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THE FAMILY FIRST PREVENTION SERVICES ACT

A New Opportunity for Expanded Service Delivery to Children and Families in Connecticut

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INTRODUCTION & OVERVIEW

The Family First Prevention Services Act of 2018 (or "Family First") was signed into law in February 2018, and represents one of the most significant pieces of legislation affecting public child welfare and other child-serving systems in over 40 years. **For the first time, a clearly identified stream of federal funding can be used to support the safety, permanency, and well-being of children who are considered *candidates for foster care*; that is, children who may be placed in foster care if areas of need and risk are not addressed.**

Connecticut has many strengths on which to build as the state engages in the planning required to capitalize on new opportunities created by Family First, which will shift its child welfare service delivery system to one that is increasingly focused on cross-sector child well-being.

Family First is a complex, multi-layered law that attempts to remedy most, if not all, of the historic challenges associated with child welfare agency operations, financing, and practice. Though wide-reaching, clear areas of focus are evident in the legislation and its provisions will significantly impact:

- funding for prevention of out-of-home placement;
- emphasis on delivery of family-based, trauma-informed evidence-based treatments;
- new opportunities for engaging in cross-system coordination of funding and service delivery; and
- the use, credentialing, and quality of residential placements.

Family First Offers Connecticut New Opportunities for Federal Funding to Support *Prevention* of Out-Of-Home Placement

Prior to the passage of Family First, federal child welfare funding through Title IV-E had been limited only to addressing the needs of children who have been exposed to abuse and neglect, removed from the home, and placed in the foster care system. Family First changes both who may be served and when services are provided using Title IV-E funds. This new opportunity makes funding available to prioritize family strengthening before a child is removed from their home, and attempts to assure the provision of high quality treatment when a child is removed from their home. By specifying both the type of out of home placement that federal child welfare funds can be used for and the reason for that placement, **Family First attempts to assure prevention services are provided so that children are not removed from their homes due to a lack of appropriate services.**

The way that states define foster care candidacy (i.e., those who are at imminent risk of foster care placement) is a key to implementing Family First and accessing new reimbursement to support prevention-related activities. States have the opportunity to define Family First candidacy in terms of critical underlying risks and needs. For example, federal legislation specifically refers to complex mental health or substance use conditions among children or caregivers, as well as parenting skills deficits. Following federal approval of a state's candidacy definition and the associated prevention plan, federal reimbursement opportunities are available for the services to address those factors. This new and clear focus on prevention of foster care placement among a defined candidate population addresses a long-standing concern among states that did not opt to use Title IV-E funding to pay for services for children defined as "at-risk of placement" due to the fear of financial penalties if the federal government did not agree with their definition. In addition to identifying groups of children and their caregivers as Family First candidates, many states have used Family First as an opportunity to plan for **a coordinated system that enhances access to prevention services for a broader population of children and families** including those who may not meet a Family First candidacy definition, but may be at-risk for negative outcomes.

Family First Prioritizes Family-Based Models of Care

A child's risk for out-of-home placement is frequently driven by parenting and family-related factors. Family First creates incentives for public systems to identify and expand services and supports for children and their biological family members and/or kinship caregivers (family members and some family friends of the affected child). The law creates discretionary grants, with funds available for every state, to develop, refine, and/or evaluate a model of **kinship care support**. It has also recognized several new and innovative models of service delivery for kinship and relative caregivers as promising practices. **States will have new opportunities to address the needs of both children and their caregivers using two-generational approaches to intervention and treatment**, as child- and family-related factors can each contribute to the risk for out-of-home placement. For example, parental substance use is a known risk factor for maltreatment and out-of-home placement, and research clearly supports the importance of promoting attachment in the infant/caregiver relationship. Consequently, Family First allows states to support residential substance use treatment models that allow parents to enter substance use treatment facilities with their young children, exempting such models from the new and more stringent restrictions placed on residential programs.

Family First Requires States to Invest in Delivery of Trauma-Informed Evidence-Based Treatments

Family First promotes effective treatment for behavioral health concerns and trauma exposure as a key strategy for preventing out-of-home placement and **requires states to invest in the delivery of trauma-informed evidence-based interventions**. Among children in the child welfare system, 85 percent have been exposed to at least one potentially traumatic event and most have experienced multiple forms of trauma. If left untreated, trauma exposure can lead to adverse health, behavioral health, family, and school outcomes. Given the high rates of trauma exposure and symptoms in this population, interventions are also required under the law to be trauma-informed. A recent **analysis by CHDI** found that **evidence-based treatments** for trauma and other behavioral health conditions improved outcomes for all children and reduced disparities in treatment for children of color when compared to usual care.

Trauma-informed models of intervention and treatment for children, families, and kinship caregivers will be curated through a new Family First Prevention Services Act Clearinghouse, and over time, only models that have been vetted and approved by this Clearinghouse will be eligible for ongoing federal reimbursement (**https://preventionservices.abtsites.com/**).

The Clearinghouse will review programs for potential inclusion on its list, and classify interventions using a tiered rating system of "well-supported," "supported," "promising," or "does not currently meet criteria." Eligibility for funding will be limited to interventions that achieve one of these first three designations, and states must eventually demonstrate that at least 50 percent of reimbursed expenditures were directed toward the highest level of "well-supported" interventions. As the Clearinghouse continues to review new models for potential inclusion, states may seek provisional approval of a model for a specified period of time while it is under review. States may also seek federal reimbursement for training and administrative costs associated with implementing these services, including data collection and reporting activities.

Connecticut is well-positioned in this area by virtue of having already developed much of the infrastructure and culture to implement evidence-based treatments, some of which have already been approved by the Clearinghouse (e.g., Multisystemic Therapy, Functional Family Therapy, **Trauma-Focused Cognitive Behavioral Therapy**), and others that are likely to be reviewed for inclusion (e.g., high-fidelity Wraparound). It is important to note, however, that the federal guidance on Family First makes clear that Title IV-E is the payer of last resort and that Family First funds cannot supplant other funding sources. In Connecticut, a number of evidence-based treatments (EBTs) are currently funded and implemented as part of the Medicaid state plan and also through state general fund grants. As a result, Connecticut will need to carefully consider the best strategy for maximizing the federal opportunity to expand evidence-based treatments through new financial opportunities in Title IV-E.

Family First Emphasizes Multi-System Collaboration

The law also establishes new requirements for cross-system collaboration in areas not previously required; for example, the Regional Partnership Grants. There are mandatory partners identified in this grant which include the public child welfare agency (DCF), the state agency responsible for substance abuse programs (DCF for children, DMAHS for adults), and the courts (Judicial Branch). Additional optional partners include nonprofit and other service providers, law enforcement, and schools. The goals of this grant program are to improve treatment outcomes for children and caregivers; promote safe, permanent caregiving relationship for children; increase reunification rates for children already in foster care; and facilitate delivery of new prevention services. The Regional Partnership Grants are emblematic of the significant opportunity in Family First to achieve stronger integration among child-serving state agencies and systems, and address and promote better planning, coordination, and funding of prevention-related activities. Champions of various child-serving systems have long been considering opportunities for earlier intervention to prevent deeper-end system involvement (e.g., foster care placement, psychiatric residential treatment, incarceration, and detention), and looking at ways to direct resources toward "front end" promotion and prevention activities within these systems. Family First may create just such an opportunity.

Connecticut is also well-positioned to align recommendations across child-serving systems for addressing the needs of all children, regardless of system involvement, and to offer front-end services that address basic needs, build social-emotional competencies, strengthen families and communities, and prevent placement in the deep end of multiple child-serving systems. Much of this work may be driven by the implementation of a broader prevention system that aligns services for children and families who are not Family First candidates, but would benefit from enhanced access to effective interventions. Various entities (e.g., the Connecticut Behavioral Health Partnership, the **Children's Behavioral Health Plan Implementation Advisory Board**) exist that bring together child-serving state agencies, providers, courts, family partners, and other system stakeholders. These entities may provide a strong platform for planning and collaboration in the implementation of Family First and for guiding and coordinating two-generational family strengthening and behavioral health service delivery strategies that together comprise a full prevention-oriented system.

Family First Restricts Placements in Residential Treatment Programs

Family First provides strict new guidelines about the placement of children in residential treatment when Title IV-E federal funding is used, although the law does not apply to residential placements paid for by other funding streams, such as Medicaid or state general fund dollars. Family First creates a new category of residential placement called Qualified Residential Treatment Providers (QRTPs), which will be the only category of residential treatment that can be funded with Title IV-E funds. QRTPs must meet certain conditions to be eligible for Title IV-E funding including national accreditation, restrictions on how many children can reside in a program, high-quality clinical assessment, and provision of appropriate levels of clinical oversight. The leadership of the public child welfare agency must sign off on a child's placement in a QRTP and a family court judge must also conduct periodic reviews of said placements to assure compliance with all aspects of the law. Ultimately, all parties must attest that placement in a QRTP is the level of treatment a child requires and that the placement is not being made because more appropriate services are not available.

Connecticut is Making Progress in Preparing for Family First Implementation

The State Department of Children and Families (DCF) holds the mandate to oversee both the child welfare and the children's behavioral health systems. As such, they have been engaged in the required planning and preparation to implement Family First legislation, in collaboration with other state agencies and partners. There are a number of reforms over the years that are consistent with **Family First** and can be leveraged and enhanced through these new opportunities. Examples include platforms for multi-system coordination, two-generation service delivery initiatives, a strong network of providers delivering outpatient and in-home evidence-based treatment, data collection and reporting infrastructure, and federal and state initiatives that have established a foundation for operating trauma-informed child welfare, behavioral health, and other systems. Furthermore, efforts over the years to reduce reliance on congregate care has resulted in 90 percent of children who are placed in out-of-home care being placed in family settings, and of those, 43 percent with relatives or kin.

A **Child and Family Services Plan (CFSP)** is required of all states in order to receive federal funding for child welfare services, and has been identified as the mechanism by which states can seek approval for a Family First implementation plan and apply for federal reimbursement. CFSPs are submitted to and reviewed at the federal level by the Children's Bureau of the Administration for Children and Families. The most recent CFSP was submitted by DCF on June 30, 2019 and subsequently approved. It incorporates the core strategies for implementing Family First and will cover services delivered from October 1, 2020 to September 30, 2024. DCF has identified the following goals in the CFSP:

1. Keep children and youth safe with a focus on the most vulnerable populations
2. Engage the workforce through an organizational culture of mutual support
3. Connect systems and processes to achieve timely permanency
4. Contribute to child and family well-being by enhancing assessment and interventions
5. Eliminate racial and ethnic disparate outcomes within our department

Among the most significant changes to the approved CFSP is an enhanced focus on expanding the child protection mandate to include child and family well-being, and to work more closely with other child and family serving agencies and community partners (e.g., community-based organizations, early care and education, public education, health care, family courts). DCF, along with partners and stakeholders across the state, will hold **a series of cross-system and collaborative workgroups (from December 2019 to Spring 2020) to translate Connecticut's CFSP into a prevention and implementation plan** that will be submitted to the federal government by June 2020, and will guide the state's activities in the coming years. Information about the planning and workgroup process can be found at **https://portal.ct.gov/DCF/CTFamilyFirst/Home**.

RECOMMENDATIONS

The following recommendations are offered to support efforts to fully prepare for and implement Family First in Connecticut.

1. Fully and authentically engage youth, families, private and public advocacy groups, providers, and others in the planning and implementation of Family First. Identify existing committees and councils with robust representation from each of these stakeholder groups for the purposes of Family First and broader prevention plan development and implementation.

2. Articulate a definition for Family First candidacy that includes children and families identified through DCF's Careline, as well as children and families who have not yet come into contact with the child protection system. Ensure that the Family First candidacy definition maximizes opportunities for expansion and federal reimbursement of two-generational prevention activities that include family strengthening, parenting skills, mental health and substance use treatment for parenting adults, and children's mental health and substance use services.

3. Inventory current prevention services within DCF, DMHAS, Department of Social Services, Department of Developmental Services, Office of Early Childhood, and other state agencies that can be positioned for federal reimbursement and expansion. Consider putting new dollars into services already funded under the Medicaid State Plan and state general fund grants, making those new dollars eligible for federal reimbursement under Title IV-E.

4. Articulate a vision for cross-sector prevention and promotion of child and family well-being that is accessible to all children, of which Family First candidates and funds will be one portion. Consider using new federal reimbursement coming from Family First to fund the expansion of a prevention service system that includes children and families who are not Family First candidates, but are in need of access to prevention and intervention services.

5. Identify one or more in-home parenting models that can be added to Connecticut's service array, and that are or will be approved by the Clearinghouse for Family First reimbursement.

6. Ensure that families with lived experience in the child protection and foster care systems have direct input into designing appropriate pathways for accessing prevention services and ensuring that Family First messaging is non-stigmatizing and designed to facilitate their participation and engagement in services.

7. Offer further support to community-based providers to implement and sustain approved evidence-based treatments, including: identifying the models that best address community needs; matching the most appropriate model(s) to the needs of each family; ensuring these models are culturally and linguistically appropriate; communicating with children and families about Family First; and enhancing training, data collection, reporting, and quality improvement activities to support and sustain evidence-based service delivery.

8. Provide structured opportunities for DCF area offices and private providers to closely monitor and manage risk among children remaining in the home, and closely monitor data on the total number of children in out-of-home placement as a key outcome for the successful implementation of Family First.