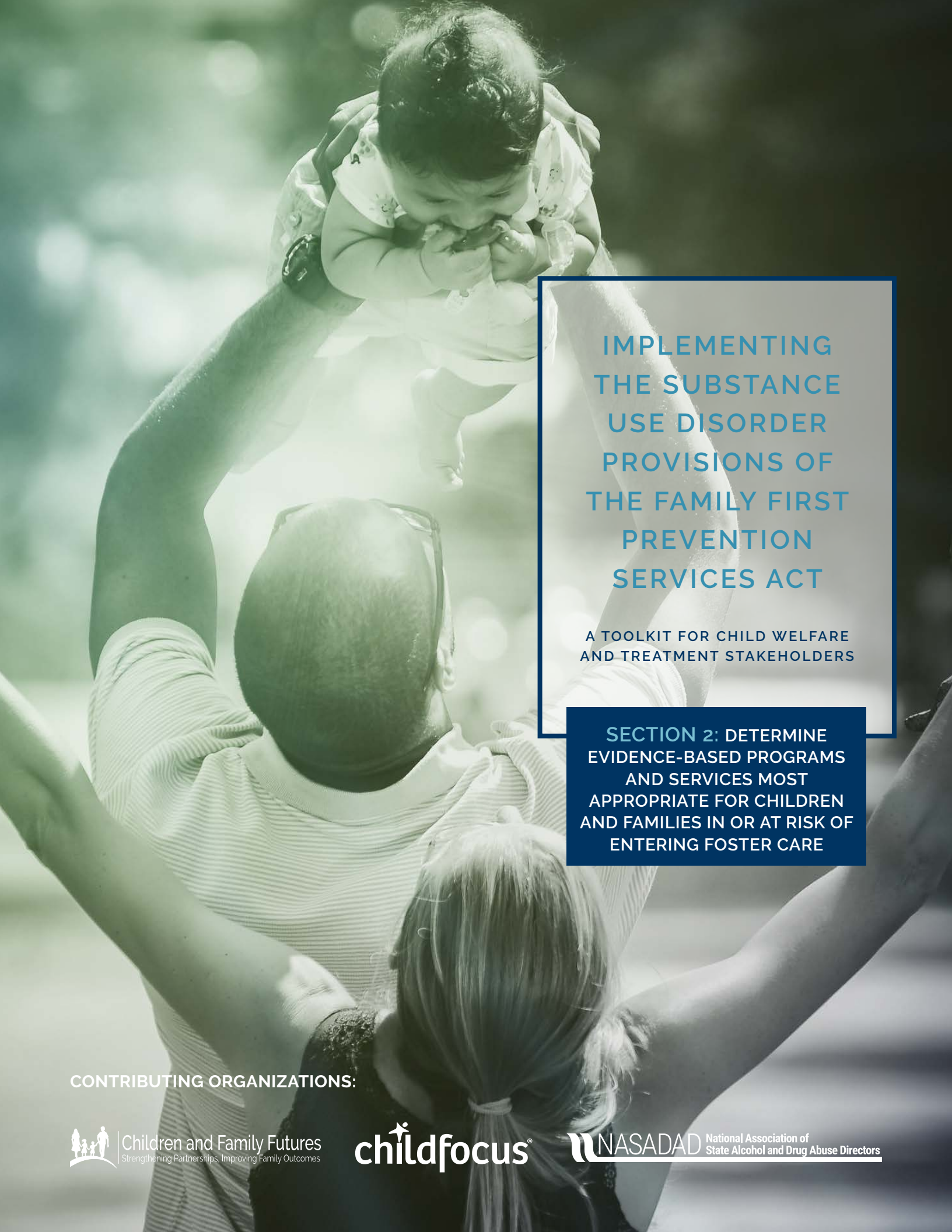

IMPLEMENTING THE SUBSTANCE USE DISORDER PROVISIONS OF THE FAMILY FIRST PREVENTION SERVICES ACT

A TOOLKIT FOR CHILD WELFARE AND TREATMENT STAKEHOLDERS

SECTION 2: DETERMINE EVIDENCE-BASED PROGRAMS AND SERVICES MOST APPROPRIATE FOR CHILDREN AND FAMILIES IN OR AT RISK OF ENTERING FOSTER CARE

CONTRIBUTING ORGANIZATIONS:

Children and Family Futures
Strengthening Partnerships. Improving Family Outcomes

childfocus®

NASADAD National Association of State Alcohol and Drug Abuse Directors

SECTION 2

DETERMINE EVIDENCE-BASED PROGRAMS AND SERVICES MOST APPROPRIATE FOR CHILDREN AND FAMILIES IN OR AT RISK OF ENTERING FOSTER CARE

From the outset of Family First implementation, SUD and child welfare partners can work collaboratively to determine which evidence-based programs and services are most appropriate for the children and families who are eligible for the new prevention services available. Family First gives states flexibility in choosing the services that best suit the needs of their states or jurisdictions. SUD stakeholders can play an important role in strengthening their state's Title IV-E Prevention Plans by engaging early in the planning process to ensure that the needs of children and families with SUDs are considered. The following steps may be helpful when SUD treatment professionals are considering how to get involved.

1. Begin with a needs assessment of children and families who are likely to meet the eligibility requirements for the prevention provisions of Family First. A needs assessment can ensure that programs and services are appropriate for the population that will be served.
2. Take stock of which evidence-based programs and services are already offered in the state and if more are needed to meet the needs of families.
3. Identify evidence-based programs and services from SUD-focused clearinghouses and other sources that may not be well-known to child welfare partners.
4. Ensure that evidence-based programs and services most appropriate for the target population's needs are included in the state Title IV-E Prevention Plan that will be submitted to the Department of Health and Human Services (HHS).
5. Work with child welfare partners to build the evidence for programs that are having positive outcomes for children and family in the child welfare system who are affect by SUDs.

Evidence-Based Prevention and Treatment for Substance Use Disorders

Family First requires programs funded through Title IV-E Prevention Services to meet evidentiary standards specified in the law, which are intended to indicate the program's efficacy for child welfare populations. To categorize these programs, the law required HHS to establish a public Clearinghouse, known as the Title IV-E Prevention Services Clearinghouse, to rate and review programs that are nominated by state and local administrators, experts, and the public. Once a program has been reviewed and rated as having met the criteria, it appears on the Clearinghouse's website. Programs will be reviewed and rated on a rolling basis; therefore, state administrators should check the website regularly for the most up-to-date list.

The law also specified that the Clearinghouse must rate the programs according to three evidentiary standards: *promising*, *supported*, and *well supported*. These standards are guided by the number of studies that show evidence of improved outcomes and the rigor of the evaluations.

MORE ON THE EVIDENTIARY STANDARDS IN FAMILY FIRST

All practices eligible for Title IV-E prevention funding must meet the following requirements:

- **Book or manual:** The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice.
- **No empirical risk of harm:** There is no empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- **Weight of evidence supports benefits:** Outcome measures are reliable and valid and are administered consistently and accurately across all those receiving the practice.
- **No case data for severe or frequent risk of harm:** There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

PROMISING	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that: • Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • Utilized some form of comparison group (such as an untreated group, a placebo group, or a wait list study)
SUPPORTED	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of at least one study that: • Was rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • Was a rigorous randomized-controlled trial (or, if not available, a study using a rigorous quasi-experimental research design) • Was carried out in a usual care or practice setting • Established that the practice has a sustained effect (when compared to a control group) for at least 6 months beyond the end of the treatment.

WELL-SUPPORTED	The practice is superior to an appropriate comparison practice using conventional standards of statistical significance (in terms of demonstrated meaningful improvements in validated measures of important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being), as established by the results or outcomes of: • At least two studies that were rated by an independent systematic review for the quality of the study design and execution and determined to be well-designed and well-executed • At least two studies that were rigorous random-controlled trials (or, if not available, studies using a rigorous quasi-experimental research design) • At least two studies that were carried out in a usual care or practice setting • At least one of the studies must have established that the practice has a sustained effect (when compared to a comparison group) for at least 1 year beyond the end of treatment

Title IV-E Prevention Services Five-Year Plan

States who wish to draw down Title IV-E prevention services payments must first submit a five-year Title IV-E Prevention Plan to HHS that includes, among other things, the following components:

- **Services and oversight:** How the state will assess children and families to determine eligibility and describe which services the state will provide and the target population(s), as well as how it will ensure program fidelity.
- **Evaluation strategy:** How the state will evaluate the services and their efficacy in meeting the needs of the target population(s). *[NOTE: Children's Bureau may waive this requirement for a well-supported practice if the evidence of its effectiveness is compelling and the Title IV-E agency meets certain continuous quality improvement requirements.]*
- **Coordination and consultation:** How the state coordinated and consulted with other agencies and stakeholders to develop the five-year state plan.

(For more information about the requirements for state Title IV-E Prevention Plans, please see ACYF-CB-PI-18-09.)

Transitional Payments for Evidence-Based Programs and Services

The primary mechanism available for states to receive Title IV-E prevention services payments to support their prevention services is by getting programs reviewed and rated by the Title IV-E Prevention Services Clearinghouse. Recognizing that many states are eager to begin implementation, and the programs currently available on the Clearinghouse are limited, HHS has also established another mechanism for states to identify and claim reimbursement for programs that meet the standards under Family First but have not yet been rated by the Clearinghouse. This process is known as "transitional payments."

Under this pathway, states may include in their prevention plans programs not yet reviewed by the Clearinghouse, so long as they conduct their own independent systematic review and submit sufficient documentation of evidence of the program or service. States can then claim "transitional payments" for

these services until they are officially rated by the Clearinghouse. Once a program receives approval from HHS through the transitional payments process, this program is officially "approved" for reimbursement, and all states can begin claiming Title IV-E prevention services for that program. These transitional payments are available until October 1, 2021. For more information about transitional payments and how they will work, please see PI-19-06.

Other Considerations in Planning for Title IV-E Prevention Programs and Services

Family First allows state Title IV-E agencies to draw down reimbursement for prevention services and programs beginning October 1, 2019, so long as their Title IV-E prevention services state plan has been approved. However, there are a few additional requirements that child welfare and SUD stakeholders planning for implementation should keep in mind.

OPTION TO DELAY: Title IV-E agencies can only access Title IV-E prevention funding if they also commit to implementing provisions of the law aimed at limiting certain types of group care that are currently supported by Title IV-E foster care maintenance payments. The law also gives Title IV-E agencies the option to delay implementing the requirements for a "qualified residential treatment program" (QRTP) for up to two years—until October 2021. (For more information about limitations on group care and the definition of a QRTP, please see ACYF-CB-IM-18-02.) For states who need more time to implement the provisions related to placements that are not foster family homes, they must also wait to draw down Title IV-E prevention services funding to support prevention activities under the law. Child welfare and SUD stakeholders in states that have chosen to delay their implementation may find that this additional time is especially helpful for readying a high-quality service array that best meets the needs of children and families affected by SUDs.

TRAINING COSTS: Title IV-E may claim at a 50 percent federal reimbursement rate for costs

related to training personnel in the programs and services included in the state plan.

SCOPE OF IMPLEMENTATION: The Children's Bureau has made clear in federal guidance that states do not have to administer their prevention services and programs statewide, and instead may decide to provide programs and services in only some areas of the state. States also do not have to provide the same services in all areas where preventive services are being provided. This means that states can choose to move forward with providing SUD prevention and treatment services, even if they do not move forward with the other categories of services (mental health and in-home parenting skill-based programs), although they will most likely find that these three categories of services complement one another.

50 PERCENT REQUIREMENT: When it was first enacted, Family First required that 50 percent of the total expenditures by the state be on services meet the "well-supported" category. However, recent federal legislation (the Family First Transition Act) delayed this requirement. In FY2022 and FY2023, at least 50 percent of the total expenditures by the state for the Title IV-E Prevention Program must be for services that meet both the "supported" and "well-supported" evidence-based practice criteria. In FY2024 and beyond, the original 50 percent requirement will be fully phased in.

KEY QUESTIONS

1. What programs are already being offered in my state? What is the landscape of providers offering these services?
2. What other evidence-based programs and services do we need to implement to ensure children and their families are getting the services they need to thrive?
3. How can I ensure that the SUD prevention and treatment programs already offered in my state are included in my state's Title IV-E prevention plan?
4. What other evidence-based programs should we be using to build an array of services in our Title IV-E prevention plan?
5. What training do providers need to deliver these evidence-based programs and how will the state support capacity building for providers?
6. Where in the state are these services needed most and how can we build those services in the areas of greatest need?

RELATED RESOURCES:

- ACYF-CB-PI-18-09: State Requirements for Electing Title IV-E Prevention and Family Services and Programs
- ACYF-CB-PI-19-06: Transitional Payments for the Title IV-E Prevention and Family Services and Programs
- Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures
- SAMHSA Evidence-Based Practices Resource Center