**REPORT** | August 2019

# Special Topic Paper – Child Welfare Waiver Demonstrations and Evidence-Based Programs

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### Disclaimer


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# Contents



## Exhibits

# Introduction

Section 1130 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to approve demonstration projects involving the waiver of certain provisions of titles IV-E and IV-B of the Social Security Act, specifically those governing federal programs related to foster care and other child welfare services. Conceived as a strategy for generating new knowledge about innovative and effective child welfare practices, waivers grant flexibility in the use of federal funds (particularly funds for title IV-E foster care) for alternative services and supports that promote safety, permanency, and well-being for children in the child protection and foster care systems. The authority to approve waiver demonstrations was first authorized in 1994; the Adoption and Safe Families Act of 1997 extended and expanded it, after which it continued with some brief lapses until March 31, 2006.

The Child and Family Services Improvement and Innovation Act (Public Law 112–34), signed into law on September 30, 2011, reinstated the authority to approve up to 10 new waiver demonstrations in each of federal fiscal years 2012–2014, with the stipulation that all active waiver demonstrations must terminate operations by September 30, 2019. In inviting proposals for new waiver demonstrations, HHS noted it would prioritize applications "in which the title IV-E agencies propose to use the flexibility under the demonstrations as a vehicle to test or implement … evidence-based or evidence-informed intervention approaches that will produce positive well-being outcomes for children, youth, and their families" (U.S. Department of Health and Human Services, 2012). Since 2012, over a dozen child welfare jurisdictions—including state child welfare departments, the District of Columbia, and one tribal child welfare agency—have implemented and evaluated one or more evidenced-based programs/interventions (EBPs)[1] under a waiver approved by HHS.[2]

This paper explores the efforts of child welfare jurisdictions to implement and evaluate EBPs as part of a child welfare waiver demonstration from 2012 through the first half of 2019. Specifically, it addresses the following questions:

- What successes and challenges have jurisdictions experienced with implementing EBPs in child welfare populations and service settings? What are the key facilitators and barriers to effective EBP implementation?
- To what extent and how did jurisdictions maintain fidelity to the service models of their EBPs?

[1] For simplicity, evidence-based programs and interventions will be referred to throughout the remainder of this paper as "EBPs."

[2] See the following section for the definition of EBPs used in this paper.

- What findings related to child and family safety, permanency, and well-being emerged from the evaluation of EBPs? To what extent have waiver jurisdictions been able to attribute these observed findings to the implementation of EBPs?
- In exploring these questions, the paper relies primarily on reporting required by the federal government, including interim evaluation reports and final evaluation reports submitted by waiver jurisdictions between 2016 and early 2019, supplemented when necessary by information in semiannual progress reports submitted to the Children's Bureau (CB) and correspondence between the jurisdictions and CB.[3]

[3] The Children's Bureau is the federal office within the Administration on Children, Youth, and Families (ACYF), Administration for Children and Families, U.S. Department of Health and Human Services, that is responsible for monitoring and managing child welfare waiver demonstrations.

# Definition of Evidence-Based Programs

Over the past 2 decades, several organizations and groups have attempted to establish a formal definition of an EBP and create accompanying rating systems for assessing the level and quality of evidence necessary to designate a given intervention as "evidence based." Examples include the California Evidence-Based Clearinghouse for Child Welfare (CEBC);[4] the National Registry of Evidence-Based Programs and Practices;[5] Social Programs That Work;[6] the Office of Juvenile Justice and Delinquency Prevention's Model Program's Guide;[7] the Promising Practices Network on Children, Families, and Communities;[8] and the U.S. Department of Education's What Works Clearinghouse.[9] Also, Administration for Children and Families has recently established the Title IV-E Prevention Services Clearinghouse in accordance with the Family First Prevention Services Act, as codified in title IV-E of the Social Security Act.[10] Regardless of their definition, EBPs have historically been rare in the child welfare field because relatively few interventions that are appropriate for child welfare-involved families have been rigorously evaluated and demonstrated to work. In recent years, the CB has sought to address the scarcity of EBPs in child welfare by actively promoting EBPs and more rigorous evaluations of child welfare programs under the latest waiver authority and its discretionary grant program.[11] Also, the CB has made efforts to build evaluation capacity through in-person and virtual "Evaluation Summits" and convening several Child Welfare Research and Evaluation Workgroups.[12]

Although organizations differ on the definition of an EBP, they all agree on the importance of conclusive evidence of effectiveness through rigorous evaluation. This paper uses the evidence

[4] See www.cebc4cw.org/.

[5] The Substance Abuse and Mental Health Services Administration discontinued the National Registry of Evidence-Based Programs and Practices in January 2018 and replaced it with a new online resource called the Evidence-Based Practices Resource Center (see www.samhsa.gov/ebp-resource-center).

[6] See www.evidencebasedprograms.org/.

[7] See www.ojjdp.gov/mpg.

[8] See www.promisingpractices.net. This site has not been updated since June 2014, when it was archived because of funding cuts.

[9] See www.ies.ed.gov/ncee/wwc.

[10] The Title IV-E Prevention Services Clearinghouse rates programs and services as "well supported," "supported," "promising," or "does not currently meet criteria." Some of the EBPs referenced in this paper may be eligible for review by the Prevention Services Clearinghouse. For more information about the review process, visit https://preventionservices.abtsites.com.

[11] See www.acf.hhs.gov/cb/grants/discretionary-grant.

[12] See www.acf.hhs.gov/cb/capacity/program-evaluation for more information about past Evaluation Summits and Workgroups. Another in-person National Child Welfare Evaluation Summit is scheduled for August 20–21, 2019.

rating system developed by the CEBC because it is widely known and understood in the child welfare field, and because many interventions implemented by waiver jurisdictions have been vetted by the CEBC and are included in its online database. This paper defines a waiver program or intervention as an EBP if it has a CEBC rating of "well supported by research evidence," "supported by research evidence," or "promising research evidence."[13] A broader definition of an EBP that includes the rating of "promising" was selected for the purposes of this paper to ensure a wide range of interventions with some credible evidence of effectiveness could be explored. An accompanying CEBC rating scale of Child Welfare Relevance (high, medium, or low) was not considered because all the interventions had already received a rating of "high" or "medium" relevance, and as will be discussed below, most jurisdictions made no or only minor changes to their target populations or EBP service models.

[13] See www.cebc4cw.org/ratings/scientific-rating-scale/ for more detailed definitions of these ratings.

# Overview of Selected EBPs

Exhibit 1 highlights the EBPs selected for inclusion in this paper, along with the jurisdictions that implemented them. Along with falling into one of the three CEBC rating categories described above, an intervention had to meet the criteria of (1) being implemented as a stand-alone component of a jurisdiction's waiver demonstration and (2) being evaluated separately from other components of a jurisdiction's demonstration.[14] Some jurisdictions implemented "hybrid" interventions that consisted of two or more distinct EBPs. For example, Kentucky's Strengthening Ties and Empowering Parents model integrates Parent-Child Interaction Therapy and Solution-Based Casework, while Maine's Enhanced Parenting Program is a composite of the Positive Parenting Program and another intervention called Matrix Model Intensive Outpatient Program. Maryland's model integrated a version of Cognitive Behavioral Therapy coupled with Partnership for Success.

This paper does not include these interventions because the EBPs they consist of were not evaluated independently from one another, which makes it difficult to draw conclusions about their individual impact on child and family outcomes.

The exhibit includes 14 EBPs implemented by 11 state child welfare agencies, the District of Columbia, and 1 tribal child welfare agency.

- Of these 14 programs, 9 have a CEBC rating of "promising," 3 have a rating of "supported," and 2 have a rating of "well supported."
- Four EBPs fall into the broad category of clinical therapeutic interventions (Child-Parent Psychotherapy, Family Centered Treatment, Functional Family Therapy, Parent-Child Interaction Therapy); five can be classified as parent/caregiver support, education, or training programs (Keeping Foster and Kin Parents Supported and Trained, Kinship Supports Intervention, Nurturing Parent Program for Parents and Their School-Aged Children 5–12 Years, Triple P – Level 4, and The Incredible Years); and five fall into the category of enhanced casework/case management models (Solution-Based Casework, Sobriety Treatment and Recovery Teams, Project Connect, Family Group Decision Making, and Wraparound).
- In general, the clinical therapeutic interventions have stronger evidence of effectiveness (and thus higher CEBC ratings) than the case management and parent/caregiver training programs.
- In most cases, the jurisdictions implemented their EBPs as designed and documented no changes to their core service components/activities or intended target populations. Some jurisdictions expanded the age range for an EBP's original target population (Arkansas for NPP

[14]In some cases, jurisdictions conducted a process evaluation of only a selected EBP rather than a full outcome evaluation, but this was considered sufficient for inclusion in this paper. Also, some jurisdictions referred children and families to EBPs that were not evaluated as part of their waiver demonstrations. Therefore, this paper does not reference those EBPs.

5-12 and Maryland[15] for IY), while others implemented additional or modified existing eligibility criteria involving a child's assessed risk of placement or trauma (Illinois with CPP and California with Wraparound) or time in placement (Hawaii for Wraparound).

- Only one jurisdiction documented a change to an EBP's service model—specifically, Arkansas reported it expanded the role of program assistants in its NPP 5-12 intervention by creating new positions called "parent coaches" who assisted with transportation, childcare, and the supervision of families in their homes.

[15] Maryland also implemented a modified version of NPP for children aged 0–11 differs from the NPP rated on the Clearinghouse. For this reason, this paper does not include NPP findings from Maryland.

## Exhibit 1. Selected EBPs Implemented by Waiver Jurisdictions

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| Child-Parent Psychotherapy (CPP) | Supported | CPP is treatment for trauma-exposed children in which the child and his or her primary caregiver are the unit of treatment. CPP seeks to support and strengthen the caregiver-child relationship to restore and protect the child's mental health. | Children aged 0–5 who have experienced trauma and their caregivers | Illinois | Enrollment priority given to children deemed "high risk" based on assessment of their trauma experiences and symptoms |
| Family Centered Treatment (FCT) | Promising | FCT is a case management model that focuses on families' internal strengths and resources and emphasizes intensive family engagement. Individual family goals are developed based on strengths as opposed to deficits. | Families with children aged 0–17 at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities | Indiana | None reported |
| Family Group Decision Making (FGDM) | Promising | FGDM is a case management model that positions the "family group" (parents, children, other relatives and kin) as leaders in decision making about child safety, permanency, and well-being. A trained, independent coordinator brings together the family group and agency personnel to create and carry out a plan to safeguard children and other family members. | Families with children aged 0–17 at imminent risk of placement into, or needing intensive services to return from, treatment facilities, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities | Port Gamble S'Klallam Tribe | The tribe's FGDM implementation team has discussed how FGDM may be adapted to reflect values of the S'Klallam community |

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| Functional Family Therapy (FFT) | Supported | FFT is a family therapeutic intervention for dysfunctional youth with disruptive, externalizing problems. Sessions are most often spread over a 3-month period. Specific intervention phases include family engagement, motivation, relational assessment, behavior change, and generalization to extend improvements into other life areas. | Children aged 11–18 with serious behavioral problems such as conduct disorder, violent acting out, and substance abuse | Maryland | None reported; Implemented in Anne Arundel County only |
| Keeping Foster and Kin Parents Supported and Trained (KEEP) | Promising | KEEP is a training program to provide parents/caregivers with effective tools to address their child's externalizing problems, trauma, and other behavioral and emotional problems. Curriculum topics include creating a safe environment, encouraging child cooperation, strategies for self-regulation, effective limit setting, and balancing encouragement and limits. | Caregivers of children aged 4–12 in foster or kinship care placements | Tennessee | None reported |
| Kinship Supports Intervention | Promising | Kinship Supports Intervention is a support program to provide kinship caregivers with support to meet children's physical, emotional, financial, and other basic needs. Kinship coordinators or other designated child welfare kinship staff complete a needs assessment to identify needed services | Kinship caregivers (relatives and fictive kin) of children aged 0–18 involved in child welfare systems regardless of custody status or supervision orders | Ohio | None reported |

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| | | and supports. A caregiver support plan is developed based on the needs assessment and is updated regularly to ensure services and supports continue to address changes in the family's needs over time. | | | |
| Nurturing Parent Program for Parents and Their School-Aged Children 5–12 Years (NPP 5–12) | Promising | NPP 5–12 is a 15-session training and education program in which parents and their children attend separate groups concurrently. Lessons cover topics including appropriate parental expectations, empathy for the needs of children, appropriate disciplinary techniques, and appropriate parent-child roles. | Families with children aged 5–12 who have been reported to the child welfare system for child maltreatment, including physical and emotional maltreatment, in addition to child neglect | Arkansas | Renamed Nurturing Families of Arkansas; Child age range expanded to 18; Role of program assistants expanded to become parent coaches who assist with transportation, childcare, and family supervision |
| Parent-Child Interaction Therapy (PCIT) | Well supported | PCIT is a dyadic behavioral intervention for children and their parents/caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression); increasing | Children aged 2–7 with behavior and parent-child relationship problems and their parents, foster parents, or caregivers | Pennsylvania | None reported |

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| | | child social skills; and improving the parent-child attachment relationship. It teaches parents play-therapy skills to use as reinforcers of positive child behavior and behavior management skills to decrease negative behaviors. | | Maryland | None reported; Implemented in Anne Arundel County only |
| Positive Parenting Program (Triple P): Level 4 | Supported | One of the five levels of the Triple P system, Level 4 helps parents learn strategies to promote social competence and self-regulation in children and decrease problem behaviors. Parents develop a parenting plan, track their children's and their own behavior, and use this information to fine tune the plan. | Parents or caregivers of children aged 0–12 with mild to moderate emotional and behavioral concerns | Pennsylvania | None reported |
| Project Connect | Promising | Project Connect offers home-based counseling, substance abuse monitoring, nursing, service referrals, home-based parent education, parenting groups, and ongoing support for mothers in recovery. | High-risk, substance-affected families involved in the child welfare system who have experienced domestic violence, child abuse and neglect, and other life challenges | District of Columbia | None reported |
| Solution-Based Casework (SBC) | Promising | SBC is a case management approach designed to help caseworkers work in partnership with families to identify their strengths, focus on everyday life events, and build skills to manage | Families with an open child welfare or juvenile justice case because of allegations of abuse and neglect | Maryland | None reported; Implemented in Baltimore County only |

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| | | difficult family and life situations. SBC combines problem-focused relapse prevention approaches with solution-focused models that have evolved from family systems casework and therapy. | | | |
| Sobriety Treatment and Recovery Teams (START) | Promising | START is an intensive intervention for substance-using parents and families involved in the child welfare system. Child protective service workers and family mentors work with families using a system-of-care and team decision-making approach. START aims to safely maintain children at home and ensure their access to intensive addiction/mental health assessment and treatment. | Families in the child welfare system with at least 1 child under 6 years of age and with a parent whose substance use is determined to be a primary child safety risk factor | Kentucky | None reported; Implemented in five counties (Jefferson, Kenton, Fayette, Boyd, and Daviess) |
| The Incredible Years (IY) | Well supported | IY is a multifaceted and developmentally based set of curricula for parents, teachers, and children. IY is designed to promote emotional and social competence and prevent and reduce behavioral and emotional problems in young children. Parent, teacher, and child programs can be used separately or in combination. | Children aged 4-8 and their parents and teachers | Maryland | Implemented in Allegany County only; Target population broadened to families with children aged 0–12 |

| EBPs | CEBC Rating | Brief Description | Target Population for Which Intervention Is Designed (as Defined by CEBC) | Jurisdictions That Implemented | Modifications to Model or Target Population |
|---|---|---|---|---|---|
| Wraparound | Promising | Wraparound is a team-based case planning and management process to provide individualized and coordinated family-driven care for children. Families, service providers, and key members of the family's social support network collaborate to build a plan that responds to the needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and adjust as necessary. | Children aged 4–17 with severe emotional, behavioral, or mental health difficulties and their families in which the child/youth is (1) in, or at risk for, out-of-home, institutional, or restrictive placements; and (2) involved in multiple child- and family-serving systems (e.g., child welfare, mental health, juvenile justice, special education) | California | Implemented by county juvenile probation departments; Some departments use a broader definition of "youth at risk of imminent placement" |
| | | | | Hawaii | Referred to as Family Wrap Hawaii (Wrap); Targets children who have been in out-of-home care for 9 or more months |
| | | | | West Virginia | Referred to as Safe at Home; Eligibility criteria modified to include youth at risk of placement with a possible behavioral or mental health diagnosis |

**Note:** The EBPs' acronyms are used in this table and throughout the remainder of this paper for greater brevity.

# Implementation Status

Exhibit 2 summarizes the implementation status of EBPs highlighted in this paper. All waiver jurisdictions are in the intermediate to advanced stages of implementing their selected EBPs, phases that parallel the National Implementation Research Network stage of initial implementation and in some cases full implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). In all cases, the jurisdictions have begun, continue with, or have completed any necessary staff training; made referrals of children and/or families to their respective EBPs; enrolled children and families in these programs; and had at least some children/families complete services. As of June 2019, all jurisdictions continue to implement these EBPs, with all active waivers scheduled to terminate no later than September 30, 2019.

The experiences of jurisdictions in implementing their selected EBPs have been influenced by several facilitators and barriers. Exhibit 3 summarizes the most common facilitators and barriers to implementation as documented by the jurisdictions in their interim or final evaluation reports.[16]

# Implementation Facilitators

## Communication and Collaboration

Clear and open communication and collaboration across child-serving organizations (including child welfare, probation, private service providers, and the courts) was one of the most frequently documented facilitators to EBP implementation (reported by at least half of the jurisdictions). For example, West Virginia described the use of community forums that included state child welfare agency staff and community service partners (e.g., juvenile justice, behavioral health, education) to identify the service needs of children eligible for Wraparound services and to increase awareness of and engagement in the state's Safe at Home demonstration.

[16] The items included in this exhibit may not reflect all facilitators and barriers experienced by jurisdictions, but rather those documented in their final reports. It is also possible jurisdictions experienced some of the facilitators and/or barriers included in the exhibit but did not explicitly document them in their reports.

## Exhibit 2. Implementation Status of EBPs

| Jurisdiction | EBP | Staff Training Begun | Referrals Made | Children/Families Enrolled | Children/Families Completed Service |
|---|---|---|---|---|---|
| Arkansas | NPP 5–12 | ● | ● | ● | ● |
| California | Wraparound | ● | ● | ● | ● |
| District of Columbia | Project Connect | ● | ● | ● | ● |
| Hawaii | Wraparound | ● | ● | ● | ● |
| Illinois | CPP | ● | ● | ● | ● |
| Indiana | FCT | NA* | ● | ● | ● |
| Kentucky | START | ● | ● | ● | ● |
| Maryland | FFT | NA* | ● | ● | ● |
| | IY | NA* | ● | ● | ● |
| | PCIT | ● | ● | ● | ● |
| | SBC | ● | NA+ | NA+ | NA+ |
| Ohio | Kinship Supports | ● | ● | ● | ● |
| Pennsylvania | PCIT | ● | ● | ● | ● |
| | Triple P | ● | ● | ● | ● |
| Port Gamble S'Klallam Tribe | FGDM | ● | ● | ● | ● |
| Tennessee | KEEP | ● | ● | ● | ● |
| West Virginia | Wraparound | ● | ● | ● | ● |

**Note:** Completed service means at least some, if not all, enrolled children/families fully completed their participation in this particular EBP.

**Note:** * = not applicable (i.e., staff training was generally not a component of this intervention but rather involved referrals to existing, trained EBP service providers); + = not applicable (i.e., SCB is a casework practice model for child welfare professionals rather than a specific intervention for families or children).

## Staff Outreach, Education, and Information Sharing

Several jurisdictions reported proactive, high-quality outreach and education regarding the EBP (e.g., through staff training). In Arkansas, for example, the state child welfare agency began preparing staff for implementation of NPP 5-12 by holding monthly staff meetings with supervisors, while supervisors met with their staff to discuss implementation of the initiative and respond to their questions and concerns. All staff received regular email updates about the launch of the program and on subjects such as changes to the program's referral criteria. An essential element of successful service delivery reported by Illinois involved providing child welfare agency staff with accurate and real-time information about their families; for example, as part of field coaching, Illinois Birth to Three (IB3) implementation staff gave both caseworkers and supervisors monthly data reports that included at-a-glance snapshots of families' status and progress. This information helped supervisors and caseworkers focus on areas for improvement, facilitate discussions with parents regarding the impact of trauma and placement disruptions, and implement strategies to improve families' readiness to engage in EBPs and achieve permanency.

## Outreach to Families and Courts

Three jurisdictions (Arkansas, Illinois, and Maryland) noted the importance of positive outreach, engagement, and communication with targeted families as an important facilitator. Two jurisdictions (Hawaii and West Virginia) specifically highlighted the role of juvenile or family courts in facilitating EBP implementation given the critical role they play in decisions regarding services received by families.

# Implementation Challenges

Jurisdictions documented an even wider range of challenges to the implementation of their EBPs, many of which are common and chronic in child welfare settings. The most common implementation barriers—documented by at least half of the jurisdictions—included logistical issues (e.g., lack of transportation, childcare, treatment space); limited caseworker knowledge of or training in the EBP; and problems with contacting and engaging families. Other common barriers reported by at least four jurisdictions included issues with caregiver/family compliance or participation in EBPs; parent/caregiver substance abuse and/or mental health problems (which likely exacerbates compliance and participation issues); and heavy staff workloads/caseloads and the associated problem of high worker turnover.

Smaller numbers of jurisdictions documented additional barriers that are common in child welfare contexts, including lack of staff and judicial buy-in or support for the EBP; the limited availability of associated services requested on behalf of families (e.g., therapeutic services); and competing

agency priorities and initiatives. Confusion about roles and responsibilities across staff and organizations in implementing an EBP is likely associated with the limited knowledge of or training in the EBP documented by some jurisdictions. Despite the allocation of title IV-E funds and other agencies' resources, these issues noted above remained problematic for many agencies in implementing their EBPs.

## Exhibit 3. Implementation Facilitators and Barriers

| Jurisdiction | AR | CA | DC | HI | IL | IN | KY | MD | OH | PA | PG | TN | WV |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Facilitators** | | | | | | | | | | | | | |
| Open, clear communication and collaboration across organizations (e.g., child welfare, probation, courts, providers) | | ● | ● | ● | | ● | | | ● | ● | | | ● |
| Proactive, high-quality outreach/education for child welfare staff, courts, other agencies | ● | ● | | | ● | | | | ● | ● | | | ● |
| Positive outreach, engagement, communication with families | ● | | | | ● | | | ● | ● | | | | |
| Support/buy-in from the courts, other government agencies | | | | ● | | | | | | | | | ● |
| Use of data from assessments, dashboards, etc., to inform case decision making and referrals | | | ● | | ● | | | | | | | | |
| **Barriers** | | | | | | | | | | | | | |
| Logistical barriers (e.g., transportation, childcare, space) | ● | | | | ● | | | | | ● | ● | ● | |
| Limited caseworker/staff knowledge of or training in EBP | | | | ● | ● | ● | | ● | | ● | | | |
| Contacting/engaging families | ● | | ● | | ● | | | ● | | ● | ● | | |
| Family/caregiver compliance/follow-through | ● | | | | | | | ● | | ● | | | ● |
| Parent/caregiver mental health/substance use issues | ● | | | | ● | | | | | ● | | | ● |
| Staff turnover | | ● | | | | | ● | ● | ● | ● | | | ● |
| Heavy workloads/high caseloads | | ● | | ● | | | | ● | ● | | | ● | |
| Confusion regarding staff/organizational roles and responsibilities | | | | | | | | ● | | ● | | | ● |

| Jurisdiction | AR | CA | DC | HI | IL | IN | KY | MD | OH | PA | PG | TN | WV |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lack of staff buy-in to EBP | ● | | | | | | | ● | ● | ● | | | |
| Service availability (quantity and/or array) | | | | | ● | | | | | ● | | | ● |
| Awareness of and buy-in to EBP by judges, attorneys | | | | | ● | | | | | ● | | | ● |
| Competing agency priorities, initiatives, service needs | | ● | | ● | | | | | | ● | | | |
| Miscommunication, lack of data sharing across organizations | | ● | | | | | | | | ● | | | |
| Slow, inefficient referral processes | | | | | | | | ● | | ● | | | |
| Payment/contract issues with service providers | | ● | ● | | ● | | | | | | | | |
| Antiquated/inadequate information systems | | | | ● | | | | | | | ● | | |
| Overly ambitious/unrealistic implementation time frames | | | | | | | | ● | | | | | ● |

**Note:** PG is an abbreviation for the Port Gamble S'Klallam Tribe.

# Implementation Fidelity

Fidelity refers to the extent to which the delivery of an intervention adheres to the protocol or program model as intended by the developers of that intervention (Dane & Schneider, 1998; Domitrovich & Greenberg, 2000; James Bell Associates, 2009; Mowbray, Holter, Teague, & Bybee, 2003). As documented by several researchers (Dane & Schneider, 1998; Durlak & DuPre, 2008; Fagan, Hanson, Hawkins, & Arthur, 2008), fidelity can be conceptualized and measured across five dimensions:

- Adherence: The extent to which program components are delivered as prescribed by the model regarding content, methods, and activities
- Exposure/dosage: The amount of program delivered in relation to the amount prescribed by the program model (e.g., number of sessions or contacts, attendance levels, frequency and duration of sessions)
- Delivery quality: The quality with which an intervention is delivered (e.g., provider preparedness, enthusiasm, interaction style, respectfulness toward participants, clarity of communication). The quality of delivery may act as a moderator between an intervention and observed outcomes (i.e., if all of a program's material is covered but is delivered poorly, positive participant outcomes may not be realized).
- Participant responsiveness: The way participants react to or engage in a program (e.g., levels of interest and enthusiasm, perceptions of the program's relevance and usefulness)
- Program differentiation: The degree to which a program's critical components are distinguishable from one another and from other programs (i.e., whether the intervention provided to program participants is sufficiently distinct from services or interventions provided to nonparticipants)

Exhibit 4 indicates which of the above fidelity dimensions jurisdictions assessed as part of the evaluations of their EBPs, to the extent that the jurisdictions documented this information in their interim or final evaluation reports. The exhibit also shows whether a jurisdiction documented the use of a formal fidelity assessment tool or protocol, which was the case for half of the EBPs highlighted in this report.

Almost all jurisdictions assessed program exposure in some form (e.g., regarding the number and/or proportion of families that received the EBP, the number of service sessions provided, or the number and/or proportion of families that successfully completed all elements of a program). Few jurisdictions reported substantial success regarding exposure, which suggests many child welfare agencies faced challenges with participant referrals, enrollment, and/or program completion. Most jurisdictions also evaluated program adherence (i.e., the extent to which prescribed EBP content and activities were delivered). In this regard, most jurisdictions documented moderate to high levels of success. A majority of jurisdictions examined participant responsiveness, for which most

documented moderate to high levels of success using metrics such as participant satisfaction. Smaller numbers of jurisdictions systematically examined the quality of service delivery through observations of program staff and other data collection methods, and only three jurisdictions reported they had assessed program differentiation in some form. Illinois, for example, tracked and documented whether any families assigned to the control group for its evaluation of its IB3 demonstration inadvertently received CPP or a combination of CPP and NPP services.[17]

This overview of jurisdictions' efforts to evaluate fidelity suggests high levels of program adherence do not always translate into high levels of program exposure; as noted previously, many child welfare agencies struggled with identifying appropriate families to refer to EBPs or with enrolling adequate numbers to ensure a robust process evaluation. Once families were enrolled, some jurisdictions faced challenges with keeping them engaged and ensuring they completed all essential elements of the program; this was sometimes true even when participants expressed satisfaction with EBP services and supports. Issues with program exposure were also associated to some degree with implementation challenges highlighted in exhibit 3, such as logistical barriers, staff turnover, and caregiver compliance and follow-through. Had more jurisdictions evaluated delivery quality, they might have identified issues with referral or enrollment or with the provision of EBP services that exerted a negative effect on participant engagement and subsequently on program enrollment and completion.

[17] Illinois implemented 2 versions of NPP—1 for parents of children aged 0–5 and 1 for foster caregivers of children aged 0–5—that have not been rated by CEBC and are therefore not discussed in this paper. The version of NPP that has been rated by CEBC is for parents of children aged 5–12.

## Exhibit 4. EBP Fidelity Measurement

| Jurisdiction | EBP | Formal Fidelity Assessment Tool/ Protocol | Fidelity Dimensions Studied | | | | |
|---|---|---|---|---|---|---|---|
| | | | Adherence | Exposure | Delivery Quality | Participant Responsiveness | Program Differentiation |
| Arkansas | NPP 5–12 | ● | ●* | ●* | | ●* | ● |
| California | Wraparound | ● | ●* | ● | | ●* | |
| District of Columbia | Project Connect | ● | ●* | | ● | ●* | |
| Hawaii | Wraparound | | ● | ● | | | |
| Illinois | CPP | ● | ●* | ●* | | ●* | ●* |
| Indiana | FCT | ● | ●* | ●* | | | |
| Kentucky | START | | ● | ● | | ● | |
| Maryland | FFT | | | ● | | | |
| | IY | | | ● | | | |
| | PCIT | | | ● | | | |
| | SBC | ● | ●* | ● | ● | | ● |
| Ohio | Kinship Supports | | ● | ● | | | |
| Pennsylvania | PCIT | | ●* | ● | | ● | |
| | Triple P | | ●* | ● | | ● | |
| Port Gamble S'Klallam Tribe | FGDM | | | ● | | | |
| Tennessee | KEEP | ● | ● | ● | ● | ●* | |
| West Virginia | Wraparound | ● | ●* | ● | ●* | ●* | |

**Note:** * indicates a jurisdiction documented partial or full success with a particular fidelity dimension.

**Note:** Partial success related to adherence and exposure was documented for the Wraparound program implemented on the island of Hawai'i, whereas less success was documented for the Wraparound program implemented on Oahu.

# EBP Outcomes

All 13 jurisdictions conducted outcome evaluations of their EBPs as required by their title IV-E waiver agreements with the federal government. Exhibit 5 summarizes the research designs used to evaluate outcomes for each EBP and the final or preliminary safety, permanency, and well-being outcomes observed for each, along with the EBPs' current CEBC ratings. To be included in this summary, an EBP had to have been evaluated for outcomes separately from any other interventions implemented by a jurisdiction as part of its waiver demonstration.[18] Also, the exhibit indicates only whether a jurisdiction reported at least one positive outcome finding and does not note any neutral or negative findings that may have been observed.

One question this paper explores is the extent to which jurisdictions documented conclusive evidence of benefit from their selected EBPs, with the CEBC's evidence rating scale used as the standard for assessing methodological rigor and demonstration of effectiveness. To justify a classification of "supported" or "well supported," the CEBC requires programs be evaluated using a randomized controlled trial (RCT)—at least one in the case of the rating of "supported" and at least two in the case of a rating of "well supported." Only one jurisdiction (Kentucky) included in exhibit 5 is using an RCT in one participating county to evaluate an EBP; this evaluation is ongoing and full results are pending submission of a final report.

If less rigorous methodological and evidentiary criteria are applied, four jurisdictions (Arkansas, Indiana, Ohio, and West Virginia) stand out that evaluated their programs using propensity score matching (PSM), a matched case design identified as a methodologically rigorous alternative to RCTs (Austin, 2011; Rosenbaum & Rubin, 1985). Three of these jurisdictions—Indiana, Ohio, and West Virginia—reported statistically significant differences in some safety, permanency, or well-being outcomes in favor of an intervention group over a matched case comparison group. Indiana, for example, found children assigned to receive FCT were significantly more likely to remain in their homes during their involvement in child welfare services than were matched comparison children. Children in the FCT group who were in out-of-home care also spent significantly fewer days in care before reunification than did children in care in the matched comparison group. In Ohio, children served by the Kinship Supports Intervention were less likely than matched comparison children to experience abuse or neglect within 6 months, 12 months, and 18 months following the end of out-of-home placement. In addition, the odds of reentry into care within 12 months of discharge from their

[18] For this reason Illinois' IB3 demonstration is excluded because its outcome evaluation examined combined outcomes from both the CPP and NPP components of its project.

first placement episode were 3 times greater for matched comparison children than for children served by Kinship Support Services. In West Virginia, youth assigned to the state's Safe at Home Wraparound program spent significantly less time in congregate care than did their historical matched case counterparts, and they had fewer subsequent maltreatment referrals within 6 and 12 months after referral to the program than did their matched counterparts.

For three programs with a CEBC rating of "promising" (FCT, Kinship Supports,[19] and Wraparound), these findings suggest some research evidence of sufficient rigor emerged to further corroborate their effectiveness, even if reclassification to a higher CEBC rating cannot be supported. For the remaining EBPs, evaluation results are still pending, insufficient data have emerged regarding the programs' effectiveness, or the evaluation designs lacked sufficient rigor to draw conclusions regarding their effects. Since both IY implemented by Maryland and PCIT implemented by Maryland and Pennsylvania already have CEBC ratings of "well supported," these jurisdictions may have chosen to focus less on rigorous evaluation and more on successful implementation in their targeted counties.

## Exhibit 5. Summary of EBP Outcomes

| Jurisdiction | EBP | CEBC Rating | Evaluation Design | Outcomes Studied and Direction of Change | | |
|---|---|---|---|---|---|---|
| | | | | Safety | Permanency | Child and/ or Caregiver Well-Being |
| Arkansas | NPP 5-12 | Promising | Matched case (PSM) | + | NS | + |
| California | Wraparound | Promising | Longitudinal analysis starting with historical baseline | TBD | NS | NS |
| District of Columbia | Project Connect | Promising | Matched case | + | TBD | + |
| Hawaii | Wraparound | Promising | Longitudinal analysis | TBD | TBD | + |
| Indiana | FCT | Promising | Matched case (PSM) | +* | +* | +* |
| Kentucky | START | Promising | RCT (Jefferson County only; other counties used PSM) | TBD | TBD | TBD |
| Maryland | FFT | Supported | Single-group pre-post test | NS | NS | +* |

[19] Kinship Supports was recently classified by the CEBC as a "promising practice" (in June 2019) based on findings from the evaluation of Ohio's waiver demonstration.

| Jurisdiction | EBP | CEBC Rating | Evaluation Design | Outcomes Studied and Direction of Change | | |
|---|---|---|---|---|---|---|
| | | | | Safety | Permanency | Child and/ or Caregiver Well-Being |
| | IY | Well supported | Single-group pre-post test and longitudinal analysis | + | NS | +* |
| | PCIT | Well supported | Single-group pre-post test | NS | NS | TBD |
| | SBC | Promising | Longitudinal analysis | TBD | TBD | TBD |
| Ohio | Kinship Supports | Promising | Matched case (PSM) | +* | +* | NS |
| Pennsylvania | PCIT | Well supported | Single-group pre-post test | ID | ID | ID |
| | Triple P | supported | Single-group pre-post test | NS | NS | +* |
| Port Gamble S'Klallam | FGDM | Promising | Qualitative/descriptive analysis | TBD | TBD | TBD |
| Tennessee | KEEP | Promising | Matched case | TBD | TBD | TBD |
| West Virginia | Wraparound | Promising | Matched case (PSM) and pre-post test for analysis of well-being data | +* | +* | + |

**Key:** + = Positive change; * = Statistically significant finding; NS = Not studied; TBD = To be determined/ evaluation still ongoing; ID = Evaluation complete but insufficient data to draw conclusions

**Note:** Participating probation departments in California are examining rearrest rates among participating youth rather than maltreatment recurrence.

# Summary and Discussion

This paper summarizes the experiences of 13 child welfare jurisdictions with title IV-E waivers in implementing a set of programs classified by the CEBC as having some research-based evidence of effectiveness (i.e., an EBP). Of the 14 EBPs implemented by these jurisdictions, 9 have a CEBC rating of "promising" (least evidence of effectiveness), 3 have a rating of "supported" (stronger evidence of effectiveness), and 2 have a rating of "well supported" (strongest evidence of effectiveness). In most cases, the jurisdictions implemented their EBPs as designed by their purveyors and documented no changes to their core service components or intended target populations.

Nearly all jurisdictions succeeded in fully implementing their selected EBPs, although with varying degrees of fidelity with respect to program exposure. Many faced implementation challenges typical in child welfare practice settings, such as logistical barriers, limited caseworker awareness of and/or training in EBPs, and issues with family engagement and compliance. Some of the most important facilitators of effective implementation included clear communication, information sharing, and collaboration across participating organizations (e.g., child welfare, court systems, private service providers); proactive outreach to and education for child welfare workers, judges, and staff from other service organizations; and fostering communication and positive relationships with caregivers and their families. To date, no jurisdictions have produced positive evaluation findings of sufficient rigor to justify assigning higher CEBC evidence ratings to EBPs currently rated as "promising" or "supported"; however, at least three jurisdictions (Indiana, Ohio, and West Virginia) have reported positive permanency, safety, or well-being outcomes for EBPs that were evaluated using rigorous matched case designs, and more complete evaluation results remain pending from several jurisdictions.

In reviewing the experiences of child welfare agencies in implementing and evaluating EBPs under the title IV-E waiver authority, several themes emerge that may provide guidance to those agencies that continue to implement EBPs under their waiver demonstrations, and to other jurisdictions that plan to implement EBPs under the new Family First Prevention Services Act.

## Education and Training

Several jurisdictions described limited knowledge or understanding of EBPs on the part of caseworkers, service providers, judges, and other stakeholders as a barrier to effective implementation, and just as many jurisdictions noted that proactive and rigorous efforts to inform and educate stakeholders were important facilitators of effective implementation. These findings speak

more broadly to the importance of early, ongoing, and high-quality outreach, education, and training for child welfare staff and other service providers. Making an EBP available as a referral resource and informing staff of its existence is insufficient; staff must perceive the value of the EBP for their families and understand when and how to connect families to this service. When an EBP is meant to be provided directly by caseworkers or other service providers, they must receive high-quality initial training along with opportunities for ongoing education, coaching, and professional guidance. Given the chronic issue of staff turnover faced by many child welfare agencies, training programs must reach a sufficient number of new and existing staff to minimize disruptions in the availability of EBP services.

# Interorganizational Communication and Information Sharing

An essential corollary to education and training is frequent and open communication and information sharing among organizations involved in EBP referral, enrollment, service provision, and decision making. Along with child welfare agencies, these organizations include courts and private service providers. Several jurisdictions described implementation barriers including confusion about staff or organizational roles regarding referrals and service provision, and miscommunication and inadequate information sharing. At the same time, about half of the jurisdictions identified clear communication and collaboration across organizations as a significant catalyst for effective EBP implementation. Along with vigorous outreach and education, facilitators of effective interorganizational collaboration and communication about EBPs include memoranda of understanding and data-sharing agreements.

# Family Outreach and Engagement

Many jurisdictions documented obstacles to delivering services to families that are not unique to EBPs but rather are common in broader child welfare practice settings; these included logistical barriers such as arranging transportation and childcare, contacting and engaging families in services, and family compliance and follow-through. These challenges relate to the fidelity domain of exposure, which affects whether and how much of a program families receive, and in turn, the magnitude of positive outcomes achieved. As in the case of child welfare staff knowing about but not referring families to EBPs, making an EBP available to families is not sufficient to ensure their participation—child welfare agencies must consider the match between specific EBPs and the corresponding needs and circumstances of caregivers and children, and they must engage in the same proactive outreach, engagement, and communication with families that are essential elements

of effective casework. Another element critical to successful service delivery, which was reported by Illinois, involves providing caseworkers with accurate and real-time information about their families. As part of field coaching, IB3 implementation staff in Illinois gave child welfare agency personnel monthly data reports that included at-a-glance snapshots of families' status and progress. This information improved case decision making for both supervisors and caseworkers and helped them monitor children's and caregivers' progress.

# Rigorous Evaluation

Although many jurisdictions reported positive benefits from their EBPs and documented valuable lessons learned during implementation, few conducted evaluations that were sufficiently rigorous to draw conclusions about their programs' effectiveness.[20] Only two jurisdictions (Illinois and Kentucky) implemented evaluations using RCTs; however, results from Kentucky's evaluation of START are still pending, while Illinois did not study the effects of its EBP (CPP) separately from other demonstration services, which means its impacts cannot be distinguished from the effects of the state's demonstration as a whole. Results from evaluations conducted under the current waiver authority speak to the need for more methodologically rigorous evaluations of EBPs—particularly those rated as "promising" or "supported" under the CEBC's rating system—to build the knowledge base regarding programs, services, and practices that benefit children and families involved in child welfare systems. As states are provided with the opportunity to use the title IV-E prevention program to fund prevention and treatment services in accordance with the Family First Prevention Services Act, it is hoped that new investments in rigorous evaluation will be made in the child welfare field to further build the evidence base for interventions that promote child and family safety, permanency, and well-being.[21]

[20] The Child and Family Services Improvement and Innovation Act of 2012, which reauthorized the current waiver authority, precluded the CB from giving preference in considering waiver applications to jurisdictions that proposed implementing RCTs for the evaluation of their demonstrations. See Information Memorandum ACYF-CB-IM-12-05.

[21] See the following program instructions, released by the CB on November 30, 2018, with detailed information about state and tribal requirements for electing Title IV-E Prevention and Family Services and Programs, and for participating in the Tile IV-E Kinship Navigator Program: ACYF-CB-PI-18-09, ACYF-CB-PI-18-10, and ACYF-CB-18-11.

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