY AND WAIVER REQUEST

North Dakota is committed to implementing prevention services that have compelling evidence of their effectiveness. This will help ensure that families are provided services that will help to keep them from moving further into the child welfare system. At the time of this submission, North Dakota will only be implementing well-supported practices and will be requesting waivers to the evaluation requirement.

The Department of Human Services (DHS) will implement a Continuous Quality Improvement process (CQI) that will include outcomes measured by both DHS and providers to monitor activities provided under the Title IV-E Prevention Plan. This CQI process will be used to ensure that participants are provided quality services that protect the safety and health of every child and family and to determine the impact of those services on child and family level outcomes and functioning. This process will involve participation from the DHS, private/community providers, children and families and other community stakeholders.

DHS (the State Title IV-E agency) will require a Memorandum of Understanding (MOU) with each provider that is approved to provide services under the Title IV-E Prevention Plan. This MOU is vital to ensure DHS oversight and will be used to ensure the collection and submission of outcomes to demonstrate that providers can meet positive outcomes for children and families. Providers will be required to follow the fidelity practices of the selected evidence-based practice interventions. As services are delivered, providers must implement fidelity monitoring procedures as delineated for the program. Providers need to submit a plan outlining their fidelity review process to include how they will facilitate fidelity reviews, work toward quality improvement, and maintain records of the continuous quality improvement procedures. Fidelity review documentation will be reviewed by DHS upon request or during audit reviews as part of the utilization review process. Providers must collect and report on outcomes including but not limited to economic stability, social and community context, neighborhood and environment, healthcare, and education. Outcomes will be collected at a minimum every three months and submitted by required deadlines as outlined in the MOU. DHS will monitor and review outcomes submitted. If outcome measures are not achieved, the provider may be required to submit an action plan that will be reviewed by DHS. DHS will facilitate utilization review, providers will be required to submit requested documentation and participate in trainings, technical assistance and other meetings as requested by DHS.

As part of the CQI process and ongoing monitoring, DHS will develop a review of programs and services to assist with determining the impact the services have on child/family outcomes and functioning to determine the effectiveness of current processes and systems. This information will be used to identify strengths and needs in implementation within and across providers in support of quality improvement. Technical assistance will be available to providers as needed to provide support in this area. Reviews will involve verification of fidelity and outcome measurement processes. Outcomes measured at the DHS level will include items such as safety, permanency (including entry into foster care) and family well-being. Provider and state level data will be used to evaluate trends and to refine and improve practices. DHS will meet regularly to review and evaluate CQI outcomes and will communicate with stakeholders and decision makers as needed to refine and improve practices. DHS will utilize the theory of constraints model to streamline processes and efficiencies involved in administration and operations.

Continuous Quality Improvement: North Dakota believes that a fully functioning statewide Continuous Quality Improvement process will provide strategies to effectively address child welfare practice concerns and establish ongoing protocols for checks and balances within the system. North Dakota has chosen the Theory of Constraints (TOC) as the model for a statewide CQI process across all divisions within the North Dakota Department of Human Services.

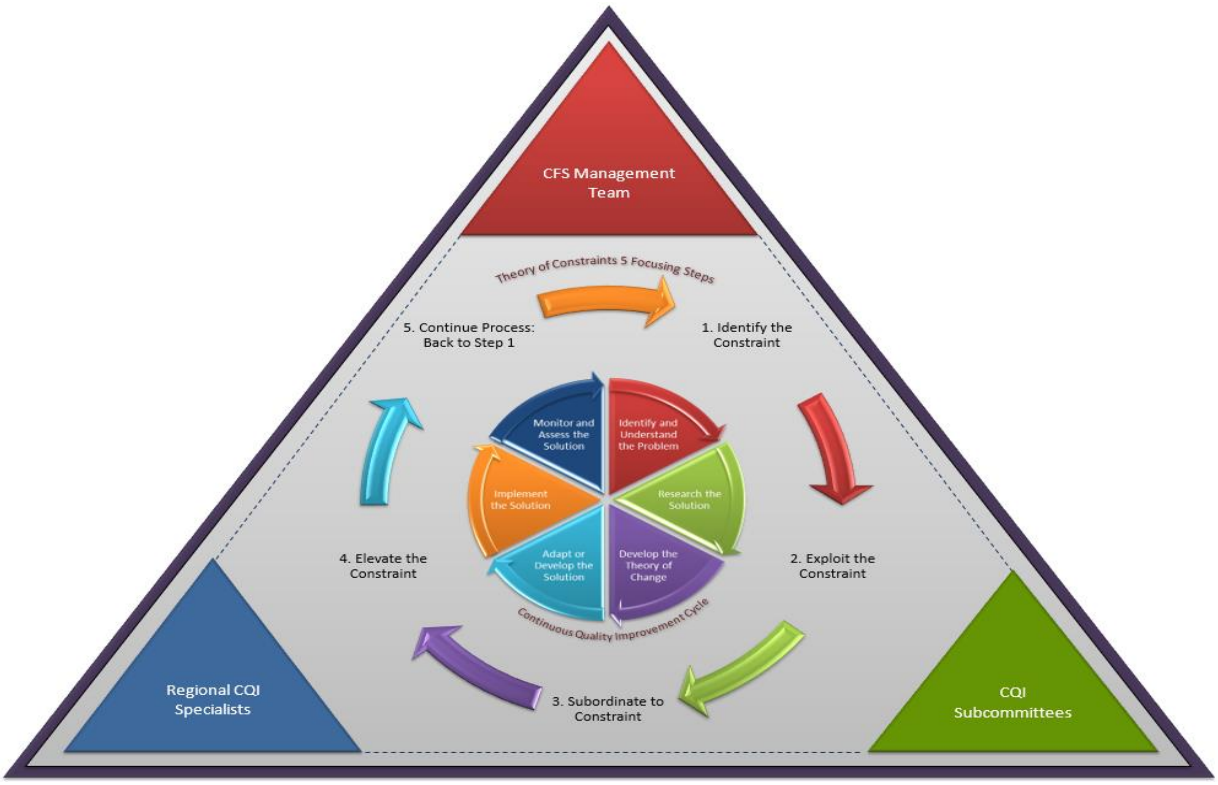
Theory of Constraints (TOC) is a methodology for identifying the most important limiting factor (i.e. constraint) that stands in the way of achieving a goal and then systematically improving that constraint until it is no longer the limiting factor. TOC focuses on how quickly results can be achieved, referred to as

“throughput”. On the other hand, theory of constraints focuses on the factors that hinder the speed of this “throughput”, referred to as a bottleneck. The “throughput” will be increased when the “bottleneck” can be reinforced or eliminated. Generally, there are five steps that are followed when working with TOC:

1. Identify the system constraints: The weakest link in an organization is identified whereupon it must be decided whether its causes are physical, or policy related.
2. Decide how to exploit the constraint: The organization determines how this constraint can be eliminated as a result of which the “throughput” can be increased. Should these actions not lead to an increase, it is considered advisable to abandon the breakthrough of this constraint.
3. Subordinate everything else to the above decision: The organization as a whole must side with the adopted solution, as a result of which the “constraint” is solved. It is wise to make an assessment in between steps 3 and 4, to establish whether performance is still being hindered by this earlier constraint.
4. Elevate performance of the constraint: Other adjustments can be used to break through the “constraints”. This could involve changes in the existing system (reorganization) or changes in the market. Such adjustments require investments and will only be deployed after all other options have been considered.
5. Continuous process: After the implementation of the opted solution and after elimination or breakthrough of the constraint, the process starts over again from Step 1. On the one hand the impact of the implemented solution is looked at and on the other hand new constraints are identified and broken through.

The following graphic shows how Theory of Constraints (outer ring of arrows) shares much of the same processes with the traditional continuous quality improvement cycle (inner grouping of arrow wedges). Both processes start with identification of the problem or constraint. The next step with TOC is Exploiting the Constraint. This corresponds with the CQI steps of Researching the Solution, Developing the Theory of Change, and Adapting or Developing the Solution. The third and fourth steps of TOC call for Subordination to the Constraint and Elevation of the Constraint, which corresponds with the CQI step of Implementing the Solution. The last steps of both cycles involve analyzing the solution and, if needed, making further changes by going through the cycle again.

With Theory of Constraints, it is important to look at one constraint per cycle. By focusing all attention on one constraint, it can be dealt with more adequately rather than diluting focus across multiple issues. The other links in the system are regarded as non-constraints and are therefore not reinforced or broken through. Reinforcement or breakthrough of the identified constraint will automatically lead to another constraint that will have to be identified again. And like the CQI cycle, the whole TOC process starts over again. Therefore, the Theory of Constraints encourages an organization to improve its system continuously: it is a continuous quality improvement process.



As depicted in the above graphic, the CFS Management Team oversees the quality improvement activities for the public child welfare system in North Dakota. This team includes the Division Director, Assistant Division Director/CQI Administrator, QA Unit Manager, Safety Administrator, Permanency Administrator, Wellbeing Administrator, and the Early Childhood Services Administrator. Not only does this allow for ongoing and timely review of data and progress made on the system change goals, it allows for more timely adjustment to be made to programs.

Essential to a well-functioning continuous quality improvement (CQI) system is building productive CQI teams and ensuring that information generated through the system will be effectively used to make needed improvements. A productive CQI system requires a mechanism that promotes circular feedback and communication among staff, stakeholders, and teams (depicted by the dashed line in the graphic above). These feedback loops permit an ongoing, bi-directional information exchange across all levels of the agency, which in turn facilitates the change process. Equally important is sharing data with agency staff and sharing data with consumers and external stakeholders.

To help move needed system changes forward, subcommittees are established as needed (refer to the above graphic). This will include permanent regional subcommittees. The regional CQI specialist will oversee the subcommittee. Membership will include representation from public and private entities participating in the public child welfare system throughout the region including:

- Human service zones;
- Tribal social services;
- Criminal justice;
- Private agencies;
- Family members.

The subcommittees will work closely with the CFS Management Team to identify systemic issues impacting service delivery and develop processes to improve outcomes for the identified service area. They will:

- Review data from various sources including project specific data, CFSR/QA data and regional/local data reports;
- Review regional Onsite Case Review (OCR) data and discusses regional initiatives or action plans to address areas needing improvement;
- Design and implement CQI projects to improve outcomes throughout the regional service delivery system and ultimately the statewide public child welfare system;
- Provide ongoing consultation and collaboration to review and evaluate the progress of the PIP strategies and CFSP goals and recommend program adjustments to allow for successful completion of the requirements of the CFSR performance improvement plan;
- Provide for or arrange for ongoing training for individual workers on CQI principles;
- Promoting a culture that values service quality and continual efforts by the Team, its partners, and contractors to achieve strong performance, program goals, and positive results for service recipients;
- Make legislative/policy/and practice improvement recommendations to the CQI Council.

North Dakota has been using TOC as its continuous quality improvement program to improve services and outcomes. An example is the project looking at Child Protective Services. Key stakeholders came together to redesign Child Protective Services (CPS) to provide individuals and families the right service at the right time, at the right frequency and intensity. Three goals were identified as part of the CPS redesign project:

- Reduce the time it takes to complete a CPS assessment.
- Conduct a face to face meeting with the identified child within 3 days.
- Conduct complete casework 100% of the time, only passing on completed casework.

Current North Dakota statute requires that CPS assessments be completed within 62 days. Regretfully, this was only occurring 48% of the time during a 12-month assessment period. The CPS redesign Pilot Project targets are:

- 50% of CPS assessments completed at 25 days
- 75% of CPS assessments completed at 35 days
- 95% of CPS assessments completed at 62 days

Preliminary pilot project data shows progress including:

- 89% of the cases were closed with 62 days (baseline was 40.8%)
- 56% of the 499 closed cases were closed within 25 days (baseline was 7.35%)
- 89% of CPS workers met face-to-face with the identified child within three days of the report, sooner if imminent concerns were identified
- Pilot regions have, in some cases, unlocked hidden capacity, increasing access to services, and transferring staff from administrative work to direct client services.

North Dakota is in the second year of a performance improvement plan for the Round 3 CFSR. Goal One of the PIP involves strengthening its QA/CQI processes. Recently, North Dakota began receiving technical assistance from the Capacity Building Center for States. The goal of the TA is to develop and implement a CQI system that not only fulfills PIP requirements but also integrates the Theory of Constraints and includes all the functional components of an effective CQI system. Practice changes would include:

- Improved engagement of key stakeholders in the generation and meaning-making of performance data at the state, regional, and case-levels
- Improved use of data and evidence in decision-making at the state, regional, and case level

- Deeper collaboration and partnership between state and regional staff in identifying performance issues, unearthing root causes, developing and implementing improvement strategies, and monitoring their effectiveness.

North Dakota will use this CQI process to evaluate and continually improve provision of Title IV-E prevention services.

Evaluation Design: North Dakota does not intend to implement any allowable supported or promising practice evidence-based practices for consideration under FFPSA at the time of this submission. Rather, the State will only leverage FFPSA funding for well-supported models in year one of implementation (see Table 1 below). Therefore, an evaluation description is not needed at this time. As additional services are added to the Clearinghouse list of well-supported, the State may submit amendments to its plan along with appropriate waiver requests or full evaluation design (for supported or promising models).

Table 1. North Dakota Year One Implementation Programs by Evaluation Strategy

Prioritized Interventions	CQI (Formal) Evaluation Waiver	Formal Evaluation	State Level CQI	Claiming FFPSA
Brief Strategic Family Therapy	X			X
Functional Family Therapy	X			X
Healthy Families	X			X
Multisystemic Therapy	X			X
Nurse-Family Partnership	X			X
Parent Child Interaction Therapy	X			X
Parents as Teachers	X			X
Homebuilders	X			X

Waiver Request: Based on the compelling evidence for each program described above – as identified in the Extend of Evidence and Summary of Finding found within the documentation in the Title IV-E Prevention Services Clearinghouse. North Dakota is submitting Appendix B, Request for Waiver of Evaluation Requirement for each Well-Supported Practice.

Compelling Evidence

Brief Strategic Family Therapy: The request for a waiver of the evaluation requirement for Brief Strategic Family Therapy is based on compelling evidence that families in BSFT 1) had higher rates of engagement, retention and were more likely both to engage 2) adolescents of parents who used drugs at baseline had a significantly lower trajectory of substance use 3) decrease of parental alcohol usage. The following summary of research highlights the compelling evidence:

Study: Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. *Addictive Behaviors, 42,* 44-50. This study is a secondary analysis to determine the effects of *Brief Strategic Family Therapy (BSFT)* on parent substance use, and the relationship between parent substance use and adolescent substance use. This paper uses data from the *BSFT* effectiveness study conducted in the National Drug Abuse Treatment Clinical Trials Network. Participants were randomized to *BSFT* or treatment as usual (TAU) across eight outpatient treatment programs community treatment programs (CTPs) across the country. Adolescent substance use was assessed at baseline and at 12 monthly follow-up assessments. All additional adolescent and family assessments were completed at baseline and 4-, 8-, and 12-months post-randomization. Parent alcohol and drug use were assessed at baseline and at 12 months post-randomization. Measures utilized include the Alcohol and Drug Use items from the *Addiction Severity*

Index-Lite (ASI), the *Timeline Follow Back (TLFB), C-Diagnostic Interview Schedule for Children, Substance Abuse/Dependence Module (DISC-SA), Parenting Practices Questionnaire,* and the *Diagnostic Interview Schedule for Children-Predictive Scales (DISC-PS)*.
Outcome: Results found parents in *BSFT* significantly decreased their alcohol use as measured by the *ASI* composite score from baseline to 12 months. Change in family functioning mediated the relationship between treatment condition and change in parent alcohol use. Children of parents who reported drug use at baseline had three times as many days of reported substance use at baseline compared with children of parents who did not use or only used alcohol. Adolescents of parents who used drugs at baseline in the *BSFT* group had a significantly lower trajectory of substance use than adolescents in the TAU group.

Study: Coatsworth, J., Santisteban, D., McBride, C., & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process, 40*(3), 313-332. This study aimed to extend the body of research investigating the effectiveness of *Brief Strategic Family Therapy (BSFT)* to engage and retain families and/or youth in treatment. The sample reported in this article was part of a large-scale, two-phase demonstration study testing the efficacy of *BSFT* with high-risk minority youth (first-phase: see above summary of Santisteban, Coatsworth, Perez-Vidal et al., 1997). 104 families were randomly assigned to *BSFT* or a community comparison (CC) condition selected to represent the common engagement and treatment practices of the community. The *Revised Behavior Problem Checklist (RBPC)*, an empirically derived measure consisting of 89 problem behaviors, was administered A primary limitation of the study was that an intent-to-treat design was not able to be fully implemented. While the experimenters were able to complete termination assessments for 77% of the families that participated in either treatment, limited resources restricted the ability to track and assess families that did not engage into treatment.
Outcome: Results indicated that the families assigned to *BSFT* had significantly higher rates of engagement (81% vs. 61%) and retention (71% vs. 42%) than those assigned to CC. A risk-ratio analysis revealed that families randomized into *BSFT* were 2.3 times more likely both to engage and to retain than families/participants randomized to CC condition. *BSFT* was also more effective than CC in retaining more severe cases, specifically cases with high levels of adolescent conduct disorder, and, despite the higher percentage of difficult-to-treat cases, achieved comparable treatment effects on behavior problems.

Study: Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F. H., Santisteban, D., Hervis, O. E. & Kurtines, W. M. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56*(4), 552. Using a two-group experimental design, this study randomly assigned subjects to either strategic structural-systems engagement (SSSE) or engagement as usual (EAU). SSSE was developed within the conceptual framework of *Brief Strategic Family Therapy (BSFT)* (Szapocznik, Kurtines, et al., 1983, 1986), which is a structural family-systems approach. This study tested the efficacy of the strategic structural systems engagement procedure for engaging hard-to-reach cases and bringing them to therapy completion. To assess the subject's psychiatric and psychosocial functioning, the *Psychiatric Status Schedule (PSS)* was one of the measures used. Another measure used was the *Client-Oriented Data Acquisition Process (CODAP)*, which requests information on drug use by type and frequency.
Outcome: A sustained higher level of engagement was found in the SSSE condition vs. the EAU condition. For example, over 57.7% of the families in the EAU condition failed to come to the center for intake, while only 7.1% of families in the SSSE condition were lost.

The goal of BSFT is to improve a youth's behavior by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems. BSFT targets children and adolescents who are displaying—or are at risk for developing—behavior problems, including substance abuse. Review of the research suggests that implementing the model in community settings in North Dakota will provide therapists with an effective tool to increase family involvement in therapy, increase retention, reduce

adolescent drug use and related risk-taking behaviors, and reconfigure family interactions to support healthy development. This will help North Dakota realize the goal of decreased out-of-home placements.

Functional Family Therapy: The evidence in favor of the use of Functional Family Therapy in North Dakota to provide change in family interactions and subsequent behavior. The request for a waiver of the evaluation requirement for FFT is based on compelling evidence that 1) FFT has shown to improve family dynamics; 2) decrease delinquent behavior in youth; and 3) decrease the recidivism rate of delinquent teenagers. The following summary of research highlights the compelling evidence:

Study: 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 a short-term behavioral intervention [now called Functional Family Therapy (FFT)] on the recidivism rates of delinquent teenagers and their families. Families were randomly assigned to either the short-term behavioral family intervention program or to one of three comparison groups: client-centered family groups program, psychodynamic family program (Mormon church-sponsored), or a no-treatment control group. Juvenile court records were examined following termination to assess recidivism, (i.e., referral for behavioral offense).
Outcome: Short-term family behavioral treatment 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.

Study: 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. Measured outcomes on three levels of evaluation: changes in the family interaction process at the termination of treatment (tertiary prevention); recidivism rates 6 to 18 months following treatment (secondary prevention); and rate of sibling contact with the court 2.5 to 3.5 years following intervention (primary prevention). Families were randomly assigned to one of four treatment conditions: the treatment program [now called Functional Family Therapy (FFT)], one of two comparison groups, or a no-treatment control group.
Outcome: The family systems approach, when compared to the other conditions, produced significant improvements in family interaction process measures and a significant reduction in recidivism. Siblings of youth receiving FFT showed lower arrest rates than siblings from alternative treatment conditions 2 ½ to 3 ½ years post-treatment.

Study: 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. Participants were randomly assigned to one of four treatment conditions: Functional Family Therapy (FFT), individual Cognitive Behavioral Therapy (CBT), a combination of FFT and CBT (joint), or a psychoeducational group. Measures to assess substance abuse included the Timeline Follow-Back (TLFB) interview, as well as collateral reports from parents and siblings of adolescents, and urinalyses. In order to assess problem behaviors that may be associated with substance abuse, the Problem Oriented Screening Instrument for Teenagers (POSIT) and Child Behavioral Checklist (CBCL) were used.
Outcome: Therapy conditions (FFT and joint CBT/FFT) had significant reductions in heavy marijuana use from pretreatment to the 4-month assessment, and this reduction persisted until the 7-month assessment. The initial changes in those in the CBT condition from pretreatment to 4 months, however, did not persist through the 7-month assessment.

The California Clearinghouse notes that FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Based on the research and how the model fits with the needs of the state, FFT will prove to be

effective in North Dakota in decreasing the number of out of home placements by decreasing the incidence of delinquent behaviors through improved family dynamics.

Healthy Families America: The request for a waiver of the evaluation requirement for Healthy Families America is based on compelling evidence that 1) reports of fewer acts of very serious abuse, minor physical aggression, and psychological aggression 2) fostering positive parenting, such as maternal responsivity and cognitive engagement 3) mothers were half as likely to be confirmed subjects for physical abuse or neglect 4) children of mothers in the home visiting group were less likely to receive a second report and had a longer period of time between initial and second reports. The following summary of research highlights the compelling evidence:

Study: DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32,* 295-315. doi:10.1016/j.chiabu. 2007.07.007. The study evaluated the effects of Healthy Families NY [now called *Healthy Families America (HFA)*] on parenting behaviors in the first 2 years of life. There was trend toward lower levels of neglect at both times for Healthy Families NY program mothers, as well, although it did not reach significance. No group differences were found for substantiated CPS reports.
Outcome: Results indicated that at one-year follow-up, mothers in the Healthy Families NY program reported fewer acts of very serious abuse, minor physical aggression, and psychological aggression in the past year, as well as fewer acts of harsh parenting in the last week. At year 2, Healthy Families NY mothers reported significantly fewer acts of serious physical abuse.

Study: Rodriguez, M. L., Dumont, K., Mitchell-Herzfeld, S. D., Walden, N. J., & Greene, R. (2010). Effects of Healthy Families New York on the promotion of maternal parenting competencies and the prevention of harsh parenting. *Child Abuse & Neglect, 34,* 711-723. doi:10.1016/j.chiabu.2010.03.004. This study utilized participants from DuMont et al. (2008). The study evaluated the effectiveness of the Healthy Families New York [now called *Healthy Families America (HFA)*] home visiting program in promoting parenting confidence and preventing maladaptive parenting behaviors in mothers at risk for child maltreatment.
Outcome: Results indicated that Healthy Families NY was effective in fostering positive parenting, such as maternal responsivity and cognitive engagement. With respect to negative parenting, Healthy Families NY mothers in the High Prevention Opportunity subgroup were less likely than their counterparts in the control group to use harsh parenting.

Study: Lee, E., Kirkland, K., Miranda-Julian, C., & Greene, R. (2018). Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. *Child Abuse & Neglect, 86*, 55-66. doi:10.1016/j.chiabu.2018.09.004. The study evaluated the effectiveness of Healthy Families New York, [now called *Healthy Families America (HFA)*] through a telephone survey. Participants were a group of mothers who had at least one substantiated CPS report who were randomly selected to assess early outcomes at their child's 1-year birthday. Participants were then randomly assigned to either HFA or a control group. Measures utilized include the *Kempe Family Stress Inventory (KFSI)*, the *Center for Epidemiologic Studies Depression Scale (CES-D),* the *Parent-Child Relationship Inventory (PCRI)*, the *Adult Adolescent Parenting Inventory (AAPI)*, and administrative information from the New York Statewide Central Register of Child Abuse and Neglect.
Outcome: Results found that by the child's seventh birthday, mothers in the home-visited group were as half as likely as mothers in the control group to be confirmed subjects for physical abuse or neglect. The number of substantiated reports for mothers in the control group was twice as high as for those in the home-visited group. Group differences were only observed after the child's third birthday. Results indicate that home-visited mothers had fewer subsequent births that may have contributed to less parenting stress and improved life course development for mothers.

Study in support of the Child Welfare Protocol: Easterbrooks , M. A., Kotake, C., & Fauth, R. (2019). Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. *American*

Journal of Public Health, 109(5), 729-735. doi:10.2105/AJPH.2019.304957. The study investigated whether Healthy Families Massachusetts, [now called *Healthy Families America (HFA)*] reduced recurrence of child maltreatment in child protective (CPS) reports for primiparous (first-time) adolescent mothers. Participants were randomly assigned to either HFA or a control group. Measures utilized include administrative data from the Massachusetts CPS agency, the Department for Children and Families. The outcome variable was CPS reports available for 688 families, specifically, re-reports following an initial report (up to mean child age of 7 years). Of the studied families 33% had a child 3 months and older at the time of enrollment.
Outcome: Results found of the 52% of families who experienced initial CPS reports, 53% experienced additional CPS reports. Children of mothers in the home visiting group were less likely to receive a second report and had a longer period between initial and second reports.

The largest group of children entering foster care in North Dakota are age 0-5 and HFA serves families with children in that age range. HFA is theoretically rooted in the belief that early, nurturing relationships are the foundation for life-long, healthy development. Building upon attachment, bio-ecological systems theories, and the tenets of trauma-informed care, interactions between direct service providers and families are relationship-based; designed to promote positive parent-child relationships and healthy attachment; services are strengths-based; family-centered; culturally sensitive; and reflective. North Dakota plans to expand Healthy Families North Dakota as well as implement the child welfare protocol which will allow families with target children up to the age of 24 months to enroll as long as the site maintains documentation to show the initial referral was received from the child welfare system. North Dakota does not want to exclude families but rather expand by using the protocol to allow families entering the child welfare system with children up to 24 months to access the service. Families engaged in the child welfare system may not have previously known about the service and even if they enroll at a later age they may see greater benefits of reducing the recurrence of child welfare involvement, increase the length of time between initial and subsequent CPS reports and strengthen the parent-child relationship. As noted above in Easterbrooks, M. A., Kotake, C., & Fauth, R. (2019.)

Healthy Families America's (HFA) best practice standard is to strive for serving at least 80% of families beginning prenatally or in the newborn period because doing so optimizes the ability to achieve greater maternal and child health outcomes, but there is flexibility so that this standard is not absolute [*pg. 48, HFA Best Practice Standard 1-3.B regarding 80% first home visits occurring prenatally or within first three months, and pg. 6-7, HFA BPS Glossary, which indicates threshold for accreditation and demonstration of model fidelity requires adherence to 85% of all HFA Best Practice Standards*]. Services delivered under the child welfare protocol are no different than the services delivered to other populations or target children in different age ranges. The only distinction under our protocol for child welfare involved families is the flexible intake window up to 24 months of age for referrals from child welfare. The HFA model has, since its inception in 1992, been working with child welfare referred families and has allowed flexibility with regard to age of child at intake in its manuals [*pg. 63, HFA Best Practice Standard 3-1.B regarding families enrolled with open and active child welfare/CPS involvement*]. These HFA target population characteristics were part of the original review, approval and well-supported rating provided by the Clearinghouse. Additionally, because the model was originally designed for families with children 0-5, model specific training covers this entire age span, meaning HFA's 3 year minimum length of service ensures children enrolled up to 24 months are served by staff trained to work with families through the age of 5. The allowance up to 24 months is intentional to remain consistent with all existing model practices.

Homebuilders: The evidence in favor of the use of Homebuilders in North Dakota to provide intensive, in-home counseling and support services for families who have a child (0-17 years old) at imminent risk of out-of-home placement or who is in placement and cannot be reunified without intensive in-home services. The request for a waiver of the evaluation requirement for Homebuilders is based on compelling evidence that 1) Homebuilders has shown to keep children in their own homes; 2) reunify children with their parents in a shorter amount of time, and 3) Homebuilders resulted in lower placement costs. The following summary of research highlights the compelling evidence:

Study: Kinney, J., & Haapala, D. (1984), First Year HOMEBUILDERS Mental Health Report. Federal Way, WA: Behavioral Sciences Institute. Study funded by the Washington State Legislature to determine the effectiveness of HOMEBUILDERS at preventing imminent placement of youth into inpatient psychiatric hospitalization. Referrals from the Washington Office of Involuntary Commitment.
Outcome: 73% of treatment group avoided hospitalization.

Study: Wood, S., Barton, K., & Schroeder, C. (1988). In-home treatment of abusive families: Cost and placement at one year. Psychotherapy, 25(3), 409-414. A comparison was made between families referred to the Families First home-based service program [now called Homebuilders®] and those receiving usual services. Group assignment was not random, but there was no significant difference between groups on financial aid, ethnicity, sex of referred children, or reason for referral. The groups were evaluated on cost of services and whether or not children remained at home.
Outcome: 74% treatment group remained at home and placement costs lower than comparison group.

Study: Fraser, M., Walton, E., Lewis, R., Pecora, P., Walton, W., (1996), An Experiment in Family Reunification Services: Correlates of Outcomes at One Year Follow Up. Children and Youth Services Review, Vol. 18, Nos. 4/5 pp. 335-361. Study by the University of Utah to determine the effectiveness of their IFPS program (using the HOMEBUILDERS model) at reunifying children with their families following out of home placement.
Outcome: 92% of the treatment group returned home.

Study: Kirk, R.S. & Griffith, D.P., (2004), Intensive family preservation services: Demonstrating placement prevention using event history analysis. Social Work Research, Vol. 28, No. 1, pp. 5-15. Study funded by the legislature of the State of North Carolina, examining a 7-year time frame, to determine the effectiveness of IFPS (using the HOMEBUILDERS model) at preventing imminent out of home placement.
Outcome: 81% of treatment group avoided placement.

Study: Blythe, B. & Jayaratne, S., (2002), Michigan Families First Effectiveness Study. Available on the web at www.michigan.gov/fia/o, 1607, 7-124-55458-7695-8366-21887-, oo.html. Study to determine the effectiveness of IFPS (using the HOMEBUILDERS model) at preventing imminent out of home placement. The first study to assure accurate targeting of subjects by randomly assigning children after a foster placement decision had been approved by the court.
Outcome: 93% of the treatment group avoided placement.

The California Clearinghouse notes that Homebuilders uses behavioral assessments to determine outcome-based goals and help families identify strengths and problems associated with child safety and intervention maintenance of change. It aims to support families during crises using tailored intervention strategies and a diverse range of services, such as support with basic needs, service navigation, and psychotherapy. Providers use cognitive and behavioral practices to teach family members new skills and facilitate behavior change. Based on the research and how the model fits with the needs of the state, Homebuilders will prove to be effective in North Dakota in decreasing the number of out of home placements.

Multisystemic Therapy : The request for a waiver of the evaluation requirement for Multisystemic Therapy is based on compelling evidence that MST 1) it is more effective than regular services to reduce out of home placement and behavioral problems in youth 2) it reduces drug use, decreases days in out-of-home placement, and decreases recidivism 3) showed improved family cohesion, improved peer relations and decreased youth incarceration 4) showed improvements in the areas of home, school and community. The following summary of research highlights the compelling evidence:

Study: *Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behavior problems in youth: Sustainability of effectiveness two years after intake. *Child and Adolescent Mental Health, 11*(3), 142-149. The aim of this study was to examine the effectiveness of *Multisystemic Therapy (MST)*

compared to "regular services" (RS) two years after intake to treatment to investigate whether *MST* was successful at preventing placement out of home, and to examine reductions in behavior problems in multi-informant assessments. Participants were randomly assigned to *MST* or RS treatment conditions. Measures utilized include the *Child Behavior Checklist (CBCL),* the *Youth Self-Report (YSR),* the *Teacher's Report Form (TRF),* and the *Self-Report Delinquency Scale (SRD)*.
Outcome: Results indicate that *MST* was more effective than RS in reducing out-of-home placement and behavioral problems.

Study: *Henggeler, S. W., Pickrel, S. G., & Brondino, M. J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*, 171-184. The effectiveness and transportability of *Multisystemic Therapy (MST)* were examined in a study that included 118 juvenile offenders meeting the *Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R)* criteria for substance abuse or dependence and their families. Participants were randomly assigned to receive *MST* versus usual community services. Outcome measures assessed drug use (as measured by the *Personal Experience Inventory* and urine drug screens), criminal activity (measured by the *Self-Report Delinquency Scale* as well as Department of Juvenile Justice arrest records), and days in out-of-home placement at post treatment and at a 6-month post-treatment follow-up. Also, treatment adherence (as measured by the *MST Treatment Adherence Measure*) was examined from multiple perspectives.
Outcome: Results showed a reduction in drug use, decreased days in out-of-home placement, and decreased recidivism. Treatment adherence was linked with long-term outcomes, and analyses suggested that the modest results of *MST* were due, at least in part, to difficulty in transporting this complex treatment model from the direct control of its developers. Increased emphasis on quality assurance mechanisms to enhance treatment fidelity may help overcome barriers to transportability.

Study: *Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60*, 953-961. *Multisystemic Therapy (MST)* delivered through a community health center was compared to usual services delivered by the Department of Juvenile Justice in the treatment of 84 serious juvenile offenders and their families. Offenders were assigned randomly to treatment conditions. Pretreatment and posttreatment assessment batteries evaluated family relations (as measured by the *Family Adaptability and Cohesion Evaluation Scales*), peer relations (as evaluated by the *Missouri Peer Relations Inventory*), behavioral symptomology and social competence (as measured by the *Revised Behavior Problem Checklist*), criminal offending based on self-reports, and arrest/incarceration records through 59 weeks post-referral.
Outcome: In comparison with youth who received usual juvenile justice services (high rates of incarceration), youths who received *MST* showed improved family cohesion, improved peer relations, decreased recidivism (43%), and decreased incarceration (64%).

Study: Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An independent effectiveness trial of Multisystemic Therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychology, 35*(2), 227-236. Families were randomly assigned to *Multisystemic Therapy (MST)* or to treatment as usual (TAU). In their introduction, the authors note that this study is unusual in that it does not involve the original *MST* developers and was conducted in a more naturalistic setting than some previous trials. Youth functioning was measured using the *Child and Adolescent Functional Assessment Scale (CAFAS)*, which focuses on school/work, home, community, behavior towards others, emotions, self-harming and risky behavior and thinking. Youth recidivism was also measure using family court records.
Outcome: The *MST* group showed a significantly lower recidivism rate. Both groups showed functional improvements, with *MST* showing particular improvements in the areas of home, school and community.

The California Evidence-Based Clearinghouse for Child Welfare notes that MST is designed to eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s) and to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise

in raising children and adolescents and empower youth to cope with family, peer, school, and neighborhood problems. Based on the research and how the model fits with the needs of the state, MST will prove to be effective in North Dakota in decreasing the number of out of home placements by decreasing the incidence of delinquent behaviors through improved parent-child interactions.

Nurse Family Partnership: The request for a waiver of the evaluation requirement for Nurse Family Partnership is based on compelling evidence that 1) women visited by nurses were less likely to be perpetrators of child abuse and neglect, and had fewer arrests, convictions, and number of days jailed 2) fewer reports of child abuse and neglect, were observed to restrict and punish children less frequently, provided more appropriate play materials and had fewer emergency room visits 3) fewer child maltreatment reports involving mother as perpetrator and study child as victim. The following summary of research highlights the compelling evidence:

Study: Olds, D. L., Henderson, C. R., Chamberlin, R., &, Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics, 78,* 65-78. Participants were determined at intake to have at least one risk factor: mother less than 19 years old, single parent status, or low socioeconomic status. Volunteers and women recruited due to a risk factor were randomly assigned to one of conditions described below: 1) Sensory and developmental screening at 12 and 24 months only (control group); 2) Free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; 3) Nurse home visitation during pregnancy only, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; or 4) Nurse home visits until the child was 2 years old in addition to nurse home visitation during pregnancy, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months [now called *Nurse Family Partnership (NFP)*]. Measures included medical examinations and developmental testing using the *Bayley and Cattell Scales* at 6, 12, and 24 months, and home observation using the *Caldwell and Bradley Procedure*. The list of participants was also checked against verified cases of abuse and neglect and medical records were examined.
Outcome: Among women at highest risk, those visited by a nurse had fewer reports of child abuse and neglect, were observed to restrict and punish children less frequently, provided more appropriate play materials and had fewer emergency room visits. In the second year, all nurse-visited women, regardless of risk status, had fewer emergency room visits and fewer physician visits for accidents and poisoning.

Study: Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R.,Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association, 278*(8), 637-643. Participants were determined at intake to have at least one risk factor: mother less than 19 years of age, single parent status, or low socioeconomic status. This study used the same sample as Olds, et al. (1986) and Olds, et al. (1994). Volunteers and women recruited due to a risk factor were randomly assigned to one of conditions described below: 1) Sensory and developmental screening at 12 and 24 months only (control group); 2) Free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; 3) Nurse home visitation during pregnancy only, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months; or 4) Nurse home visits until the child was 2 years old in addition to nurse home visitation during pregnancy, free transportation to regular prenatal and perinatal visits, and sensory and developmental screening at 12 and 24 months [now called *Nurse Family Partnership (NFP)*]. Assessments at this follow-up included behavioral impairments due to drug or alcohol use, use of welfare, and reviews of Child Protective Services and New York State criminal justice records.
Outcome: Women visited by nurses were less likely to be perpetrators of child abuse and neglect, and had fewer arrests, convictions, and number of days jailed.

Study: Eckenrode, J., Ganzel, B., Henderson Jr, C. R., Smith, E., Olds, D. L., Powers, J.,...Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation. *Journal of the American Medical Association, 284*(11), 1385-1391. Participants were mothers determined at intake to have at least one risk factor: mother less than 19 years of age, single parent status, or low socioeconomic

status. This study used the same sample as Olds, et al. (1986, 1994, 1997, and 1998). Mothers were interviewed at 15 years, using a life history calendar designed to help them recall major life events. **Outcome:** Families receiving nurse visitation during pregnancy and infancy had fewer child maltreatment reports involving mother as perpetrator and study child as victim. The treatment effect decreased as level of overall domestic violence increased. The authors conclude that the presence of domestic violence may limit the effectiveness of early visitation interventions.

The Nurse-Family Partnership (NFP) program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. The program's primary goals are: to improve pregnancy outcomes by promoting health-related behaviors, to improve child health, development and safety by promoting competent caregiving, to enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment, to enhance families' material support by providing links with needed health and social services and to promote supportive relationships among family and friends. The largest group of children entering foster care in North Dakota is age 5 years and under. As Nurse Family Partnership focuses services primarily on pregnant women and families with children from birth to age 5, it fits well with North Dakota. The research supports the belief that this program will help the state to decrease the target population of children age 0-5 from entering foster care.

Parent Child Interaction Therapy: The request for a waiver of the evaluation requirement for Parent Child Interaction Therapy is based on compelling evidence that PCIT 1) Reductions in negative parent behavior 2) higher levels of praise and lower levels of criticism by parents in interactions with children 3) Children's compliance also increased in the observed interaction and their *ECBI* scores improved significantly. The following summary of research highlights the compelling evidence:

Study: Shuhman, E. M., Foote, R. C., Eyberg, S. M., Boggs, S., & Algina, J. (1998). Efficacy of Parent Child Interaction Therapy: Interim report of a randomized trial with short term maintenance. *Journal of Clinical Child Psychology, 27*(1), 34-45. Families with children referred for conduct disorder were randomly assigned either to receive *Parent-Child Interaction Therapy (PCIT)* or to a wait-list control. Observations were made of parents and children interacting at baseline using the *Dyadic Parent Child Interaction Coding System (DPICS-II)*. Parents also completed the *Eyberg Child Behavior Inventory (ECBI)* for the child and the *Parental Locus of Control Scale (PLOC)*, the *Beck Depression Inventory (BDI)*, *Parenting Stress Inventory (PSI)*, and the *Dyadic Adjustment Scale (DAS)*, which measures quality of adjustment between marital pairs. The authors note that this sample of families had no significant levels of marital distress or depression at baseline and were recruited from a group that actively sought treatment for their children and so results might not generalize to other populations.
Outcomes: At follow-up, the intervention group showed higher levels of praise and lower levels of criticism in interactions with children than the control group. Children's compliance also increased in the observed interaction and their *ECBI* scores improved significantly. Parental stress scores and *Locus of Control* scores shifted to normal levels in the *PCIT* group, while those for the control group remained at clinical levels. Although comparisons could not be made with the control group at 4-month follow-up, all gains made by *PCIT* treatment families were maintained.

Study: *Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., … Bonner, B. (2004). Parent-Child Interaction Therapy with physically abusive parents: Efficacy for reducing further abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500-510. Parents and children were randomly assigned to a control group receiving standard services, a *Parent-Child Interaction Therapy (PCIT)* intervention group, or to a *PCIT* enhanced group which also included extra services targeting parental depression, substance abuse, and family violence problems. Parents received the *Child Abuse Potential Inventory (CAP)*, the *Child Neglect Index (CNI)*, the *Abuse Dimensions Inventory (ADI)*, the *Dyadic Parent-Child Interaction Coding System (DPICS-II)*, the *Beck Depression Inventory (BDI)*, and the *Diagnostic Interview Schedule (DIS) Alcohol and Drug Modules* and *Antisocial Personality Disorder Module*, which were modified to be administered as self-reports. The *CNI* and *ADI*

were completed by consultation with the child welfare workers or reviewing written material on cases. Parents reported on their children's behavior using the *Child Behavior Checklist (CBCL)*.
Outcome: Results showed that the *PCIT* alone group had significantly fewer re-reports of abuse over the follow-up period than did the control condition and also fewer reports than the enhanced *PCIT* condition, although this difference did not reach significance. Reductions in negative parent behavior, measured by the *DPICS-II*, were significant for both *PCIT* groups, compared to the control. Positive behaviors were high in all groups and did not differ.

Study: *Chaffin, M., Funderburk, B., Bard, D., Valle, L.A., & Gurwitch, R. (2011). A motivation-PCIT package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology, 79*(1), 84-95. This study uses the same sample as Chaffin, M. et al. (2009). Objectives were to test effectiveness in a field agency rather than in a laboratory setting, and to dismantle the SM Group vs. services as usual (SAU) orientation and *Parent-Child Interaction Therapy (PCIT)* vs. SAU parenting component effects. Assessment information was drawn from three sources—self-report questionnaires administered via audio-assisted computerized self-interview (ACASI) using touch-screen computers, observational coding of parent-child interactions, and administrative data from the state child welfare database. Measures used included *Readiness for Parenting Change Scale (REDI), Child Abuse Potential Inventory (CAP), Dyadic Parent–Child Interaction Coding System (DPICS-II), Child and Parent-Directed Interaction (CDI* and *PDI),* and *P.R.I.D.E. skills*. An imputation-based approach was used to estimate recidivism survival complicated by significant treatment related differences in timing and frequency of children returned home. Methodological considerations for analyzing child welfare event history data complicated by differential risk deprivation are also emphasized
Outcome: Findings demonstrated that previous laboratory results can be replicated in a field implementation setting, and among parents with chronic and severe child welfare histories, supporting a synergistic SM+*PCIT* benefit.

Parent-Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2 – 7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Based on the research and how the model fits with the needs of the state, PCIT will prove to be effective in North Dakota by reducing the incidence of child welfare recidivism and improved parent-child interactions.

Parents As Teachers: The request for a waiver of the evaluation requirement for Parents as Teachers is based on compelling evidence that 1) decreased likelihood of CPS substantiations 2) first substantiations of CPS also occurred later in the child's life 3) greater acceptance of child behavior among moderate-income parents 4) greater tendency to read aloud or tell stories to the child among low-income parents. The following summary of research highlights the compelling evidence:

Study: Wagner, M., Spiker, D., & Linn, M. I. (2002). The effectiveness of the Parents as Teachers program with low-income parents and children. *Topics in Early Childhood Special Education, 22*(2), 67-81. https://doi.org/10.1177/02711214020220020101. This study investigated the effectiveness of the *Parents as Teachers (PAT)* program with low-income families. Families were recruited through community services and agreed to be randomly assigned to receive the *PAT* program or to a comparison group. Measures utilized include the *Knowledge of Infant Development Inventory,* the *Parenting Sense of Competence Scale,* the *Child Maltreatment Precursor Scale,* the *Home Observation and Measurement of Environment (HOME) Inventory,* the *Developmental Profile II,* and the *Adaptive Social Behavior Inventory*.
Outcome: Results indicate lower scores on parent knowledge, attitude toward parenting, and parenting behaviors were noted for lower-income families. Few measures were affected by participation in the *PAT* program. These included higher self-reported happiness when caring for the child, greater acceptance of child behavior (2nd year) among moderate-income parents, and a greater tendency to read aloud or tell

stories to the child among low-income parents. There was also a moderate effect on prosocial behavior among low-income children.

Study: Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. *Child Abuse & Neglect, 79*, 476-484. https://doi.org/10.1016/j.chiabu.2018.02.019. Participants were socially high-risk families involved with child welfare services. The objective of this study was to assess the impact of voluntary participation in *Parents as Teachers (PAT)* for socially high-risk families on child maltreatment as identified by Child Protective Services (CPS). Measures utilized include three CPS-related outcomes were ascertained: 1) investigated reports of maltreatment, 2) substantiated reports of maltreatment, and 3) out-of-home placements.
Outcome: Results indicate in the unmatched sample, families who participated in home-visiting had significantly higher median risk scores. After matching families on measured confounders, the percentages of families with CPS investigations were similar between the two groups. However, there was a 22% decreased likelihood of CPS substantiations (hazard ratio [HR] 0.78, 95% confidence interval) for families receiving home visiting. First substantiations also occurred later in the child's life among home-visited families. There was a trend toward decreased out-of-home placement.

Study: Jonson-Reid, M., Drake, B., Constantino, J. N., Tandon, M., Pons, L., Kohl, P., Roesch, S., Wideman, A., & Auslander, W. (2018). A randomized trial of home visitation for CPS-involved families: The moderating impact of maternal depression and CPS history. *Child Maltreatment, 23*(3), 281-293. https://doi.org/10.1177/1077559517751671. The objective of this study was to assess the impact of participation in *Parents as Teachers (PAT)* in reducing recurrent maltreatment. Participants were randomized to either the *PAT* program or to usual care services from child protection. Measures utilized include the *Center for Epidemiologic Studies Depression Scale (CES-D)*, the *Parenting Stress Index*, the *Family Support Scale*, and official re-reports to child protective services (CPS) as a maltreatment measure.
Outcome: Results indicate no significant changes were found in maternal outcomes by group. Among nondepressed mothers or families without multiple CPS reports prior to study enrollment, *PAT* was associated with a significantly lower likelihood of CPS report recidivism.

Parents as Teachers is an early childhood parent education, family support and well-being, and school readiness home visiting model based on the premise that "all children will learn, grow, and develop to realize their full potential." The four goals of Parents as Teachers are: increase parent knowledge of early childhood development and improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect and increase children's school readiness and school success. As the program can focus services primarily on pregnant women and families with children from birth to age 3 or through kindergarten, it fits well with North Dakota and will help the state to decrease the target population of children aged 0-5 years from entering foster care.

Contract Monitoring: Monthly and quarterly data analyses, and quarterly case-record reviews will be performed by the Contract Manager to oversee the providers performance and ensure quality service delivery to children and families. The providers are required, as part of their contracts, to maintain fidelity with evidence-based model standards and have dedicated staff to perform internal quality assurance checks. The requirements of the prevention plan and all aspects of the prevention plan management and ongoing risk assessment are being written into the providers contracts.

SECTION 3: MONITORING CHILD SAFETY

The core mission of the child welfare system in North Dakota is child safety. North Dakota is currently going through a social service redesign and working towards implementing a more comprehensive safety practice model. Decisions about safety will not be reactionary, but based on information observed, gathered and analyzed. The information determines if threats, protective capacities and child vulnerability exist.

DHS and the family's child welfare worker from the human service zone will monitor and oversee the safety of children and their caregivers who are involved with the child welfare system and are receiving evidence-based prevention services under North Dakota's Title IV-E Prevention Plan. Child welfare staff will be trained to conduct safety and risk assessments. Assessing safety and risk is an ongoing process continued throughout the family's involvement with the child welfare system, starting with the initial contact and ending with a safe case closure. Assessments will be conducted by the child welfare worker that is most closely engaged with the family at any point in the case, acknowledging that assessments are more accurate when conducted by a worker who routinely engages with the family. If it is determined that the risk of foster care entry remains based on the assessments, the child's prevention plan and eligibility for prevention services will be re-examined at a minimum of every six months.

The prevention plan as part of the child and caregiver's case plan will be routinely examined to help monitor and track progress during the provision of prevention services. Parents and caregivers will have the opportunity to participate in the development and reexamination of the written plan. Children listed on the plan who are developmentally appropriate will have the opportunity to participate in the development of the plan to the degree that they can contribute. Updated safety and risk assessments may be used to inform the plan review.

A variety of tools and practices will be used to assess and monitor the safety of children who are involved with the child welfare system and receiving prevention services, including:

- Determining which families to refer for prevention services.
- Developing appropriate safety plans.
- Identifying the level of intensity needed for intervention with a family, including how frequently the family needs to be seen.
- Determining when it is appropriate to close an in-home services case.

Present Danger Assessment and Present Danger Plan: When the family enters the child welfare system through child protective services (CPS) a Present Danger Assessment will be completed by the CPS worker to assess if any present danger exists or not. If present danger exists, a Present Danger Plan will be completed with the family to address and control the immediate danger or safety threats to the child.

CPS Assessment and Safety Plan Determination: The CPS Assessment is used to identify possible threats to a child's safety and guides the worker on what interventions are necessary to protect a child from dangerous family conditions. When an in-home services case is opened as a result of a CPS case, the CPS worker will complete the initial Safety Assessment and Safety Plan Determination prior to referring the case for in-home services. If the in-home services case is not the result of a CPS case, the in-home caseworker will complete the initial Safety Assessment.

Each family will receive a CPS Assessment and Safety Determination within 62 days of the case opening and will be completed or updated at minimum of every 90 days or sooner if there are new circumstances or new information that would affect risk. A final Safety Assessment is required prior to closure of an in-home services case. Resolution of any identified safety threats must be documented in the case record.

Safety Plan: A safety plan is required when impending danger is identified. In every case where danger is identified, a written safety plan will exist identifying safety actions to be implemented to ensure child safety.

Safety and risk assessment results will be monitored alongside progress towards service goals by the responsible caseworker.

Protective Capacity Family Assessment: The Protective Capacity Assessment (PCFA) is a collaborative process between the caseworker and the parent/caregiver to examine and understand the behaviors, conditions or circumstances that resulted in a child being unsafe.

The collaborative process identifies enhanced protective capacities that can be employed to promote and reinforce change, and diminished protective capacities that must change in order for the parent/caregiver to regain full responsibility for the safety of the child. The case plan is developed based on information gathered in this assessment.

Case Plan: The Case Plan specifies what must change to reduce or eliminate safety threats and increase the parent or caregiver's protective capacities to assure the child's safety and well-being. The child and/or caregiver's prevention plan will be a part of the case plan.

Protective Capacity Progress Assessment: The Protective Capacity Progress Assessment (PCPA) measures progress toward achievement of goals in a case plan. It focuses on progress and change related to enhancing diminished caregiver protective capacities. The assessment also evaluates the status of impending danger and the effectiveness of safety plans. During this assessment, adjustments to a case plan are considered as well as caregiver participation and service provision effectiveness. With respect to safety management, it is during the assessment event that reunification is considered when the safety plan is out-of-home placement. The assessment occurs as an evaluation event at least every 90 days following the implementation of a case plan for out of home cases, at least every 30 days for in-home cases.

Provider Responsibility: The approved provider is responsible for conducting a thorough and accurate assessment of the child and family to determine the most appropriate services. An assessment for safety and risk is also conducted on a regular basis. The approved provider must complete all tracking and reporting requirements as deemed necessary by the Department of Human Services for reimbursement. The approved provider will be required to also review the child's prevention plan with the parents, caregivers, and child if developmentally appropriate and complete an eligibility determination for prevention services a minimum of every 6 months.

Section 4: Consultation and Coordination

Consultation: The North Dakota Department of Human Services (DHS) has consulted with other state agencies responsible for administering behavioral health (mental health and substance abuse prevention and treatment) services, and with other public and private agencies with experience in providing child and family services.

DHS held nine monthly informational meetings in 2019 on the Family First Prevention Services Act (PL 115-123) to provide implementation updates to stakeholders and to give them an opportunity to ask questions and offer feedback. Meetings were held on-site at the State Capitol, and a conference call line was also available for those unable to attend in person. Information regarding these meetings can be found online at http://www.nd.gov/dhs/services/childfamily/family-first.html

DHS established the Title IV-E Prevention Services Planning Workgroup to oversee and guide overall implementation of provisions of the Title IV-E Prevention Plan. The committee consists of members from Children and Family Services, Division of Juvenile Services, Behavioral Health, Regional Human Service Centers, DHS fiscal and other key staff. Additional meetings and stakeholder phone calls provided additional consult with community organizations, tribal partners, private providers, and other state agencies. These efforts helped guide the services included in the North Dakota IV-E prevention plan and will continue to guide development of a continuum of mental health and substance abuse prevention and treatment services, and in-home parent skill-based programs.

Prior to finalizing and submitting the Title IV-E Prevention Plan for Federal review, DHS published a draft for public comment. DHS received a public comment specific to the omission of culturally responsive and inclusive prevention services to Native American children and their families. Currently the Clearinghouse does not include models that are culturally adapted to specifically meet cultural needs of various groups, however, there is potential for that to change as more models are reviewed and added to the list. As new models are added to the Clearinghouse, DHS will collaborate with tribal partners to evaluate if such models provide culturally appropriate services to Native American children. DHS recognizes access to a broader variety of models would be beneficial for our tribal partners to best meet their needs.

Coordination: The CFS Division coordinates and collaborates with several public and private providers in carrying out the continuum of Child Welfare Services, including prevention services under this plan. Coordination and collaboration occur in a variety of capacities, from day-to-day conversations, planned meetings on a regular basis, etc. For example, as we developed the Children and Family Services 2015-2019 Plan, we invited numerous public/private partners to the table. These partners included: Regional Human Service Centers, private/non-profit agencies, human service zone agencies and tribal child welfare agencies, Division of Juvenile Services, State legislators, ND court representatives, Department of Public Instruction.

DHS continues a partnership with the Native American Training Institute (NATI) and tribal leadership through the Title IV-E Work Group established through the enhanced Title IV-E agreement signed in September 2019 and the State and Tribes Enhancing Partnership Strategies (STEPS) meetings. The STEPS meetings continue to be held quarterly with Tribal Child Welfare Directors, the Children and Family Services Director, Human Service Zone staff, ICWA representatives, Court Improvement Project staff and the Native American Technical Institute staff. The STEPS meetings included information and data sharing on caseworker visits, IV-E requirements, CFSP development and progress, ICWA compliance, and service array planning and development. The Title IV-E Work Group meetings utilize leadership staff from DHS and the Tribes to execute change in program access and deliverable services on a larger systemic platform with greater department division involvement (including Economic Assistance, Medicaid, Fiscal, Legal, etc.) The workgroup identified the need for enhanced communications and access to financial assistance for relative caregivers by expanding the eligibility criteria for TANF Kinship Care to allow children under the custody of a tribe access.

The Title IV-E Prevention Plan will be made available to all eligible foster care candidates statewide, including the Tribes. The Department will continue to offer ongoing communication and education regarding the Title IV-E Prevention Services Plan through various meetings for all stakeholders.

The collaborations listed above illustrate the importance of the public/private partnerships in North Dakota. We continue to find ways to collaborate with our state and federal partners and this list continues to grow as new relationships are developed.

Services provided under Title IV-B Parts 1 and 2 of the Social Security Act, which include: Intensive In-Home Family Therapy; Safety/Permanency Funds; Subsidized Guardianship Program; In-Home Case Management; Parent Aide services; and Prime Time Child Care will be coordinated with services provided for or on behalf of the child and the parents or caregivers.

For FFY 20, the CFS Division has budgeted to spend 23% of IV-B, subpart 2 funds for Family Preservation services, 23% for Family Support Services, 23% for Time Limited Family Reunification Services and 23% for Adoption and Support Services.

SECTION 5: CHILD WELFARE WORKFORCE SUPPORT

North Dakota is a state-supervised, human service zone administered child welfare system. All parties are committed to supporting and strengthening the competencies of the child welfare workforce, ensuring that quality, effective, and efficient services are provided to children and families throughout the state.

North Dakota's eligibility for foster care candidacy is determined when "a child may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of the child or the parent/kinship caregiver's ability to safely care for and nurture their child." This allows our state to serve children both in the child welfare system and to prevent children and families from entering the child welfare system. DHS and contracted providers will monitor and oversee the safety of children who receive prevention services under North Dakota's Title IV-E prevention plan.

The North Dakota Department of Human Services contracts with the University of North Dakota for the UND Children and Family Services Training Center. Established in 1984, the Training Center serves as the primary training agency for child welfare services in North Dakota including the Child Welfare Certification Training: a competency-based, trauma-informed curriculum. Training is designed to meet the child welfare initial training requirements for child welfare social workers in the state of North Dakota. Child welfare social workers are required to complete this training within their first year of employment in the State of North Dakota. Beyond the core training, the Training Center works closely throughout the year with Children and Family Services Division staff members, child welfare supervisors, and frontline staff to support development of competency and skills of the workforce which are centered on the systems overall practice model. As addressed in Section 3, the child welfare caseworkers, supervisors, and regional representatives will be trained on the safety framework practice model which clearly outlines requirements for safety and risk assessments to occur both initially and ongoing through the life of the case.

Competencies of the workforce are assessed continually by the supervisors and measured through the case review process. Adjustments to current training or new training curricula are developed to address the needs of the workers. When new programs are implemented, state/zone administrators work closely with the Training Center to implement corresponding training. By using quality improvement strategies, adjustments are made when needed to enhance quality casework and focus caseworker time on critical case activities most important to help achieve positive outcomes for children and families.

Key to successful frontline staff is solid, competent supervision. It influences every aspect of the child welfare arena. Supervisors set the tone and expectations in the work environment; they ensure how policies are followed, and what practices are used. Effective supervision leads to be better outcomes for children and families.

The Training Center, along with the Children and Family Services Division, has developed a comprehensive foundation training for supervisors. The Child Welfare Supervisor Foundation Training consists of four sessions: Administrative supervision; Educational supervision; Leadership and supervision; and Basics of clinical supervision. As the prevention programs come online, adjustments will be made to ensure supervisors are able to provide the best support to achieve positive outcomes for children and families including the development of appropriate child and family prevention plans and conducting risk assessments for children receiving prevention services.

These activities will enhance implementation of the Title IV-E Prevention Plan, by ensuring that the workforce is qualified and receive the ongoing support needed to provide for positive outcome.

As indicated above, the child welfare caseworkers, supervisors, and regional representatives will be trained on the safety framework practice model which clearly outlines requirements for safety and risk assessments to occur both initially and ongoing through the life of the case. Children and families not

involved with the child welfare system, will receive services from a DHS approved provider. In order for a provider to become approved, the provider will be required to submit an application that includes program information, certification/accreditation and other supporting documentation that ensures the provider is qualified to provide the approved service as outlined in the selected Title IV-E programs. The approved provider must follow minimum basic training requirement(s) per discipline of the evidenced-based program/service they will be providing and must have supporting documentation that their staff have competency in the recommended training areas through their degree or continuing education.

Children's safety and protection from trauma is a priority and is vital to a child's wellbeing. North Dakota understands that assessing safety and risk is an ongoing process throughout the entire time a child is receiving prevention services. Therefore, threats to safety will be evaluated during each contact with the child/family. These client contacts will be used to help monitor safety and ongoing assessment of risk. Regular and purposeful visiting with the child and family will enable the caseworker to assess how well the parents and other caregivers are meeting the children's needs for safety and well-being, as well as the family's progress towards case goal achievement.

DHS will require a Memorandum of Understanding (MOU) with all providers approved under the Title IV-E Prevention Plan. This MOU will require the approved provider to train their employees and certify that their staff have received training and/or are qualified to conduct risk assessments to ensure ongoing child safety and the development of prevention plans (treatment plans) to include goals/strategies to keep the child safely in the home and list the services being provided to ensure success of the goals/strategies. As part of the utilization review DHS may request employee training record to verify training. The provider will evaluate through the identified prevention plan whether the service is functioning as intended, addressing the needs that have been identified, and working toward the achievement of the prevention plan.

SECTION 6: CHILD WELFARE WORKFORCE TRAINING

North Dakota is well poised to ensure that the child welfare workforce is well trained. The North Dakota Department of Human Services contracts with the University of North Dakota for the UND Children and Family Services Training Center. Established in 1984, the Training Center serves as the primary training agency for child welfare services in North Dakota. Its goals are to:

- Design and provide training opportunities for child welfare practitioners and foster parents.
- Serve as a resource center for child welfare training activities.

Central to the Training Center's work is the Child Welfare Certification Training: a competency-based, trauma-informed training curriculum The Child Welfare Certification Training Program is a competency-based training curriculum developed to meet the child welfare initial training requirements for child welfare social workers in the state of North Dakota.

The training is delivered as a four-week curriculum (over 100 hours of training), one week per month, with sessions offered in both the spring and fall. During each of the training weeks, assignments and tests are completed by trainees that assess their level of knowledge and skill on several of the training topics. Successful completion of these tasks is required for certification. Child welfare case workers are required to complete this training within their first year of employment. During FFY 2018, 55 individuals completed Child Welfare Certification training in its entirety. Each week provides special emphases as follows:

- **Week 1:** Philosophical, ethical, and legal mandates of child welfare with a special emphasis on the assessment of child abuse and neglect.
- **Week 2:** Wraparound strength-based case management services (this week also fulfills the requirement for initial Wraparound Certification).
- **Week 3:** Knowledge and skills in working with the legal system, including understanding the role of the Indian Child Welfare Act and providing testimony in court.
- **Week 4:** Understanding and working with children and families in out-of-home care with emphases on attachment and separation issues, concurrent and permanency planning, visitation, reunification and providing support to the foster family.

A key component of child welfare certification training is engaging with families in a culturally sensitive and developmentally appropriate manner, around key decisions involving safety, stability, and well-being for the child. Family engagement is necessary to measure and achieve case progress. Practice standards guide caseworkers to involve family members in decision-making and ensure full disclosure is maintained with families throughout the process. Manualized support is provided through policy and procedure to the field as well.

Attendance is required at all sessions. Trainees are also required to complete all assignments in order to become certified. Regardless of the specific duties in their individual job descriptions, all child protection, in-home services, and foster care caseworkers are required to complete all four weeks. In addition to the child welfare workforce, case managers with Nexus-PATH Family Healing and the Adults Adopting Special Kids (AASK) program are required to complete all four weeks of training. Tribal child welfare personnel are invited and encouraged to attend.

At the completion of each week of training, participants evaluate their specific competencies and skills. They rate themselves on their understanding of the concepts or their skill acquisition. Feedback is also elicited from the training group on any additional training needs they identify. For example, if a participant does not understand a concept or skill, CFSTC staff will work with the individual and their supervisor to help them attain the skill. CFS Program Administrators work closely with CFSTC as trainers and evaluators of the training, suggesting modifications when necessary, particularly when laws and policies

change.

Children and families in the child welfare system experience high rates of trauma and associated behavioral health problems. Unrecognized and untreated child traumatic stress can lead to the development of trauma-related symptoms. These symptoms can persist and worsen over time, making it critical to identify them early. It is important for the child welfare system to identify interventions that best meet the needs of those it serves and to adopt a trauma-informed approach. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), a trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing.

The Department of Human Services has embraced the concepts of trauma-informed and is actively working to increase its workforce's knowledge of the impact of trauma on those served as well as bolstering trauma treatment services. Trauma screening in child-service systems, such as child welfare, is one way to identify children and adolescents with trauma symptoms and improve access to evidence-based treatments. Trauma screening by frontline workers helps identify youth who need further assessment and possible intervention, inform service planning, create structure to discuss a child's welfare, and sustain trauma-informed systems. North Dakota has adopted the University of Minnesota's Traumatic Stress Screen for Children and Adolescents (TSSCA). It is designed to provide clinicians, caseworkers, educators, and other staff with a tool for screening children, ages 5–18 years, that have or may have experienced a traumatic event and need services. Systems across North Dakota, including the child welfare system, are using the screening to identify those who may benefit from further assessment and treatment. In addition, there are over 100 clinicians statewide that are trained in trauma-specific and evidence-based treatments including Trauma-Focused Cognitive Behavioral Therapy, Alternatives for Families Cognitive Behavior Therapy, and Child and Family Traumatic Stress Intervention. As Title IV-E prevention services are brought online, the Children and Family Services Division will work closely with the Training Center and other training entities to design and implement additional trauma-focused prevention practice model training.

In addition to child welfare certification training ND is implementing a safety framework practice model that will provide caseworkers and supervisors with initial and ongoing training and coaching sessions that will assist in the comprehensive assessment of the child and family's needs. For example, one of the tools that will be implemented is the protective capacities family assessment (PCFA). The PCFA is a collaborative process between the caseworker and the parent/caregiver to examine and understand the behaviors, conditions or circumstances that resulted in a child being unsafe. This collaborative process identifies enhanced protective capacities that can be employed to promote and reinforce change, and diminished protective capacities that must change for the parent/caregiver to regain full responsibility for the safety of the child. The case plan is developed based on information gathered during this assessment. Once trained on the model, the caseworkers and supervisors will be provided ongoing consultation support by regional representatives and others with expertise in the model as they apply this practice to their cases. The support to the workforce will be ongoing.

Through implementing the new safety framework practice model, North Dakota has redesigned how training is delivered. In the past training was offered through distinct events. It is envisioned that the new training process will be ongoing at local and regional levels by coaching supervisors and caseworkers as they apply the new practice to their cases. This will involve the training calls to begin after the cohort has completed their initial week of training on the safety framework practice model and will be ongoing. The regional representatives will be key in organizing and facilitating this effort.

Training on how to use the portal will be provided to the child welfare workforce. This training will include the state's definition of Title IV-E candidacy, the current approved Title IV-E evidence -based services available in North Dakota including the descriptions, target populations, and expected outcomes as well as how to utilize the portal. Through the portal's candidacy application process, a caseworker can refer

the child for foster care candidacy determination for the ND Title IV-E prevention services. Once determined a candidate, the child and parent/caregiver can access the approved Title IV-E prevention services and/or programs. The caseworker will assist the family in accessing the most appropriate evidence-based service based on the identified needs. Determination of the most appropriate service occurs through discussing with the family the service descriptions, target populations, and expected outcomes. Caseworkers will be trained on the Protective Capacity Progress Assessment (PCPA.) The training, and the expectation for caseworks will be to provide a systematic and periodic review/assessment of: the effectiveness of evidence based service provision, behavioral progress towards enhancing caregiver protective capacity, the quality of agency engagement with the family, and the re-assessment of child safety. Caseworkers will be trained in identifying indicators of behavioral change, as well as assessing and facilitating the readiness of caregiver change. Additionally, the child and family team will determine whether the service is functioning as it is intended, address the needs that have been identified and work toward the achievement of the prevention plan goals. The caseworker will maintain contact with the service provider to ensure the recipient is progressing as expected.
For cases outside the child welfare system served by an approved provider through the Memorandum of Understanding, the provider will determine the identified prevention plan strategies on whether the service is functioning as it is intended, addressing the needs that have been identified and working toward the achievement of the prevention plan goals/strategies

For cases outside the child welfare system served by an approved provider through the MOU, the provider will determine the identified prevention plan strategies on whether the service is functioning as it is intended, addressing the needs that have been identified and working toward the achievement of the prevention plan goals/strategies. This MOU is vital to ensure DHS oversight and will be used to ensure the collection and submission of outcomes to demonstrate that providers can meet positive outcomes for children and families.

SECTION 7: PREVENTION CASELOADS

North Dakota has been incrementally absorbing social (human) service costs since the 1990s. Throughout the 2017-2019 biennium, the Department of Human Services, the North Dakota Association of Counties (NDACo) and human service zone leaders worked closely together with the support of the governor's office and state lawmakers to review and begin to redesign social services to better serve North Dakotans and deliver more effective services in a more efficient way. As part of this redesign effort, the Department of Human Services adopted the Theory of Constraints (TOC) as its CQI process departmentwide. TOC has been, and will continue to be, applied to all child welfare programs so that holistic change can occur in each area of service.

An important system component analyzed during the Theory of Constraints work is caseload size. Manageable caseloads are vital to allowing caseworkers the ability to spend adequate time with children and families to complete critical case activities resulting in improved outcomes for them. The In-Home services redesign team has recommended a caseload standard of 7-9 families for frontline In-Home caseworkers. North Dakota will continue to monitor and oversee caseload standards through Theory of Constraints work and ongoing CQI practices.

SECTION 8: ASSURANCE ON PREVENTION PROGRAM REPORTING

Please refer to the Appendix A for assurance that North Dakota will report to the Secretary such information and data as the Secretary may require with respect to the Title IV-E Prevention Plan, including information and data necessary to determine the performance measures.

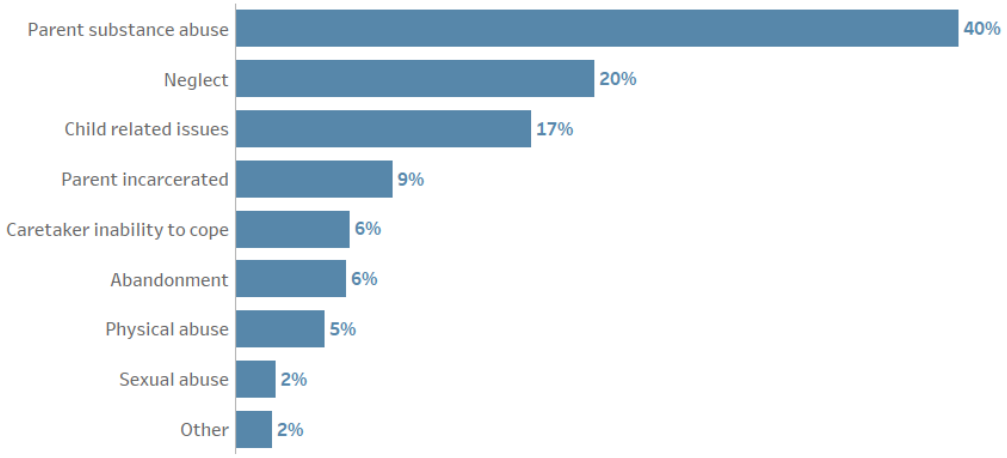
SECTION 9: CHILD AND FAMILY ELIGIBILITY FOR TITLE IV-E PREVENTION PROGRAMS

The North Dakota Department of Human Services (DHS) is in the process of developing a web-based portal. Through this portal, individuals or other referral sources such as private and public agencies, treatment providers, juvenile court, parents or caregivers will be able to submit the eligibility referral to determine foster care candidacy for Title IV-E prevention services. The goal of the portal in the final phase will be to connect and identify the most appropriate program(s) the child and/or family member(s) may be eligible for (ex., Title IV-E, 1915i, ND Substance Use Disorder Voucher, Free Through Recovery, etc.). DHS (the State Title IV-E agency) will review the eligibility referral information and give final approval of the foster care candidacy determination for the Title IV-E prevention services.

North Dakota's definition of a candidate for foster care: *A candidate for foster care is a child who is at risk of out of home placement and has an active case plan to maintain the child in the child's home.*
A child may be at risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of the child or the parent/kinship caregiver's ability to safely care for and nurture their child. See Appendix D for Eligibility Referral Form. Circumstances or characteristics for eligibility may include:

1. Under 18 years of age;
2. DSM Diagnosis for an emotional, behavioral, or mental health disorder;
    a. Symptoms that are expected to last or have lasted one year or longer
    b. Serious Emotional Disturbance that without supportive service or preventative care, out of home placement is likely
3. Significant interference or limitations of the child's functioning in home, school or community;
4. Difficulty or difficulties interfering or limiting achievement or maintenance in one or more developmentally appropriate skill (social, behavioral, cognitive, communicative or adaptive);
5. Child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement;
6. Child in foster care is pregnant or parenting a child(ren);
7. Siblings in foster care;
8. Prior out of home placement (hospitalization, Psychiatric Residential Treatment Facility, attendant care, relative placement, respite care, residential treatment, Qualified Residential Treatment Provider, detention, prior Department of Juvenile Services custody, assessment center);
9. Currently involved in two or more community services/agencies mental health, substance abuse, health, special education, juvenile justice or child welfare, respite care, alternative school programming;
10. Reunification has occurred;
11. Inadequate Supervision based on family and youth circumstances;
12. Parent/Custodian/Guardian/Kin Caregiver with limited parental capacity to meet educational, medical, safety, or basic needs of child(ren) due to:
    a. Behavioral health concern
    b. Incarceration of one parent
    c. Inability to address serious needs of the child
    d. Physical or intellectual disability
    e. Debilitating or life-threatening medical needs
    f. Homeless or substandard living conditions
    g. Verbalization of no longer wanting their child
    h. Substance Exposed Newborns

Figure 4. Percent of children entering care for each removal reason, FY 2019



Specific highlights of candidacy for foster care include:

1. Candidacy is eligibility criteria, not maintenance reimbursement;
2. States claim IV-E administrative reimbursement;
3. A child may not be considered a candidate for foster care solely because the ND Department of Human Services or its authorized agents are minimally involved with the child and his/her family;
4. In order for the child to be considered a candidate for foster care, the ND Department of Human Services or its authorized agents involvement with the child and family *must* be for the specific purpose of either satisfying the reasonable efforts requirement with regard to preventing removal from the home or if needing removing the child and placing him/her in out of home care. Section 471(a)(15)(B)(i);
5. Determinations for foster care candidacy in relation to the Title IV-E Prevention Plan will be made by DHS (the State Title IV-E agency.) DHS maintains valid agreements with the Division of Juvenile Services and four federally recognized Tribes pursuant to section 472(a)(2) of the Social Security Act. (45 CFR 205.100) allowing them to determine candidacy for Title IV-E administrative claims.
6. There are three acceptable forms of documentation that establish a child's candidacy for Title IV-E eligibility: a case plan, an eligibility form or evidence of a court proceeding. DHS will determine foster care candidacy for Title IV-E prevention services using an eligibility referral form and requiring all candidates must have a defined case plan with a service provider. The case plan shall specify the prevention services provided to the child and/or family, goals, tasks and an indication that absent effective preventative services the child is at risk of out of home placement. The case plan must be updated by the service provider and reviewed for candidacy eligibility every six months by the North Dakota Department of Human Services or designee.

APPENDIX A: State Title IV-E Prevention Program Reporting Assurance

Title IV-E Prevention and Family Services and Programs Plan

State of North Dakota

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, ND 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.

5-22-2020
(Date)

CFS Director
(Signature and Title)

(CB Approval Date)

(Signature and Title

APPENDIX B: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Title IV-E Prevention and Family Services and Programs Plan

State of North Dakota

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 ND Dept. 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 Brief Strategic Family Therapy (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.

05-22-2020 (Date)

CFS-Director (Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 (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.

05-22-2020
(Date)

(Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 Healthy Families (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.

05/22/2020
(Date)

CFS - Director
(Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 (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.

5-22-2020
(Date)

CFS-Director
(Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 Nurse-Family Partnership (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.

5-22-2020
(Date)

CFS- Director
(Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 Parent Child Interaction Therapy (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.

5/22/2020
(Date)

CFS-Director
(Signature and Title)

(CB Approval Date)

(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 ND Dept. 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 Parents as Teachers (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.

05-22-2020
(Date)

CFS-Director
(Signature and Title)

(CB Approval Date)

(Signature, Associate Commissioner, Children's Bureau)

Title IV-E Prevention and Family Services and Programs Plan

State of North Dakota

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 ND Dept. 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 Homebuilders (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.

05-22-2020 CFS-Director

(Date) (Signature and Title)

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

APPENDIX C: State Assurance of Trauma-Informed Service-Delivery

Title IV-E Prevention and Family Services and Programs Plan

State of North Dakota

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 ND Dept 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.

5-22-2020
(Date)

CFS-Director
(Signature and Title)

(CB Approval Date)

(Signature and Title)

Appendix D: State Annual Maintenance of Effort (MOE) Report

Title IV-E Prevention and Family Services and Programs Plan ATTACHMENT IV
State of North Dakota

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
Administration on Children, Youth and Families
Children's Bureau

State Annual Maintenance of Effort (MOE) Report

State: North Dakota	FFY:
Baseline Year:	FFY14
Baseline Amount: $	$304,071.15
Total Expenditures for Most Recent FFY:	

This certifies that the information on this form is accurate and true to the best of my knowledge and belief. **This also certifies that the next FFY foster care prevention expenditures will be submitted as required by law.**
Signature, Approving Official:
Typed Name, Title, Agency: Cory Pedersen CFS- Director
Date: 05/22/2020

Appendix E: Eligibility Referral

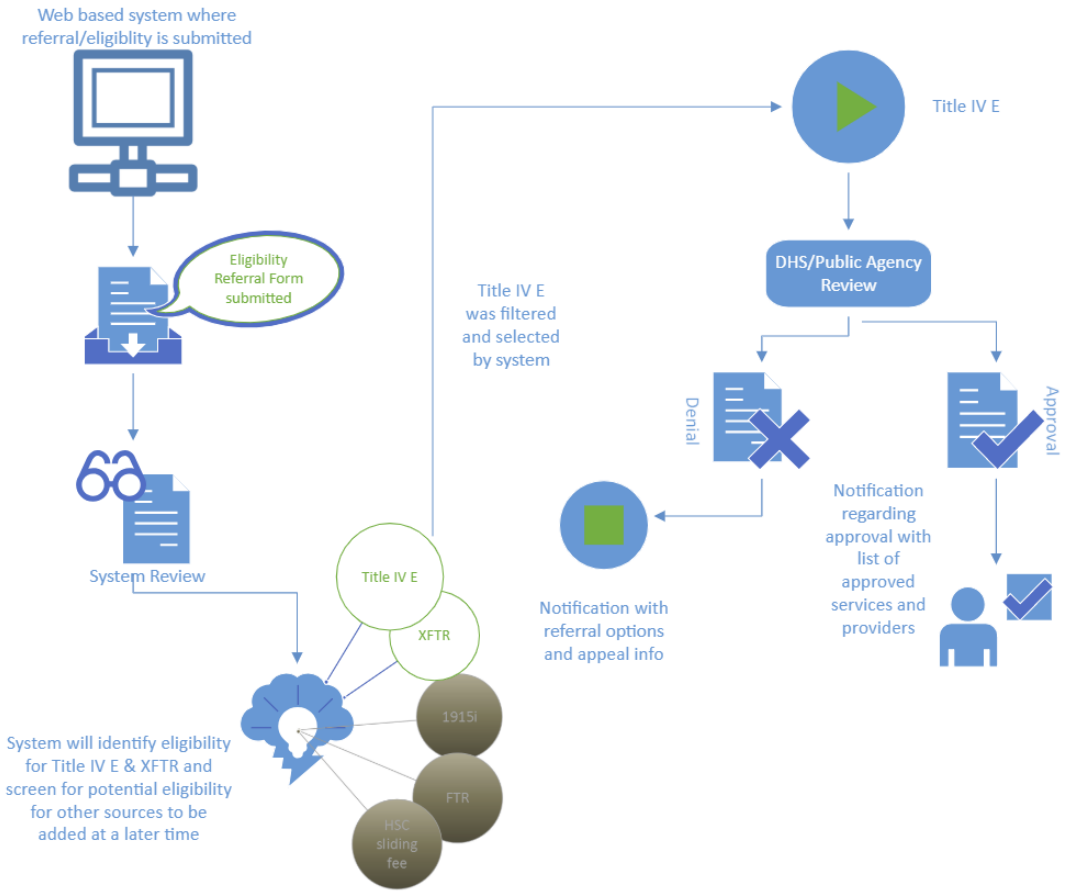
A child may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of the child or the parent/kinship caregiver's ability to safely care for and nurture their child.

Check all that apply:

- ☐ Under 18 years of age
- ☐ DSM Diagnosis for an emotional, behavioral, or mental health disorder
  - ☐ Symptoms that are expected to last or have lasted one year or longer
  - ☐ Serious Emotional Disturbance that without supportive service or preventative care, out of home placement is likely
- ☐ Significant interference or limitations of the child's functioning in home, school or community
- ☐ Difficulty or difficulties interfering or limiting achievement or maintenance in one or more developmentally appropriate skill (social, behavioral, cognitive, communicative or adaptive)
- ☐ Child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement
- ☐ Child in foster care is pregnant or parenting a child(ren)
- ☐ Siblings in foster care
- ☐ Prior out of home placement (hospitalization, Psychiatric Residential Treatment Facility, attendant care, relative placement, respite care, residential treatment, Qualified Residential Treatment Provider, detention, prior Division of Juvenile Services custody, assessment center)
- ☐ Currently involved in two or more community services/agencies mental health, substance abuse, health, special education, juvenile justice or child welfare, respite care, alternative school programming
- ☐ Reunification has occurred
- ☐ Inadequate Supervision based on family and youth circumstances
- ☐ Parent/Custodian/Guardian/Kin Caregiver with limited parental capacity to meet educational, medical, safety, or basic needs of child(ren) due to:
  - ☐ Behavioral health concern
  - ☐ Incarceration of one parent
  - ☐ Inability to address serious needs of the child
  - ☐ Physical or intellectual disability
  - ☐ Debilitating or life-threatening medical needs
  - ☐ Homeless or substandard living conditions
  - ☐ Verbalization of no longer wanting their child
  - ☐ Substance Exposed Newborns

Please share how the child's characteristics or circumstances places them at risk of out of home placement:

Appendix F: Title IV-E Process Flow



Appendix G: ND Candidate for Foster Care

NORTH DAKOTA CANDIDATE FOR FOSTER CARE		
ND Definition	***A candidate for foster care is a child who is at risk of out of home placement and has an active case plan to maintain the child in the child's home.***	
Home Means	The parental or relative dwelling where the child primarily resides.	
Risk Means	A child may be at risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of the child or the parent/kinship caregiver's ability to safely care for and nurture the child.	
Child or Caregiver Circumstances or Characteristics May Include But Are Not Limited to	Under 18 years of age	DSM Diagnosis for an emotional, behavioral, or mental health disorder
	Significant interference or limitations of the child's functioning in home, school or community	Child whose adoption or guardianship arrangement is at risk of a disruption
	Child is pregnant or parenting a child(ren)	Prior out of home placement
	Siblings in foster care	Reunification has occurred
	Inadequate supervision based on family and youth circumstances	Difficulty(ties) interfering or limiting achievement or maintenance in one or more developmentally appropriate skill
	Currently involved in two or more community services or agencies	Parent/Custodian/Guardian/Kin Caregiver has limited parental capacity to meet educational, medical, safety, or basic needs of child(ren) due to: Behavioral health concern, Incarceration of one parent, Inability to address serious needs of the child, Physical or intellectual disability, Debilitating or life-threatening medical needs, Homeless or substandard living conditions, Verbalization of no longer wanting their child, or Substance Exposed Newborns.
Candidacy IV-E Federal Regulations	1. Candidacy is eligibility criteria, not maintenance reimbursement	
	2. States claim IV-E administrative reimbursement	
	3. A child may not be considered a candidate for foster care solely because the ND Department of Human Services or its authorized agents are minimally involved with the child and his/her family.	
	4. In order for the child to be considered a candidate for foster care, the ND Department of Human Services or its authorized agents involvement with the child and family must be for the specific purpose of either satisfying the reasonable efforts requirement with regard to preventing removal from the home. Section 471(a)(15)(B)(i).	
	5. Determinations for foster care candidacy in relation to the Title IV-E Prevention Plan must be made by DHS (the State Title IV-E agency.) DHS maintains valid agreements with Division of Juvenile Services and four federally recognized Tribes pursuant to section 472(a)(2) of the Social Security Act. (45 CFR 205.100) allowing them to determine candidacy for Title IV-E administrative claims.	
	6. Three acceptable forms of documentation that establish a child's candidacy for Title IV-E Eligibility: a case plan, an eligibility form or evidence of a court proceeding. DHS will determine foster care candidacy for Title IV-E prevention services using an eligibility referral form and requiring all candidates must have a defined case plan.	
Case Plan	Candidacy case plan must be in the child's file and updated every six months. Case plan shall specify the prevention services provided to the child/family, goals, tasks and an indication that absent effective preventative services, the child is at risk of out of home placement.	