Kansas Title IV-E Prevention Plan

Five-Year Plan: 2025-2029

Submitted To:

U.S. Department of Health and Human Services

November 14, 2024

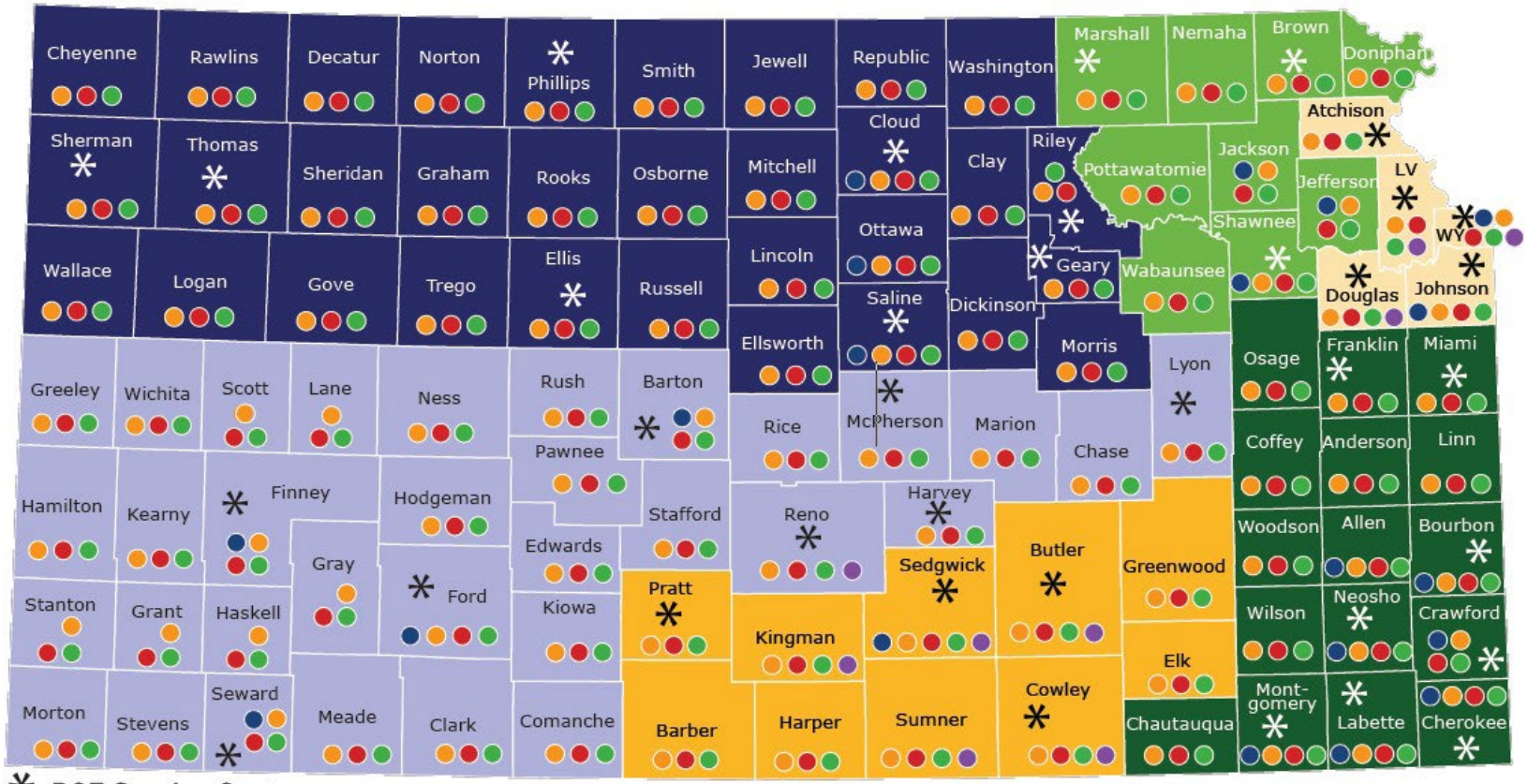
Written in collaboration by

The Family First Family Council;
The University of Kansas Center for Public Partnerships and Research; and
The Kansas Department for Children and Families

Submitted by: The Kansas Department for Children and Families, 555 S. Kansas Ave., Topeka, KS 66603 | familyfirst.dcf.ks.gov

Facebook: KansasDCF | Twitter: @dcfkansas | Vimeo: vimeo.com/dcfkansas

Family First Prevention Services Act Programs



* DCF Service Center

Northwest
Northeast
Wichita
Southwest
Southeast
Kansas City

Mental Health
Substance Use Disorder
Parent Skill Building
Kinship Navigator
Other Primary Prevention Services

Rev: 07-19-23

Introduction

The Kansas Department for Children and Families (DCF) will administer a prevention service array with key programs and services aligned along a spectrum of care. These services, characterized by proximity of the service to the child welfare system and risk of formal child welfare system involvement[1] address primary prevention needs in the community as well as services for families with identified risk for secondary prevention. All services along this spectrum, including Family Resource Centers, Family First Prevention Services, and Family Preservation Services, are intended to mitigate the need for child removal to foster care whenever possible to safely do so.

Prevention services as defined in the SFY2020 – SFY2024 approved Title IV-E Prevention Plan included community-based resources as the most upstream prevention approach. This is followed by the DCF funded Family First and Family Preservation programs, which together, sat further downstream along the prevention spectrum and require formal family engagement and assessment with DCF child protective services through the Kansas Protection and Reporting Center (KPRC) hotline to access services. Both Family First and Family Preservation have been used as secondary/tertiary prevention approach in the Kansas prevention services spectrum. This is because these programs are delivered to families who have come to the attention of DCF through the KPRC in an *intensive* effort to prevent *imminent* removal among families experiencing challenges posing safety risks to children.

This new 2025-2029 Plan builds on the initial Prevention Plan foundation and includes the addition of the new services which support core upstream community strategies that do not require family engagement with child protective services. Although the addition of state-funded primary prevention services is not claimed by Title IV-E, the State is currently exploring ways to further invest in communities.

[1] Formal child welfare system involvement is defined as family contact and engagement with state administered child protective services initiated through a report or referral to the Kansas Protection and Reporting Center (KPRC) hotline for concerns related to child abuse and neglect. Formal system involvement includes this initial contact and all subsequent activities related to this contact, including simple assessment for services through child removal to foster care.

Advancing Equity, Equality, & Supporting Underserved Communities

During the 2020-2024 Title IV-E Prevention Plan reporting period, DCF and stakeholders embarked on a learning journey led by voices of lived experts involved in child welfare systems. Kansas partners have analyzed policy, practice, and data focusing on disproportionate numbers of Black and Brown children in foster care. These efforts have propelled creative collaboration efforts toward elevating and advancing equity.

SFY 2021 DCF, Kansas Children's Cabinet and Trust Fund, Kansas Children's Service League (KCSL), and individuals with lived expertise participated in "Thriving Families, Safer Children: A National Commitment to Well-Being." This included analysis and uncovering systemic barriers to racial disparities in the child welfare system by identifying policies and practices which may or may not inadvertently lead to disproportionate or unnecessary removal of children from their families.

SFY 2021 Over 60 child welfare staff across the state attended "Death by a Thousand Nicks- Healing the Wounds of Racial Trauma." Discussions heavily focused on intergenerational trauma clients may experience. The training assisted staff in being able to identify techniques to have difficult conversations about race in a productive, trauma-informed manner.

SFY 2022 The University of Kansas Family First evaluation team provided a summary of state and regional child welfare outcomes, by race/ethnicity drawn from DCF administrative data to each regional Interagency Community Advisory Board (ICAB) meeting. Data included child welfare outcomes at a statewide and regional level from State Fiscal Year (SFY) 2012 through SFY 2021. Data was also disaggregated by race to examine whether families are experiencing and achieving equitable outcomes. Discussion included region-specific deviations from statewide trends, racial disparity in outcomes, and region-specific factors driving differences. Outcomes examined included: (1) reunification length of stay; (2) adoption length of stay; (3) time to adoption from termination of parental rights (TPR); (3) and relative placements. The goal of sharing the data was to inform, to discuss structural factors that promote and sustain disparities, regional implications, and identify potential solutions.

SFY 2022 In exploring the above-mentioned data, counties with high race disproportionality metrics were selected to participate in a pre-petition pilot offering high-quality legal resources to parents to prevent unnecessary family separation and advance racial equity. Partnering with KLS, the Parent Advocate Program was implemented to serve Cowley, Douglas, Kingman, Leavenworth, Reno, and Sumner counties. DCF granted with this program during the Family First RFP and has expanded into additional Kansas counties. This program is later discussed in detail in Section 2.

SFY 2022 DCF used Family First allocated state funds and selected FosterAdopt Connect (FAC) to provide a community referral Kinship Navigation service in Johnson and Wyandotte counties. This was a result of information provided by the Family First evaluator gathered from families who participated in the Family First Kids 2 Kin program. Families voiced a need for further kinship supports such as advocacy, healthcare, educational assistance, finances, social supports, transportation, and community supports. This program continues today by way of a DCF TANF 2Gen grant.

SFY 2022 and SFY 2023 Representatives from the Kansas Department for Children and Families (DCF), CarePortal and the University of Kansas School of Social Welfare (KUSSW) created the Kansas Racial Equity Collaborative (REC), to address the disproportionately higher number of Black and Brown children entering the child welfare system in comparison to White children. Fueled with the mission to end racial disparities in the child welfare system in the state, the REC led Kansas on an 8-month learning

journey to further racial equity in child welfare and hosted (2) in-person symposiums to elevate a national conversation about neglect versus poverty and the confusion that exists. Kansans from various sectors ranging legal, social, education, medical, law enforcement and academic fields, to faith and community-based organizations, attended a robust series of statewide trainings designed to equip them in understanding racial disparities, and partner in creating a more equitable system for Black and Brown Families.

SFY 2023 and SFY 2024 During the Family First Request for Proposals (RFP), Kansas expanded parent skill-building programs for each region. Early childhood prevention services are a supported resource for advancing child development and addressing deeply rooted disparities and disproportionality among children of color in the child welfare system.

SFY 2024 and SFY 2025 During various stakeholder venues, families expressed a desire to access services in their communities without the need for formal contact with DCF. To elevate family voice, DCF partnered with the Family First Family Council (FFFC), and the University of Kansas Center for Public Partnerships and Research (KU CPPR), Family First Evaluation Team in co-designing a community pathway for services.

As Kansas moves forward, prevention partners have committed to creating more equitable outcomes for children, youth, and families. Partners all over the state continue to amplify and listen to the voices of those with lived expertise, guiding the future of our child and family well-being system.

Prevention Service Track, 2025-2029:
Furthering prevention investments in communities

Unique community-based services-
Each Kansas community has its own set of resources which strengthen families, increase protective factors, and promote social connection. These may include TANF funded 2Gen grants, Family Resource Centers, public health departments, food and clothing banks, and other services, which are considered primary prevention resources to help families if children do not meet the candidacy of care definition.

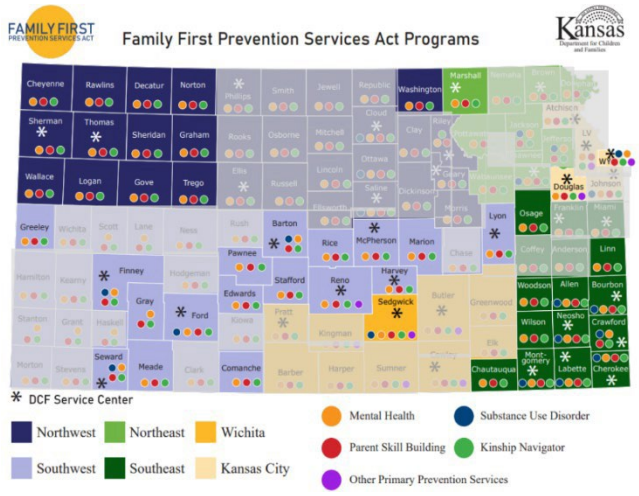


Figure 1, the unshaded counties represent areas where a state funded FRC provides services or outreach.

In late 2022, DCF invested state funds in community services by providing grants to (10) unique Family Resource Centers (FRCs) across the state. FRCs support community-based primary prevention support for families in 45 of 105 counties, see Figure 1. This network of providers, along with other organizations operating as FRCs throughout the state, are supported by the Prevent Child Abuse America's Kansas chapter organization, Kansas Children's Service League, who is contracted by DCF as the Kansas Family Support Network Technical Assistance Provider. All DCF state funded FRCs implement the National Family Support Network Standards of Quality for Family Strengthening & Support, complete the Standards of Certification Training, and are evaluated by the University of Kansas Center for Public Partnerships and Research to understand reach, implementation, and impact.

The National Family Support Network (NFSN) Standards of Quality for Family Strengthening & Support (NFSN, 2020) provide a practice framework for working with families using family-centered, strengths-based, and multigenerational approaches to family support. Support services delivered under this framework are intended to build and strengthen protective factors that support family stability, promote healthy child development, and reduce child abuse and neglect. The Standards also reflect priority focus on equity and addressing the community conditions that enable healthy development for all children and families.

The Standards, as defined by the NFSN (2020) include 17 standards of practice across five domains:

1. Family centeredness: Working with a family-centered approach that values families and recognizes them as integral to the Program.
2. Family strengthening: Utilizing a family strengthening approach to support families to strong, healthy, and safe, thereby promoting their success and optimal development.
3. Diversity, equity, and inclusion: Valuing, respecting, and embracing families' diversity, and advancing equity and inclusion.
4. Community strengthening: Developing a strong and healthy community by working collaboratively with various stakeholders and supporting families' civic engagement, leadership development, and ability to effect systems change.
5. Evaluation: Looking at Program strength areas and areas for further development to guide continuous quality improvement and achieve positive results for families.

This framework operationalizes definitions of best practices for service delivery and details benchmarks for assessing quality implementation of family support services. Key among The Standards are provisions for authentic inclusion of families and lived experts in program development and implementation that set forth considerations for optimizing family inclusion. The Standards provide an overarching framework aligning prevention services under a set of common principles, while also remaining flexible to the local context by not prescribing specific models of service.

Family First Prevention Services sit centrally in the prevention continuum. Family First services include innovative and evidence-based programs addressing specific issues related to social determinants of health and well-being (e.g., mental health, substance use, parenting skills, kinship navigation). Family First prevention services are intended to prevent out of home foster care services and to mitigate complex family challenges before they become crises impacting child safety.

Services in this array are defined according to their Title IV-E Prevention Services Clearinghouse assessment of evidence (i.e., Promising, Supported, Well-Supported, Not rated/Not supported). Programs not rated or not currently supported according to Title IV-E Clearinghouse criteria are defined as state-funded prevention programs that are part of the Family First prevention array, see map on page 4.

Finally, **Family Preservation Services** represents the prevention program situated with greatest proximity to the child welfare system. The aim of Family Preservation (FPS) is to prevent imminent removal of the child from the home into foster care, intervening to support and stabilize families once they have come to the attention of the child welfare system. Family Preservation provides voluntary services alongside families to build their strengths and reduce the risk of children being placed in foster care.

FPS provides an array of services developed to meet family and child needs. These services can range on a continuum of high to low intensity through the time in service with case management services and/or non-case management meaningful supports or intervention approaches to the family. Services provided

through FPS are in the family home and serve families who have one or more children at risk for out of home placement or who will be at risk of out of home placement at birth.

FPS Case Management services are provided to the family in the home to include ongoing assessment of risk and emergent safety issues, service coordination, and when identified, initiating services to stabilize and support the family.

DCF awarded new contracts for FPS beginning on July 1, 2024 and expiring on June 30, 2028 with an optional one-time, two-year renewal. The incumbent three providers; DCCCA, Cornerstones, and TFI will continue to serve Kansas families in the same regions as the previous contract, Figure 2. Feedback gathered from stakeholders structured services differently for this contract period, allowing providers to customize the intensity of the services based on the family's needs and meet them where they are. Every family will have case management services.

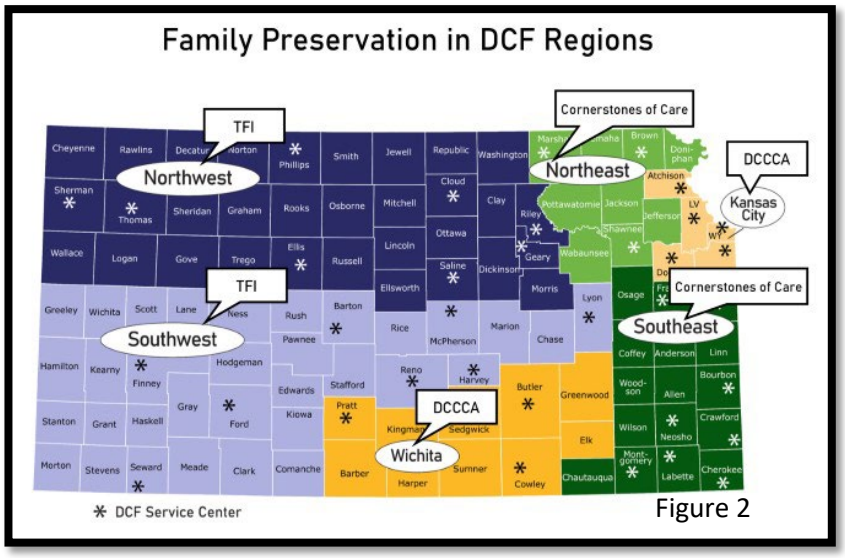


Figure 2

DCCCA, Cornerstones of Care, and TFI are committed to align and integrate the Kansas Practice Model (KPM) into agency engagement with families. This promotes the family's voice with the motto "nothing about you without you". All providers ensure services are diverse, equitable, and inclusive to children and families and their staff will be culturally competent and responsive to each family's unique needs.

All Family Preservation Service Providers are utilizing Evidence Based Practices (EBP). DCCCA will be practicing Functional Family Therapy (FFT), Together Facing the Challenge (TFTC), Motivational Interviewing (MI), and Sobriety Treatment Recovery Teams (START). Cornerstones of Care will be practicing Functional Family Therapy (FFT), Behavioral Intervention Support Team (BIST), Solution Based Casework (SBC), and Motivation Interviewing (MI). TFI will be practicing Trust Based Relational Intervention (TBRI), Solution-Based Casework (SBC), and Alternative for Professionals (APF). FPS is available Statewide in all 105 counties and serves approximately 1500 families per year. The annual budget of $13,000,000 consists of a variety of funding sources; TANF, Children's Initiative Funds, IV-B, State General Funds, and IV-E.

Section 1: Child and Family Eligibility *(Pre-print Section 9)*

Under the Family First Prevention Services Act, the target population is described as children who are at imminent risk of entering foster care and who can remain safely at home with services. This population fits the statewide developed definition of candidacy of care staff are familiar with and currently use to determine if a family is eligible for services. Neither Family First nor Family Preservation is bound to income restrictions for families. "Children" are defined as a population of youth under the age of 18.

Family First **Candidacy of Care** is defined as:

- A child(ren) or youth who is determined at imminent risk of foster care and out of home placement but can be safe at home with prevention services.
- A child(ren) or youth who exited foster care to adoption or permanent custodianship or guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement.
- A child or youth temporarily or permanently residing with a relative or kin caregiver. A child(ren) or youth living with parents but needs to be with a relative caregiver with prevention services in place.
- Pregnant and parenting youth in foster care and in an out of home placement.
- A child remaining in the home whose siblings are in foster care.

Eligibility Determination

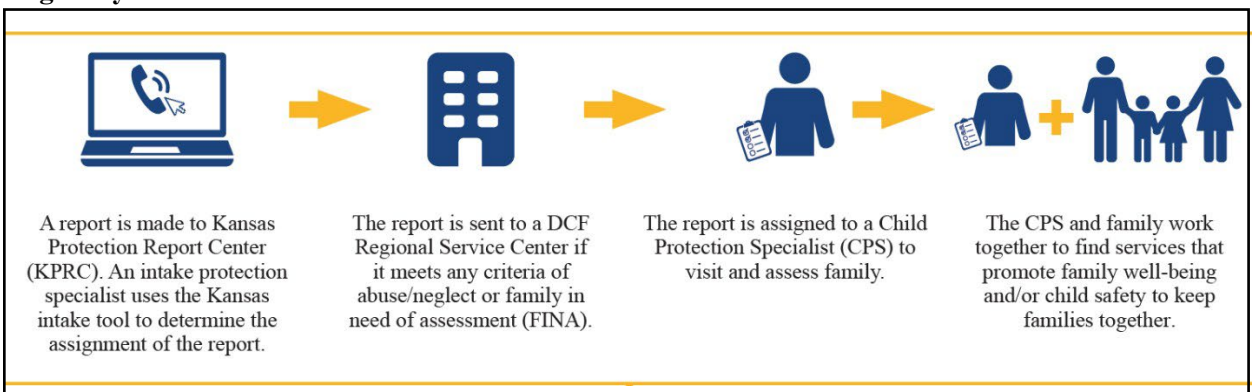


Figure 3

As Figure 3 illustrates, initial reports are made to the Kansas Protection Reporting Center (KPRC). An intake specialist completes an initial assessment of the report using the Kansas intake tool. If the report meets criteria of Abuse and/or Neglect or Family in Need of Assessment, it will be assigned to the regional DCF Service Center. An assigned PPS practitioner within the region will then locate and assess the family.

The PPS practitioner completes an assessment with the family, using the Family-Based Assessment tool, to determine if they meet criteria for services. If answers to questions 1-3 below are "yes"; and questions 4-7 are either "yes" or "NA," they are deemed eligible for services.

1. The family is at risk of having a child(ren) removed; and

2. A parent/caregiver is available to protect the child; and
3. A parent/caregiver is willing and able to participate in services.
4. A family with chronic problems has experienced a significant change which makes them able to progress.
5. A parent/caregiver with mental/emotional health issues has been stabilized.
6. A parent/caregiver with limitations demonstrates an ability to care for self and children.
7. A parent/caregiver with substance abuse issues functions adequately to care for children.

In addition to the questions above, the regional DCF PPS practitioner utilizes the Kansas Practice Model tools to help guide their candidacy for care decision and service referral (refer to Section 6 to read more about the Kansas Practice Model). These tools, outlined below, were created in collaboration with Safe Generations. Components of these tools includes emphasis on family input, highlight what is working well, worries for the family and what needs to happen to keep the child safe.

- Conversation Notes (see Attachment 3) capture the immediate and lasting safety scaling for a family.
- The Assessment Map (see Attachment 4) further defines worries and safety for the family, outlining current and past harm, complicating factors, future dangers, as well as current and past safety, family resources, and safety goals.
- The Immediate Safety Plan (see Attachment 5) is a statement of worry and includes an action to prevent or address the worry, and identified family supports.

The PPS practitioner and the family will decide on which program(s) best meets the family's needs. The PPS practitioner will upload the required documentation into Kansas Initiatives Decision Support (KIDS). KIDS is a web-based data system used to record decisions and maintain documentation for cases assigned to PPS for assessment. Key milestones and the family's services are also tracked in the Family and Child Tracking System (FACTS), the DCF-PPS system for maintaining data and reporting to legislature, federal government, internal management, department budget, and the general public.

Section 2: Service Description and Oversight *(Section 1 Pre-print)*

The title IV-E Prevention Clearinghouse (section 476(d)(2) of the Act) ratings will be defined as such:

Promising Practice

- At least 1, independently verified, "well-designed and well-executed" study
- Used some form of control measures outcome

Supported Practice

- Same as above + used "rigorous random-controlled trial or quasi-experimental research design"
- Carried out in usual care or practice setting
- Showed sustained effect after 6 months

Well-Supported

- At least 2, independently verified, "well-designed and well-executed" studies
- Used "rigorous random-controlled trial or quasi-experimental research design"
- Carried out in usual care or practice setting
- Showed sustained effect after 12 months

Evidence-Based Table of Services

Under the approved 2020 – 2024 Kansas Title IV-E Prevention Plan, Kansas service providers delivered fourteen unique prevention models across the state. These services, detailed in Table 1, included programs in each of the four service domains. Among these programs, half are approved, reimbursable services under Family First Prevention Services guidelines. The other programs are services either not yet assessed or not currently supported according to the Title IV-E Prevention Services Clearinghouse. Many of these state-funded programs were selected based on their alignment with unmet community needs and supported with Kansas' prevention investments. State-funded prevention programs include services within the four Family First designated domains and other services meeting a targeted community need outside these four domains. Based on evidence from local evaluation to date, paired with direction and recommendations from community partners and stakeholders, the array of services currently available in Kansas and detailed in Table 1 will continue during the 2025-2029 Prevention Plan

See Appendix 1, Attachment B.3 for DCF's signed assurance all services provided under this Prevention Plan will be administered within a trauma-informed organizational structure and treatment framework.

Table 1

Kansas Family First Evidence-Based Services

Evidence Based Service	Target Age	Title IV-E Clearinghouse Rating (X = not rated)	California Evidence Based Clearinghouse Rating	Funding Source
Substance Use Disorder Services				
Parent Child Assistance Program (PCAP)	Prenatal to 1 year	Does not meet criteria	Promising	State
Seeking Safety (SS)	0 to 5 years; teens	Does not meet criteria	Supported	State
Sobriety Treatment and Recovery Teams (START)	0 to 6 years	Supported	Promising	Family First
Strengthening Families (SF)	6-11 years	Does not meet criteria	X	State
Mental Health Services				
Multi-Systemic Therapy (MST)	12 to 17 years	Well-Supported	Well-Supported	Family First
Parent Child Interaction Therapy (PCIT)	2 to 7 years	Well-Supported	Well-Supported	Family First
Kinship Navigator Services				
Kansas Legal Services Kinship Navigation	0 to 18 years	Does not meet criteria	X	State
Parent Skill Building Services				
Family Centered Treatment (FCT)	0 to 17 years	Supported	Promising	Family First
Family Check-Up (FCU)	2-17 years	Well-Supported	Well-Supported	Family First
with Family Mentoring (NPP) component add-on available	2-17 years	Does not meet criteria	X	State
Fostering Prevention (NPP)	6-16 years	X	X	State
Healthy Families America (HFA) Signature Model & Child Welfare Protocols	Prenatal to 5 years	Well-Supported	Well-Supported	Family First
Parents as Teachers (PAT)	Prenatal to 3 years	Well-Supported	Well-Supported	Family First
Other Services				
Community Support Specialist (CSS)	0-17 years	X	X	State
Pre-Petition Parent Advocate Program (PAP)	0-17 years	X	X	State

Parent-Child Assistance (P-CAP)

Does not meet criteria on Title IV-E Clearinghouse
Promising on California Evidence-Based Clearinghouse

P-C AP will help parents maintain sobriety and learn skills to help them parent their child and provide an environment which teaches skills like self-regulation. The target population for this program is parents using substances with a child under the age of one, or pregnant women who may be referred if there is concern of substance use during pregnancy. Goals of the program are:

- Assist mothers in obtaining alcohol and drug treatment and to stay in recovery
- Link mothers and their families to community resources that will help them build and maintain healthy and independent family lives
- Help mothers prevent the births of future alcohol and drug-affected children

Service Provider: Kansas Children's Service League

Available in
Northeast Region: Shawnee County

Approximate Number of Families to be Served: 32

Seeking Safety (SS)[2]

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse Supported on California Evidence-Based Clearinghouse

Seeking Safety is an integrated cognitive behavior-based model designed to concurrently address symptoms of post-traumatic stress disorder and substance use through a single trained person with flexibility to treat other high-risk behaviors. Gender-specific and gender-responsive treatment led to the integration of family-centered treatment approaches to engage the whole family, helping members find their voice and feel valued. Services are provided in individual, group and/or family settings to support recovery.

The SS program targets families with children ages 0–5 and teens who are at-risk of being removed from the home as a direct or indirect result of the teens or parent's substance use. Children ages 0–3 could be currently living with a relative due to a parent's substance use. Pregnant or parenting youth in foster care or out-of-home placement experiencing SUD are also eligible. Services typically last 6 months. Goals of the program are:

- Reduce trauma and/or substance abuse symptoms
- Increase safe coping in relationships
- Increase safe coping in thinking
- Increase safe coping in behavior
- Increase safe coping in emotions

Service Provider: Saint Francis Ministries

Available in
Northwest Region: Saline, Ottawa, Cloud Southwest Region:
Finney, Barton, Ford, Seward Wichita Region: Sedgwick

[2] Source: California Evidence-Based Clearinghouse. https://www.cebc4cw.org/program/seeking-safety-for-adults/

Approximate Number of Families to be Served: 90

Sobriety Treatment and Recovery Teams (START)

Supported on the Title IV-E Prevention Clearinghouse
Promising on California Evidence-Based Clearinghouse

START is an intensive child welfare program for families with cooccurring substance use and child maltreatment delivered in an integrated manner with local addiction treatment services. START pairs workers trained in family engagement with family mentors (peer support employees in long- term recovery) using a system of care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the model include quick entry into services to safely maintain child placement in the home when possible and rapid access to intensive addiction/mental health assessment and treatment. Each worker mentor dyad has a capped caseload, allowing the team to work intensively with families, engage them in individualized wraparound services, and identify natural supports with goals of child safety, permanency, and parental sobriety and capacity.

START will be offered to families with children under the age of 6 years and having a parent whose substance use is determined to be a primary child safety risk factor. Families often have multiple risk factors including poverty, lack of basic needs, and criminal behavior. Children sometimes have unmet medical needs and physical or mental developmental delays. Infants are particularly susceptible to neglect, because of their inability to meet any of their own needs. Concrete services to meet basic needs can reduce parental stress and help the family on the road to recovery.

The START model places families at the center of treatment and includes them in the decision-making team during treatment and case planning. Intervention activities may include: (1) intensive SUD recovery services, (2) coaching to help parents with parenting and life skills, (3) intensive case management, and (4) individual, group, and/or family counseling for parents, children, and other family members. Motivational Interviewing will also be incorporated into the services provided by staff. A strong collaborative partnership with the SUD treatment provider(s) is required to coordinate treatment services for the family.

Goals of the program are:

- Ensure child safety and well-being
- Prevent and/or decrease out-of-home placement
- Increase parental recovery
- Increase parenting capacity and family stability
- Reduce repeat maltreatment
- Improve system capacity for addressing parental substance use and child maltreatment

Service Provider: DCCCA

Program manual/book/information used in Implementation:

The Sobriety Treatment and Recovery Teams (START) Model: Implementation Manual. Produced in partnership between the Kentucky Department for Community Based Services and Children and Family Futures, 2018.

Huebner, R.A. (2018). Chapter 1: Basic tenets and essential elements of START: No more business as usual. Lake Forest, CA: Children and Family Futures.

Posze, L. (2018). Chapter 5: Developing Agreements with Treatment Providers. Lake Forest, CA: Children and Family Futures.

Willhauer, T. (2018). Child Welfare START Strategies: Developing the Team and the First 60 days of Service Delivery. Lake Forest, CA: Children and Family Futures.

Willhauer, T. (2018). CPS Strategies for Ongoing Case Management and Team Development. Lake Forest, CA: Children and Family Futures.

Posze, L. (2018). START Treatment Provider Strategies. Lake Forest, CA: Children and Family Futures.

Huebner, R.A. (2018). START Program Evaluation Essentials. Lake Forest, CA: Children and Family Futures.

Available in
Northeast: Shawnee, Jackson, Jefferson
Southeast: Cherokee, Crawford, Labette, Neosho

Approximate Number of Families to be Served: 104

Strengthening Families (SF)

Does not meet criteria on Title IV-E Clearinghouse
Not Rated on California Evidence-Based Clearinghouse

Strengthening Families Program (SF) focuses on three targeted areas: parenting skills training, child skills training, and family training. Content is focused on child development, behavior management techniques, child skills training, family skills enhancement and attachment/bonding, parental supervision, and psycho-educational material targeted to improve the parent child relationships. The group begins with a family meal and is followed by age-specific group breakouts for children and a separate parent breakout group. Weekly training focuses on areas such as family communication, parental supervision, family attachment, child development, parental substance use, and understanding risk and protective factors to avoid substance use.

The Strengthening Families Program primary goals are:

- Reduce child maltreatment
- Reduce costs of foster care and kinship care
- Reduce parent and child substance abuse
- Reduce child development and behavior problems
- Reduce academic and school failure
- Increase parent/child attachment and bonding
- Increase positive parenting and parenting skills
- Reduce family conflict and violence
- Reduce children's and parent's depression and stress
- Increase children's positive behaviors

Service Provider: KVC

Available in
Kansas City Region: Johnson/Wyandotte

Northeast Region: Shawnee

Approximate Number of Families to be Served: 36

Mental Health Services

Multisystemic Therapy (MST)[3]

Well-Supported on the Title IV-E Clearinghouse

Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program is designed to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12- to 17-year-old 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 identified drivers. The program is delivered for an average of three to five months, and services are available 24/7. Program duration and availability enables timely crisis management and allows families to choose which times will work best for them.[4] [6] Goals of the program are:

- Eliminate or significantly reduce frequency and severity of the youth's referral behavior
- Empower parents with the skills and resources needed to:
    - Independently address the inevitable difficulties which arise in raising children and adolescents
    - Empower youth to cope with family, peer, school, and neighborhood problems

Service Provider: Community Solutions, Inc.

Program manual/book/information used in Implementation:

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.

Alternative manual/book/information used in Implementation:

Cunningham PB, Schoenwald SK, Rowland MD, Swenson CC, Henggeler SW, Randall J, Donohue B. Implementing contingency management for adolescent substance abuse in outpatient settings. Family Services Research Center, Medical University of South Carolina; Charleston, SC: 2004.

Available in: Statewide

Approximate Number of Families to be Served: 600

[3] Source: California Evidence-Based Clearinghouse. https://www.cebc4cw.org/program/multisystemic-therapy/

[4] Source: Title IV-E Prevention Services Clearinghouse. https://preventionservices.abtsites.com/programs/121/show

Parent-Child Interaction Therapy (PCIT)[5]

Well-supported on the Title IV-E Clearinghouse

In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two- to seven-year-old children and their parents or caregivers designed to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve quality of the parent-child relationship. During weekly sessions, therapists coach 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 or caregivers from behind a one-way mirror (there are some modifications in which live same-room coaching is also used). Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families achieve mastery of program content in 12 to 20 one-hour sessions.[6] Goals of the program are:

- Build close relationships between parents and their children using positive attention strategies
- Help children feel safe and calm by fostering warmth and security between parents and their children
- Increase children's organizational and play skills
- Decrease children's frustration and anger
- Educate parent about ways to teach child without frustration for parent and child
- Enhance children's self-esteem
- Improve children's social skills such as sharing and cooperation
- Teach parents how to communicate with young children who have limited attention spans
- Teach parent specific discipline techniques which help children to listen to instructions and follow directions
- Decrease problematic child behaviors by teaching parents to be consistent and predictable
- Help parents develop confidence in managing their children's behaviors at home and in public

Service Provider: TFI Family Services, Inc. will provide Grow Nurturing Families utilizing PCIT

Program manual/book/information used in Implementation:

Eyberg, S. & Funderburk, B. (2011) *Parent-Child Interaction Therapy Protocol: 2011.* PCIT International, Inc.

McNeil, C. B. and Hembree-Kigin, T. L. (2011). Parent-Child Interaction Therapy Springer.

Niec L. N (2018). Handbook of Parent-Child Interaction Therapy Springer.

Available in

Northeast Region: Shawnee

Southeast Region: Allen, Anderson, Bourbon, Chautauqua, Cherokee, Coffey, Crawford, Franklin, Labette, Linn, Miami, Montgomery, Neosho, Osage, Wilson and Woodson

Wichita Region: Sedgwick

[5] Source: California Evidence-Based Clearinghouse. https://www.cebc4cw.org/program/parent-child-interaction-therapy/

[6] Source: Title IV-E Prevention Services Clearinghouse https://preventionservices.abtsites.com/programs/105/show

Northwest Region: Riley, Geary
Southwest Region: Finney, Lyon

Approximate Number of Families to be Served: 125

Kinship Navigator Services

Kansas Legal Services Kinship Navigation

Not rated on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse

The target population for this program will be children and youth at risk for out-of-home placement, and their kin caregivers. Services provided include legal advice, representation, mediation services for guardianship, adoptions family law issues and assistance with other legal issues impeding progress to permanency. Kinship caregivers who participate in services can access resources through multiple channels.

Service Provider: Kansas Legal Services

Available: Statewide

Approximate Number of Families to be Served: 200

Parent Skill-Building Services

Family-Centered Treatment (FCT)[7]

Supported on the Title IV-E Prevention Clearinghouse

FCT provides intensive in-home treatment services for youth and families to prevent children being removed from the home, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's physical, mental, emotional and educational well-being through changing family value.

FCT will be offered to families with children 0-17 and crossover youth. Services last an average of 6 months. Specifically, families eligible for this service include those: impacted by trauma, conflict due to abuse and/or neglect, who have environmental stressors which have deteriorated the family's resiliency, whose prior treatment models indicate the client's progress is thwarted by non-involved family members, those with a family member who is hospitalized or in OOH placement, who need intervention due to crisis or the cumulative effect of a family member with chronic physical or mental illness, and those with serious behaviors of a family member which include substance abuse, domestic

[7] Source: California Evidence-Based Clearinghouse. https://www.cebc4cw.org/program/family-centered-treatment/

violence, youth running away or delinquent. Referrals for children who are actively suicidal, homicidal, or psychotic without medication stabilization are not appropriate. However, referrals for a child who is stabilizing/finishing treatment can be accepted. Goals of the program are:

- Enable family stability via preservation of or development of a family placement
- Enable necessary changes in the critical areas of family functioning identified as the underlying causes for the risk of family dissolution
- Bring a reduction in hurtful and harmful behaviors affecting family functioning
- Develop an emotional and functioning balance in the family so the family system can cope effectively with any individual member's intrinsic or unresolvable challenges
- Enable changes in referred client behavior to include family system involvement so changes are not dependent upon the therapist
- Enable discovery and effective use of the intrinsic strengths necessary for sustaining the changes made and enabling stability

Service Provider: Saint Francis Ministries

Program manual/book/information used in Implementation:

Painter WE, Smith MM. (2004). Wheels of Change—Family Centered Specialists Handbook and Training Manual. Richmond, VA: Institute for Family Centered Services.

Wood TJ, (2014) Family Centered Treatment® Design and Implementation Guide. Revised 2018, Charlotte, NC: Family Centered Treatment Foundation Inc.

Family Centered Treatment® is taught to staff through an intensive training and orientation curriculum entitled "Wheels of Change©." This dynamic education program includes tools and resources tailored to various learning styles and clinical backgrounds. In 2008, the Wheels of Change (WOC) training manual was digitalized as part of an interactive online learning platform. Currently, the WOC is maintained by the FCT Foundation and hosted by Mindflash[8].

Available in
Wichita Region: All Counties
Southwest & Northwest Regions: All Counties

Approximate Number of Families to be Served: 500

Family Check-Up

Well Supported on the IV-E Prevention Clearinghouse

The Family Check-Up model is a family-centered intervention that promotes positive family management and addresses child and adolescent adjustment problems. The program serves families with children ages 2-17 years.

The goals of the program are:

- Improve children's social and emotional adjustment by providing assessment- driven support for parents to encourage and support positive parenting, and to reduce coercive conflict

[8] http://www.familycenteredtreatment.org/continuing-education

- Reduce young children's behavior problems at school
- Reduce young children's emotional distress
- Increase young children's self-regulation and school readiness
- Improve parent monitoring in adolescence
- Reduce parent-adolescent conflict
- Reduce adolescent depression
- Reduce antisocial behavior and delinquent activity
- Improve grades and school attendance

Additionally, the Family Mentoring Program is available to any family that is also participating in Family Check-Up:

Family Mentoring Program (NPP)[9]

Does Not Meet Criteria on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse

The Family Mentoring program utilizes the Nurturing Parenting Program (NPP) to educate parents about healthy child development through parenting skills training and comprehensive professional support. A Family Mentor provides in-home visitation, one- one-one parent training, classroom instruction, parent/child intervention and advocacy and support to the parent. Goals of the program are:

- Measurable gains in the individual self-worth of parents and children
- Measurable gains in parental empathy and meeting their own adult needs in healthy ways
- Measurable gains in parental empathy towards meeting the needs of their children
- Utilization of dignified, non-violent disciplinary strategies and practices
- Measurable gains in empowerment of the parents and their children
- Reunification of parents and their children who are in foster care
- High rate of attendance and completion of their program
- Reduction in rates of recidivism of program graduates

Service Provider: Child Advocacy and Parenting Services

Program manual/book/information used in Implementation of Family Check-Up:

Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019). *Family check-up in early childhood: An intervention manual* (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon.

[9] Source: California Evidence-Based Clearinghouse. https://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-school-age-children-5-to-12-years/

Available in

Northwest Region: Saline and Ottawa

Approximate Number of Families to be Served: 60

Fostering Prevention (FSP)

Not Rated on the on the Title IV-E Prevention Clearinghouse
Not Rated on the California Evidence-Based Clearinghouse

Fostering Prevention operates on the Nurturing Parenting Program (NPP) curriculum of a 15- session group-based family-centered program. Parents and their children attend separate groups which meet concurrently. Lessons in the program are based on known parenting behaviors contributing to child maltreatment: Inappropriate parental expectations, parental lack of empathy in meeting the needs of their children, strong believe in the use of corporal punishment, reversing parent-child family roles, and oppressing children's power and independence. Program outcomes as follows:

- Parents experience an increase in family cohesion
- Parents experience an increase in nurturing and safety capabilities

Service Provider: Foster Adopt Connect, Inc.

Available in

Kansas City Region: Johnson and Wyandotte
Southeast Region: Bourbon, Cherokee, Crawford, Labette, Neosho

Approximate Number of Families to be Served: 65

Healthy Families America (HFA)[10]

Well-Supported on the Title IV-E Prevention Clearinghouse

Healthy Families America (HFA) is a home visiting program model designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance use issues. Services are offered to families during pregnancy or at the time of birth of their child and can be provided long term. Goals of the program are:

- Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth
- Cultivate and strengthen nurturing parent-child relationships
- Promote healthy childhood growth and development
- Enhance family functioning by reducing risk and building protective factors

Service Provider: KVC

Available in:

Northeast Region: Marshall, Nemaha, Brown, Doniphan, Pottawatomie, Jackson, Wabaunsee

Approximate Number of Families to be Served: 66

[10] Source: California Evidence-Based Clearinghouse: https://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-prevention-of-child-abuse-and-neglect/

Service Provider: Kansas Children Services League (KCSL)

Available in
Northeast Region: Shawnee, Jefferson
Wichita Region, Kansas City Region, Southeast Region: All counties
Southwest Region: Barton, Stafford, Rice, Reno, McPherson, Marion, Harvey, Chase, Lyon, Pawnee, Rush

Approximate Number of Families to be Served: 160

Program manual/book/information used in Implementation:
All Healthy Families partners will utilize the signature model of Healthy Families America and the protocols for working with families referred from child welfare. The following is currently utilized for implementation:
Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America.

Healthy Families America. (2018). *State/multi-site system central administration standards*. Prevent Child Abuse America.

Parents as Teachers (PAT)

Well-Supported on the Title IV-E Prevention Clearinghouse

Parents as Teachers (PAT) is an early childhood parent education, family support and well-being, and school readiness home visiting model. Parent educators work with parents to aid in assisting caregivers with strengthening protective factors and ensuring young children are healthy, safe, and ready to learn. Goals of the program 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
- Increase children's school readiness and school success

Service Provider: Kansas Association for Parents as Teachers (KPATA) and local Parents as Teachers Affiliates

Program manual/book/information used in Implementation: Program will primarily serve families with children 0-3 years of age utilizing:
Parents as Teachers National Center, Inc. (2016). *Foundational curriculum.*

Periodically the program may serve older children utilizing:

Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.*

Available in: Statewide

Approximate Number of Families to be Served: 90

Other Prevention Services

Community Support Specialist (CSS)

The Community Support Specialist is a multilevel support for families in their county and serves law enforcement agencies and DCF with improved partnership involving early family intervention, follow-up, and assistance.

The CSS can connect the family to community resources for meeting basic needs, locating mental health or disability resources, and can assist with behavioral and educational concerns.

The goal of the Community Specialist (CSS) is to reduce law enforcement/DCF contact and to increase the social and safety network supports helping families become more resilient and functioning to reduce neglect, maltreatment, child abuse, and the risk of child fatalities. Preferably, for the CSS Program to be the step the schools and community agencies utilize before they file a child welfare hotline report when possible. In doing so, this step may be able to strengthen a family before reaching a level where DCF intervention is required and may result in removal of children from their home. This program is designed to resemble the Families First Utah Village Model.

Service Provider: Sedgwick County Sheriff's Office

Available in
Wichita Region: Sedgwick County

Approximate Number of Families to be Served: 40

Parent Advocate Program

The Parent Advocate Program delivers high-quality legal representation and parent advocacy services to families. KLS is using a dyad approach, involving a parent advocate and (if needed) an attorney, to provide services. The parent advocate has either experience working with families or has lived experience pertaining to some of the issues facing families. After a referral is sent to KLS, the parent advocate and family develop a client-centered plan with the family to identify goals and service needs. The parent advocate will provide case management type activities and connect the family to an attorney if any legal guidance or services are needed.

Parent advocates can help families access benefits, support families with truancy issues or other educational supports, provide guidance in situations with lack of supervision, and provide legal assistance to families with housing issues, expungements, protection orders, and other situations involving legal professionals.
The goal of the program is to provide advocacy and legal help to families, and prevent future reports to DCF.

Service Provider: Kansas Legal Services

Available in:
Wichita region: Butler, Cowley, Kingman, Sumner, and Sedgwick counties.
Southwest region: Reno counties.
Kansas City region: Johnson, Leavenworth, Douglas, and Wyandotte counties.

Approximate Number of Families to be Served: 600

Oversight

In addition to the detailed evaluation plan (Section 9) Title IV-E allowable services will be continuously monitored to ensure fidelity to the practice model by the provider and DCF. The Family First Evaluation Team will rely on model-specific accreditation monitoring and provider-based fidelity assurance methods and administrative data to corroborate the quality and fidelity of the service delivery of each intervention. These findings will be included in the evaluation. In addition to the evaluation plan's fidelity monitoring approach, each provider of a well-supported or allowable service has their own fidelity monitoring activities used to refine and improve practices, as outlined below.

Family Centered Treatment (FCT)

Family Centered Treatment will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Services are monitored through video review of specialist sessions with families, weekly staffing in team, tracking dosage and activity completion of each family based on the wheels of change. Additionally, a monthly reporting process developed by the FCT Foundation is utilized to collect data related to dosage, monitoring of progress through the treatment phases, and fidelity to the model. FCT also collects information from families at discharge through a survey process and follows up with families after discharge. Specialists, with family input, complete the Discharge Data Collection form, and information from this form is reported to the Foundation utilizing the Discharge Tracker report.

Information learned from monitoring Family Centered Treatment will be used to refine and improve practices. Family Centered treatment offers a consultant that will assist Program Director and Clinical Supervisor on refining and improving practices through analyzing data for dosage, oversight of training and skills completion of supervisor and specialists.

Family Check-Up (FCU)

Family Check-Up will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. The COACH Provider Assessment Tool (PAT) is the fidelity measure used to assess adherence and competence in the delivery of the Family Check- Up and Everyday Parenting interventions. It is an observational measure of fidelity with five dimensions. The COACH PAT for the Family Check-Up Feedback session and a version for Everyday Parenting sessions overlap significantly, but there are also minor differences between the two forms. Family Check-Up COACH PAT will be used when reviewing Feedback sessions and the Everyday Parenting COACH PAT for Everyday Parenting sessions.

The acronym "COACH" represents the initial letter of each of the five dimensions:

Conceptually accurate in the FCU Model
Observant and responsive to the family context and needs
Actively structures sessions to optimize effectiveness
Carefully teaches and provides corrective feedback
Hope and motivation

Each COACH dimension is rated on a scale from 1 to 9. Scores in the 1–3 range indicate minimal skills and knowledge; 4–6 indicates process skills and conceptual understanding are acceptable; 7–9 indicates mastery of key process skills and concepts. A score of 4 on each domain is considered "threshold" fidelity. COACH scores are predictive of change in parenting practices and child outcomes. The COACH helps supervisors tailor support for providers to advance providers' skill development.

Using the same 9-point scale, providers can also use the COACH to assess parent engagement in the session. Reflecting on how engaged a parent is in session is valuable because parent engagement has been linked to intervention outcomes in the Family Check-Up and Everyday Parenting.

CAPS will have one or more certified on-site Supervisor-Trainers and will maintain our Family Check-Up Supervisor-Trainer certification in good standing. Recertification of each Supervisor- Trainer is completed within 2 years of the last date of certification.

Information learned from monitoring Family Check-Up be used to refine and improve practices. The Supervisor-Trainers use the UO/NPS COACH tool to review recorded sessions completed by provider staff monthly at a minimum. Consistent use of core tools for implementing both components of the model including FCU online questionnaires, Interaction Task materials, Feedback Forms generated on the FCU portal, and tools to support Everyday Parenting sessions will be monitored, all tools can be accessed on the FCU portal. CAPS will conduct annual check-in with NPS to do the following: review program implementation data as applicable and permissible (e.g., number of families served, number of providers using the model, etc.), problem solve as needed to address implementation barriers, engage in planning for Supervisor-Trainer recertification, fidelity assessment, etc. This process ensure adherence to the model and will be used to determine if additional training for staff is needed to improve services and outcomes for families.

Healthy Families America (HFA)

Healthy Families America will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Kansas Department for Children and Families is partnering with two agencies to provide HFA: KVC and Kansas Children and Service League.

Model fidelity is illustrated through a comprehensive accreditation process. Currently, there are over 550 affiliated HFA program sites in the United States and Internationally.

KVC Home Visiting will utilize important documents published by HFA as its comprehensive planning guide for expert guidance and practical tips. These documents offer guidance on model implementation and expectations related to all aspects of policy and practice. Sites implementing HFA commit to providing high quality home visiting services and demonstrate model fidelity through the Quality Assurance and Accreditation process established through national standards. In addition, KVC currently offers a monthly leadership meeting to include staff from around the state whereby model fidelity and implementation, peer record results, and adherence to best practices is assured. For example, the *12-critical element Standards* are integral to the Quality Assurance and Accreditation process. They serve as the site's guide to model

implementation and are structured into 3 steps: completion of a thorough program self-study, a site visit, and final determination on accreditation.

Kansas Children's Service League (KCSL) has been providing Healthy Families services in Kansas since 1996, and in 2017 became an affiliated multi-site system with Healthy Families America. As a multi-site system, KCSL goes through an additional level of accreditation for central administration functions to provide training, quality assurance, technical assistance, evaluation, and administrative functions for the Healthy Families programs within the multi-site system. KCSL contracts with HFA to bring national trainers to Kansas or arranges for staff to travel to other states when necessary to complete required training. The central administration staff at KCSL complete an annual site visit with each program, ensure a random selection of files are reviewed twice each year, and regularly monitor program outcomes and outputs to ensure fidelity to the model. KCSL completed five site visits for re-accreditation in 2019 and expects to receive final approval for renewed accreditation in 2020.

Information learned from monitoring Healthy Families America will be used to refine and improve practices. KVC's Performance and Quality Improvement (PQI) team completes quarterly site visits and facilitation of quarterly Peer Record Review of select cases, and monitors timeliness and completion of programmatic data entry, and adherence to Healthy Families America Best Practice Standards. Quarterly, the PQI department also assesses client and shareholder satisfaction with services. PQI provides detailed information and recommendations on how to enhance client satisfaction with services. PQI has been instrumental in assisting teams to increase consistent application of assessment tools and consistent entry of data crucial to monitoring progress and outcomes.

KCSL's administration team reviews participant files twice each year. They manage the database for all programs and assist with data entry. The administration team provides reports to the programs twice each year to show their compliance with specific HFA standards. They complete an annual evaluation of outcomes and an annual site visit with each program to ensure fidelity to the model. Technical assistance is provided in any area the program may be struggling in.

Annually, the central administration team meets to review reports and feedback from the previous year. This information assists in determining what improvements to policies, forms, procedures, and/or reports are needed. The process for improvement is ongoing as systems are continually reviewed and adjusted to improve effectiveness.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. Staff and stakeholders work together to ensure referred clients are a good fit with the program and problem solve challenging cases. The therapists and clinical supervisor meet monthly with referral sources and other key stakeholders for case review. Pertinent staff are updated on each case and collaborate in the planning process. Case specific and systemic concerns are addressed using the MST analytical process.

MST teams use myEvolv, or a similar electronic case record management system, where therapists record the progress of each case. Client files are the permanent record of services provided and detail a client's progress in the program. Each therapist uploads weekly summaries into myEvolv within 72 hours (about 3 days) of service. The clinical supervisor logs into the system and reviews the summaries. They add feedback and ultimately approve or request an addendum to the case note. The clinical supervisor downloads all summaries from myEvolv and scans them into the System Supervisor for further review and feedback. In addition, MST programs comply with all layers of the MST QA system. As part of MST Quality Assurance Program implementation, information is gathered from caregivers, therapists, and Clinical Supervisors.

Families receiving MST will be asked to answer a few questions about treatment periodically. In addition, therapists will be asked bimonthly, to rate their clinical supervisor. Finally, clinical supervisors report on organizational practices.

In all recently developed MST programs and in most of the mature programs, ratings of therapist adherence are received from caregivers two weeks after the start of treatment and monthly thereafter. The Therapist Adherence Measure Revised (TAM-R) is completed via phone interview through the MST Institute Call Center or by completion of a written TAM-R.

The TAM-R is a validated 28-item tool used to evaluate a therapist's adherence to

the MST model as reported by the primary caregiver of the family. The adherence measure was originally developed as part of a clinical trial on the effectiveness of MST and has proved to have significant value in measuring an MST therapist's adherence to MST. The tool is equally significant in predicting positive outcomes for families who received MST treatment.

Therapists rate their clinical supervisors by completing the Supervisor Adherence Measure (SAM) one month after their first MST supervision session. Ongoing subsequent ratings occur at two-month intervals. The SAM is a 43-item tool designed to measure and evaluate the MST Supervisor's adherence to the MST model of supervision, as reported by MST therapists.

Like the TAM-R, data from the SAMS are entered into a database via an internet-based system. Structure for collection and the Quality Insurance process for monthly SAMS surveys includes:

- The System Supervisor sets the dates for the collection of SAMS.
- The MST clinical supervisor instructs therapists after supervision and consultation to complete SAMS before leaving the office.
- The System Supervisor pulls the SAM report monthly and reviews with each supervisor during their development plan meeting.

Information learned from monitoring Multisystemic Therapy will be used to refine and improve practices. Family Feedback is used to provide feedback to the MST program about how to improve adherence and program outcomes. Performance assessments of staff are primarily based on the employee's understanding of model principles, their ability to comply with the model, achievement of outcome measures, and compliance with agency policies.

Supervisors complete staff supervision plans monthly. These staff plans acknowledge Clinicians strengths during the month, along with any areas of improvements. Monthly staff plans provide data for the quarterly development plans. The development plan reviews the clinician's outcome measures for the quarter based upon model criteria. The development plan includes strengths and areas for improvement. Interventions are put in place for any outcome measures not meeting model requirements. Data from the staff plans and quarterly development plans are an integral part of the annual evaluation. Strengths and weaknesses of the staff and development plan become a part of the annual evaluation. Any issues identified will be addressed through additional training, coaching, modeling, supervision, and/or disciplinary action when necessary. When the formal CAMs evaluation is administered, the employee is aware of their performance up to this point. All evaluations are performance-based and tied directly to the job description, model adherence and outcomes.

Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. TFI Family Services therapists and support workers have a firm understanding of behavioral principles. They are trained in cognitive-behavior therapy, child behavior therapy, and therapy process skills. The PCIT training model requires therapists to complete forty (40) hours of intensive skills training followed by supervised service delivery with two (2) families. This must be completed prior to independent practice. Training requirements for supervisory staff remain consistent in the required 40 hours (about 1 and a half days) of intensive skills training. Supervisor training differs by requiring supervised service delivery to four (4) families prior to independent practice. Clinical fidelity tools for both agencies include observation, videotaping, completing supervision, and consultation with a Master PCIT practitioner. TFI Family Services collaborates with an established Master Training agency.

Information learned from monitoring Parent Child Interaction Therapy will be used to refine and improve practices. TFI Family Services will ensure Therapist are trained and moving toward certification. On-going supervision will occur after certification is completed. TFI will engage and collaborate with the institute related to data or information leading to needs for enhancement to the model. PCIT International is currently working on protocols for adaptations. TFI ensures they will remain aware of updates or changes to the protocols.

Parents as Teachers (PAT)

Parents as Teachers (PAT) will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved. All Kansas State Department for Education (KSDE) Parents as Teachers Affiliates partnering with DCF through Family First Prevention Services will have completed the PAT Quality Endorsement and Improvement Process (QEIP). This process ensures the PAT program is functioning with fidelity to the model.

The degree to which an affiliate accurately implements the PAT model with an emphasis on the Essential Requirements and Quality Standards indicates fidelity to the PAT model. KSDE PAT affiliates must be designed to meet all Essential Requirements. Annually, PAT affiliates must submit data addressing the requirements to PAT National Center, KSDE, and Kansas Parents as Teachers Association.

PAT affiliates achieve success in all 20 Essential Requirements and 75 of the 100 Quality Standards ensure fidelity is achieved through the model and high-quality services are delivered.

Information learned from monitoring Parents as Teachers will be used to refine and improve practices. Data is collected by local program affiliates, KSDE, and PAT National Center. Aggregate data capturing usage of funds, outcome compliance, and families served is collected by the Kansas Parents as Teachers Association (KPATA) in a monthly performance measure report (PMR) and in the annual performance review (APR). These reports include data related to length of visits, number of families served, and cancellations. The report informs and provides program staff with targeted approaches in mitigating challenges affiliates are facing.

As a grantee with a statewide footprint, KPATA utilizes referral trend data to identify geographic areas which may benefit from expanded PAT programs in the coming years. Based on the planned funding strategy of incorporating private donors, grants, and foundations, the data provides support and justification for increased investments in communities who experience a high level of referrals.

Sobriety Treatment and Recovery Teams (START)

START will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved.

DCCCA conducts a fidelity review with our START consultant, through Children and Family Futures, where we review all the essential components of the model and rate how well the agency is doing on each item. Following the review, the team discusses what went well and steps for improvement, if needed. There are monthly meetings with a START consultant where some fidelity measures are reviewed and discussed. Also, there is a START performance monitoring report composed of data from the electronic record used to monitor fidelity and performance. One of the items captured in this report is the PRC intake date and the referral date. The program has requirements for SUD assessment that begin at intake, so it is important to track the timeframe from intake to referral.

Information learned from monitoring START will be used to refine and improve practices. DCCCA conducts monthly meetings with a START consultant through Children and Family Futures. The consultant can share best practices from across the country to aid in learning. DCCCA staff also use the START monitoring report comprised of data from the electronic record. There are specific timeframes that must be met to ensure fidelity to the model. Due to the data from this report, DCCCA refined its referral process for substance use treatment. DCCCA continues to review the data and improve practices as necessary.

DCCCA holds regular START meetings with participation from family preservation and behavioral health. The departments collaborate on START fidelity and outcomes. Barriers are also discussed, and potential solutions are developed. START also collects feedback from families at the end of the intervention through a survey monkey. The program uses this information for practice improvement.

Program Reach to Date

As of the end of State Fiscal Year 2024, Kansas Family First service providers contracted by the Kansas Department for Children and Families received referrals to serve 5,885 families using programs approved under the state prevention plan. These families accessed services across all Family First service domains (Table 2), including a small percentage of families who received more than one type of service. Trends in service reach have remained consistent throughout program implementation. Additionally, services of all types have reached families across every region of the state (Table 3).

Table 2. Family First Service Access by Type (SFY 2020 - 2024)

Service Type Accessed	Referrals, by domain (%)
Mental Health	41%
Parent Skill Building	31%
Kinship Navigation	14%
Substance Use Services	6%
Other Prevention Services	7%
Multiple Service Types	3%

Table 3. Family First Services Accessed by DCF Region (SFY 2020 - 2024), Overall and By Service Domain

Region	Overall N = 5,885	Mental Health N = 2,432	Parent Skill N = 1,810	SUDS N = 362	Kinship N = 848	Other* N = 432
Northwest	16%	15%	21%	16%	7%	NA
Northeast	10%	7%	12%	34%	10%	NA
Southwest	16%	20%	16%	17%	11%	NA
Southeast	15%	14%	12%	11%	29%	NA
Kansas City	19%	20%	18%	1%	15%	NA
Wichita	24%	24%	21%	21%	28%	NA

*Other prevention services are limited state-supported services delivered in targeted communities across the state, including Cowley, Reno, Sedgwick and Wyandotte counties and are not tracked by region

Program Outcomes to Date

Evaluation of this braided prevention service array tailored to the Kansas context has demonstrated outcomes for children and families aligned with the goals of the Family First Prevention Services Act (Table 4). Importantly, the vast majority of target children and youth[11] receiving services under the Family First Prevention Service Act remain safely together at home with their families twelve months from the time of referral.

[11] Target children are candidates for care according to the approved Kansas 2020 – 2024 Prevention plan within the target age range of the referred program.

Table 4. Family First Service Array Outcomes (SFY 2020 - 2024), Overall and By Service Domain

SFY2020-2024 Goal	Overall N = 5,885	Mental Health N = 2,432	Parent Skill N = 1,810	SUDS N = 362	Kinship N = 848	Other N = 432
90% of target children and youth who have reached 12 months from the time-of-service referral remained together at home without need for foster care. *	90%	90%	91%	83%	92%	NA^
95% of families referred to Family First were engaged timely in services (within 2 days).	74%	77%	75%	92%	66%	49%
95% of cases served and closed had successfully completed the referred service.	49%	54%	37%	49%	55%	NA^
Fewer than 10% of target children and youth served have been placed in foster care during Family First program delivery.	5%	5%	3%	10%	4%	2%

* Target children are candidates for care according to the approved Kansas 2020 – 2024 Prevention plan within the target age range of the referred program.

^ Other prevention services are not tracked by DCF and do not report these data

The state Family First service array has consistently met the goal of maintaining 90 percent of target youth within the home, both during active service delivery and over the course of the twelve months following referral. This finding pertains to all services, except substance use services.

Collaboration and co-interpretation of evaluation findings with community partners and lived experts, grantees, and other stakeholders, revealed that permanency outcomes reflect the overall strength of prevention services together with challenges related to the nonlinear process of substance use recovery, the high prevalence of co-occurring needs (e.g., mental health services, concrete economic and family supports, etc.) without adequate additional resources, and the high level of stigma associated with substance use services and the risk of child removal. These findings suggest the need to augment services to better support the complexity of family needs, particularly when substance use is a factor.

Across all service types, programs did not meet the program goals related to timely engagement (i.e., engage 95% of families timely in services within two days) and successful case completion (i.e., close 95% of cases with family having successfully completed the program requirements). Qualitative findings of the local Family First evaluation, informed through co-interpretation with lived experts and service providers, revealed that providers make extraordinary effort to conduct outreach within two days of receiving referrals. However, *engagement* of the family, which does not occur until they make contact,

may be longer than two days depending on family availability and their willingness to engage with the service.

These findings reflect the inherent challenges in community-based services of engaging families experiencing issues that strain their time and resources. It also reflects the limited acceptability of Family First services among families, as currently constructed. The evaluation team has adjusted program aims and outputs in response to this finding to include assessing both *outreach* and *family engagement*. Understanding both metrics, provides a better understanding of acceptability and uptake while ensuring provider accountability to rapid engagement practices.

In terms of successful program completion, approximately half of families across programs (48.8%) successfully complete all aspects of the referred program. This, again, reflects the time constraints, competing priorities, and reality of complex family life. These findings suggest the need to monitor program goals and measures of success related to engagement and successful completion over the course of implementation of new program components, adjusting as necessary to reflect the reality of family contexts.

Assessment of children, youth, and caregivers completing Family First prevention service programs across the array also have shown statistically significant improvement in the areas of child social-emotional health, caregiver sense of competency, caregiver mental health (e.g., depression, anxiety, and stress), and caregiver substance use following completion of Family First services in Kansas. Assessment data were collected from families at the time of program enrollment (Time 1), and at completion (Time 2) by service providers using a battery of validated measures selected to assess program aims. Table 5 details the measures used to assess program impact on family functioning.

Table 5. Assessment Tools Included in Evaluation of Family First Service Array (October 2020 - June 2024)

Assessment Tool	Outcome Measure	Target Pop.	Scoring and Interpretation
Ages & Stages Questionnaire: Social Emotional	Social emotional development (i.e., communication, physical ability, social skills, problem solving	Children 1 month – 5.5 years	• Lower scores indicate more positive outcomes • Cutoff scores (by age) range from 45-70
Strengths & Difficulties Questionnaire	Strengths and difficulties with behaviors, emotions, and relationships	Children 2 – 17 years	• Total difficulty scores range from 0-40 • Lower scores indicate fewer difficulties • Difficulty scores between 19-40 indicate very high difficulty
Parenting Sense of Competency Scale	Skills and confidence in problem solving and feelings of success as a parent	Caregivers of children at any age	• Higher scores indicate greater sense of competence • Scores under 58 may be considered low
Depression, Anxiety, and Stress Scale	Severity of behavioral and emotional symptoms associated with depression, anxiety, and stress	Adults of any age	• Lower scores indicate fewer symptoms • Clinical cutoff for Depression = 10+; Anxiety = 8+; Stress = 15+

Alcohol Use Disorders Identification Test	Risky and harmful alcohol consumption	Adults Youth Caregivers	• Lower scores indicate fewer risks • Scores of 8+ indicate potential hazards

Table 6. details child and caregiver outcomes resulting from this data collection effort. Each measure was administered according to the program aim; thus, sample sizes vary across measures. Of note, positive changes measured by the Ages and Stages Questionnaire: Social Emotional were not statistically significant in alignment with other findings. This finding is attributed, at least in part, to limitations in data collection that impacted the overall sample size and data quality for this tool. Child and youth social emotional well-being was also assessed according to the SDQ. This, and all other measures demonstrated significant improvements across child and caregiver outcomes, as anticipated.

Table 6. Assessment of Child and Caregiver Outcomes, Pre- and Post-Family First Service Completion (October 2020 - February 2024)

	N	Mean	Median	SD	Min	Max
Ages & Stages Questionnaire: Social-Emotional (ASQ:SE-2) (child well-being)						
Time 1	391	24.2	15.0	31.7	0	265
Time 2	391	22.7	20.6	11.7	0	115
Strengths and Difficulties Questionnaire (SDQ) (youth well-being)						
Time 1	888	18.2	18.1	8.6	0	106
Time 2	888	13.8	13.0	6.2	0	35
Parenting Sense of Competency Scale (PSOC) (parenting skill)						
Time 1	1205	64.5	64.0	12.1	29.7	102
Time 2	1205	68.8	69.7	8.3	29.0	96
Depression, Anxiety, & Stress Scale (DASS-21) (caregiver mental health)						
Time 1 Depression	574	4.3	2.0	4.9	0	23
Time 2 Depression	574	1.9	1.0	2.6	0	19
Time 1 Anxiety	574	3.8	2.0	4.4	0	21
Time 2 Anxiety	574	1.8	1.0	2.4	0	15
Time 1 Stress	574	6.5	5.0	5.2	0	21
Time 2 Stress	574	3.7	3.6	3.2	0	20
Alcohol Use Disorders Identification Test (AUDIT) (caregiver alcohol use)						
Time 1	186	2.8	1.0	5.5	0	38
Time 2	186	0.9	0.4	1.6	0	15
Drug Abuse Screening Test (DAST-10) (caregiver drug use)						
Time 1	185	2.6	2.0	2.5	0	10
Time 2	185	1.2	1.0	1.3	0	8

In another analysis of prevention services using Cox regression survival analysis, the evaluation team examined time to removal across prevention service types. The aim of this analysis was to understand the likelihood of removal to foster care for children and youth receiving services across the various state-administered prevention program types – specifically Family First Prevention Service Array as compared to other, established DCF-supported prevention practices (i.e., Family Preservation) in order to establish the array of Family First services as *at least as effective* as other established approaches. It was our expectation that *all prevention services in the array* (e.g., Family First and Family Preservation) would prevent child removal to the foster care system from their unique position in the array.

This analysis used data extracted from the Kansas FACTS data system between October 2019 and March 2023 and examined 14,990 cases receiving Family First or Family Preservation.

Specifically, results of this analysis showed that for families receiving Family First services, the likelihood of remaining together at home, after one-year of receiving services was 97 percent. These families were more likely to remain intact than families receiving other types of prevention services (i.e., Family Preservation) in the short-term (i.e. within one year of service referral) and in the long-term (i.e., within four years of service referral). The statistical significance of the differences in groups may be an artifact of large population-level sample size and/or positionality of the service to the foster care system which may influence chances of child removal from the home. Of importance is that this analysis revealed families receiving either type of prevention programs were likely to remain together safely in the home 12 months from the time of referral at a rate of 92 percent or more. These probabilities did not vary significantly by demographic factors such as gender. Children in the 12+ age group experienced slightly higher risk of removal than other age groups, however permanency rates remained high across subpopulations.

This analysis confirmed that in this sample, families receiving any of the two types of prevention services offered were highly likely to remain together safely at home. Further, families receiving Family First services were as or more likely to stay safely together in the home as families receiving the other established prevention approaches, both in the short and long-term.

Taken all together, these data support the effectiveness of the Kansas Family First service array to date. This array's effectiveness may be further strengthened through the following enhancements identified through mixed method process evaluation and partnership with lived experts.

Rationale for Selected Services

During the Request for Proposal, programs were evaluated, scored and rated by a Grant Peer Review Panel, consisting of representatives from each DCF region and program experts. Peer reviewers evaluated applications to ensure the information presented was reasonable, understandable, measurable and achievable, as well as consistent with program and legislative requirements. Reviewers made recommendations based on many factors such as: existing Family First program array outcomes, underserved populations, strategic priorities, geographic balance, and feedback from their communities.

A variety of data sources and learnings since implementation of Family First were assessed during review of proposals, and all except two programs from the 2020-2024 Prevention Plan were selected to continue their awards by the review team. The budget for prevention services increased by $5.4 million in state general funds for the RFP awards in SFY 24, allowing expansion of individual agencies supporting

families from (11) to (14) programs and allow the state to claim more in federal funding for approved programs. Other notable additions include:

- After success in implementing the intensive mental health program Multisystemic Therapy (MST) in select counties during the initial Prevention Plan, Kansas expanded with a statewide grant.
- (2) new substance use disorder (SUD) programs added, Substance Treatment and Recovery Teams (START), and Strengthening Families, giving each DCF region at least one SUD service.
- Expansion of current parent skill-building programs; Fostering Prevention and Healthy Families America (HFA)
- Continued focus on early childhood parent skill-building programs; Parents as Teachers offered statewide, and Healthy Families America expansion into almost half of the state, providing families more options.
- The inclusion of "Other Primary Prevention Services" in some counties, including the high-quality legal representation/pre-petition parent advocate program and funding for a Community Support Specialist position in the Sedgwick County Sheriff's Office.

Collective Efforts Toward Decreasing the Numbers of Children in Care

As stated in the initial Prevention Plan in 2019 and still true today, prevention continues to be an area of focus and growth for Kansas. Since implementing Family First Prevention Services in 2019, there have been several initiatives that have led to the overall decrease in the number of children in foster care. Figure 4 represent various components which make up Kansas' approach to reducing the need for foster care.

Figure 4: Kansas efforts and approaches to reduce the need for foster care

Reducing the number of children in care by 24% since 2019 (Figure 5) can be attributed to activities, such as implementation of Family First evidence-based prevention programs, implementing the Kansas Practice Model, building community awareness around distinguishing differences between poverty and neglect, and engaging stakeholders in supporting families to prevent foster care, which all lead to better outcomes for children and families.

Figure 5

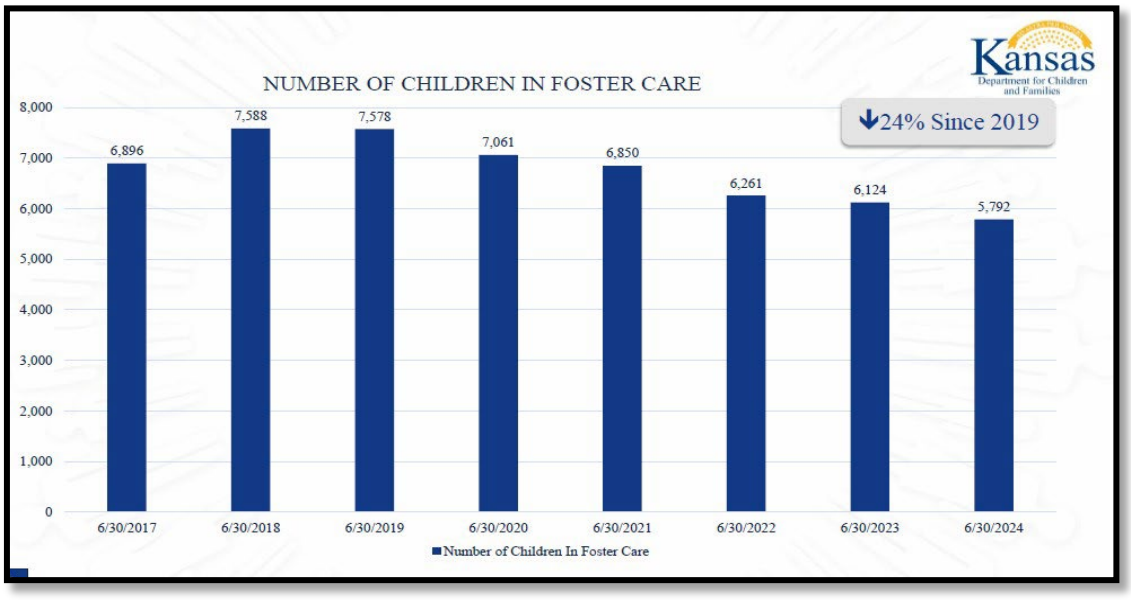
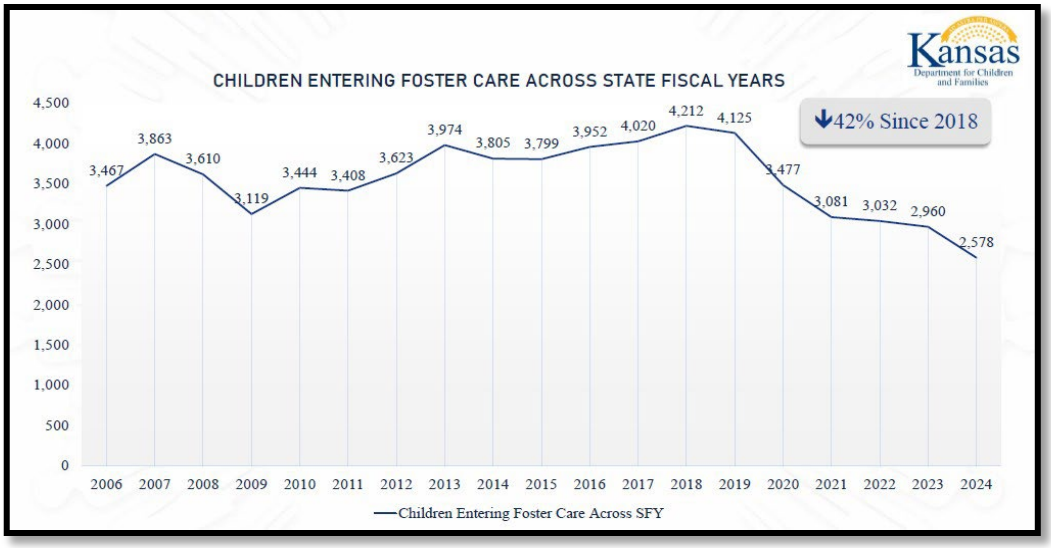


Figure 6 displays the dramatic 42% reduction in children entering foster care since 2018. This graph illustrates how DCF's prevention focused work, partnered with the community engagement activities together help achieve the goals set forth in the initial Prevention Plan. This data validates the collective work that has been done over the past five-years and continues to inspire communities to continue this momentum forward.

Figure 6



Section 3: Evaluation Strategy and Waiver Request *(Section 2 Pre-print)*

Since 2019, Kansas has contracted with an independent evaluator to conduct a well-designed and rigorous evaluation. The KU Center for Public Partnerships and Research conduct evaluations for all Kansas Family First Prevention Service providers and service interventions.

The evaluation plan is guided by a utilization-focused approach that includes three components: (1) needs assessment; (2) process evaluation; and (3) outcomes evaluation. Collectively, these interrelated components, which are guided by the overall Family First logic model, will understand the need, implementation, and outcomes related to the suite of Family First interventions in Kansas. Thus, the evaluation plan will be exploratory (through ongoing examination of child and family well-being and service array alignment in Kansas), formative (by examining outputs and process-oriented success indicators and short-term outcomes) and summative (by examining long-term outcome measures). The primary audience of the evaluation comprises state child welfare administrators, child welfare and community-based child and family service providers, and other stakeholders interested in the prevention of child welfare involvement and well-being of families.

See Section 9 for the detailed Evaluation Plan for Family First Prevention Services.

Kansas is not requesting evaluation waivers for well-supported services. Kansas has a contract with an independent evaluator to conduct a well-designed and rigorous evaluation of all services.

Section 4: Monitoring Child Safety *(Section 3 Pre-print)*

The foundation of the DCF child protection system is the Kansas Protection Report Center (KPRC). KPRC receives reports regarding allegations of abuse and/or neglect statewide, 24 hours per day, and seven days per week, including holidays. KPRC works in a web-based phone service, Amazon Connect, allowing practitioners to receive and answer calls through the computer. KPRC practitioners may receive a report by mail, phone (single toll-free number), fax, or online. A report to DCF begins the initial assessment steps to inform an assignment decision. KPRC utilizes a web-based information system to document reports and decisions for further assessment. KPRC practitioners conduct an initial assessment to determine if the report meets the policy definitions of abuse and neglect under the Revised Kansas Code for Care of Children. Reports meeting criteria for further assessment are assigned with one of the following response types: Abuse/Neglect, Family In Need of Assessment (FINA), and Pregnant Woman using Substances (PWS).

The regional PPS practitioner uses the report, agency systems and web tools to learn the history of the family. This information allows them to understand who the members of the family are, potential collateral contacts and prior services the family may have accessed. The PPS practitioner completes this review to inform the assessment they complete with the family once they make contact.

The regional PPS practitioner contacts the family within the response time at a location where they are most likely located. Based on information from the report, this could mean seeing the child at school, day care, or home. PPS practitioners will meet with adult family members at their residence allowing them to complete an informal home safety and risk assessment and see other children in the home who may or may not be the subject of the report. Depending on the outcome of the assessment, the PPS practitioner

may complete an immediate safety plan with the family. PPS practitioners use assessments and tools customized and integrated in the Kansas Practice Model.

The PPS practitioner uses three column mapping and immediate safety scaling with the family to assess whether immediate danger to the child is present. When danger to the child is indicated the PPS practitioner immediately initiates a safety staffing with the PPS supervisor to discuss information gathered from the assessment. The supervisor assists the PPS practitioner with assessment of safety, identification of the support network, protective factors and potential service needs. If the decision is made to offer Family First Prevention Services, the PPS practitioner and family develop a prevention plan (see Attachment 2, PPS 4311 Family First Prevention Plan and Referral for Services). Services are reviewed with the family and decisions added to the prevention plan. A referral is then made for services within 24 hours of the family acceptance for services. Service referrals are not limited to abuse/neglect assessments; FINA and Pregnant Woman Using Substances case types are also eligible to receive services.

Once a family has been referred to a FFPSA service provider, they are contacted by the provider within 2 business days to review the prevention plan with the family and begin assessment. The PPS practitioner promotes engagement between the provider and family and may attend the initial meeting. Throughout the service period, the PPS practitioner maintains open communication with the provider. If a subsequent report regarding the family comes to the KPRC while the family is working with the provider, the PPS practitioner shares this information with the provider. The provider reviews the information and incorporates it into the work they are doing with the family. In this circumstance, the provider role is not an investigator. The shared information is to inform their assessment and service decisions. The PPS practitioner will assess the family based on the subsequent report.

Throughout the 12 months a family is eligible for Family First services, the PPS practitioner and the Family First service provider complete formal and informal safety assessments of the child at each critical juncture. The PPS practitioner and the service provider work collaboratively to ensure child safety by completing ongoing assessments of the family, home and individual child. PPS maintains an open case and collaborates with the Family First service provider as needed to ensure child safety and risk throughout the life of the open case.

When a family completes a program or service, the PPS practitioner will assess whether the child is still at risk of being placed out-of-home. Depending on the assessment, the child's prevention plan will be updated to reflect service closure with safety and risk mitigated, referral to another service, service extension, or, as a last option, petition for out-of-home placement.

If initially the family refuses to engage with the provider or the family is not making progress, the provider may contact the PPS practitioner to assist with engaging the family in services. After attempts are made to engage the family and they decide to not accept services, the provider requests a referral retraction. The PPS practitioner will assess the current risk and safety concerns and review information from the provider then consult with their supervisor. The supervisor and PPS practitioner decide next steps which may include, reviewing other service options with the family, closing the prevention plan with the family or requesting a Child In Need of Care action from the county or district attorney.

Section 5: Consultation and coordination *(Section 4 Pre-print)*

All aspects of this prevention plan are designed, implemented, evaluated, and refined through close and authentic community engagement, consultation, and coordination. Under the guiding principles of the Kansas Thriving Families approach, Family Council, and the University of Kansas (KU), and the KU Center for Public Partnerships, and DCF aim to create a system of transparent coordination and consistent cross-sector feedback loops, driven by family and community needs and voices. Together, these levers support an effective family support and prevention service array.

This philosophical commitment to collaboration is operationalized in several ways, including DCF prevention-specific investments in and support for: (1) the Kansas Thriving Families core team; (2) the Kansas Interagency and Community Advisory Board; (3) the Kansas Family Council; (4) integration with the KDHE Family Advisory Council; (5) the Intake to Petition Citizen Review Panel; (6) collaborations with tribal partners; (6) sister agency collaborations; and (7) other community collaborations.

Kansas Thriving Families Core Team
The Kansas Thriving Families core team helps shape new directions in family support to promote well-being. These directions are shaped by family, community, and partner recommendations, program and state data, and other factors brought together by members for cross-sector discussion and planning. Emergent ideas are infused in planning efforts by member agencies and disseminated to the field and community to help shape future directions for programs, services, and supports for families.

Kansas Interagency and Community Advisory Board
Integrated cross-sector collaboration driven by Kansas Thriving Families principles is supported by the Interagency and Community Advisory Board (ICAB).

The ICAB is a cross-system multi-agency community collaboration and accountability structure established to support the statewide implementation of the Family First Prevention Services Act. The ICAB's overarching goal is to support and activate a comprehensive service array that spans a broad continuum of care for families by building cross-sector knowledge of gaps, needs, challenges and best practices. Toward this aim, the ICAB leverages data and continuous quality improvement to monitor processes and outcomes and develops action plans and specific recommendations to address service gaps.

The initial ICAB structure consisted of a statewide board and six regional boards representing each of the six child welfare regions in Kansas with feedback loops between regions and between regional and statewide groups. The statewide group was comprised of statewide agencies and service representatives across sectors (e.g. child welfare, corrections, public health, health, early childhood, behavioral health, courts and legal systems, etc.). Regional groups co-led by community and child welfare leaders in each region were comprised of regional stakeholders across child and family serving sectors and Family Council members as lived experts representing the community.

During the course of implementation to date, the ICAB has engaged in learning and cross-sector and regional strategizing on topics of common relevancy related to child and family safety, permanency, and well-being. Through their activities, the ICAB strives to establish and sustain a common understanding of cross-sector priorities, initiatives, and resources.

To date, the ICAB has contributed to some success toward the overarching vision of achieving child and family well-being for all. The Statewide ICAB has elevated critical resource sharing to increase parent

engagement and inform service array, including promoting the statewide parent resource and helpline 1800Children, and its accompanying website 1800childrenks.org to a wide network of stakeholders. ICAB members at the state and regional level engaged in co-interpretation of emergent data from Family First implementation and outcomes evaluation, generating additional insights into program refinement and optimization.

And importantly, in 2022 the ICAB formed a policy workgroup to examine the Family First enabling legislation as it related to the experience of early implementation. This workgroup produced a policy memo with synthesized recommendations for refining the federal and Kansas Family First approach to more closely align with a primary prevention approach.

Policy limitations identified by the ICAB included:

- **Policy Limitation #1 Candidate for Care Determination:** The Title IV-E agency must be the entity to determine if the child is a candidate for care to receive services, limiting access to those willing and able to engage with the state agency. Further, this limitation prevents pregnant mothers without other children living in the home from accessing services. Parents of unborn children have been deemed ineligible for services, yet the federally mandated evidence-based practice clearinghouse offers parent skill building services that serve prenatal populations (e.g. Healthy Families America home visiting).

- **Policy Limitation #2 Open Title IV-E Agency (DCF):** All services provided through Title IV-E-funded FFPSA services require an open case with child protective services for monitoring and oversight, increasing surveillance bias among families experiencing vulnerabilities.

- **Policy Limitation #3 Data Collection & Federal Reporting**: The child welfare agency must report child-specific data to the Department of Health and Human Services for each child receiving services for 24 months (about 2 years), beginning when the child is determined eligible for services, also reflecting an increase in surveillance bias exposure tied to accessing FFPSA prevention services in the community. All children receiving services must have a Unique Child Identifier, which is a record number used across all federal reporting platforms.

In response to these limitations, the ICAB recommended the following:

- **Change the statute language from "candidate for foster care" to "candidate for services".** Language changes, such as moving from "candidate for foster care" to "candidate for services", takes a strengths-based approach. It removes the emphasis on the possibility of the child being separated from their family and places the focus on the family's eligibility to be supported by services.
- **Allow agencies other than the Title IV-E agency to determine if the child is a candidate for services.** Allowing agencies other than the Title IV-E agency to determine if a child is a candidate for services prevents the family's involvement with the Title IV-E agency.
- **Allow direct referral to FFPSA services.** Expanding the law to allow community-based referrals will circumvent the need for Title IV-E agency involvement.
- **Expand evidence-based service options.** Only services housed within the federally created Prevention Services Clearinghouse are approved for use with FFPSA funding. The roll-out of this clearinghouse has been slow, costly, and limiting the number of services available to families. Expanding the clearinghouse to align with existing, rigorously reviewed sources of information such as the California Evidence-Based Clearinghouse would expand service offerings to clinicians and families.

Since the time of these recommendations, interpretation of the Family First Prevention Services Act nationally and locally has shifted, providing opportunity for alignment. The enhancements to the prevention access infrastructure included in this plan are founded in these recommendations. Adoption of these strategies reflects the state's commitment to building a family-driven community-based system of support to optimize child and family well-being.

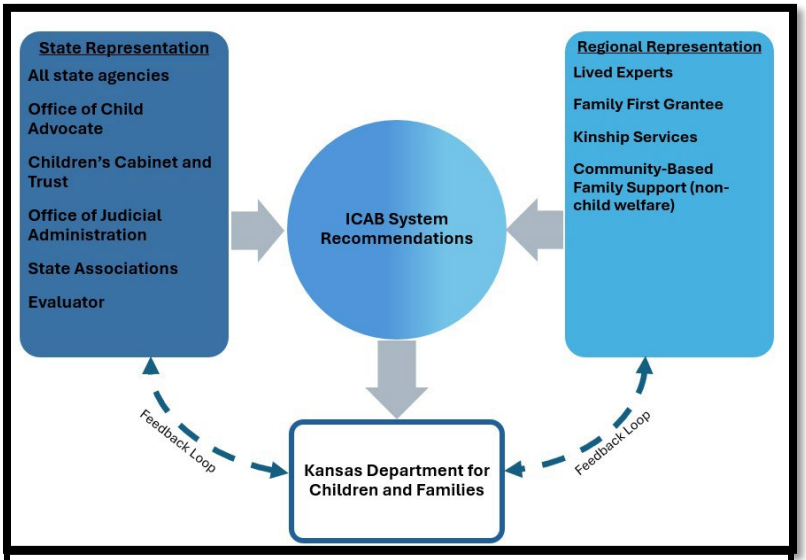


Figure 7: Kansas ICAB structure and feedback loops.

The ICAB structure has undergone an optimization process in response to implementation outcomes. A new structure going forward emphasizes the role of members in co-designing initiatives with DCF and generating innovative solutions for statewide and regional policies. Specific leadership roles are designated within each region to ensure comprehensive representation of sectors and stakeholder views. Importantly, members of the Family Council, lived experts representing the perspectives of families, comprise the largest proportion of the ICAB to ensure community voice is amplified and a driver of system planning.

The structure of the ICAB is illustrated in Figure 7. This advisory board meets quarterly with an agenda driven by co-created priorities guided by the Kansas Thriving Families vision. Topics may be data-driven or may be generated by DCF, the ICAB, the Family Council or other stakeholders. Representatives are responsible for engaging with emergent data and cross-sector topics impacting child safety, permanency, and well-being and generating concrete recommendations for action toward system change supporting children and families. Key takeaways and recommendations generated at the end of each meeting are synthesized by evaluators and provided to DCF for consideration and action after each meeting. DCF is charged with reporting back any resulting action at the following meeting to close the accountability feedback loop.

Kansas Family Council

The Family Council, formed in July 2021, centers and elevates the voices of lived experts in child welfare and prevention services. The overarching purpose of the proposed Family Council is to structurally integrate family and youth voice into Family First and other prevention services to ensure authentic engagement across the spectrum of decision making from system planning and service delivery to evaluation. The primary goal of the Council is to ensure programs, services, and structures are designed with, and not for, children, youth, and families in Kansas, thus accounting for their needs, priorities, and goals.

The Kansas Family Council, comprised of 22 family members with lived expertise navigating child welfare or prevention service systems representing all regions of the state, provides unique perspectives to ensure services are congruent with their family-identified needs and goals, which then informs statewide

decision-making. The central aim of this board is to ensure community accountability to family-driven services.

This board is tasked with:

1. Reviewing and co-interpreting findings from the family perspective and providing recommendations to refine, optimize, and transform services.
2. Informing management of the prevention services service array.
3. Co-developing and recommending agency policy to support children and families.
4. Establishing council priorities for action.
5. Representing the family perspective as regional members of the Interagency and Community Advisory Board.

The Family Council meets in person quarterly, generating key takeaways and formal recommendations, and up to monthly, virtually, to engage in collaborative development and action. Specifically, since its inception, the Family Council has shaped the Kansas Thriving Families Approach, reviewed policy language and new programming proposed by DCF and provided family reflections on language, need, design, and potential impact; and co-designed a new operational definition of holistic well-being that is informing development of a community well-being data dashboard and toolkit.

Following a successful SFY2024 pilot of a policy review process between DCF and the Family Council, the DCF Policy Workgroup collaborated with evaluators to formalize and codify a policy review and co-design process. The jointly developed Family Council/DCF Policy Development and Review form may be used to provide responses to DCF initiated policy changes at DCF's request. It may also be used by the Council or other members of the community to identify and recommend policy changes to the DCF policy workgroup. This process formalizes co-development, formally integrating the Family Council into the DCF policy development and review workflow. This is a key feature of the Kansas approach to consultation and coordination, ensuring family voice is the bedrock of our system.

Of note, and further demonstrating the deep commitment to family-driven system transformation, the Family Council members are the primary drivers of this prevention plan – working closely with agency and evaluation partners to craft the vision for the services and prevention infrastructure necessary to support achieving holistic family well-being.

The Family Council has made suggestions for future enhancements to our Kansas Prevention Plan to include a community pathway for referral and the other following ideas:

- **Intensive Care Coordination Using Fidelity Wraparound for community access hubs-** A family-driven, strengths-based, team approach to coordinating a set of identified supports and services. Wraparound uniquely engages the family, friends, and other care providers to support the family in a jointly developed care plan designed to meet the specific needs of the child and family. Adding wraparound as a service to augment support in cases where more intensive case coordination across systems and community service providers may be required will ensure providers meet holistic family need and further work to mitigate emergent family crises in the community.
- **Peer-support** - Identified as a critical service array need by the Family Council for promoting family success in engaging and completing community-based prevention services. Adding a formal model of peer support to the prevention service array will further engage and leverage lived experts to support families, deepening the types and quality of community and family engagement harnessed by FRCs to deliver family-centered support.

- **Further investments in concrete supports for families** - including economic assistance for addressing housing instability, food insecurity, childcare, transportation, and other basic needs. Investing in concrete support for families is crucial for fostering safe, stable, and nurturing environments and preventing the need for foster care.

KDHE Family Advisory Council

The Family Advisory Council (FAC), supported by the Kansas Department of Health and Environment Bureau of Family Health, comprises families, lived experts, and community members invested in informing maternal and child health programs and services and driving positive systems change. The purpose of the FAC is to partner with and inform Title V Maternal and Child Health Services Block Grant. One of the Family First Family Council members also participates in the FAC to build connections across prevention services and to align efforts between public health and child welfare.

Intake to Petition Citizen Review Panel

The Kansas Citizen Review Panel – Intake to Petition (ITP) is one of three Citizen Review Panels (CRPs) in Kansas. The CRP-ITP is a body comprised of members from private and public agencies, law enforcement, attorneys, judges, social workers, and community members committed to child protection in Kansas. The Kansas CRP-ITP also serves as Kansas' Children's Justice Act Task Force, as required under federal Section 107 of CAPTA. This enables a state agency to receive funding from the Department of Justice – Office of Victims of Crime, and oversees grant funds used to improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect. The work of this task force includes gathering input from members of the community, creating a network of community-engaged partners across the state, and recommending actions to improve the state child protective services system from the point of intake of a child into care to the point a petition is filed. The Task Force meets quarterly and collaborates annually with the other two Citizen Review Panels, providing an opportunity for understanding comprehensive goal achievement and strategic joint goal development. This taskforce includes advisory members who bring added perspective, specifically representatives from executive branch agencies with whom collaboration is essential for system-wide improvement.

Tribal Collaborations

Building upon the engagement described in this section, future collaboration efforts will include DCF strengthening of partnerships with Kansas child welfare leaders among the recognized indigenous tribes, specific to prevention efforts. Four federally recognized tribes have lands in Kansas. They are the Iowa Tribe of Kansas and Nebraska, Kickapoo Tribe in Kansas, Prairie Band Potawatomi Nation and Sac and Fox of Missouri in Kansas and Nebraska. State and tribal child welfare leaders have a long history of collaboration and coordination of services to serve Indigenous families with respect for tribal sovereignty and with cultural humility. The aim of this collaboration is to support reciprocal coordinated prevention planning and shared learnings across jurisdictions. Streamlining programming across local jurisdictions and engaging in ongoing thought partnership related to prevention will strengthen cross-system efforts for all children living on this land.

Currently, if a tribal social services representative works with a family and identifies a program in the Kansas Prevention Service Track, they believe would help prevent foster care, the process is explained as such:

1) Tribal social services representative will call Kansas Protection Report Center (KPRC) and relay the following information to the intake specialist: (1) which service they have identified, (2) what

is the specific concern for the family, is it related to the child's behavior problem, and/or is it related to the caregiver's inability to provide care to the child.
2) DCF Practitioner will contact the tribal social services representative to coordinate services. The DCF practitioner will complete the prevention plan, if applicable.
3) The family will receive services by the state's grantee or contractor who will coordinate and communicate with both the tribal social services director and DCF

Existing policies and procedures for accessing services will be applied.

Tribal partners have shared feedback with DCF that the current design of connecting families to Family First services through a KPRC hotline is not a process they feel comfortable with. They worry their trust with families will suffer if they need to "hotline" to access services.

Other Collaborations

DCF Family First Liaison Workgroup
The statewide DCF Family First liaisons, meet at least quarterly to discuss the program process, review policy, and agency vision and culture. The workgroup focuses on improving statewide capacity and utilization of FFPSA programming and each EBP model within the program, promoting the program's best practices, and enhancing DCF's collaboration and coordination with the providers and community-based services. The group comprises FFPSA Liaisons, their supervisors, and is hosted by the prevention team. This group is a contributing partner in the co-design and review of policy. The intention is to keep communication open, collaborate, and share in mutual learning of Family First.

Statewide Kansas Kinship Advisory Board Meeting
Operating under the guidance of the Ministry of Kansas Family Advisory Network (KFAN), in close partnership with DCF. Comprising KFAN staff, representatives from DCF, and various community partners, the board convenes virtual meetings monthly. The advisory board aims to foster collaboration and synergy among Kansas kinship programs, community partners, and DCF, to elevate the level of support provided to kinship families. This objective is realized through a commitment to keeping board members well-informed on the latest resources and services available to families in need to help remain at the forefront of advancements and innovations in kinship care support. Each month, a board member will showcase their organization, providing an overview and addressing any inquiries from the advisory board. The Kinship Program Manager at KFAN consistently extends invitations to local and national speakers, who share insights about their resources, services, and insight pertinent to kinship care. Members of the Statewide Kansas Kinship Navigator Advisory Board include DCF, Saint Francis Ministries (SFM), KVC Health Systems (KVC), TFI Family Services (TFI), Foster Adopt Connect (FAC), CAK, Safe Families, Stand Together Foundation, CarePortal, Unite Us, CASA, CALM, Families Together (FT) Inc., Kansas Community Health Workers, and KDHE.

Section 6: Child welfare workforce training and support *(Section 5 & 6 Pre-print)*

DCF continues with requirement changes adopted in May 2018 related to allowing hiring of Child Protection Specialists (CPS), also referred to as PPS Practitioners, with a four-year degree in a Human Services or Behavioral Sciences field of study. These changes have made it possible to decrease significant staff shortages experienced within the Kansas child welfare system.

Initial Staff Training for DCF staff- Required by all DCF PPS Staff, initial training requirements must be completed prior to being assigned assessments or within 90 or 180 days of hire depending on the course. All new hires or current staff who transition to the unlicensed CPS positions are required to complete the DCF PPS Academy prior to carrying a caseload. New PPS Academy Training groups are scheduled as needed based on hiring patterns. The first face-to-face course is Investigation and Assessment, which concentrates on topics related to safety, such as abuse/neglect definitions, policies and procedure related to the investigation and assessment, engagement, and documentation. The second face-to-face course focuses on various topics related to ethics, confidentiality, documentation, interviewing, critical thinking, decision making, the assessment process, testifying in court, ICWA/ICPC/MEPA, worker safety, and mandated reporting.

Each of the Pre-Service workshops are led by Learning and Development Specialists (L&D Specialists). The Kansas Practice Model Overview workshop is led by L&D Specialists and sometimes other DCF staff who have completed, or are in the process of completing, the Kansas Practice Model Trainer Certification process. The Kansas Practice Model is discussed further in this section.

PPS practitioners and case management providers for Family Preservation and Foster Care services attend the Kansas Child Welfare Professional Training Program (KCWPTP) Caseworker Core Modules. The modules provide ongoing in-service trainings to ensure Kansas child welfare practitioners are equipped with the tools they need to effectively provide service to children and families in Kansas and satisfy continuing education requirements. Topics include utilizing a family-centered approach, engagement and rapport building with families, legal aspects in child welfare, assessment and safety planning, exploring fact finding principles common to all child welfare cases, case planning, child development implications, and separation, placement and reunification in family-centered child protective services. Staff from the different agencies, including tribal and military partners, are encouraged to take advantage of training opportunities, including trauma-informed care with children and families.

The Kansas Protection Report Center (KPRC) Intake Specialist Training- KPRC serves as the origin for contact with the Department for Children and Families. Community partners and families need to be assured the information provided is used to determine next steps concerning allegations of abuse and neglect. Early interventions can prevent further maltreatment and are important to provide families tools and resources they need to raise their children in healthy, nurturing homes free from abuse and neglect. In January of 2024, KPRC transitioned to the Kansas Intake Tool which ensures a more balanced assessment by applying the strengths and protective factors into decision making. Additionally, the tool aligns with the Kansas Practice Model.

Kansas Practice Model- In 2019, Kansas implemented the Kansas Practice Model (KPM). KPM provides a consistent and customized framework to support engagement, safety planning, and decision-making to guide work alongside families. Using family voice and practice approaches, practitioners connect families with needed services which support safety and well-being. A short video was developed for families and community partners to learn about KPM: https://vimeo.com/735551766. DCF offers ongoing KPM learning opportunities through various courses. In addition, DCF focuses on learning through Group Learning Consultations that are facilitated by KPM Learning Leaders in the agency

KPM integrates aspects and tools from multiple practice approaches with promising evidence research and best practices for working with families. These specific approaches include Team Decision Making (TDM), Family Finding, Signs of Safety (SOS), Structured Decision Making (SDM), Solutions Focused Questions, and the Resolutions Approach. The KPM provides a consistent and customized framework to support engagement, safety planning, and decision-making to front line practitioners in child protection, who work alongside families, caregivers, and community members to help build a network of safety and support for the child and adults who care for them. Several tools are used in the assessment and planning

process, and they are grounded in principles and approaches linked to better engagement, equity, inclusivity, and outcomes for children and families.

The practice model also emphasizes the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the importance and priority of kinship placement in the event a child cannot safely remain in the home. See Attachment 1 for the Kansas Practice Model explainer.

Kansas PPS practitioners currently use the immediate safety scale to document immediate safety of the children and the rationale. The lasting safety scale is used to document the lasting safety of the children and the rationale. The PPS 2020 Assessment map is the tool PPS Practitioners use to document and analyze the family risk assessment. See Attachment 4 for the PPS 2020.

Family First Training for PPS Practitioners – Since implementation, prevention services have been incorporated into new employee training. Additional resources are provided to regional practitioners for specific evidence-based services, included in Kansas' Title IV-E Prevention Plan, to help workers understand the service target population, needs the service addresses, and availability. Family First service providers work directly with regional DCF staff to build awareness and provide education about their services, target population, and program outcomes. Emphasis is given to incorporating the assessed needs into the written prevention plan in a way which identifies strategies making it safe for the child to remain safely at home or with kin caregiver and connecting to appropriate evidence-based trauma-informed services and programs.

Supporting a skilled workforce and training enhancements

The agency continues to build a Learning and Development Team to create a safe place to learn, practice and reflect together as an embedded part of everyday business. This goal is supported by practitioners from across the state who are certified to lead initial pre-service PPS Academy, small group facilitators to lead online/blended curriculum, and learning leaders who develop expertise in leading internal group learning and consultation sessions, conduct Appreciative Inquiry interviews and offer mini workshops. These practices continue to embed ongoing learning and honor Child Protection Specialist work through the Appreciative Inquiry interviews and give Child Protection Specialist the skills to use this tool with families they work with.

From No one to Network- DCF collaborated with the Academy for Professional Excellence to adapt three of their courses for Kansas. These courses are now available in the DCF Learning Management System. Adapted for Kansas, this microlearning is designed to show child welfare workers how to talk with parents and families to identify and build networks of support, using tools like genograms and scripts for connecting with relatives or non-related kin to engage their support for family members. Useful Resources include great questions that can be used to locate and identify additional relatives or non-related kin supports, developed by Kevin Campbell and Andrew Turnell. Pre-requisite for Family Seeing: Family Finding from the Start.

Introducing LGBTQIA + youth- Adapted for Kansas, this microlearning teaches child welfare workers about their role when working with LGBTQIA+ youth and how they can best engage and provide support for these youth. Resources are provided for youth, family members and professionals. This course is the pre-requisite for the DCF-developed LGBTQIA workshop.

Recognizing Child abuse - The purpose of this training will help educate frontline Child Welfare Practitioners on child abuse and practitioners will be better equipped to recognize the subtle signs of child maltreatment as compared to accidental injuries. Several subsections of child maltreatment will be discussed, including bruising, burns, head injuries and abdominal trauma. CARE legislation and ways to document injuries in a written format and capturing through photos; giving practitioners ways to use these

tools in child welfare. This training is in partnership with Children's Mercy Hospital (CMH) and Kansas University Medical Center (KUMC) to host two sessions a year.

Collaboration with Kansas Coalition Against Sexual and Domestic Violence (KCSDV)- DCF and KCSDV have been collaborating to provide training addressing domestic violence in child welfare on a regular basis since January 2021. Two core and two advanced trainings for child welfare professionals are offered each spring and fall with additional trainings and webinars being offered throughout the year. The audience includes Child Welfare Professionals, including DCF Staff, Reintegration and Family Preservation Case Managers and Family Support Workers; Social Workers; Mental Health Professionals; Foster Home, Kinship, and Adoption Workers; CASAs; and Domestic and Sexual Violence Advocates. Kin/relative, foster, and adoptive families are also welcome and encouraged to attend. The core training content focuses on getting to know the family including identifying risk and dangerousness factors of batterers, understanding the safety and protective actions of the non-abusive parent, and supporting the parent/child bond between children and non-abusive parents. During the advanced training, participants practice strategies and skills to document batterer tactics and accountability, as well as the safety and protective actions of the non-abusive parent. Participants also learn how to identify interventions appropriate for families experiencing domestic violence and interventions that are not recommended. A PDF copy of the *Domestic Violence Manual for Child Welfare Professionals* is provided to all participants and utilized as a training tool during each training. In addition to training, KCSDV project staff participate in collaboration building opportunities including working groups, meetings with DCF staff and other child welfare professionals, and ongoing state committee meetings, including the Supreme Court Task Force on Permanency Planning and the Family First/ KS Strong Statewide Interagency and Community Advisory Board.

Safe Sleep Instructor Training- In fiscal year 2024, seven (7) employees from DCF attended the Safe Sleep Certification Training, provided by The Kansas Infant Death and SIDS Network (KIDS), to become certified Safe Sleep Instructors (SSI). This brings the total number of active SSIs at DCF to thirty (30).

The goal of the certification process is to educate instructors on SIDS and other causes of sleep-related infant death, the recommendations of the American Academy of Pediatrics (AAP), and how to address challenges to implementing safe sleep (such as cultural standards and mental health issues). During the certification process, SSIs are also equipped with information on the following topics:

- Presenting Safe Sleep Community Outreach and Professional Trainings, including Wrestling with Safe Sleep,
- Presenting Community Outreach Trainings,
- Facilitating Community Baby Showers/Crib Clinics,
- Obtaining safe sleep resources, as well as
- Access to a database that allows collaboration with other SSIs within and outside of DCF.

The agency goal is to train all DCF staff in safe sleep practices, partner with other community agencies to host Community Baby Showers and provide Crib Clinic sessions to families served by the agency. In the next five years, the agency plans to hold at least four Wrestling with Safe Sleep sessions a year. Families receiving DCF services in need of additional resources may be eligible to receive free bassinettes, wearable blankets, and/or other supplies to provide safe sleep environments for their infants. By increasing the number of DCF staff who are trained on safe sleep recommendations, staff in various positions can engage and equip families with informative resources regarding safe sleep practices, thereby increasing the community's capacity to prevent the sleep-related deaths of infants in Kansas.

Kansas Strong for Children and Families -The University of Kansas School of Social Welfare (KUSSW) and its partners, the Kansas Department for Children and Families and the state's network of

privatized providers of adoption and foster care in concert with the Court Improvement Program (CIP), are currently in the planning period of a federal five-year grant to develop and deliver Kansas Strong for Children and Families (KS Strong). Kansas Strong is a cooperative agreement between KUSSW and the U.S. Department of Health and Human Services, administration for Children and Families, Children's Bureau. Kansas is one of five grantees nationally aimed at strengthening child welfare systems to improve outcomes for children and families.

A goal of the project is to implement KanCoach, a coaching program for public and private supervisors across child welfare programs to address basic social work practices in four areas: parent and youth engagement; risk and safety assessment; relative/kin connections; and concurrent planning. Plans include training and implementing coaching for supervisors and developing a comprehensive set of methods and tools for supervisors to deliver coaching to frontline workers. Since October 2023, KanCoach began delivering coaching through the Children's Alliance.

KanCoach promotes shared principles across the child welfare system on safety and risk, assessment, and case planning:

1. Children should be maintained safely in their homes when possible.
2. Children should be safe when they reside in kinship, foster, or adoptive homes or in congregate care.
3. When a report concerning child safety staff will make a timely safety and risk assessment.
    a. Factors to consider when assessing for safety include (but are not limited to):
        i. Severity of harm to the child
        ii. Imminent danger
        iii. Child vulnerability
        iv. Caregiver protective capacity
    b. Factors to consider when assessing for risk include (but are not limited to):
        i. Parent or caregiver factors
        ii. Family factors
        iii. Child factors
        iv. Environmental factors
4. Information obtained during safety and risk assessments should inform the case planning process.

Family First Workforce Support and Training- Family First Title IV-E evidence-based programs are provided by qualified staff. The selected services each have their own training requirements and staff qualifications specific to their model. DCF requires all providers working with families to uphold staffing and training requirements specified by each model to meet fidelity of the program, more information included in Section 2: Service Description and Oversight. Providers will be required to meet prescribed staffing ratio or needs to serve the desired population of impact with information on duration of service, number of classes or number of contacts or engagement session as applicable to the program.

Section 7: Prevention caseloads *(Section 7 Pre-print)*

Reported in the 2025 approved Child and Family Services Plan, DCF believes "A Strong Workforce with a Strong Organization leads to Strong Outcomes." The agency began rebuilding the workforce in State Fiscal Year 2019. Recruitment and retention efforts and analyzing and building on strategies over the past five years to modernize and enhance the employee experience have all been on the forefront.

In SFY 2024, DCF saw success in the following strategies which relate to maintaining manageable caseloads.

1. Decrease in agency vacancy rates. However, thus far in SFY 24 Kansas has seen an increase in vacancy rates in PPS staff statewide on average.

Date	Vacancy Rate
April SFY 2022	18.53%
March SFY 2023	13.9%
May SFY 2024	20.3%

2. Decrease in CPS practitioner case load sizes. February 2023, a CPS practitioner had an average caseload of 16.2. Reported caseload size in February 2024 decreased to 14.4.
3. Decrease in staff to supervisor ratio. February 2023, the CPS staff to supervisor ratio was 3.3. Reported staff to supervisor ratio in February 2024 is 3.2.

DCF Assessment and Investigation caseloads are monitored and reported monthly to demonstrate trends and complement weekly tracking of retained and vacant positions. Attributes of full staffing levels, maintenance of workload standards and increased supervisor ratios improves assessment decisions and the bridge for families to the appropriate dose and scope of service.

DCF management and monitoring of the grant referral programs is a blend of two methods for the family's time limited period of 12 months. PPS practitioners may maintain a family within their assigned caseload for up to 45 working days as the assessment is completed or concluded. For families whose prevention service extends past the 45 workdays of assessment or conclusion date (whichever comes first), the family's prevention plan program will be monitored by a DCF referred Family First service, a designated PPS practitioner or program consultant position within the region who has a dedicated liaison monitoring caseload of up to 25 referrals (families) of Family First or Family Preservation;

The Family First programs will perform such duties as receiving the Plan of Safe Care and other update or process documents related to the program emphasis, assure start end dates of service and other data elements are accurate in reporting systems, serve as connection for any changes in service status and may evolve to liaison with the prevention Grant Evaluator as needed or appropriate.

Prevention caseload or workload size within Family Fist prevention program providers is consistent with their evidence-based model program delivery, intensity and service setting. The grant agreement with DCF sets forth the provider's responsibility to manage caseload size in manner consistent with the model approach. Model fidelity, drive time, intensity of service based on family progress, and other factors are considered to determine a caseload. Service providers coordinate with DCF regional and administrative staff to determine frequency and pace of referrals based on family presenting situation, candidate for care determination and program intervention population focus and program capacity.

Title IV-E allowable Family First Program	# of cases assigned to caseworker,
Sobriety Treatment and Recovery Teams (START)	Maximum 12 cases
Multisystemic Therapy (MST)	Maximum 6 cases, goal of 5
Parent Child Interaction Therapy (PCIT)	Maximum 14 cases
Family Centered Treatment (FCT)	Maximum 5 cases
Family Check-up (FCU)	Maximum 24 cases
Healthy Families America (HFA)	Maximum 15 cases, goal of 10
Parents as Teachers (PAT)	Maximum 19 cases

Section 8: Assurance on prevention program reporting *(Section 8 Pre-print)*

The Title IV-E Prevention Program Reporting Assurance in Appendix 1, Attachment B.1, reflects Kansas' commitment to comply with all reporting requirements set forth by the Children's Bureau.

Section 9: Family First Evaluation Plan

This evaluation is led by the University of Kansas Center for Public Policy and Research.

Interventions

Below are the interventions being implemented for Kansas' Family First Prevention Services.

1. Family Centered Treatment (FCT)
2. Family Check-Up (FCU); offered with optional Family Mentoring (NPP) component add-on available
3. Healthy Families America (HFA)
4. Kids2Kin Legal Services (KLS-K2K)
5. Parent Advocacy Program (KLS-PAP)
6. Multisystemic Therapy (MST)
7. Nurturing Parenting Program (NPP) includes Fostering Prevention and the Family Mentor Program optional add-on available with Family Check-Up
8. Parents as Teachers (PAT)
9. Parent Child Assistance Program (PCAP)
10. Parent Child Interaction Therapy (PCIT) includes Grow Nurturing Families
11. Seeking Safety (SS)
12. Sobriety Treatment and Recovery Teams (START)
13. Strengthening Families Program (SFP)
14. Community Support Specialist Program (CSSP)

For a description of each intervention please refer to Section 2: Service Description and Oversight within the Kansas Prevention Plan.

Target Populations

For a description of the target populations for each intervention please refer to Section 2: Service Description and Oversight within the Kansas Prevention Plan.

Evaluation Goals and Rationale

The evaluation plan is guided by a utilization-focused approach that includes three components: (1) needs assessment; (2) process evaluation; and (3) outcomes evaluation. Collectively, these interrelated components, which are guided by the overall Family First logic model, will understand the need, implementation, and outcomes related to the suite of Family First interventions in Kansas. Thus, the evaluation plan will be exploratory (through ongoing examination of child and family well-being and service array alignment in Kansas), formative (by examining outputs and process-oriented success

indicators and short-term outcomes) and summative (by examining long-term outcome measures). The primary audience of the evaluation comprises state child welfare administrators, child welfare and community-based child and family service providers, and other stakeholders interested in the prevention of child welfare involvement and the well-being of families.

Research Questions

The proposed research questions for ongoing evaluation of the Kansas Family First initiative align directly to the activities, outputs, and outcomes detailed in the overall logic model. The research questions, which are categorized into several broad categories, are provided in Table 1. By addressing these questions, the evaluation will provide data needed to understand the implementation of prevention services, including Family First Prevention Services, in Kansas and whether intended outcomes are achieved.

Table 1. Kansas Prevention Plan Research Questions

Evaluation Component	Research Question	Data
Ongoing Assessment of Community Need	1. What is the scope of the need for prevention services in Kansas, by type? 2. Is the use of prevention service proportional to need? By population? 3. How does family well-being change over time in the Kansas population? 4. What gaps and opportunities exist for aligning the service array to population need? 5. What are the population level views of DCF, community help-seeking, and prevention services?	Annual pop-level Family Well-Being Survey Program outputs Prevention Framework Story/Survey Public health data
Process Evaluation	1. To what extent did Family First interventions achieve service delivery success indicators of: a. Outreaching to families timely following referral b. Engaging Families timely c. Successful service completion	DCF admin data
	2. What program elements support or detract from participant success?	Qualitative interviews/focus groups with families who completed services
	3. To what extent did program uptake and completion vary depending on referral pathway (i.e., community access point versus KPRC access)?	DCF admin data Qualitative interviews and focus group
Outcomes Evaluation	1. How much did the Kansas prevention service array improve the child permanency outcome of keeping children safely at home during service delivery? Within 12-months of referral?	DCF admin data

	2. How much did racial disproportionality in child welfare abuse, neglect reporting and removal from the home change over time in relation to prevention service implementation?	DCF admin data
	3. To what extent did the Kansas prevention service array impact family well-being across social determinants of health domains?	Annual pop- level Family Well-Being Survey
		Prevention Framework Story/Survey

Theory of Change

The Family First Prevention Services Act was responsive to a substantial growth in the foster care population nationally, which was also evident in Kansas at the time of its passage. The number of children in the Kansas foster care system had risen dramatically with an all-time high of 7,558 in SFY2020. Since that time, Kansas has seen a steady decline in the foster care population more substantial than the change in population. At the end of SFY2024, there were 6,036 children and youth in out of home foster care. This is the lowest number of kids in care since 2014. This improvement in maintaining children and youth safely at home with their families cannot be attributed to any one initiative, but rather is the result of a comprehensive statewide commitment to and investment in child, family, and community well-being.

In 2021, Kansas joined the national Thriving Families, Safer Children: A National Commitment to Well-Being initiative supported by national partners Administration for Children and Families Children's Bureau, Annie E. Casey Foundation, Casey Family Programs, Prevent Child Abuse America, and the Centers for Disease Control.

Kansas was selected to participate in round two of this initiative, which supports the state's ongoing work to transform the child welfare system into one focused on child and family well-being, demonstrating our strong commitment to fundamentally rethinking child welfare. DCF co-leads Kansas Thriving Families efforts along with a core team comprising the Kansas Children's Cabinet and Trust Fund, KCSL, Kansas State Department of Education, Kansas Department of Health and Environment, the University of Kansas, and individuals with lived expertise with the child welfare or prevention services system. The aim of this collaborative movement is to reimagine the child welfare system in Kansas. Like the national approach, Kansas Thriving Families serves as a movement and commitment of the state toward building a system of child and family well-being.

Kansas Thriving Families, Safer Children's vision – that every child deserves a family; that every family deserves to live in a safe, supportive community – drives collaborative cross-sector action to create a flourishing future for our state. Kansas must actively pursue an agenda that maximizes every opportunity for a child's experiences to be positive, nurturing, and safe. Kansas Thriving Families vision is built upon the theory that when families have seamless, universal access to a continuum of comprehensive prevention services, child maltreatment is prevented, and the well-being, safety, and stability of children and families is ensured. As part of this work, Kansas is committed to combatting, ameliorating, and preventing racial inequity and to promoting equity, access, inclusion, and engagement.

The state's priorities for the Kansas Thriving Families movement are to:

1. Address systemic barriers to create a well-being system in Kansas.
2. Develop robust networks of community based primary prevention supports.
3. Integrate family/youth/community expertise into design, operation, and improvement of well-being systems.
4. Revise definitions of neglect and mandatory reporting that clearly differentiate maltreatment from poverty.
5. Align with Maternal Child Health and other public health initiatives that strengthen and support children and families.

This prevention plan and associated evaluation reflect these core priorities.

Through Kansas Thriving Family efforts we have instituted policy and systemic reforms at the state level, including refinements integrated in this prevention plan, that support the well-being of children and families without the need for foster care.

The Kansas commitment to family well-being is further demonstrated through our significant state investments in prevention infrastructure and supports not currently reimbursable under the Title IV-E Prevention Plan criteria. These investments include: (1) early adoption of Family First and ongoing optimization and transformation in response to stakeholder perspectives and recommendations; (2) support for unrated Family First programs meeting needs identified by the community; (3) introduction of Family Resource Centers as community-facing support hubs; (4) commitment of state funds to support community-based prevention approaches targeting two generations; and (4) and engagement in the National Family Support Network.

Our goal moving forward is to capitalize on this commitment, investments, and the early wins in prevention to further strengthen the prevention service array with the infrastructure necessary to reach all families needing additional support to thrive safely together at home.

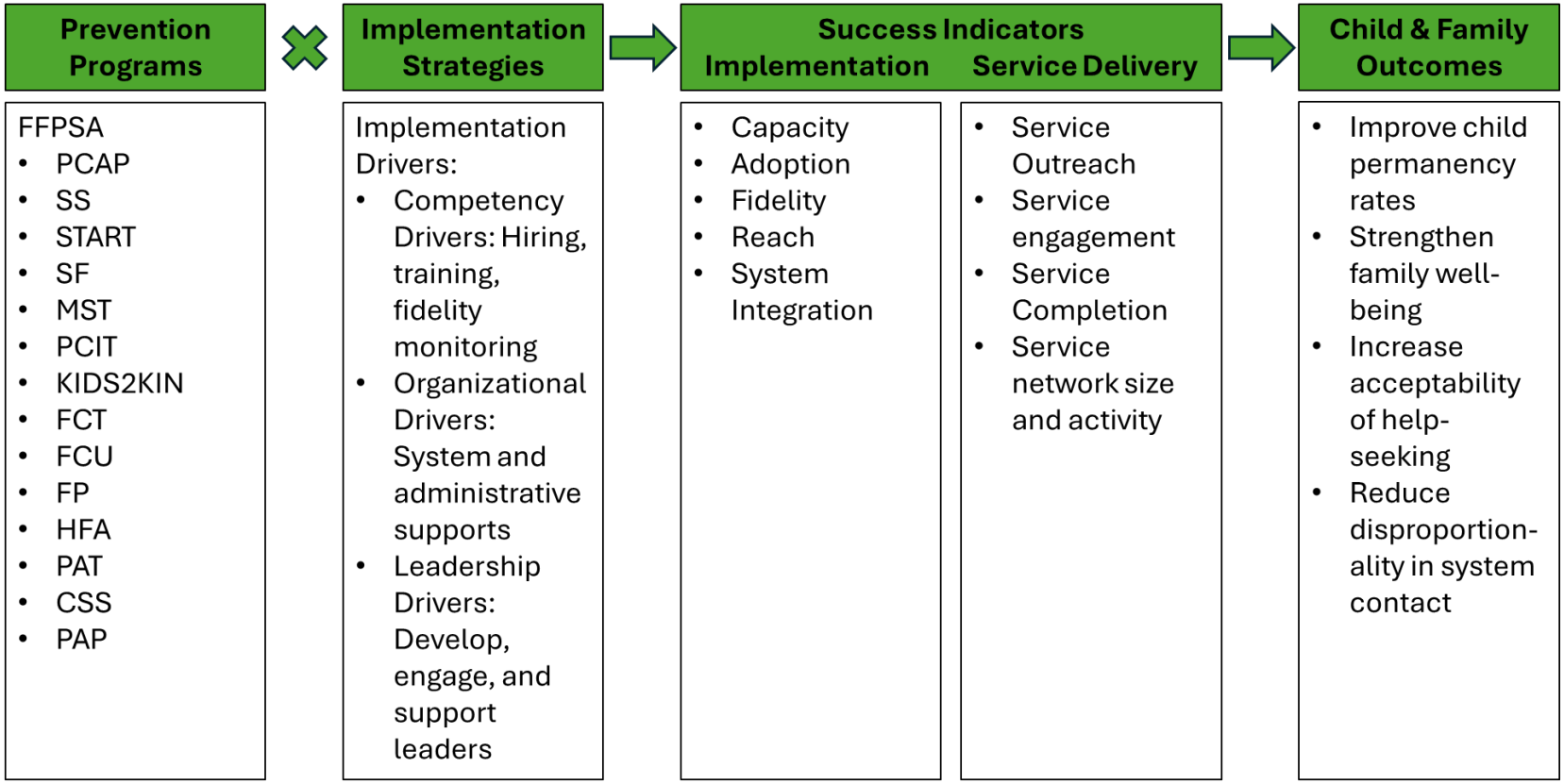
Evaluation Design

The evaluation plan is guided by a utilization-focused approach with needs assessment, process evaluation, and outcomes evaluation components. Collectively, these interrelated components, which are guided by the overall Kansas Prevention Logic Model (Figure 2, page 61), will help ensure ongoing community alignment of prevention resources, support continuous improvement efforts, and establish robust evidence of the effectiveness of the Kansas Title IV-E prevention service array. The evaluation includes the use of rigorous, data-informed sampling strategies; complementary data collection modalities; sound measurement approaches; and sophisticated analyses conducted in partnership with community partners and lived experts. The evaluation plan will be implemented and monitored in close collaboration among the evaluation team, Kansas DCF, and the prevention service provider agencies.

Using an implementation science framework, the evaluation design applies an adapted version of The Conceptual Model of Implementation Research developed by Proctor and colleagues (2009) to organize the process and outcomes evaluations. This heuristic model is informed by three different frameworks in implementation research (i.e., stage, pipeline models; multi-level models of change; and models of health service use), resulting in a framework that distinguishes but connects key interventions, implementation strategies, success indicators for implementation and service delivery, and child and family outcomes. Additionally, this model is well-aligned with quality improvement perspectives that will support a utilization-focused evaluation. Figure 1 (page 56) illustrates the conceptual model of implementation research,

describing how this the prevention programs and implementation strategies together lead to child and family outcomes when supported by implementation and service delivery success indicators.

Figure 1. Conceptual Model of Implementation Research



Needs Assessment

The landscape of family need is a shifting target, and ongoing monitoring is necessary to understand and align programs and services to these changing needs over time. To support initial implementation and selection of the Title IV-E prevention service array, DCF conducted six community convenings across the state to hear the voices of stakeholders and providers about the services needed in their area. To that end, the Kansas prevention plan evaluation includes an ongoing needs assessment to understand child and family needs across the state, the ways in which those needs are met, and unmet needs that require adjustments to this plan. Using a combination of quantitative and qualitative data including an annual population-level assessment of change in well-being aligned with social determinants of health, Family First and Family Resource Center program outputs, population-level collection of qualitative stories, and publicly available population health data, evaluators will report on statewide needs, gaps, and recommendations for future system alignment. Research questions associated with the ongoing assessment of family need are detailed in Table 2 and focus on understanding the scope of need and use, gaps, and perceptions of program acceptability to families and providers. These questions are mapped to success indicators in Table 3.

Table 2. Needs Assessment Research Questions and Associated Success Indicators

Needs Assessment Research Question	Success Indicator
1. What is the scope of the need for prevention services in Kansas, by type?	Capacity
2. Is the use of prevention service proportional to need? By population?	Reach
3. How does family well-being change over time in the Kansas population?	Capacity
4. What gaps and opportunities exist for aligning the service array to population need?	System Integration
5. What are the population level views of DCF, community help-seeking, and prevention services?	Adoption Reach System Integration

Process Evaluation

The process evaluation has a longitudinal mixed-methods design and involves multiple data collection strategies, including focus groups, interviews, and process tracking documentation. The process evaluation will focus on documenting the implementation strategies of providers and the success indicators of implementation and service delivery. This design is advantageous because it supports a utilization-focused evaluation that seeks to routinize feedback loops that will inform and facilitate successful implementation of the Family First interventions. Using a combination of quantitative and qualitative data, evaluators will address the process evaluation research questions detailed in Table 3, which are mapped to implementation success indicators.

Table 3. Process Evaluation Research Questions and Associated Success Indicators

Process Evaluation Research Questions	Success Indicator
1. To what extent did Family First interventions achieve service delivery success indicators of: a. Outreaching to families timely following referral b. Engaging Families timely c. Successful service completion	Service Outreach Service Engagement Service Completion
2. Do prevention service use trends change following introduction of a community access approach?	Adoption Reach Service Engagement
3. What are the strengths and challenges related to introducing a community access point for Family First service referral? For families? For providers? For DCF administrators and staff?	System Integration Capacity
4. What program elements support or detract from participant success?	Adoption System Integration Fidelity
5. To what extent did program uptake and completion vary depending on referral pathway (i.e., community access point versus KPRC access)?	Reach Adoption

Outcomes Evaluation

The outcomes evaluation concentrates on child, family, and system outcomes. The outcomes evaluation will collect primary and secondary data to understand improvements in outcomes among children, parents, and communities served by the Kansas prevention service array. Evaluators will seek to understand impacts of prevention services on child permanency, racial disproportionality in child welfare system contact, and family well-being. To determine the influence of the interventions on child permanency outcomes, we will use a longitudinal approach and repeated measures design with annual statewide and program-specific cohorts. This design was selected primarily due to its feasibility and fit with the service delivery structure that has been established for implementing Family First interventions statewide. This design leverages learnings from early program implementation which established the impact of this service array related to child social-emotional well-being, caregiver sense of competency, and caregiver well-being related to mental health and substance use. In this evaluation design, we shift our area of inquiry to better understand changes to holistic well-being according to the Center for Disease Control's social determinants of health framework. Outcomes evaluation research questions are mapped to benchmarks of success by target outcome in Table 4.

Table 4. Outcomes Evaluation Research Questions and Associated Outcomes of Interest with Benchmarks

Outcomes Evaluation Research Questions	Target Outcome	Benchmark
1. How much did the Kansas prevention service array improve the child permanency outcome of keeping children safely at home during service delivery? Within 12-months of referral?	Permanency	90% of target children receiving Family First services remain safely at home during service delivery and within 12 months of service referral.
2. How much did racial disproportionality in child welfare abuse, neglect reporting and removal from the home change over time in relation to prevention service implementation?	Disproportionality in System Contact	Disproportionate representation of children of color in abuse/ neglect reporting has decreased significantly.
3. To what extent did the Kansas prevention service array impact family well-being across social determinants of health domains (i.e., economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context)?	Family Well-Being	Family well-being improves in all social determinant of health domains among families receiving prevention services.
		Family perceptions of community help-seeking improves among families receiving prevention services.

Administrative data are provided monthly from DCF to the evaluation team for children and youth receiving Family First services. Data provided include permanency outcomes (e.g. child retained in the home during service delivery and within twelve months of referral) and state abuse and neglect reporting data. Reporting data will be used to understand trends in racial disproportionality as it relates to reports of child abuse and neglect made to the Kansas Protection and Reporting Center. These trends will be compared against the demographics of the state population of children. This evaluation hypothesizes that the provision of targeted community-based prevention services according to the community needs prioritized by the community will result in a significant reduction in overreporting of families of color to the Kansas Protection and Reporting Center for allegations of child abuse or neglect.

Permanency data will be used to compare positive permanency outcomes across service populations to assess differential outcomes across types of prevention services (i.e., parent skill building, mental health, substance use, and kinship navigation). Previous analysis demonstrated that the general statewide prevention approach comprised of Family First, Family Preservation, and Family Services return similar positive results in terms of permanency, with families receiving these services having a more than 92 percent likelihood of remaining safely together 12 months after referral to prevention services. Future analyses will seek to understand differences within the Family First service array by program type.

Service populations will be examined by service type to assess for statistically significant differences. Assuming non-significant results, program differences will be assessed at the population level. Should population differences emerge between prevention program types, evaluators will apply a one-to-one propensity score matching approach to establish family preservation and in-home family service samples that are statistically matched demographically to the Family First population. Criteria for conducting a 1:1

match for comparison among prevention service populations will include demographic characteristics of age, race, and county of residence. Matching criteria will also include the risk factor of previous DCF involvement. These factors will ensure an equivalent comparison between like prevention service populations that are statistically comparable geographically, racially/ethnically, and as it relates to formal contact with the child welfare system as a proxy for level of environmental risk. Significant differences in group demographics and other characteristics will be shared with DCF to inform service planning and targeting of prevention services to most appropriately meet family needs.

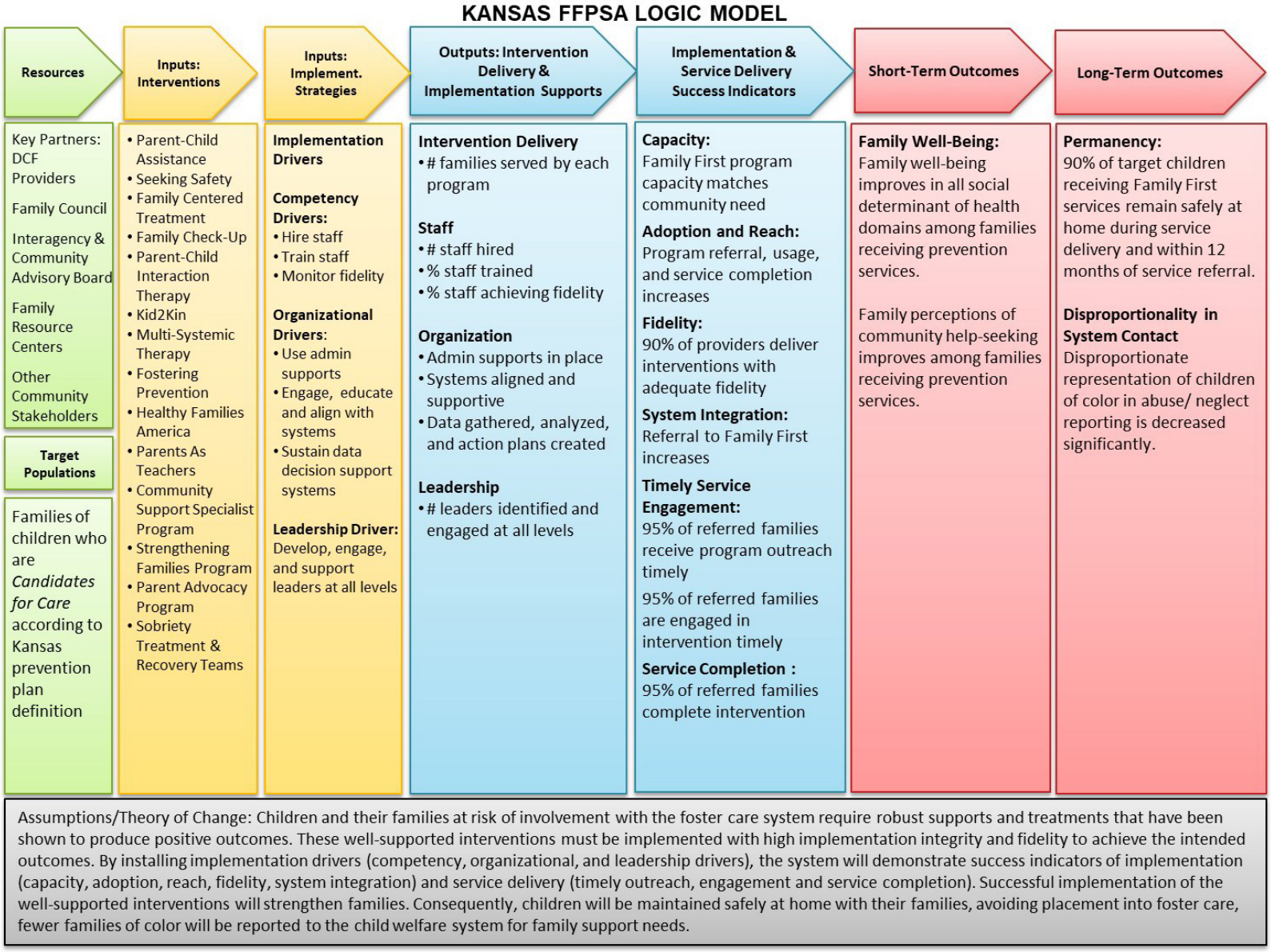
Finally, to understand the extent to which the Kansas prevention service array impacts family well-being across social determinants of health domains, this evaluation includes an annual statewide, population-level administration of a survey of family well-being. This survey, administered as a retrospective pre/post-test, will assess changes in family well-being according to the CDC's five SDOH domains along a spectrum from crisis and disenfranchisement to strength and access.

Performance targets of this evaluation are shown on the Kansas Family First Logic Model (Figure 2, page 61).

Logic Model

The Family First logic model (Figure 2) demonstrates the connections between target populations, resources, the inputs of interventions and implementation activities, outputs of interventions and implementation activities, success indicators of implementation and intervention delivery, and short-term and long-term outcomes. It also visually represents our theory of change related to the interventions and implementation strategies and provides the framework for our evaluation questions to assess delivery of the interventions, implementation progress, and effectiveness. The interventions and implementation strategies identify the interventions and key implementation strategies used to implement them. Outputs and success indicators are presented in the logic model in blue shading. Outputs are delineated for intervention delivery by tracking service numbers and outputs for implementation strategies. Next, indicators that align with and operationalize the key constructs of the process evaluation's constructs of successful service delivery and implementation supports are shown. Five of the success indicators link to implementation strategies (i.e., capacity, adoption, reach, fidelity, and system integration) and three of the success indicators link to the service delivery of the interventions (i.e., service engagement, service completion, service network). Outcomes, shown in red shading, represent family outcomes as short-term outcomes; and, reporting and permanency outcomes as long-term outcomes. The evaluation design includes elements to measure all aspects of the logic model.

Figure 2. Kansas Prevention Plan Evaluation Logic Model



Data Collection Plan

As guided by the Logic Model (Figure 2), the data collection plan identifies specific indicators for each output and outcome. Outputs have been established with two categories, outputs and success indicators. Outputs include tracking number of families served by each intervention and tracking data on implementation strategies, such as number of staff hired, percent of staff trained, and percent of staff achieving fidelity in service delivery. Benchmarks for each of the outputs are unique to each program and, therefore, not shown on the overall logic model. Under success indicators, benchmarks are provided for each of the implementation and service delivery constructs. Finally, indicators with benchmarks are also presented for short-term and long-term outcomes.

Previous data collection prioritized individual level data collection using low-cost, relevant, and low-burden measurement tools. Findings to date demonstrate consistent evidence of the impact of this service array on improved outcomes related to the service domains (i.e., parent skill, mental health, substance use) for families completing Family First services. Given the provider and family burden of ongoing individual-level data collection, future data collection prioritizes population level data collection and community-level qualitative methods to add richness to the evidence base supporting the Kansas prevention service array. This approach, paired with the use of administrative data will provide a deep and robust understanding of the impact of Family First, as well as the implementation levers most likely to result in family engagement and improved outcomes.

The process evaluation centers on the outputs and success indicators, which will largely be collected through tracking tools developed and administered by the evaluation team, and qualitative methods. For the outcomes evaluation, outcomes of interest were selected to deepen understanding of the impact of prevention services on holistic family well-being across multiple domains and uncover system levers for implementing an effective community-based prevention initiative.

Table 5 details how individual program goals for each program in the array target child well-being, and parent functioning, inclusive of parenting, mental health, and substance use – the stated program goals. Given evaluation findings to date, we anticipate that families receiving services within this array delivered with fidelity would continue to experience improvements in well-being across multiple domains of functioning that ultimately influence permanency. We plan to adapt our common measure approach to comprise a population level assessment of family well-being and prevention service use to assess outcomes at the statewide aggregate level and the individual program and subpopulation level. All programs will be assessed on permanency regardless of target as these outcomes are key prevention-focused indicators. The Kids2Kin, Parent Advocacy Program, and CSSP programs will be evaluated using a case study approach, applying staff and client interview data along with program outputs to demonstrate these service approaches as mechanism of prevention.

Table 5. Program Goals by Domain

Program	Child Well-Being	Parent Functioning		
		Parenting	Mental Health	Substance Use
Parent-Child Assistance (PCAP)			Link mothers to community resources to maintain healthy family life	Assist mothers in obtaining treatment and maintain recovery Help mothers prevent births of future alcohol and drug-affected children
Seeking Safety (SS)	Reduce trauma symptoms	Increase safe coping in relationships	Reduce trauma symptoms Increase safe coping in thinking Increase safe coping in behavior Increase safe coping in emotions	Reduce substance abuse symptoms
Family Centered Treatment (FCT)		Enable changes to family functioning Reduce hurtful or harmful behaviors Enable changes to family system Enable family stability	Develop emotional balance and coping to resolve challenges Enable use of intrinsic strengths	

Program	Child Well-Being	Parent Functioning		
		Parenting	Mental Health	Substance Use
Family Check-Up (FCU); with optional NPP add-on component	Improve children's social and emotional adjustment Reduce young children's behavior problems at school Reduce young children's emotional distress Increase young children's self-regulation Reduce adolescent depression Reduce antisocial behavior and delinquent activity Improve grades and school attendance	Improve parent monitoring in adolescence Reduce parent-adolescent conflict		
Functional Family Therapy (FFT)	Eliminate youth problems (i.e. delinquency, oppositional behaviors, violence, substance use) Improve prosocial behaviors (i.e. school attendance)	Improve family skills		

Program	Child Well-Being	Parent Functioning		
		Parenting	Mental Health	Substance Use
Parent-Child Interaction Therapy (PCIT)	Help children feel safe and calm Increase organizational and play skills Decrease frustration and anger Enhance child self-esteem Improve children's social skills (i.e. sharing and cooperation) Decrease problematic child behaviors	Build close parent/child relationships using positive attention Foster warmth and security between parents and children Educate parent to teach child without frustration Teach parents to communicate within child attention span Teach parents discipline techniques Teach parents to be consistent and predictable Help parents develop confidence managing child behavior		
Multisystemic Therapy (MST)	Eliminate or significantly reduce frequency and severity of youth's referral behavior	Empower parent parents with skills and resources		
Family Mentoring Program – Nurturing Parenting Program (NPP)	Gains in child self-worth Gains in child empowerment	Gains in parental empathy toward meeting child needs Use of dignified, non-violent discipline	Gains in parent self-worth Gains in parental empathy and meeting own adult needs in healthy ways Gains in parent empowerment	
Fostering Prevention – Nurturing Parenting Program (NPP)		Increase in family cohesion Increase in nurturing and safety capabilities		

Program	Child Well-Being	Parent Functioning		
		Parenting	Mental Health	Substance Use
Healthy Family America (HFA)	Promote healthy childhood growth and development	Cultivate and strengthen nurturing parent-child relationships Enhance family functioning by reducing risk and enhancing protective factors		
Parents as Teachers (PAT)	Early detection of developmental delays and health issues Increase children's school readiness and school success	Increase parent knowledge of early childhood development Improve parenting practices Prevent child abuse and neglect		
Sobriety Treatment and Recovery Teams (START)	Ensure child safety and well-being Prevent and/or decrease out-of-home placement	Increase parenting capacity and family stability Reduce repeat maltreatment	Increase parental recovery	Increase parental recovery
Strengthening Families Program (SFP)	Reduce child maltreatment Reduce child development and behavior problems Reduce academic and school failure Increase children's positive behaviors	Increase parent/child attachment and bonding Increase positive parenting and parenting skills Reduce family conflict and violence	Reduce children's and parent's depression and stress	Reduce parent and child substance abuse

Table 6 provides an overview of evaluation responsibilities by showing the individuals responsible for leading or assisting with each of the main data collection activities and the individuals who will participate (respond to) in the data collection activities.

Table 6. Summary of Data Collection Activity

Data Collection Activity	Families Served	Community	Providers	DCF	Evaluators
Tracking outputs			P	P	P
Interviews and focus groups	l		l		P
Community survey: Well-Being	l	l			P
Community survey: Prevention framework	l	l			P
Sensemaking	l	l	l	l	
Administrative data: Community provider network			P		P
Administrative data: DCF permanency and disproportional contact (FACTS)			P	P	P
l - Participant of data collection activity; P - Responsibility for assisting with or leading data collection efforts					

The data collection plan for each research question and benchmark is articulated in Table 7. The data collection plan calls for four types of data collection activities: tracking of inputs/outputs, surveys and other tools, interviews/focus groups, and data extraction (administrative data). Output tracking will be conducted by providers and shared through secure channels with evaluators. Interview and focus group data will be collected and securely stored by evaluators using informed consent procedures. All survey data will be collected using secure online platforms designed for research and capacity building, including REDCap and Spryng. Administrative child welfare data is provided from DCF to KU evaluators via an existing secure service known as Results Oriented Management. A data sharing agreement for accessing these data is in place.

Table 7. Summary of Data Collection Plan for Each Research Question and Benchmark

Evaluation Component	Research Question	Benchmark	Data Collection Tool (Planned Frequency) [Sample]			
			Document	Survey	Qual. Int/FG	Admin Data
Needs Assessment	1. What is the scope of the need for prevention services in Kansas, by type? [capacity]	Conduct annual assessment of community needs related to parenting, mental health, substance use, and kinship navigation.		Annual WB Survey [pop.]		Publicly avail health data [pop.]
	2. Is the use of prevention service proportional to need? By population? [reach]	Conduct annual assessment of the alignment of program capacity and need.	Output tracking [program]			
	3. How does family well-being change over time in the Kansas population? [capacity]	Conduct annual assessment of family well-being at the state population level by social determinant of health domain.		Annual WB Survey [pop.]	Story/Sense-making [pop.]	
	4. What gaps and opportunities exist for aligning the service array to population need? [system integration]	Conduct annual gap assessment.		Annual WB survey [pop.]	Story/Sense-making	
	5. What are the population level views of DCF, community help-seeking, and prevention services? [adoption, reach, system integration]	Annual assessment of community perspectives of help-seeking, prevention, and stigma.			Story/Sense-making [pop.] Provider and family Int/FG [program]	
Process Evaluation	1. To what extent did Family First interventions achieve service delivery success indicators of: a. Outreaching to families timely following referral b. Engaging Families timely c. Successful service completion [service outreach, service engagement, service completion]	95% of referred families receive program outreach within 2 business days of referral. 95% of referred families are engaged (in communication with program staff) in services timely.			Story/Sense-making [pop.] Provider and family Int/FG [program]	Track DCF Data [pop.]

Evaluation Component	Research Question	Benchmark	Data Collection Tool (Planned Frequency) [Sample]			
			Document	Survey	Qual. Int/FG	Admin Data
		95% of referred families complete the interventions				
	2. What are the strengths and challenges related to introducing a community access point for Family First service referral? For families? For providers? For DCF administrators and staff? [system integration, capacity]				Story/Sense-making [pop.] Provider and family Int/FG [program]	
	3. What program elements support or detract from participant success? [adoption, system integration, fidelity]				Story/Sense-making [pop.] Provider and family Int/FG [program]	
	4. To what extent did program uptake and completion vary depending on referral pathway (i.e., community access point versus KPRC access)? [reach, adoption]					Track DCF Data [pop.]
Outcomes Evaluation	1. How much did the Kansas prevention service array improve the child permanency outcome of keeping children safely at home during service delivery? Within 12-months of referral? [permanency]	90% of target children receiving Family First services remain safely at home during service delivery and within 12 months of service referral.				DCF Data [pop.]
	2. How much did racial disproportionality in child welfare abuse, neglect reporting and removal from the home change over time in relation to prevention service implementation? [disproportionate system contact]	Disproportionate representation of children of color in abuse/ neglect reporting has decreased significantly.				DCF Data [pop.]

Evaluation Component	Research Question	Benchmark	Data Collection Tool (Planned Frequency) [Sample]			
			Document	Survey	Qual. Int/FG	Admin Data
	3. To what extent did the Kansas prevention service array impact family well-being across social determinants of health domains? [well-being]	Family well-being improves in all social determinant of health domains among families receiving prevention services.		Annual WB Survey [pop.]	Story/Sense-making [pop.] Provider and family Int/FG [program]	
		Family perceptions of community help-seeking improves among families receiving prevention services.		Annual WB Survey [pop.]	Story/Sense-making [pop.] Provider and family Int/FG [program]	

Sampling Methods

Depending on the data collection strategy, different sampling approaches will be used, including the entire population and purposeful samples. The needs assessment will include analysis of publicly available health data for the population of children and families in Kansas along with child welfare data for the population of children and families who have received a report alleging child abuse or neglect.

The entire population of children and youth receiving Family First services will be used to evaluate the long-term permanency outcome for one-year cohorts, as compared to the entire population of children and youth receiving other DCF in-home services such as Family Services and Family Preservation. Though we anticipate similar population characteristics across these service types as we saw in our first examination of survival analysis findings supporting this hypothesis, if significant differences are found a one-to-one matched comparison sample of Family Preservation and Family Service cases will be used in comparison to the population of Family First cases.

Statewide administration of the annual survey of family well-being and the prevention framework survey will be guided by a robust sampling plan that targets data collection to achieve a representative sample of the state population according to geography and racial and ethnic identity.

The entire population of providers and the children and families they serve will be used for all monthly tracking related to monitoring the intervention delivery, fidelity, monitoring the implementation supports, and determining the extent to which two of the success indicators were attained (adoption and reach).

This evaluation applies a purposive sampling approach to qualitative data collection, targeting service providers delivering Family First services and families receiving prevention services in Kansas. Samples for qualitative interviews and focus groups will be constructed from these populations according to the line of inquiry and will draw from all individuals across the state within these groups.

Sample Size

Given that the evaluation plan proposes to use the entire population of children and families served, the evaluators will conduct post-hoc power analyses to determine the power of the study. In the case that the sample is underpowered, the evaluators will explore the use of Bayesian statistical approaches to address this limitation to the extent possible. We will also include indication of the effect size required for the actual sample to detect a statistically significant difference in our analysis.

Data Analysis Plan

Our analytic plan includes an integrated mixed methods approach that triangulates findings across multiple data sources to articulate the holistic impact of prevention services in Kansas.

Quantitative Analysis

Univariate, bivariate, and multivariate statistical analysis will be used to examine permanency and disproportional contact outcomes. In addition to the evaluation questions, the measurement level of variables (e.g., continuous or categorical/discrete), the number of dependent and independent variables included in the analyses, and whether covariates are used will determine the statistical analysis to be conducted (Tabachnick & Fidell, 2012). When missing data is present, the evaluation team will assess the missingness and choose modern and appropriate strategies for addressing it (e.g., multiple imputation). The degree of association among variables will be assessed through Pearson correlations and crosstabs

(Chi-square). Significance of group differences and population differences over time will be assessed through t-test, one-way ANOVA/ANCOVA, factorial ANOVA/MANCOVA. Effect sizes will be reported whenever possible. Logistic regression will be used to examine associations between the interventions and dichotomous outcome of keeping children out of foster care, while controlling for a range of covariates. Time course events analysis (e.g., Cox regression) may also be used to examine time variables, such as time to removal. Social network analysis will be applied to understand network size and activity

Qualitative Analysis

Analysis of qualitative data comprises two approaches: thematic analysis and sensemaking. Thematic analysis of interview and focus group data collected from prevention providers and families receiving service will be guided by the evaluation's conceptual framework and themes that emerge inductively from the data. This approach was selected due to its robustness in instances of time restrictions and suitability for member checking and data triangulation using multiple stakeholder sources and different data collection methods (e.g., data from quantitative surveys). These data will be analyzed, and preliminary themes will be developed and will be presented to partner organizations for reflection and refinement as part of a process of co-interpretation prior to finalizing findings. Community sensemaking through data-supported facilitation will be applied to analyze stories and their associated quantitative data. This community-based participatory action analytic approach was selected to increase the trustworthiness and applicability of the findings to community. This approach is also centered on realizing actionable findings to strengthen the service array and drive additional systems change on behalf of children and families.

Interpretation of Findings

To ensure results are presented in a balanced and objective manner the evaluation plan incorporates specific strategies that can be used to promote a collaborative as well as rigorous evaluation. These strategies include: (a) articulating a clear logic model with SMART process and outcome objectives (i.e., include prospectively determined benchmarks); (b) using multiple informant and multiple sources of data – privileging the perspectives of lived experts – to inform formative and summative conclusions; (c) seeking input from external sources to confirm data-based decisions and conclusions; and (d) using transparent reporting of evaluation methods.

Study Limitations

As noted, we are using needs assessment along with process and outcome evaluation to evaluate the service array over time. This longitudinal approach is the most feasible evaluation plan to achieve the goal of building evidence and knowledge of the continuum of interventions being delivered, and to scale those interventions statewide. We have developed a rigorous evaluation plan that allows for emergent knowledge on best practices while also maximizing economies of scale for a state-level cross-site evaluation of the state prevention array.

A feasibility review precludes designs with control or comparison groups for individual program evaluation, such as randomized controlled trial and broader use of propensity score matched groups, because in most areas the population would not be large enough to support the required sample size for an intervention group and a comparison group. Small sample sizes limit our ability to test for causality with an experimental design; however, repeated within-group design and measures allow for evaluating change longitudinally. Additionally, statewide implementation and overlapping catchment areas and service populations among Family First grantees compounds the difficulty of identifying a comparison group as

outcomes for treatment as usual candidates may be confounded by the receipt of other well-supported evaluations.

Therefore, despite limitations associated with this approach, the context of the evaluation restricts our design options. Thus, we have incorporated multiple strategies and approaches to mitigate these limitations. These strategies include use of robust and integrated mixed methods to triangulate and add depth to findings, effect size comparison and Bayesian statistical approaches and use of statewide population level data for children and youth receiving other DCF in-home services not associated with Family First.

Though lacking a true counterfactual, this cross-program analysis provides a benchmark of success for prevention services across the spectrum of prevention services. Understanding permanency and disproportional contact outcomes across this array has implications for informing DCF practices related to state-administered prevention services. This analysis will continue to show how services are currently used by DCF and demonstrate how prevention services writ large are meeting permanency outcomes statewide.

Feasibility concerns also make it impossible for the evaluation design to include time and labor-intensive observational methods with each provider, intervention, staff member and family. We will rely on model-specific accreditation monitoring and provider-based fidelity assurance methods and administrative data to corroborate the quality and fidelity of service delivery of each intervention and include such findings in our evaluation.

Selection bias is also a limitation given the criteria for inclusion in the interventions are set through federal requirements rather than the voluntary approach to engagement in services these interventions typically adhere to in their model development and fidelity. However, with adoption of a community access point as a pathway to Family First services, may lessen this bias. Thus, evaluation will include comparative analyses of the effects found in the sample served under the 2019 – 2024 prevention plan as compared to those served under the 2025-2029 prevention plan. We will also assess the referral process specific to introduction of the community access pathway.

Our planned approach of using post-hoc power analyses to determine study power introduces additional limitations. However, our capacity for a priori estimations of sample size is limited by state and program context. Though the statewide prevention plan is targeting service to more than 2168 families, some individual program service goals are quite modest, with goals of as few as 32 families served. Therefore, we must assess the power for individual analyses based on the constellation of programs and subpopulations included, individually, by analysis, adjusting methods accordingly. When feasible, we will apply sophisticated statistical methods. Additionally, we will apply methodological approaches (e.g. Bayesian methods, etc.) to maximize our capacity to derive actionable findings from data with limited power.

Finally, as intervention implementation and evaluation plans begin, we will review our design, measurement, and monitoring approach along with emergent findings and changing state/local contexts to identify opportunities to strengthen rigor in key evaluation areas (e.g., measurement, comparative analyses, progress metrics, and methods for evaluating effectiveness and impact over time). Finally, we will work with ACF technical assistance providers and attend any relevant federal grantee meeting sessions to share and improve our evaluation plan and methodological approaches as relevant and necessary and to apply federal guidance on reporting and data collection.

Reporting, Disseminating, and Using Findings

Critical components of our utilization-focused evaluation approach include data literacy and use as our reporting and disseminating frame: Reports and findings must be understandable and accessible in language, meaning, style, and format to broad audiences and the information contained within must be actionable for families, providers, and stakeholders. To that end, we will present findings, lessons learned, and areas of improvement in ways that are timely and relevant to practice, programmatic impact, and policy implications.

In partnership with DCF, local providers, and state stakeholders, we will develop a reporting and dissemination plan that is responsive to the unique needs of each audience and transparent in sharing strengths and opportunities to improve practice and service delivery with fidelity to the intervention. We will focus on translating findings and results in language and framing so that evaluation data and information creates meaning and advances understanding of the impact of these interventions. We will augment all dissemination products with visuals that are intuitive, explanations in plain language, and conclusions that draw connections between implementation drivers, practice and intervention delivery, quality improvements, and intended impact. All front-facing dissemination products will be created in website-accessible formatting for readers with visual impairments. We will work with DCF to develop protocol for posting materials to their website in accordance with their communication and marketing requirements. Table 16 presents a high-level overview of dissemination plans that will guide co-development of specific dissemination products. Individual products will be developed in close collaboration with evaluators, DCF, prevention service providers, and lived experts.

Table 8. Summary of Dissemination and Reporting Plans

Research Product	Intent	Frequency	Format	Audience
Community needs and well-being report	Report on status of family well-being in Kansas and alignment of the service array to community needs	Annual	• Brief report	• DCF • Legislators • Providers • Families and communities
Aggregate outcome report	Routine monitoring of reach and impact of Family First programs	Monthly	• 1-page report posted online and via email	• DCF • Family First Providers • Public
Continuous quality improvement monitoring and reporting	Routine monitoring for data quality	Semi-annual	• Report of data quality metrics and technical assistance call/email	• Family First Providers
Presentations	Communicate progress and findings to broader audiences	As scheduled	• Stakeholder Meetings • Webinars • Conference Presentations	• State agencies • Providers, associations, advocates • Legislators

				• Lived expert and parent groups
Practice briefs	Knowledge transfer to the field to amplify lessons and outcomes from Kansas prevention array	As scheduled	• 3–5-page issue, research, and policy briefs	• State agencies • Provider, associations, advocates • Legislators • Lived experts and parent groups • National field
Publications	Share and disseminate knowledge, findings, and results of this evaluation with the field to inform national prevention approaches	As scheduled	• Peer-reviewed journal articles	• National and international field

Data Security and Privacy

The evaluation team will observe high standards for data privacy, security, and confidentiality. Several steps will be taken to minimize the risks associated with electronic data security, to establish and maintain data privacy, and to hold all confidential data securely. First, the research team will observe the security measures stipulated in the Data Sharing Agreement and in the Business Associates Agreement between Kansas DCF and the University of Kansas. To increase protection against potential risks associated with protected health information, all personnel on the research team maintain Human Subjects Research and HIPPA-certified training in safe-guarding sensitive information and data, including individually-identifiable data, careful orientation of potential participants as to the nature, risk and benefits of the research, strict adherence to study protocols, and regular surveillance for adverse events.

Second, to protect the confidentiality of focus group and interview participants, all identifying information or potential links to any individual informant will be removed from the transcripts. Third, survey data will be collected in an anonymous fashion. Fourth, steps will be undertaken to safeguard the identifying and sensitive information belonging to children and families included in the data (primary or secondary), complying with HIPAA standards. Personal identifiers, including names, case, client, and plan IDs, are currently used to accurately link a variety of child welfare information from multiple sources, such as removal (reasons for removal and removal dates), case plan goal, parental rights termination, discharge (discharge dates and reasons for discharge), adoption, adoption finalization date, and relationship to adoptive parent(s). Thus, digital security is of upmost importance for the evaluation.

Electronic data will be stored at the University of Kansas, which maintains HIPAA-compliant data protection security features, including (a) protection by a 128–bit secure socket layer (SSL) encryption system and Cerberus NT authentication software; (b) server access limited to analysts with proper approval and housed in a secure room with keypad entry; (c) identification code and a password required

for users to access the system; and, (d) a user level system to ensure that only information relevant to the individual user's needs is accessible and to limit data entry to only certain users. Child welfare secondary data files will be stored in a directory on the KU secure server. Dual factor authentication will be required to access the data to allow access only to the evaluation team who will have username and password.

Informed Consent Procedures and IRB

Informed consent procedures will be determined according to each data collection activity. Evaluators have conducted multiple evaluation and research projects and have extensive experience writing and executing cooperative research protocols approved by the IRB. All study procedures are reviewed and approved by the University of Kansas Institutional Review Board (IRB). Considering that some of the data collection strategies proposed in this study involve the participation of human beings or collecting their information from a database (e.g. child welfare database, agency database), IRB review will be necessary. The University of Kansas has a Business Associate Agreement and a Data Sharing Agreement with DCF. In addition, where indicated, evaluation representatives will sign Data Sharing Agreements with partner agencies.

Evaluators

Evaluation of the Kansas prevention plan will be conducted by an entity with expertise in community-engaged research design and implementation science, along with expertise in child welfare, community-based child abuse prevention, early childhood, behavioral and mental health, and substance use disorder programming. Researchers at The University of Kansas Center for Public Partnerships and Research (KU-CPPR) serve as plan evaluators.

KU-CPPR holds a long history of collaboration with DCF, the Kansas Department of Health and Environment, the Kansas Children's Cabinet and Trust Fund, the Kansas State Department of Education, the Kansas Department for Aging and Disability Services, and the state associations comprised of providers in the field of child protection and prevention services, public health, behavioral health, substance use disorders, and child/family serving organizations.

The KU Family First evaluation team works closely with DCF and its contracted providers, co-developing and implementing a responsive and comprehensive evaluation approach that is rigorous and grounded in community-based practice and research. Evaluators leverage existing partnerships, areas of expertise, community-based engagement across Kansas, and involvement in state-level efforts to inform this evaluation and align efforts and data for maximum utility at the state and local levels. Senior-level staff and subject matter experts directing the work include Dr. Kaela Byers, Dr. Jared Barton, and Ms. Meghan Cizek.

The evaluation plan, data collection, data management, and data analyses and reporting will be overseen by the Principal Investigator, Dr. Kaela Byers. Dr. Byers is an Associate Director at KU-CPPR. She has served as a Principal Investigator or evaluator on numerous research projects, has expertise in child welfare, program implementation, and evaluation, and has published in the areas of child well-being, child welfare, and permanency. As principal investigator, Dr. Byers directs all design, deliverables, and fiscal management. Co-Investigator, Dr. Jared Barton provides substantive and methodological expertise in child welfare, implementation science, management reporting, program improvement planning, and management decision making. Co-investigator, Ms. Meghan Cizek provides implementation expertise in community-engaged capacity building and substantive expertise in family and community well-being and program implementation.

Evaluators contribute an overarching framework and relevant methods in support of a robust program evaluation. Additionally, all aspects of the evaluation plan will be conducted in authentic partnership, using community-based participatory action methods, with evaluators, DCF, the Kansas Family Council, Family First providers, and the Kansas Interagency and Community Advisory Board.

Evaluation Timeline

Table 9 details a high-level timeline of annual evaluation activities by data collection type.

Table 9. Evaluation Activity Timeline

Activity	Performance Measure	Q1	Q2	Q3	Q4
Needs assessment	Data collected and analyzed	■	■	■	
Community well-being survey collection	Data collected and analyzed	■			
Prevention framework story survey collection and community sensemaking	Survey active in the field	■	■	■	■
Receive and monitor DCF administrative data	Data received and reviewed monthly	■	■	■	■
Program output tracking and data management	CQI Plan implemented	■	■	■	■
Data quality reporting and CQI	Data quality report delivered to providers with CQI	■		■	
Analyze DCF administrative data	Analysis completed			■	
Report of community needs and well-being	Report submitted to DCF				■
Reporting and dissemination	Dissemination products delivered according to dissemination plan	■	■	■	■
Convene and support Family Council for oversight and accountability, policy development, and systems change efforts	Quarterly meetings convened with emergent recommendations synthesized for DCF	■	■	■	■
Convene and support Interagency and Community Advisory Board to develop recommendations for action	Quarterly meetings convened with emergent recommendations synthesized for DCF	■	■	■	■

Conclusion

Kansas has made substantial progress toward its vision to shift from a child welfare system to a family well-being system. A family well-being system is a system prioritizing a culturally responsive practice to include family voice and partnership, primary prevention resources, co-designing policy, and thrives on community engagement. Family First Prevention Services Act has been integral to this shift. With five years of data to back the high-quality evidence-based services and show children can stay safely stay in their homes, Kansas prevention leaders are recognizing how investing in and partnering with communities and families achieve lasting safety and increase well-being.

Acronym Guide

2GEN- Two-Generation
APF- Alternatives for Professionals
BIST- Behavioral Intervention Support Team
CAPS – Child Advocacy and Parenting Services
CEBC - California Evidence Based Clearinghouse
CRP- Citizen Review Panel
CWCMP- Child Welfare Case Management Provider
CPS- Child Protection Specialist
CSS- Community Support Specialist
CSSP- Community Support Specialist Program
DCF- Department for Children and Families
EBP- Evidence Based Program
EES- Economic & Employment Services
FAC- FosterAdopt Connect
FACTS- Family and Child Tracking System
FCT- Family Centered Treatment
FCU- Family Check-Up
FFFC- Family First Family Council
FFT- Functional Family Therapy
FINA- Family in Need of Assessment
FPS – Family Preservation Services
FFPSA - Family First Prevention Services Act
FRC- Family Resource Center
HFA- Healthy Families America
ICAB- Interagency Community Advisory Board
ICWA- Indian Child Welfare Act
ITP- Intake to Petition
KCSL – Kansas Children's Service League
KCWPTP – Kansas Child Welfare Professional Training Program
KDADS- Kansas Department of Aging and Disability
KDHE- Kansas Department of Health and Environment
KDOC-JS- Kansas Department of Corrections Juvenile Services
KIDS- Kansas Initiatives Decision Support
KPRC – Kansas Protection Report Center
KUSSW- University of Kansas School of Social Welfare
KCWPTP- Kansas Child Welfare Professional Training Program
KPATA – Kansas Parents as Teachers Association
KPM- Kansas Practice Model
KPMO- Kansas Practice Model Overview
KPRC- Kansas Protection Report Center
KUCPPR- University of Kansas Center for Public Partnerships
KUSSW- University of Kansas School of Social Welfare
L&D- Learning and Development
MI- Motivational Interviewing
MST- Multisystemic Therapy
NFSN- National Family Support Network
NPP - Nurturing Parenting Program
PAP- Parent Advocate Program
PAT- Parents as Teachers
P-CAP- Parent-Child Assistance Program
PCIT- Parent-Child Interaction Therapy
PPS – Prevention and Protection Services
PWS- Pregnant Woman using Substances
REC- Racial Equity Collaborative
RFP – Request for Proposal
SBC- Solution Based Casework
SDM- Structured Decision Making
SF- Strengthening Families
SFY – State Fiscal Year
SS- Seeking Safety
SOS- Signs of Safety
START – Sobriety Treatment and Recovery Team
SUD – Substance Use Disorder
TANF- Temporary Assistance for Needy Families
TBRI- Trust Based Relational Intervention
Together Facing the Challenge- TFTC
TDM – Team Decision Making
TPR- Termination of Parental Rights

Appendix 2: Supporting Documentation for Attachment B

DCF PPS Policies

0160 Glossary

Candidate for Care: A child is determined a candidate for care when any one of the following situations apply:

- A child(ren) or youth who is determined at imminent risk of foster care and out of home placement but can be safe at home with prevention services.
- A child(ren) or youth who exited foster care to adoption or permanent custodianship or guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement.
- A child or youth temporarily or permanently residing with a relative or kin caregiver. A child(ren) or youth living with parents but needs to be with a relative caregiver with prevention services in place.
- Pregnant and parenting youth in foster care and in an out of home placement.
- A child remaining in the home whose siblings are in foster care.

2753 Eligibility and Criteria for Referral to Family First Prevention Services

The Family Based Assessment, per PPM section 2700, assists in identifying needed services for families. The following provides criteria to consider a referral to Family First Prevention Services for families.

Child(ren) and Families Eligible for Family First Prevention Services:

A. There must be a Candidate(s) for Care, which is determined when any one of the following situations apply: (See 0160 Glossary Candidate for Care)

1. a child or youth who PPS determines is at imminent risk of foster care and out of home placement but can be safe at home with prevention services;
2. a child or youth who exited foster care to adoption or permanent custodianship/guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement;
3. a child or youth temporarily or permanently residing with a relative or kin caregiver;
4. a child or youth living with parents but needs to be with a relative caregiver with prevention services in place;
5. pregnant or parenting youth in foster care and in an out of home placement.
6. a child/youth remaining in the home whose siblings are in foster care.

B. Immediate Safety and Lasting Safety criteria from the following practice model tools may help guide the decision for Candidacy of Care and service referral eligibility:

   a. PPS 2019 Mapping Conversation Notes

   b. PPS 2020 Risk Assessment Map

   c. PPS 2021 Immediate Safety Plan

If DCF and the family are agreeing to actions the family will take to build lasting safety within the family, a referral may be made.

C. Family Criteria for Referral

A family is eligible for a referral to Family First Prevention Services, if the family meets eligibility criteria outlined above and the answer to questions 1-3 below is "yes"; and questions 4-7 are either "yes" or "NA." The Prevention Services screen is documented on the Family Based Assessment Summary PPS 2030F, Section III.

1. The family is at risk of having a child(ren) removed; and
2. A parent/caregiver is available to protect the child; and
3. A parent/caregiver is willing and able to participate in services.
4. A family with chronic problems has experienced a significant change which makes them able to progress.
5. A parent/caregiver with mental/emotional health issues has been stabilized.
6. A parent/caregiver with limitations demonstrates an ability to care for self and children.
7. A parent/caregiver with substance abuse issues functions adequately to care for children.

D. Completion of PPS 4311 Family First Prevention Plan and Service Referral

Utilizing the guidance provided above and the service needs of the family, Child Protection Specialists should determine whether the family would be best served by Family First Prevention Services or Family Preservation Services. (reference PPM 4000). If the decision is made to refer to Family First Prevention Services, and the family is in agreement, the Child Protection Specialist (CPS) shall complete the (PPS 4311) The form shall include:

1. Candidate for Care determination for all children. At least one child must be identified as a candidate for care to refer to Family First Prevention Services, unless the prevention plan is for a pregnant or parenting youth in the custody of the Secretary.
2. The foster care prevention strategy for the child(ren) so the child may remain safely at home, live temporarily with relative or non-related kin caregiver until the child can safely return to their parent(s)/caregiver(s), or live permanently with a relative or non-related kin caregiver.

3. The services or programs to be provided to or on behalf of the child is clearly documented to ensure the success of that prevention strategy.

E. Updating Prevention Plans When the Family is Engaged in Services

The PPS 4311 Family First Prevention Plan and Service Referral is a living document and should reflect all selected services identified by the family.

If the prevention plan has not exceeded 12 months from initial completion date, the plan shall be updated by the CPS, reflecting the revised prevention plan reason. Circumstances which require a revision include, but are not limited to:

1. A new family first service is identified with the family. The CPS shall also complete and send the referral to the service provider.
2. An adult "family member" not originally identified on the plan is needing the current service.

The revised PPS 4311 shall be submitted to FACTS. The initial Prevention Plan date will remain in effect.

F. Creating New Prevention Plans When the Family is Engaged in Services

Family First Prevention Services can be provided for up to 12 months beginning on the date the child(ren) are identified as a "candidate for care" on the PPS 4311.

If the Prevention Plan is approaching 12-months from the initial date it was completed and it is determined the family still has a need for Family First Prevention Services, a new PPS 4311 shall be completed, identifying it as an extended prevention plan in Section III. 1B. The child(ren) shall be redetermined as a candidate for care. The new prevention plan will identify continuing services and a new prevention plan start date, matching the previous end date. (See PPS 4320 DCF Responsibilities for Open Family First Prevention Services and PPS 4370 Duration of Family First Prevention Services)

4300 Family First Prevention Services Grants

Family First Prevention Services (FFPS) grants support families in their communities with the goal to prevent children from entering the custody of the Secretary and foster care placement through implementation of evidence-based programs. Grantees apply an approach using approved evidence-based or emerging programs.

Foster Care prevention approaches are family-centered, safety-focused and provide voice to and for a child and family's safety network. Family-centered practice is characterized by mutual trust, respect, honesty and open communication between parents and service providers. Families are active participants in the discussion of program improvement, service referrals and evaluation. They are active decision-makers in selecting services for themselves and their children. Family and child assessments are strengths-based and solution-focused. Specified services are community-based and build upon formal and informal supports and resources.

Programs were evaluated, scored and rated by a Grant Peer Review Panel. Family First Grants were awarded to selected partners with specialization in evidence-based treatments provided by qualified clinicians, and other programs, in the arenas of:

1. Mental Health
2. Substance Use
3. Parent Skill Building
4. Kinship Navigation
5. Other Primary Prevention Programs

Family First Prevention Services grants are awarded to multiple organizations across and within communities whose services demonstrate the ability to make a community impact to prevent the need for entry into foster care. Program boundaries or service areas may be any jurisdiction, catchment area, collection of jurisdictions or existing population parameters of an organization (e.g. judicial district, collection of counties or neighborhoods).

4310 Family First Prevention Grant Service Population and Referral

A. Prevention Services for Child(ren) deemed Candidates for Care

The CPS (Child Protection Specialist will refer families to Family First Prevention Services (FFPS) Grantees. The CPS completing child protection assessments and investigations make this determination. A referral to the program is consistent with the family's needs related to the program's intervention population when a child is at imminent risk of entering foster care. The CPS will complete the Prevention Plan and Service referral after a conversation and agreement from the family. In the referral, PPS will list each child or youth in the family and determine candidacy for care (See 0160 Glossary and 3229 Determination/Redetermination Candidacy for Care).

Families with any one of the following situations are eligible for a referral to a Family First grant program:

1. a child or youth who PPS determines is at imminent risk of foster care and out of home placement but can be safe at home with prevention services;
2. a child or youth who exited foster care to adoption or permanent custodianship/guardianship, or who was reunified with parents is at risk of entering foster care and out of home placement;
3. a child or youth temporarily or permanently residing with a relative or kin caregiver;
4. a child or youth living with parents but needs to be with a relative caregiver with prevention services in place;
5. pregnant or parenting youth in foster care and in an out of home placement;
6. a child/youth remaining in the home whose siblings are in foster care.

B. Pregnant and Parenting Youth in the Custody of the Secretary

Pregnant or parenting youth in the custody of the Secretary with infant/child are eligible for Family First Prevention Services. The CWCMP will complete the Prevention Plan which is integrated in the child's Permanency Plan (PPS 3051, Section 7) and will notify the PPS Foster Care Liaison to make the appropriate referral to needed services. (Reference PPM 5238)

4320 DCF Responsibilities for Open Family First Prevention Service Case

Following the referral to Family First Prevention Services grantee, the Child Protection Specialist (CPS), unless otherwise noted, shall be responsible to:

A. Provide current information for data entry into FACTS.

B. Assist the family in connecting with the grantee to begin service relationship.

C. Assist in the engagement process with the family as requested.

D. If requested, participate in the initial meeting held within 2 business days of referral with the grantee and family.

E. Complete all child abuse/neglect assessments in accordance with PPM section 2000.

F. Inform the grantee of ongoing child abuse/neglect investigations and assessments.

G. Inform the grantee of any new report received by the Kansas Protection Report Center involving a child receiving services by the grantee. Grantee may consider and incorporate the information into the work with the child and family as appropriate. The role of grantee is not to investigate or determine validity of report.

H. Provide the grantee a copy of the PPS 2012. Inform the provider of the status of appeal, if applicable.

A. Meet with the family and grantee to discuss options if there is a refusal of services.

J. Provide reports to the court as indicated.

K. Monitor prevention plan timelines. If the initial date for the Prevention Plan is approaching the 12-month mark, consult with the grantee and DCF supervisor to determine if the child(ren) remain candidates for care and are in need of continuing services. If it is determined Family First Prevention Services remain necessary, a new PPS 4311 shall be completed redetermining the child(ren) candidates, extending the prevention plan in section III. 1B. and outlining needed services (See PPS 2753 Eligibility and Criteria for Referral to Family First Prevention Services)

L. Review the PPS 4311 Family First Prevention Plan and Service Referral/Case Status form, when submitted by the grantee. Based on the information provided and progress made by the family, the CPS and Supervisor shall determine if follow-up is needed. Follow-up may include determining no action is required, attempting to re-

engage the family with the CWCMP, or contacting the County Attorney/District Attorney and requesting a petition for Child in Need of Care.

4330 Family First Prevention Services Grantee Responsibilities

Grantees shall accept all referrals from DCF when the program has openings. Following the referral to the Family First Prevention Services (FFPS), the grantee shall:

A. Acknowledge receipt of the FFPS referral within 24 hours.

B. Complete or continue a Plan of Safe Care (PPS 2007) for families served who have an infant to support families affected by substance use disorders. If, initially, criteria for a Plan of Safe Care was not met, but, during the life of the case, additional information becomes available, which indicates criteria for a Plan of Safe Care may be met, the requirements per PPM 2050 shall be followed. The needs of the infant and family shall be documented on the PPS 2007 Plan of Safe Care and submitted to DCF.

C. Meet with the family within 2 business days of referral to begin initial assessment and review Prevention Plan and Service Referral (PPS 4311). Submit the Family First Prevention Plan and Service Referral/Case Status Form (PPS 4311) outlining date of contact in Section VI. to referring CPS (Child Protection Specialist) and FACTS unit within 5 business days of initial contact.

D. Request necessary releases be signed by family to coordinate services, reduce service duplication and ensure family's needs are met. Verify provision of necessary services, when applicable, with other Family First Grantees, Family Services, Family Preservation Services, or Foster Care/Reintegration/Adoption Contractor.

E. Notify referring CPS if any child in the family is a runaway or missing.

F. Participate in a Team Decision Making meeting, if requested by PPS. Complete and submit the PPS 4311 with case closure reasons and summary of closure to referring CPS and FACTS unit within 5 business days of case closure. Grantee may request retraction of services within 5 days of referral due to non-engagement by the family and/or in-eligibility of family in services. Retractions are not included in grantees outcomes. Grantee shall submit the PPS 4311 with retraction request and complete summary in Section VII. of why retraction is needed.

G. Maintain case information on a timely basis reflecting complete and current history of assessment information, services provided and progress of services for the family.

H. Review any forwarded report from DCF involving a child receiving services by the grantee. The grantee may consider and incorporate the information into the work with the child/family as appropriate. The role of grantee in this circumstance is not to investigate or determine validity of report.

A. Make available, develop or accept DCF process or procedure of releases so all client records and information may be shared with DCF. The following are examples of when this may occur: if a child in the home enters foster care, at case closure, to obtain status reports, to provide court

updates, service case is a part of case review sample and/or as needed. Make available all client records and information to DCF within 24 hours of a request, whether written or verbal.

J. Participate and cooperate in the DCF performance improvement process, including interviews when requested.

K. Participate in regional, local, and statewide meetings to promote program and maintain orientation to referral process.

L. Work with external evaluator to provide data, implement other quality assurance, success factor or evaluation tools such as surveys of families served, case file reviews or other tools. Provide access to existing quality assurance tools or case files for respective programs for children served in the PPS grant referred program or service. The external evaluator shall work with the grantee to develop an evaluation plan for each program.

M. Provide direct services supporting the implementation of strategies resulting in improvements in targeted State-or community-level factors, while contributing to and monitoring the following outcomes:

1. Families are engaged timely;
2. Children are maintained safely at home.

N. Additional outcomes related to safety and well-being may be identified by the external evaluator.

O. Participate in stakeholder, statewide or regional meetings regarding implementation of Family First Prevention Services.

P. Ensure all direct service or program staff have training and meet qualifications required consistent with evidence-based programs.

Q. Initiate and follow Critical Incident Protocol (see PPM 0510).

R. In some circumstances, such as court involved cases, documentation for court and testimony may be required.

S. Submit brief case level monthly reports outlining family progress to the CPS Specialist. This may be completed in a format determined by the grantee such as email, existing grantee form or development of new forms.

T. Provide weekly capacity updates to those identified by regional leadership. Updates include capacity, number of active cases, utilization rate, and approaching openings.

U. After service closure, the grantee shall coordinate with regional staff on the method for transfer of closed files or pertinent documentation.

4370 Duration of Family First Prevention Services

Family First Prevention Services can be provided for up to 12 months beginning on the date the state identifies the child as either a “candidate for foster care” or a pregnant or parenting foster youth in need of those services in the prevention plan. Services may continue beyond 12 months on a case-by-case basis.

Grantees shall consult with the CPS (Child Protection Specialist) prior to the end of the 12-month period to discuss relevant details of the family's progress, willingness to continue services, and any risk or safety concerns. If it is believed the child(ren) may need to continue with services, the CPS and the supervisor shall evaluate the current risk and safety concerns. Services may be extended when the following conditions are present:

A. the family is making progress on achieving the service goals, and
B. the child(ren) remains a candidate for care.

If an extension of services is needed, the CPS shall complete a new PPS 4311 Family First Prevention Plan and Service Referral, selecting the extension in Section III. 1B. redetermine the child(ren)'s candidate for care and select the services that will be continuing in Section IV.

If it is determined a service extension is not needed, the Grantee will complete closure of Prevention Services on the PPS 4311 Section VII. Closure date must not exceed the end date in Section III.

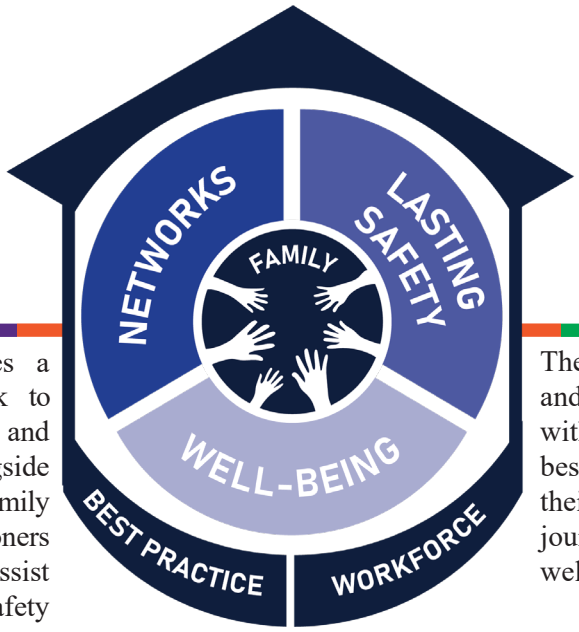
Attachments

KANSAS PRACTICE MODEL

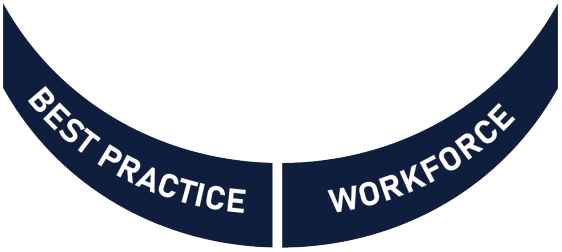
Kansas
Department for Children and Families

What it means and how it works

The Kansas Practice Model provides a consistent and customized framework to support engagement, safety planning and decision-making to guide our work alongside families, children and youth. With family voice and practice approaches, practitioners use their skills to engage the family and assist with needed services to support family safety and well-being.



The Kansas Practice Model integrates aspects and tools from multiple practice approaches with promising evidence research and best practices to come alongside families, their natural supports and community on a journey toward improved safety and family well-being.



The Foundation of Our Practice

The selected practice approaches and tools from Team Decision Making, Family Finding, Signs of Safety, Structured Decision Making, Solution Focused Questions and the Resolutions Approach comprise the foundation of the Kansas Practice Model. These practice approaches, along with practitioners committed to using these new tools, are moving us forward in working alongside families to improve safety and family well-being.

Family and Community Prevention Networks

Prevention, support and safety networks are vital to the Kansas Practice Model framework. Practitioners focus on helping families expand their support system with assistance in identifying individuals who support them and who want the family to experience the best outcomes. By working alongside families to build stronger networks for support and safety, the Kansas Practice Model helps families stay together or reunify safely and improve the well-being of all family members.

Permanency and Stability

One of the most critical goals of the Kansas Practice Model is to establish and support lasting safety for families. Practitioners and families work together to identify and implement solutions that support stability, security and permanency. While these may look different for every family, whether it is maintaining children safely in the home, early reunification or alternatives identified with the family, practitioners using the framework of the Kansas Practice Model are focused on working alongside families to identify their goals and maintain lasting safety.

Healthcare and Well-Being Coordination

The Kansas Practice Model puts the well-being of the family and safety of the children at the forefront of every step in the process. This model supports practitioners in their work alongside families with a goal of meeting the needs of parents and caregivers, who in turn, are better able to meet the needs of their children. Practitioners help families discover ways to integrate self-care, enjoyment and passion in their lives and access needed healthcare services and community supports.

State of Kansas
Department for Children and Families
Prevention and Protection Services

Family First Prevention Plan and Service Referral/Case Status Form

PPS 4311

SECTION I: Identifying Information – Completed by CPS/FC Liaison/IL Coordinator			
Case Head Name:	Case Head Client ID:	FACTS Case #:	FACTS Event #:
Date of Intake Assignment: Click or tap to enter a date.			
Address of Family: City, State, Zip: County where family resides:	Phone number: Best way to contact family (phone, text, person, other):		
Non-custodial Parent(s) Name: Address: City, State, Zip:	Phone: Best way to contact family (phone, text, person, other):		
Is there a reason to believe that any family member is a member or eligible to be a member of a recognized Tribe, and the Indian Child Welfare Act (ICWA) applies? ☐ No ☐ Yes (If yes, list Tribal Affiliation): Name of Enrolled Family Member(s):			
Referring DCF CPS/ Foster Care Liaison/IL Coordinator: Email: Phone number(s): Supervisor: Family First Regional Email (check one below): **Northwest Region** ☐ DCF.WERFFLiaison@ks.gov **Southwest Region** ☐ DCF.WERFFLiaison@ks.gov **Wichita Region** ☐ DCF.WROFF@ks.gov **Northeast Region** ☐ DCF.NortheastFamilyFirst@ks.gov **Southeast Region** ☐ DCF.SoutheastFamilyFirst@ks.gov **KC Region** ☐ DCF.KCRegionFamilyFirst@ks.gov DCF Office: List any other DCF division or employee actively involved with the family if applicable (Name/role):	Is there a current CINC case: ☐Yes ☐No If yes: Court Number: Next Court Hearing/Division: Any child in the family in DCF custody: ☐Yes ☐No If yes, Name: **Answer the following *FACTS CODES in parentheses:** **Is this referral due to a Juvenile Offender case?** ☐Yes **(JO01N)(PSW)** ☐No **Is the referral for a pregnant youth in foster care?** ☐Yes **(FC01N)(FGC)** ☐No If yes, Name: **If the referral is for a parenting youth in foster care is their child:** ☐ Not in custody **(FC02N)(FGC)** ☐In custody of the Secretary **(FC03N)(FGC)** Name of parenting youth: Child's name:		

Section II: Candidacy for Care Determination – Completed by CPS/FC Liaison/IL Coordinator – Determine if the child meets criteria as a candidate for care.			
Child Name (List all children in the home)	**Age**	**Candidate for Care**	**Reason for candidacy determination**
		☐Yes ☐No	Reason for imminent risk of removal:
		☐Yes ☐No	Reason for imminent risk of removal:
		☐Yes ☐No	Reason for imminent risk of removal:

		☐Yes ☐No	Reason for imminent risk of removal:
		☐Yes ☐No	Reason for imminent risk of removal:

Indicate if any children above have, within approximately a year, participated in mental health treatment, or if any child is on a psychiatric residential treatment facility (PRTF) waitlist. This will assist in service coordination.

Name of child/youth	Agency delivering service	Name of past/current therapist or case manager

Is any child/youth listed above on a PRTF waitlist? ☐ No ☐ Unknown ☐ Yes. If yes, add name of child:

Section III: Prevention Plan – Completed by CPS /FC Liaison/IL Coordinator

A prevention plan expires after 12 months of being open. The prevention plan date will match the start date of the service referral (Section IV). Select one of the following below:

1A. Complete for initial prevention plan (most common)

☐ This is an initial prevention plan

Enter the start date for this plan/referral: Click or tap to enter a date.
Enter the end date (12 months from start date): Click or tap to enter a date.

OR

1B. Complete when services extend beyond 12 months of previous prevention plan

☐ This is an extension of an active prevention plan/that follows an expired prevention plan

Enter the start date (use end date from previous plan): Click or tap to enter a date.
Enter the end date (12 months from start date): Click or tap to enter a date.

1C: Is this a revision to an open prevention plan? ☐Yes ☐No

Reason for revision:

Has this family been actively engaged in conversations about Family First services? ☐ Yes ☐ No

Prevention Strategy (Check one)**:**

☐ Maintain the child safely in the home
☐ Live temporarily with a kin caregiver until the child can safely return to their parent(s)/caregiver(s), or
☐ Live permanently with a kin caregiver.

***FACTS:** When entering an extension for a Prevention plan (Section III. 1B.) on RESP Screen:

- Close previous Prevention Plan
- Close Candidacy for Care related to previous Prevention Plan
- Close all open Family First Services using the code (SD) in the RespStatus field
- Add new Candidacy for Care for this Prevention Plan
- Re-Add Family First Services that were closed for extension, use the extension Prevention Plan Start date in the AchDt field. RespInDt of service must match the start date of the extension Prevention Plan.

Section IV: Family First Prevention Service Referral – Completed by CPS/FC Liaison/IL Coordinator – Check the appropriate service box to identify the service the family agrees to receive available in the county where the family resides.

***NOTE FOR FACTS STAFF:** Service is added to all family members.

Kinship Navigator (FK01N)	**Mental Health (FM01N)**	**Parent Skill Building (FI01N)**	**Substance Use Disorder (FS01N)**
☐ Kids 2 Kin – Kansas Legal Services **(NIT)**	☐ MST – Multisystemic Therapy – Community Solutions **(MST)**	☐ Bright Futures Program – KPATA **(PAT)**	☐ START – DCCCA **(STA)**
Other Services (FP01N)	☐ Functional Family Therapy – Cornerstones **(FFT)**	Healthy Families America ☐ KVC **(HFB)** ☐ Kansas Children's Service League **(HFA)**	☐ Parent Child Assistance Program, PCAP – Kansas Children's Service League **(PCA)**
☐ Community Support Specialist – Sedgwick Co. Sheriff's Dept. **(CSP)**	☐ Parent Child Interaction Therapy – TFI Family Services **(PCI)**	☐ Family Mentoring – CAPS **(NPP)**	☐ Seeking Safety – Saint Francis **(SES)**
***NOTE FOR FACTS STAFF: (FACTS CODES)**		☐ Fostering Prevention – FAC **(FSP)** ☐ Family Centered Treatment – Saint Francis **(FCT)**	☐ Strengthening Families – KVC **(SFA)**

List all family members/relatives, including any minor children, and non-related kin, in or out of the household who will participate in the service.

Family Member / Role	Is this a new service or a service added to an already existing prevention plan?	Add the date only if this is an additional service.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.
	☐ New ☐ Additional service	Click or tap to enter a date.

SECTION V: Family First Referral Opening – Completed by CPS/FC Liaison/IL Coordinator
Reason for Referral (Describe what brought the family to the attention of the agency, why is the family being referred for specified services, and historical involvement with agency):

Required attachments for Family First Prevention Services:

- ☐ A/N referrals; PPS 1000, PPS 2020 Kansas DCF Assessment Map
- ☐ FINA referrals; PPS 1000, PPS 2020 Kansas DCF Assessment Map
- ☐ All cases; PPS 2021 Immediate Safety plan – if applicable
- ☐ Attach and email all forms to the grantee/provider, regional Family First mailbox and your region's FACTS mailbox

(End DCF responsibility, Grantee portion begins next page)

DCF Distribution: Case File, Family First Provider, FACTS

GRANTEE: Acknowledge receipt of referral within 24 hours.

Family First Prevention Plan and Service Referral/Case Status Form

SECTION VI: Timely engagement – Completed by Grantee – Assessment and/or review of prevention plan with family to occur within 2 business days of referral. Provide initial contact date below and submit to emails listed at the end of this form for the appropriate region within 5 business days of initial contact.
Use the email subject line: FF_county abbreviation_Lastname_Firstname_4311_Initial Contact

Name of Grantee: **Date of Initial contact with Family:** Click or tap to enter a date.	**Referred Service Category:** ☐ Kinship Navigator **(FK01N)** ☐ Mental Health **(FM01N)** ☐ Substance Use Disorder **(FS01N)** ☐ Parent Skill Building **(FI01N)** ☐ Other **(FP01N)**	
Name of Grantee Assigned Worker:	**Email:**	**Phone:**
Name of Grantee Assigned Supervisor:	**Email:**	**Phone:**

SECTION VII: Closure of Family First Prevention Services – Completed by Grantee – At time of case closure, add date, closure reason, and summary below. Submit to emails listed at the end of the form for the appropriate region within 5 business days of closure.
Use the email subject line: FF_county abbreviation_Lastname_Firstname_4311_Closure

Name of Grantee: **Closure Date:** Click or tap to enter a date.	**Referred Service Category:** ☐ Kinship Navigator **(FK01N)** ☐ Mental Health **(FM01N)** ☐ Substance Use Disorder **(FS01N)** ☐ Parent Skill Building **(FI01N)** ☐ Other **(FP01N)**

Closure Reason – Completed by Grantee – Select reason case is closing and provide a summary reason for case closure.

☐ Retraction within 5 days of referral. *Exception: Family determined ineligible after 5-day window.* **(JD)**

The following are applicable after 6+ days.

☐ Family declined or chooses to end services after 5 days of referral. **(CD)**

☐ Family is not progressing or addressing issues/needs identified in the prevention plan. **(AD)**

☐ Child was removed from home; a referral was made to the Reintegration/Foster Care/Adoption provider. **(LD)**

☐ Unable to locate the family or family moved out of provider services area or out of state. **(MV)**

☐ Family has successfully completed services. **(CM)**

Closure Summary – Completed by Grantee – Provide a description of the family's progress/functioning at closure, a summary of the reason for closure, or special circumstances leading to closure. If applicable, document attempts to locate or engage family.

GRANTEE: Return the form to the following emails for the appropriate region where the family resides.

Region	FACTS email inbox	Family First email inbox	Referring Child Protection Specialist or Foster Care Liaison (Listed in Section I)
Northwest	DCF.WERFP@ks.gov	DCF.WERFFLiaison@ks.gov	Both
Southwest	DCF.WERFP@ks.gov	DCF.WERFFLiaison@ks.gov	Both
Wichita	DCF.WROCPFP@ks.gov	DCF.WROFF@ks.gov	Both
Northeast	DCF.EastFacts@ks.gov	DCF.NortheastFamilyFirst@ks.gov	Both
Southeast	DCF.EastFacts@ks.gov	DCF.SoutheastFamilyFirst@ks.gov	Both
Kansas City	DO NOT SEND TO FACTS	DCF.KCRegionFamilyFirst@ks.gov	Both

END FORM

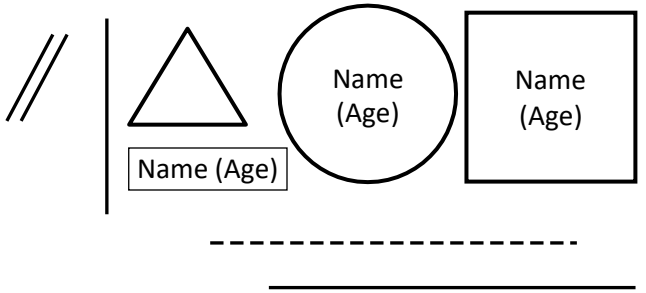
(3) Kansas DCF Conversation Note

FACTS Case #:		Event Number:	

Name of Contact: _____ **Date/Time/Location:** _____

Type of Interaction: _____ **PPS Worker:** _____

GENOGRAM



Kansas DCF Conversation Note

FACTS Case #:		Event Number:	

INFORMATION PROVIDED BY WORKER

GENERAL NOTES

Kansas DCF Conversation Note

FACTS Case #:		Event Number:	

What are we worried about?	What's working well?	What needs to happen?
•	•	•

Kansas DCF Conversation Note

FACTS Case #:		Event Number:	

Immediate Safety

(Safety Assessment)

Immediate Safety Scaling Question: On a scale of 0–10 where 10 is, you're confident the child(ren) will be safe enough staying where they are while the assessment is completed and 0 is the child(ren) are likely to be seriously hurt if they stay where they are even for tonight, where would you rate it?

0 ⟷ 10

Immediate Safety Ratings:

Name	Role	Rating

Reasons for Ratings:

-

TDM Referral.

- ☐ *Yes; confirm with supervisor*
- ☐ *Maybe; consult with supervisor*
- ☐ *No*

Kansas DCF Conversation Note

FACTS Case #:		Event Number:	

Lasting Safety

(Risk Assessment)

Lasting Safety Scaling Question: On a scale of 0–10, where 10 is you're confident the kids will grow up safe and well enough without child protection involvement and 0 is you're very worried they will suffer serious harm at some point unless the family gets help, where would you rate it?

0 ⟷ 10

0 is…

Lasting Safety Ratings

Name	Role	Rating

10 is…

Reasons for Ratings:

-

(4) Kansas DCF Assessment Map

Family Name:		FACTS Case #:		Event Number:	

PPS Worker: _____

GENOGRAM

Kansas DCF Assessment Map

Family Name:		FACTS Case #:		Event Number:	

Worries	Safety
CURRENT & PAST HARM *First describe the current reported harm and then summarize any pattern of past harm. Be sure to describe both what happened and impact on the child(ren).* •	**CURRENT & PAST SAFETY** *First describe what is in place that's keeping the children safe right now and then describe how the children have been kept safe in the past when the worries were present. Be sure to describe both what happened and the impact on the child(ren).* •
Complicating Factors *What is happening in and around this family that might make building safety more challenging?* •	**Family Resources** *Who or what does this family have around them that might help in the safety building process? Who are the strongest connections for this family and their children?* •
FUTURE DANGER *Write a separate description of the future danger for each type of alleged harm. The future danger statement should answer three questions: Who is worried? What they are worried might happen? What's the possible negative impact on the children?* **1.**	**SAFETY GOAL** *For each future danger, write a corresponding safety goal. The safety goal should answer three questions: What is the desired outcome? What needs to be happening differently in the care of the children? What's the anticipated positive impact for the children?* **1.**

Kansas DCF Assessment Map

Family Name:		FACTS Case #:		Event Number:	

Lasting Safety

Lasting Safety Scaling Question: On a scale of 0–10 where 10 is the worries for this family are no more serious than for a typical family in our community everyone is confident the kids will grow up safe enough and well enough in their current situation without CPS involvement and 0 is things are so bad for these children that everyone is really worried they are likely to be hurt or suffer lasting/serious negative effects if something doesn't change. Where would you rate this situation today from that 0 to that 10?

0 is… *Use this space to turn the future dangers and corresponding safety goals into case-specific safety scales*

1.

Ratings

Name	Role	Date	Rating

10 is… *Use this space to turn the future dangers and corresponding safety goals into case-specific safety scales*

1.

Reasons for Ratings: *Describe each person's reasons for giving the rating they did on the Lasting Safety Scale.*

-

Next Steps

What steps will be taken to mitigate the risk and build lasting safety with this family for their children?

1.

(5)

Kansas Department for Children and Families

Immediate Safety Plan

PPS 2021
July 2020

Case Head:	Case Number:	Event Number:
Worry Statement:		
To prevent the worries from starting we will:		
If the worries do start, we will respond by:		
These are our safe and supportive people: (names and phone numbers)		

We understand and have helped develop this immediate safety plan:

Parent/Caregiver:	Date:	Parent/Caregiver:	Date:
Child:		Child:	
Family member:		Support Person:	
DCF Worker:		Other:	

Adapted from Safe Generations 2019