ADMINISTRATION FOR CHILDREN & FAMILIES
Administration on Children, Youth & Families | 330 C Street, S.W., Washington, DC 20201
www.acf.hhs.gov/acyf

August 5, 2025

Anthony Catone
State Director
South Carolina Department of Social Services
1535 Confederate Ave
Columbia, South Carolina 29201

Dear Director Catone,

Thank you for submitting South Carolina's amendment to the agency's approved title IV-E prevention program five-year plan.

Plan Amendment Approval

South Carolina submitted an amendment to the agency's approved title IV-E prevention program five-year plan (five-year plan) to the Children's Bureau (CB). We are pleased to notify you that South Carolina's five-year plan amendment has been found to be in compliance with applicable federal statutory and regulatory requirements. South Carolina's five-year plan amendment is approved as outlined below.

South Carolina's five-year plan amendment is effective from July 1, 2025. Please maintain this approval letter as a part of the final, approved plan.

Title IV-E prevention program federal financial participation claims must be for allowable costs on behalf of eligible program participants and may be submitted for applicable periods beginning no earlier than the above listed plan effective date. Additionally, all program costs other than payments for provision of prevention services directly to program recipients must be identified in an approved cost allocation plan as per federal regulations at 45 CFR §1356.60(c). This cost allocation plan may have an effective date that is the same or later than the title IV-E prevention program five-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan (PACAP) amendment must be submitted addressing title IV-E prevention program administrative and training costs in accordance with applicable regulations at §95.509(a)(3). We encourage the state to review its previously submitted/approved PACAP to determine if updates are required as a result of this amendment to the IV-E Prevention plan.

Data Collection and Reporting Requirements

Pursuant to Section 471(e)(4)(E) of the Act, states electing the title IV-E prevention program are required to collect and report on child-specific data to HHS for each child who receives title IV-E prevention services. South Carolina provided an assurance that the state will collect and submit

information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures. Data element details are provided in Revised Technical Bulletin #1. For amendments, agencies must begin reporting data in the period after the agency's title IV-E amendment is approved. Title IV-E Prevention Program Data submission timelines are provided in Technical Bulletin #2.

Payer of Last Resort

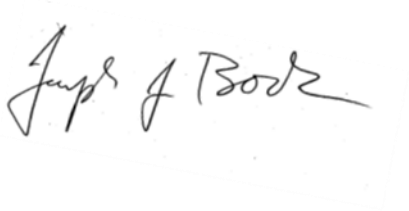
In approving the title IV-E prevention program five-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those providers have the responsibility to pay for these services before the title IV-E agency is required to pay.

The title IV-E prevention program is part of the Children's Bureau's broader vision of advancing national efforts that strengthen the capacity of families to nurture and provide for the well-being of their children. We look forward to working together with you to implement the title IV-E prevention program as part of the broader vision, and to meet our shared goal of keeping families healthy, together and strong.

For any question or concerns you may have, please email the Children's Bureau at ivepreventionprogram@acf.hhs.gov

We wish to thank you and your staff for your work and wish you all the best in implementing your important plan.

Sincerely,



Joseph Bock
Acting Associate Commissioner
Children's Bureau

Enclosures: Plan Submission Certification

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South Carolina:

Building Strong and Thriving Families

Title IV-E Prevention Plan Amendment

DSS
SOUTH CAROLINA
DEPARTMENT *of* SOCIAL SERVICES

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As a condition of the receipt of Prevention Services and Program funds under title IV-E of the Social Security Act (hereinafter, the Act), the South Carolina Department of Social Services submits this plan to provide, in appropriate cases, Prevention Services and Programs under title IV-E of the Act and hereby agrees to administer the programs in accordance with the provisions of this plan, title IV-E of the Act and all applicable Federal regulations and other official issuances of the Department. This Pre-print is provided as an option for title IV-E agencies to use over the course of the five years that the Prevention Services and Programs Plan is in effect.

The state agency understands that if and when title IV-E is amended, or regulations are revised, a new or amended plan for title IV-E that conforms to the revisions must be submitted.

Section I: Introduction

Pre-Print Section 4 (Consultation and Coordination)

The South Carolina Department of Social Services ("the Department" or SCDSS) is charged with protecting the state's most vulnerable populations; its mission, to promote the safety, permanency, and well-being of children[1] while strengthening families. The Department's core principles of competence, courage, and compassion serve as a foundation for all SCDSS efforts. The Department envisions a child welfare system that is trauma-informed, family-centered, strengths-based, and culturally-responsive. The Department's goal is to ensure that children and families thrive in their communities.

On February 9, 2018, President Donald Trump signed the Bipartisan Budget Act of 2018 (H.R. 1892) into law, which included the Family First Prevention Services Act (FFPSA; Public Law 115-123). This Act dramatically changed the way Title IV-E funds can be spent by states and points the nation toward robust prevention strategies. Multiple reforms within the legislation provide a novel opportunity for child welfare to transform into a system of well-being for children and families. This legislation, paired with the SCDSS mission and vision, uniquely poises the state for systemic transformation.

Family First authorizes states, territories, and tribes with an approved Title IV-E prevention plan to provide time-limited prevention and treatment services for mental health, substance use prevention and treatment, and for in-home parent skill-based programs. Services may be provided to children who are identified as "candidates for foster care" and their parents or kin caregivers. It is through the provision of these empirically sound interventions and services that states may strengthen families, reduce the number of children entering out of home placements, and prevent the trauma associated with separating children from their family and natural supports.

The Department is electing to implement the optional Title IV-E Prevention Program authorized by Family First. SCDSS believes that by seizing this opportunity, the Department and it's South Carolina partners will be able to leverage available resources to better achieve the agency mission and strategic vision of transforming to a system of well-being for the children and families of South Carolina.

Vision and System Transformation

Family First came at an opportune time for South Carolina as the Department was then , and currently is undergoing tremendous system transformation. The Department's engagement in Thriving Families, Safer Children: A National Commitment to Well-Being (Thriving Families) exemplifies its commitment to promoting well-being of children, strengthening families, and preventing foster care entry. South Carolina aims to move the child welfare system from a traditional reactive child protection approach to a cross-sector system designed to support holistic and equitable child and family well-being. Thriving Families requires collaboration across public, private, and philanthropic sectors to design a system of well-being and to develop strategies to prevent child maltreatment and avoid unnecessary family separation.

[1] When used in this document, the word *child* or *children* means an eligible person under the age 21.

By building upon the solid foundations established through Thriving Families and Family First, the Department aims to strategically expand and enhance its networks of community-based support for children and families to bolster South Carolina's prevention continuum. SCDSS' commitment lies in embracing a genuine prevention and well-being approach, a sentiment echoed by feedback from families and stakeholders and emphasizes the critical importance of proactive outreach and external support, even before any interaction with the child welfare system.

Within this amendment to South Carolina's approved Title IV-E Prevention Plan, SCDSS is excited to unveil the integration of a community pathway as an alternative prevention strategy beginning with the Parents as Teachers model (PAT). The integration of the PAT is made possible through South Carolina's robust partnership with the South Carolina Office of First Steps (SCFS), which is also the designated state office for PAT by the Parents as Teachers National Center. This choice is rooted in PAT's well-established effectiveness and pre-existing capacity across the state. The community pathway
seamlessly aligns with South Carolina's existing plan, further fortifying its merit as a prevention approach. Central to this strategy is the active involvement of a diverse spectrum of community stakeholders, alongside families and youth with firsthand experience, who together identify the essential support systems, resources, and personalized approaches needed to address the unique needs of families.

SCDSS is channeling resources to enhance youth and family representation across all divisions. To elevate family and youth voice in planning and decision-making, the Department has been collaborating with lived experts through the development of agency policy and practice, as evidenced by its successful partnerships with the Family Voice Alliance (Birth parent Workgroup), Kinship Council, and the Youth Engagement Advisory Council (YEA).

SCDSS has integrated lived experience members in several of its FFPSA, practice model, Subsidized Legal Guardianship, Extension of Foster Care, and various agency wide initiatives. The Capacity Building Center for States has been working with SCDSS and the Family Voice Alliance in creating a mission statement and defining the roles and responsibilities of the group. As the group more clearly defines their role, they will be focusing on creating a structure for implementing youth and family workgroup members across agency initiatives. This includes increasing participation and recruitment, identifying ways to provide stipends and reimbursements, and structuring the integration of workgroup member voices into additional areas across the agency.

In early 2023, SCDSS was awarded an approximately $1 million grant to implement the Iowa Parent Partner approach. This approach pairs peer parents with parents whose children have been removed from the home. Those serving as peers are parents who have former involvement with the child welfare system, who have achieved reunification with their children. The selection process focuses on interpersonal skills, successes, and the proven ability to overcome obstacles. The peer parents provide mentorship through social support, offering guidance on how to navigate the process of reunification, as well as working with the agency to ensure the family is getting needed services and resources. The overall goal of this program is to support reunification and reduce repeat incidences of child maltreatment. In May 2023, SCDSS released a technical assistance grant with the Children and Families of Iowa to support readiness work as the agency prepares for the implementation of the Peer Parents program. In addition to planning for a readiness assessment through this TA grant, SCDSS is in the process of hiring a program manager who will lead this effort.

The Department believes that being in a safe and supportive family positively impacts a child's development. While most families can care for their children with the support of their family, friends, and community, some need the additional support of the child welfare system and network of community partners. Providing supportive and preventive services to the most vulnerable children and families is necessary and urgent. This will largely be dependent on the Department's ability to engage, assess, team, and plan with families, and communities, so that families are not navigating this unfamiliar and often difficult path alone.

The Department's vision is to provide the support necessary so that children and families get what they need, when and where they need it. The amended Family First Prevention Plan detailed herein articulates how South Carolina strives to elevate family voice and choice, fully understand individual strengths and needs, honor culture and beliefs, be sensitive to the trauma experienced, provide responsive services that are aligned with needs, and collaborate as partners with families to achieve common goals. Ultimately, South Carolina's Family First Prevention Plan is designed so that children's holistic well-being is improved, and families are stronger after engaging with us.

In addition to the pairing and cross-leveraging of Thriving Families and Family First, the Department is deploying a set of specific transformation strategies. Each is described below. These strategies combine to amplify each other and serve cohesively towards the development of a system of well-being for children and families across the entire child welfare continuum—from prevention to aftercare. Additionally, the Department, alongside its partners and stakeholders, are engaging in systems learning and continuous quality improvement to identify, deploy, and scale additional cross-sector strategies necessary to create a System of Family and Child Well-being.

Strengthening SCDSS Workforce: Practice Model Development, Training, and Supervision

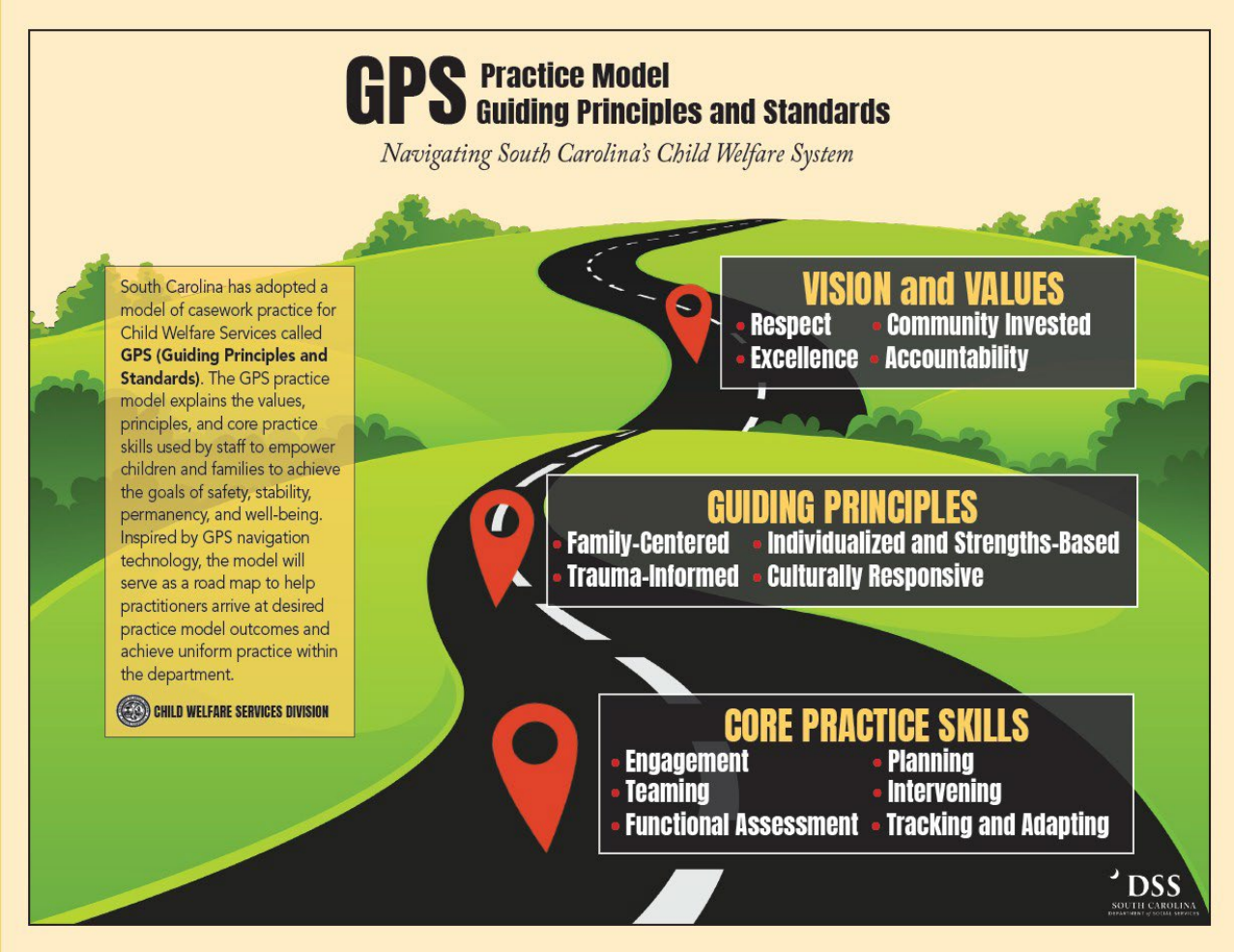
Pre-Print Section 5 & 6 (Child Welfare Workforce Support & Training)

Guiding Principles and Standards (GPS) Practice Model and Child and Family Teaming

The Department has developed and is implementing its Guiding Principles and Standards (GPS) practice model for Child Welfare Services. This new practice model will serve as a catalyst for the culture changes requisite for successful implementation of Family First. As a roadmap for daily practice with families and their support teams, the GPS practice model establishes a new vision for teaming with and serving children and families, demonstrates a commitment to a different way of working with communities and the broader child and family well-being system, and challenges long-held mindsets about how to partner with families.

The GPS practice model values are the behaviors and qualities the Department seeks in those it hires and contracts with for services. As the Department trains and coaches, the workforce and educates partners on the approach and skills necessary, SCDSS expects the guiding principles to be present in every interaction with children, families, and community partners. The values and guiding principles align with the goals of Family First including the recognition that all families are worthy of and deserve respect; services are data-driven, evidence-informed, and culturally relevant; a trauma-informed service array is available to meet the needs of families; and the workforce can deploy the array of community-based services and supports available to meet the needs of the children and families.

Figure 1. SCDSS GPS Practice Model



The Department, as a core component of the practice model, is implementing a collaborative assessment approach and child and family teaming. Families and their support teams are at the center of assessment and decision-making in the team meetings and throughout the teaming process. Teaming with families will elevate their voice and promote alignment of service selection to assessed needs.

To ensure the new practice model is deployed consistently with families, the Department is redesigning the Child Welfare Pre-service Certification and ongoing in-service training. In 2019, the Department's Staff and Training Team began its partnership with Affinità Consulting and the University of South Carolina, Center for Children and Families Studies to assess current training and create the new curriculum. The new training curriculum focuses on strategies for building a prevention-oriented system by including an emphasis on how SCDSS staff can leverage kinship relationships and natural supports to preserve family relationships to prevent future maltreatment and reduce the need for foster care. The training also provides guidance to staff to disrupt bias and overcome personal barriers to ensure best practice and encourage prevention opportunities for the best interest of the families. Chapin Hall at the University of Chicago is providing capacity building as SCDSS stands up new training and coaching of the workforce in child and family teaming. This includes train-the-trainer efforts so that the Department builds ongoing coaching capacity. Lastly, the Department established the Child Welfare Certification Review Team, made up of frontline DSS team leaders, county and regional leadership, consent

decree monitors, and central office program staff, to assist with the training review and finalization. The new training was completed in the Spring of 2021.

Along with training on the practice model and child and family teaming, the Department worked with the Capacity Building Center for States (the Center) to enhance supervisory practice. In collaboration with the Center, SCDSS is providing their team leaders workforce change management and other professional development through training and coaching on evidence-based practices so that team leaders, in turn, can train and coach frontline staff setting both expectations and accountability to an organizational culture focused on prevention and children remaining safely in their home. Using this approach, team leaders will engage with workers ahead of contact with families to prepare case managers to assess needs and identify strengths and opportunities to strengthen families and avert foster care entry.

In 2020, the Department established the Training Advisory group comprised of SCDSS and their organizational consultants and partners (e.g., Chapin Hall at the University of Chicago, the Center, the Annie E. Casey Foundation, the Center for Innovation in Public Health at the University of Kentucky and others involved in the Department's transformation to increase prevention of child maltreatment and foster care reduction). The Training Advisory group is focused on coordination and planned service delivery to support efforts to train and coach the SCDSS workforce on the implementation of the GPS practice model and evidence-based practice. Through the combined assistance of these consultants, SCDSS has already begun to see several positive changes in their practices as they work towards building their prevention framework to strengthen families and keep children out of foster care.

From July 1, 2021 through June 30, 2022, SCDSS partnered with Chapin Hall to implement Phase II of the GPS Practice Model Implementation, which included a coaching model for child and family teaming supervisors and coaches. Activities focused on strengthening policy and practice through enhanced training for the workforce, an evidence-informed coaching model, and SCDSS GPS-enhanced Child and Family Teaming (CFTM) program. Within Phase II of the GPS implementation, SCDSS strengthened their CQI infrastructure and developed fidelity indicators within each of the SCDSS GPS Practice Profiles to ensure workforce fidelity to the model values and principles and the timely achievement of safety, permanency, and well-being outcomes for youth and families.

Along with training on child and family teaming, SCDSS began phase III of the GPS implementation, focusing on embedding the GPS fully into day-to-day child welfare practice through regional coaching, training refreshers using the Coach Approach Framework, peer learning networks, and continuous quality improvement processes. To develop the coaching competency in Child Welfare leaders, the agency chose the Coach Approach to Adaptive Leadership (CAAL) coaching model. The Coach Approach to Adaptive Leadership Coaching Model has its roots in the Atlantic Coast Child Welfare Implementation Center (ACCWIC) Coaching Model. The ACCWIC Model evolved into the CAAL Model through the incorporation of adaptive leadership content which improved the effectiveness and sustainability of the model. Strengthening the ability to implement adaptive leadership and the coach approach framework is a workforce development strategy that will strengthen the quality of supervision, improve and sustain quality case practice, and provide the needed psychological safety allowing staff to feel safe, seen and heard. The agency launched The Child Welfare Academy: Team Leader Certification Training Program in May 2023. This program is designed to provide training and support for intensive supervisory professional development of quality practice standards. It focuses on improving the capacity of team leaders to lead through an understanding of quality practice standards and requirements and an understanding of their role in carrying out the

agency's mission, goals, and values. The training program is an intensive 6-week learning experience focused on the knowledge, skills, and abilities in administrative, supportive, and educational supervision. As of July 2023, the approximate number across all Child Welfare Divisions that have completed Coach Approach is 500 people. This includes: 260 Team Leaders, 55 Team/Program Coordinators, 7 County Deputy Directors, 45 County Directors, 4 Regional Directors and the Deputy Director of Child Welfare and all 5 division leaders along with their direct reports.

Phase III of the GPS implementation also established a partnership with Chapin Hall to build on earlier implementation efforts to establish a GPS practice model and Family First infrastructure within the courts and legal system. While SC judicial partners contributed to the design and development of GPS, the courts and legal community had not been formerly trained or fully engaged in the development of the GPS. DSS believes courts and legal partners could benefit from a better understanding of the DSS child welfare practice model as well as its alignment with the philosophy and requirements associated within Family First. Specifically, DSS and Chapin Hall partnered with the courts to improve child welfare-family-court collaboration to help the state achieve and sustain their desired GPS-related practice changes. Enhancing the courts and legal systems' understanding and ability to apply Family First and GPS values and principles puts children and families at the center of child welfare-court practice and creates a seamless approach to improving family engagement and partnership, safety, well-being, and timely and lasting permanency.

The success of SCDSS practice changes will be measured through regular fidelity reviews, case outcomes, and family/stakeholder feedback. Ultimately, the GPS aims to fundamentally strengthen family engagement, teaming, and child-centered practice. By aligning all system components around this cohesive model, the state hopes to achieve dramatic, lasting improvements in child safety, permanency, and well-being. GPS represents a multi-year culture change process, but one with immense potential to uplift South Carolina's most vulnerable children and families.

Strengthening SCDSS Infrastructure

The Department recognizes that along with an effective workforce, it needs the tools and accountability mechanisms to ensure family decision-making is informed by the best possible evidence. To that end, since 2019, the Department has been working to embed the Structured Decision-Making (SDM) tool into its intake screening model and is building an improved Continuous Quality Improvement system to strengthen accountability to positive outcomes for children, youth, and families. Both initiatives will be important to an effective implementation of South Carolina's Family First Prevention Plan.

To further improve practice and decision-making, the Department's Office of Safety Management has been partnering with the Center to improve safety practices and decision making across the continuum of care, from intake to case closure. The Center's efforts have focused on research, design, development of practice and policy; training; CQI to improve fidelity to practice; improve consistency of decision making at intake; investigation finding decision making; safety assessment threat criteria and safety decision making, in-home safety plan analysis to accurately determine if children can safely remain in the home and prevent out of home care; and, safely and timely reunify children from out of home placement thus reducing the foster care population. All of these activities, individually and collectively, support one or more goals of Family First.

With support from the Center's Safety/In Home Services and Training Advisory group work, SCDSS is focused on creating an organizational culture focused on prevention services and maintaining the safety of children while continuing to keep children safely in their home and engaging families in a collaborative manner. Training and coaching the agency's workforce to set these expectations and hold the workforce accountable to this culture further promotes the Department's goals for Family First.

Assessment of Child and Family Needs and New Tools

Beginning in 2019, the Department has been implementing the Structured Decision-Making (SDM) tool, a tool designed to analyze the information gathered during initial intake and assessment to determine whether a safety threat exists that meets the criteria warranting screening into a CPS investigation. The SDM differs from other assessment tools used during the course of an investigation, as there is a much lower threshold at the time of intake.

Additionally, the Department is implementing the Family Advocacy Support Tool (FAST), a non-custodial decision-making framework that will be aligned with strategies for improving assessment, engagement, safety and case planning, and the provision of services. While the SDM informs intake decisions, the Family Advocacy and Support Tool (FAST) will be completed at investigations and throughout the family's involvement with family preservation. The Child & Adolescent Needs and Strengths (CANS) will be utilized with pregnant and parenting youth in foster care to assess needs and strengths of the family unit. (Please find a detailed description of SCDSS implementation plans for the FAST & CANS below). With multiple assessment tools in place, integration of information is key. The FAST & CANS training for investigations case managers, family preservation case managers, foster care case managers and their team leaders (supervisors) emphasizes the importance of integration of all risk, safety, needs, and strengths data gathered throughout the case. Decision-making is enhanced through these tools, as the workforce has data points informing the opportunity for prevention, the need for specific interventions, measures of progress, overtime, and case closure.

Historical data shows that too many families enter the child welfare system unnecessarily and family preservation cases remain open far longer than is helpful to the family. The use of strengths-based assessment tools, like the FAST and later the CANS, will help increase practice consistency and assessment accuracy as well as help to limit bias and subjectivity in decision- making that can be harmful to children and families. These tools are also intended to help the Department determine with greater specificity which families can be served by prevention services rather than through foster care placement.

The implementation of the Family Advocacy and Support Tool (FAST) and the Child and Adolescent Needs and Strengths (CANS) are integral pieces of SCDSS' work to improve assessment of the needs of children, youth and families. In mid-2019, when initial engagement began, SCDSS approached the provider community for their recommendations for assessment and planning tools. The providers overwhelmingly recommended the CANS for youth in foster care and FAST for investigations and family preservation.

In September 2019, SCDSS staff engagement began with a workgroup that assisted in crafting a FAST/CANS reference guide and algorithm well suited to the state's specific needs. With support and assistance from the Praed Foundation, the FAST/CANS has been developed and was introduced to internal staff and the provider network in March 2020. Engagement continues through information about FAST and CANS being embedded in other trainings such as the Child and Family Team Meeting trainings conducted quarterly throughout the agency.

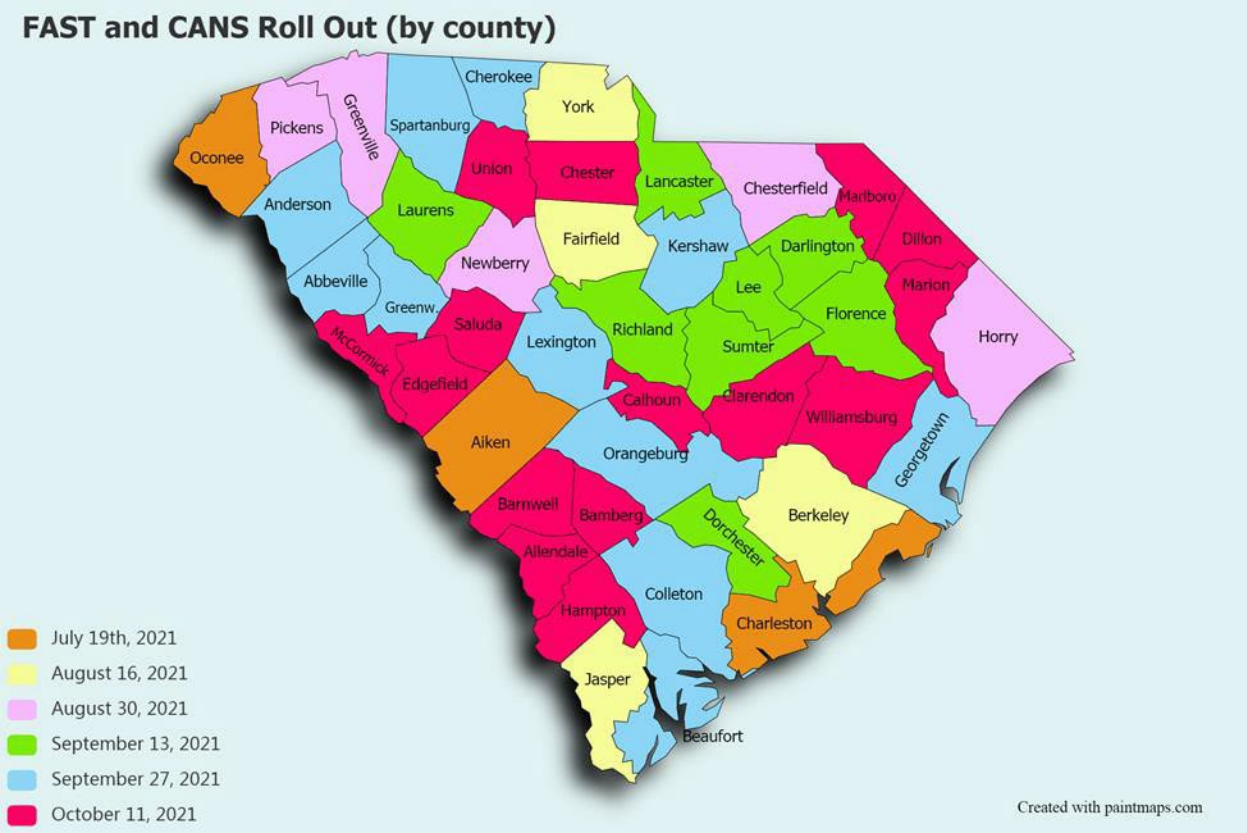
Implementation science teaches us that Engagement, Implementation, Feedback Loops and Sustainability phases are crucial to implementation success. The implementation phase began in September 2020 with Assessment and Planning Coordinators receiving FAST/CANS training and certification. The four regional Assessment and Planning Coordinators will serve as subject matter experts and consultants for Case Managers and Supervisors who will be completing the FAST/CANS. Implementation for frontline staff will begin with five-county pilot in two different regions in February 2021.

Through implementing reforms, SCDSS has learned that training supervisors first to prepare them to implement any new practice is crucial in successful implementation and adoption of new practices. For the pilot counties, Investigations, Family Preservation, and Foster Care Team Leaders will receive the Transformational Collaborative Outcomes Management (TCOM) training. This is an introductory training that helps staff understand what the FAST and CANS are and how they can be used for assessment purposes. Next supervisors will receive the FAST/CANS Item Orientation training in small groups of 25. This training is intended to help staff build skills in completing the FAST/CANS. This cohort of supervisors will also receive two other trainings, a Supervisor Training on how to supervise staff completing the FAST/CANS and Action Planning, translating FAST/CANS into service plans for children, youth, and families. Once supervisors are trained and working towards certification, case managers will then begin the TCOM, Item Orientation, and Action Planning training in March and April 2021. Using lessons learned from the four pilot counties, implementation will begin in the remaining six CFSR Program Improvement Program counties and finally statewide in October 2021.

Following initial CANS and FAST implementation, the SCDSS Assessment and Planning Team began conducting FAST/CANS Refresher training for DSS staff in January 2023. Refresher trainings are held monthly and geared toward enhancing staff knowledge surrounding how to complete the CANS and FAST tools. Training also focuses on topics that case managers and team leaders tend to struggle with while completing the assessment while in the field. The Assessment and Planning team has continued to sponsor monthly coaching sessions for team leaders to assist them with supporting their direct staff members every 2nd Thursday of the month. Additionally, CANS/FAST modules have been updated to strengthen clinical practice, planning, and decision-making. Medical and Physical Modules were added to both the FAST and CANS to ensure appropriate medical care was being provided to children during investigations and family preservations services and to ensure continuity of care occurs when children enter foster care. Similarly, Exploited and Victimization Modules were added to the FAST and CANS in April 2023 to ensure children who may have been victimized and exploited are appropriately identified. There was also a new question section added to the FAST tool to support decision making. These questions will aid the case manager in determining Safety Services such as: developing plans and recording required actions, activities and task for the management and control of safety threats and implementing and creating plans for family situations that may be formal or informal for the management and control of safety threats. Should a combination of ratings fall within the Immediate Intervention standard, the FAST will require additional questions to address Immediate Intervention objectives and plans imposed via case manager or agency. Lastly, the level of care (LOC) Decision Support Module went live in the CANS in April 2023 to assist with identifying appropriate placement for all youth entering foster care and throughout their time in foster care. Specified criteria which identify the LOC recommended are based upon a combination of ratings for specific domain items. The recommended LOC will aid the case manager and Child and Family Team with determining placement that: Enhances and supports the Guiding Principles and Standards Practice Model regarding Child Well Being and Permanency goals and ensures best practice measures are

taken for the least restrictive, most appropriate, and most stable placements available.

Figure 2. FAST/CANS Roll-Out Dates



One of the key lessons learned during SCDSS' reform work thus far is how crucial feedback loops are, both in frequency and early in the process to successful implementation. Currently, implementation feedback loops consist of open weekly calls with frontline staff implementing and planning the reforms. Subject matter includes understanding concerns, addressing barriers and adapting implementation strategies. Implementation of the FAST/CANS will also use this strategy.

Once statewide implementation is completed, work to continually improve implementation of the FAST/CANS will be ongoing. One mechanism for continual quality improvement is Praed's Collaborative Helping Quality Inventory Survey. This is a survey completed by youth, parent/caregiver and frontline professionals. This process will provide information on how youth, parent, caregivers, and frontline professionals are experiencing their work with FAST/CANS. Information from the survey will identify areas needing improvement. A key component of the frontline survey assesses the frontline professionals' supervisory experience. Survey results will help SCDSS know where supervision needs attention and how to address those deficits.

Continuous Quality Improvement

The Department previously engaged with the Capacity Building Center for States to develop a continuous quality improvement system that will deepen a culture of data driven decision-making. Current CQI activities are focused on increasing workforce knowledge and skills, providing critical feedback, tracking performance on the key child maltreatment and foster care

indicators so that SCDSS can target additional training, coaching, supervision, and evaluation efforts in a data informed fashion. South Carolina's Family First continuous quality improvement strategy is a key component and described in detail in Section 6.

Each of the above-described transformation efforts underway is crucial to the Department's development of a System of Family and Child Well-being and the implementation of Family First. SCDSS anticipates significant improvements in the safety, permanency, and well-being of children and families over the course of this five-year Family First Prevention Plan and through the deepening of the Department's commitment to become a prevention-oriented cross-sector system of support for and with families.

Family First: Development of a full continuum of care for prevention services

The Department's initial Family First Prevention Plan was narrowly focused on building a sustainable system of care for children and families. It aligned initiatives across multiple child and family serving agencies with the long-term goal of removing the stigma of seeking assistance and making the shift to a broad child and family well-being system that encompasses a holistic, life-course approach that enables families to thrive and grow. The next phase of system transformation commences with this plan amendment, which includes amending the SCDSS Family First candidacy definition and adding additional well-supported evidence-based services.

The Department has strong partners working to support families across the continuum of prevention services. The Children's Trust of South Carolina offers prevention resources and programming, prevention training and professional development opportunities, including Adverse Childhood Experiences (ACEs) training to community members and professionals. ACEs training helps attendees to understand the impact of adverse experiences on neurodevelopment. Children's Trust also convenes coalitions, like the South Carolina Child Well-Being Coalition seeking to improve opportunities for South Carolina families living in poverty.

South Carolina is also fortunate enough to have a range of well-established providers offering evidence-based prevention services including Nurse-Family Partnership, Strengthening Families Program, Parents as Teachers, Triple P, and Healthy Families America.

Despite having strong prevention partners, the preponderance of resources in South Carolina's child welfare system, as with those in many other states, is focused on its foster care populations and often overlooks the service needs of its non-custodial children and families. Examples of this are apparent in that all foster children are Medicaid eligible (if they are documented citizens) and subsequently are eligible for services that are included in the SC Medicaid State Plan. This coverage enables children to receive services targeted at addressing healthcare needs, behavioral health issues, trauma, and other psychosocial stress responses. Children in care also receive other Departmental supports such as therapeutic wraparound services, educational and training vouchers, and access to family support resources provided by other entities in the state. Whereas children and families receiving Family Preservation services historically have been responsible for financing the provision of services at their own expense. This reality creates a complex conundrum for socio-economically disadvantaged families, as they are sometimes placed in a position to choose between paying for services and meeting their basic needs.

The Department is committed to resolving these systemic barriers as it works towards expanding prevention supports and resources to families and children brought to the attention of Child Welfare. The Department envisions Family First as a core tool to address these challenges, by building a system over time that is equipped to meet the needs of children and families.

This plan amendment represents a significant advancement in the Department's initiatives and collaborations. The original plan featured a range of highly effective programs, including Nurse Family Partnership (NFP), Healthy Families America (HFA), Parents as Teachers (PAT), Brief Strategic Family Therapy (BSFT), Homebuilders, Parent Child Interaction Therapy (PCIT), Functional Family Therapy (FFT), and Multisystemic Family Therapy (MST). Over the last two years the Department has been engaging in ongoing collaboration with the Department of Mental Health and the Department of Juvenile Justice to leverage statewide capacity and implementation of three Evidence Based Practices included in this plan: Brief Strategic Family Therapy, Multisystemic Therapy, and Functional Family Therapy. DSS and DMH have engaged in a Memorandum of Understanding to share the model purveyor and training costs for one Brief Strategic Family Therapy Team in the Upstate. DSS and DJJ are collaborating to determine the best strategy to leverage Multisystemic Therapy and Functional Family Therapy, both of which are being funded throughout the state by DJJ. In 2024, SCDSS intends to further enhance the agency's repertoire of prevention services for families by incorporating two additional well-supported evidence-based interventions, Motivational Interviewing and Intercept.

The Department is implementing Motivational Interviewing (MI) by contracting with local service providers to deliver MI to families receiving a community-based service called Family Resource Connection and Preservation Services (FRCPS). MI will be utilized as a standalone intervention (for families with substance abuse) and as an adjunctive strategy to promote client engagement and motivation. Families with an open investigation or open Family Preservation case may be referred to an FRCPS provider after SCDSS staff determine that the family has a need identified by the FAST and that the identified need can be supported by the provision of Motivational Interviewing and FRCPS. In addition to having primary or secondary issues related to substance abuse, FRCPS will provide assistance with economic and concrete needs, development of parenting skills through an evidence-based model, substance use support, tutoring, and life skills support. FRCPS is delivered in the home or community. The core of FRCPS is MI which will be utilized in every FRCPS service interaction as well as in conjunction with the delivery of in-home parenting skills, substance use disorder support, and other concrete services to promote family engagement and participation in services, address the family's ambivalence towards change, and prevent the need for further child welfare involvement. Families with open investigations or open Family Preservation Cases may receive FRCPS. FRCPS, like other services in the State's Prevention Plan, is only available to families who have an open case through the Department of Social Services Child Welfare Division.

At this time, MI will only be delivered by contractual FRCPS community providers. DSS staff will not utilize MI in case management. Details regarding Family Resource Connection and Preservation Service, along with MI and Intercept, are discussed further in the Prevention Services section of this plan.

Family First: Stakeholder consultation and coordination in planning and implementation

The Department recognizes the critical nature of engaging and coordinating with its community

partners, key stakeholders, and other members of the broader South Carolina family and child well-being system. These partnerships are critical to the development and scaling up of programs and ensure the sustainability and longevity of a continuum of evidence-based services and a system of care that supports families.

SCDSS convened a prevention services workgroup with representation from the Department of Mental Health (DMH), First Steps, Child Advocacy Centers, Project Best, Department of Alcohol and Other Drug Abuse Services (DAODAS), South Carolina Primary Health Care Association (SCPHCA), Department of Health and Human Services (DHHS), Department of Education (DOE), National Youth Advocate Program (NYAP), South Carolina Youth Advocate Program (SCYAP), Justice Works Behavioral Health Services, Carolina Youth Development Center (CYDC), SAFY, South Carolina Infant Childhood Mental Health Association (SCIMHA), Behavioral Health Services Association (BHSA; County 301s), Citizens Review Panel (CRP), A Child's Haven, Epworth Children's Home, the Palmetto Association for Children and Families (PAFCAF), the South Carolina's Children's Trust, the South Carolina Continuum of Care (COC), and the South Carolina Department of Children's Advocacy (SCDCA), members of the Joint Citizens and Legislative Committee on Children (JLCC), along with a number of other community partners. The workgroup also includes SCDSS designated leads working in collaboration across multiple other initiatives including Thriving Families Safer Children, FAST/CANS implementation, Guiding Principles & Standards Practice Model, CFSR/PIP, and Michelle H Consent Decree. By including the leads of these initiatives in the prevention services workgroup ensures communication, alignment of efforts, and cross-project collaboration.

The prevention services workgroup has been central in supporting planning and decision making for Family First including:

- cataloguing the existing EBPs across South Carolina,
- reviewing relevant data to better understand the characteristics of South Carolina's candidacy population, and
- providing recommendations regarding which prevention interventions best align with the needs of children and families in South Carolina and therefore should be included in this Prevention Plan.

The creation of an inventory of family preservation services is one of the most critical supports that SCDSS is building to create and contract with a varied network of providers who can deliver evidenced-based family focused services on a statewide level. The services offered to families are focused on strengthening parental capacities and addressing root causes of child maltreatment through the provision of therapeutic and concrete services that address family needs in the hope of maintaining a child in their home and preventing out of home removals.

The Department has determined to build an effective continuum of resources and services for families, it will need to leverage funding opportunities and will need to continue seeking public-private partnerships to uncover all available resources necessary for lasting transformation in South Carolina. The prevention services workgroup has also assisted the Department in identifying cross-sector funding opportunities to supplement the reimbursement opportunities through Family First.

An innovative offshoot of the prevention services workgroup has taken the form of a task force devoted to developing South Carolina's Family First evidence-based practice capacity building grants. The objective of this specialized group is to improve the quality and reach of services by augmenting the roster of providers and standardizing service delivery across the state. To this end, SCDSS has purposefully utilized capacity-building grants to identify and equip prospective

providers with the required training for implementing a range of interventions, such as Brief Strategic Family Therapy (BSFT), Homebuilders, and Family Centered Treatment. This initiative underscores the Department's commitment to delivering the highest standard of evidence-based services for families and children.

SCDSS has initiated the creation of an EBP provider workgroup committed to the widespread implementation of BSFT, PAT, Homebuilders, Intercept and Motivational Interviewing across the state. This endeavor exemplifies the Department's pledge to empower the Family Preservation case manager workforce with the most effective engagement and practice methodologies and techniques, thereby bolstering the child and family service framework in South Carolina.

In formulating this plan amendment, SCDSS has collaborated closely with the South Carolina Office of First Steps (SCFS), the state agency responsible for administering the PAT program in South Carolina. This collaboration was operationalized through on-going planning meetings to support the development of this amendment and to also support the provision of PAT for children and families who already have some level of child welfare involvement. We believe that through this partnership and thoughtful planning that we are well poised to implement a community pathway for PAT.

SCDSS is also committed to expanding the inclusion of family and youth voice when developing and implementing systems of care and persons with lived experiences in the child welfare system such as birth parents, kin caregivers, and youth. The inclusion of family and youth voice is central to DSS' long-term systemic change, practice improvement, and effective service provision.

In September 2023, SCDSS received a grant from the BlueCross® BlueShield® of South Carolina Foundation to fund the development and implementation of a peer parent mentoring program. Parent Partners will mentor eligible families by providing social support, offering guidance on how to navigate the process of reunification, and working with social workers and other professionals to ensure the family is getting needed resources. SCDSS will utilize the Iowa Parent Partner Approach model, which is rated as a "Promising" practice on the Title IV-E Prevention Services Clearinghouse. The Iowa Parent Partner Approach is rated as a promising practice because at least one study achieved a rating of moderate or high on study design and execution and demonstrated a favorable effect on the target outcomes of child permanency and reunification.

"The South Carolina Department of Social Services is thrilled to begin this work in partnership with the community and individuals with lived expertise thanks to the funding provided through this grant," said Michael Leach, DSS State Director. "Research shows that implementation of Parent Peer Support Models, like the Iowa Parent Partner Approach, increase the likelihood of reunification for children and youth in the foster care system, often reduce the time in care for these children and youth, and decrease the likelihood of re-entry into foster care, or recurrence of experiences of neglect and abuse."

Evidence shows that effective implementation leads to a reduction in trauma experienced for the children and youth whose parents engage in the peer mentor program. Reduction in trauma and decreased recurrence of abuse and neglect have direct impacts on the improved mental, emotional and physical health for the children and youth impacted, as well as for their parents and caregivers.

SCDSS is one of many grant recipients through the BlueCross BlueShield of South Carolina

Foundation. Additional information can be found at https://www.bcbsscfoundation.org/grant-recipients. The BlueCross BlueShield of South Carolina Foundation is an independent licensee of the Blue Cross Blue Shield Association.

Together, the prevention services workgroup and representatives from the Peer Parent Mentoring Program will serve as a feedback loop between the Department, other members of the state's shared child well-being system, and community partners to ensure resources are collectively supporting the needs of children and families across South Carolina.

Section II: Eligibility and Candidacy Identification

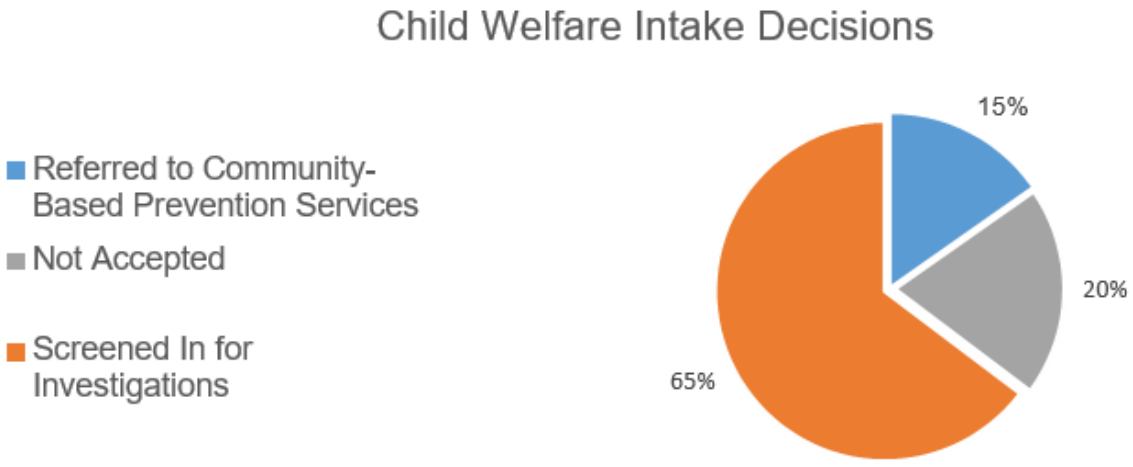
Pre-Print Section 9 (Child and Family Eligibility for Title IV-E Prevention Program)

Background Data

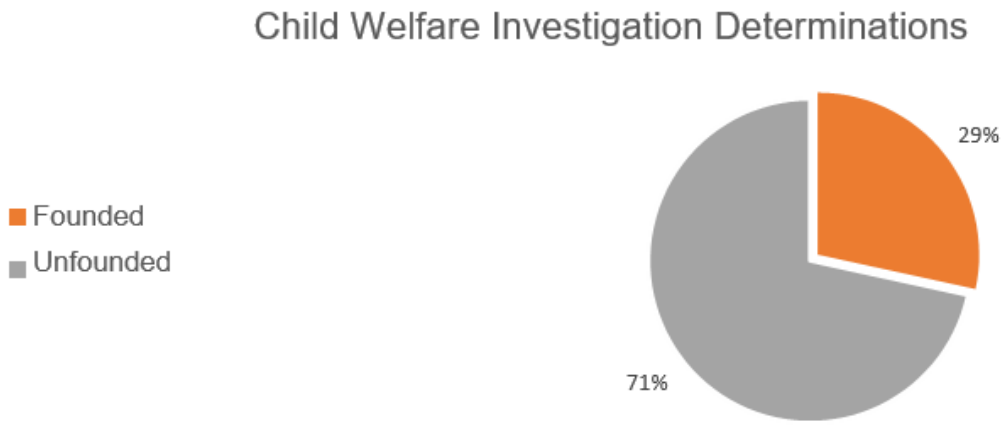
In 2019, the Department's Child and Adult Reporting Hotline received approximately 58,619 reports. Of those reports, 11,706 (20%) were not accepted as they did not meet the threshold to be screened in for investigation and required no further action; 8,959 (15%) were not accepted for investigation but did present with identifiable needs and were referred to Community-Based Prevention Services (CBPS); 37,954 (65%) were screened in for investigations.

Figure 3. Number of Reports by Intake Decision

Intake Decisions	# of Reports
Total Hotline Calls	58,619
Not Accepted (no further action)	11,706/20%
Not Accepted (identifiable needs, referred to CBPS)	8,959/15%
Screened in	37,954/65%



Of the reports accepted for investigations, 29% received a substantiated finding and 71% received an unfounded case determination. This percentage is a decrease in substantiated cases from previous years. In 2018, 33% of investigations were substantiated, and 35% in 2017. Investigations that received a substantiated determination led to the opening of a Family Preservation service case or Foster Care services.

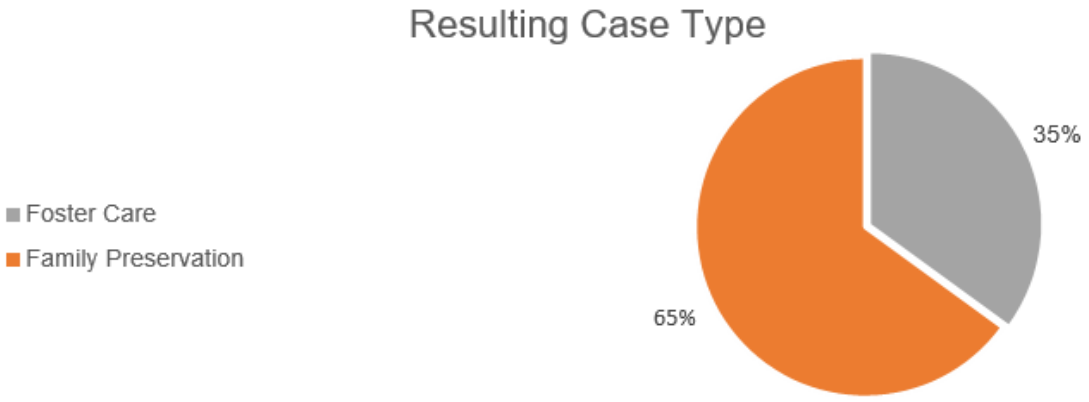


The Department undertook an analysis of the types of maltreatment present in founded cases during 2018 and 2019 to better understand the needs of children and families and the concerns bringing them to the attention of the Department. In both years, neglect and physical abuse were the top two concerns present in founded cases.

Figure 4. Number of Founded Instances of Maltreatment

Founded Types of Maltreatment	2019	2018	% Change
Abandonment	140	116	+21%
Contributing to the Delinquency of a Minor	34	43	-21%
Educational Neglect	841	793	+6%
Medical Abuse and Neglect	380	395	-4%
Mental Injury	71	98	-28%
Neglect	10,230	9,914	+3%
Physical Abuse	10,959	10,591	+3%
Sexual Abuse	1,026	1,070	-4%
Other	22	28	-21%
Note: Multiple maltreatment typologies may be associated with a single case			

Of the cases that were founded in the 2019 review period, approximately 65% were referred to Family Preservation, and 35% resulted in foster care entry. In 2018, 32% of founded cases resulted in foster care entry, and 31% in 2017. SCDSS will deploy Family First prevention services to reverse this trend when appropriate.



During the same review period, approximately 30.1% (n=1242) of children had Family Preservation services directly prior to entry into Foster Care. The Department recognizes this is an opportunity for improvement and will use Family First as a tool for strengthening Family Preservation services and service delivery to families to prevent entry into foster care.

Family Preservation service cases represent approximately two thirds of children and families involved with the Department. These cases are non-custodial and receive short-term, family-centered services designed to assist, support, and strengthen families who have an indicated case of child abuse, neglect, or harm. Services may be delivered to a family voluntarily or by court-order.

Within Family Preservation, services are delivered while children are living in their homes whenever it is safe to do so. The goals of Family Preservation services are to strengthen parental and family capacity to care for and protect children, prevent further maltreatment and trauma, promote overall child well-being, and prevent the need for foster care. Services are deployed based on the Department's mission and GPS values: all children deserve a safe and stable home in which to grow and that they thrive when raised with their families, near their support systems, siblings, extended family, friends, and schools. In keeping with these goals, the Department will leverage Family First to build the service array and strengthen the support families receive when they enter Family Preservation.

Note: Functional assessment data are not presently available to better understand mental health, substance abuse, and parenting needs.

At the time of the initial submission of the Prevention Plan the state was only beginning implementation of FAST/CANS. The FAST/CANS serves as a core strategy to support the Department's increased understanding of child and family strengths and needs.

At the end of FY 2023, more than 13% of children with a prevention case have experienced an adjustment to trauma in a way that is causing problems for the child, 41% had experienced neglect and 8% experienced emotional abuse. The FAST Assessment also measures several emotional/behavioral aspects of the child. The most common challenge for children noted within in-home cases face includes:

- 25% of children with in- home cases had struggles related to school -- 15% school behavior, 25% school attendance, 21% school achievement, and 22% behavioral needs.
- 14% struggle with anxiety and 11% struggle with depression.
- Many others struggle with conduct (4%), delinquency (5%), intentional misbehavior (5%)

and opposition (7%).
- 12% struggle with impulsivity or hyperactivity.

The FAST Assessment also includes items that relate to the child's caregiver and family environment. These include:

- 20% of caregivers with in-home cases are experiencing mental health issues, 39% substance use, 26% criminal activity, 24% parental monitoring, 20% anger control, and 21% difficulties related to caregiver involvement.
- 43% are experiencing family conflict, 40% family safety. 20% financial resources, 17% home maintenance,
- 23% have parents needing parenting knowledge, 30% have parents struggling with parental collaboration, and 17% struggle with residential stability.

Identifying Candidates

There are two candidacy populations eligible for Family First prevention services 1) children who are determined to be at imminent risk for foster care and 2) pregnant or parenting youth who are in foster care. South Carolina estimates the number of pregnant and parenting youth in foster care to be approximately 20 youth currently. When a child is determined to be eligible, the child, parent, and/or kin caregiver of the child may receive prevention services. The pregnant and parenting youth in foster care may have open cases as parents, in addition to being a child in foster care on their own parents' case. If this is the case, both the parenting youth and their child are provided services and resources as children in the child welfare system.

Based on a thorough review of available data, the Department has determined that a child meeting any one of the following criteria would be at imminent risk for entering foster care:

1. All children under 18 named in an open Child Protective Services Investigation (not in Foster Care).
2. All children under 18 who are receiving Family Preservation services.
3. All pregnant or parenting youth in foster care.
4. Children aged 0-5 who are not a part of an open child protective services investigation, family preservation, or foster care case and are enrolled in the SCFS PAT Program, and at least one of the following risk factors is present or imminent.:
    a. Child within a family with a history of child abuse or neglect, but who is not currently experiencing maltreatment.
    b. Child or family is enrolled in or eligible for Temporary Assistance for Needy Families (TANF).
    c. Child or Family is enrolled in or eligible for Supplemental Nutrition Assistance Program (SNAP).
    d. Child or Family is enrolled in or eligible for Woman Infant and Children Nutrition Program (WIC).
    e. Child has a disability or developmental delay as documented by a physician or standardized assessment (not a screening tool).
    f. Child is blind or visually impaired.
    g. Child is deaf or hearing impaired.
    h. Child is eligible for services under the Individuals with Disabilities Education Act, Parts B (Preschool Special Education, ages 3-5) or C (BabyNet, ages 0-3).
    i. A teenage mother/primary caregiver at or under the age of 20 (at the time of the focus child's birth).
    j. Low maternal/primary caregiver education (less than high school graduation at the

time of focus child's birth).

k. Child's parent or caregiver has had a substance abuse issue during the child's lifetime.
l. Child's parent or caregiver has had depression or another mental health condition during the child's lifetime.
m. Child's parent or caregiver has an intellectual disability.
n. Child has been exposed to domestic violence within their family.
o. Child had a low birth weight (under 5.5 lbs.) in association with serious medical complications.
p. English is not the primary language spoken in the child's home and has a need for services.
q. Single parent household and has need of other services.
r. Transient/numerous family relocations and/or homeless.
s. Parent(s) incarcerated in federal or state prison or local jail or was released from incarceration within the past year.
t. Death in the Immediate Family (death of a parent/caregiver or sibling).
u. Child's parent or caregiver is currently serving in the military away from home or has returned from military duty within the last two years.
v. Recent Immigrant or Refugee Family - One or both parents are foreign-born and entered the country within the past 5 years.
w. Child was removed for behavioral reasons from one or more childcare, Head Start or preschool settings
x. Child is enrolled or is eligible for Medicaid
y. Child's parent or caregiver is enrolled or eligible for Medicaid or is within one year after giving birth.

In calendar year 2022, South Carolina's assessment of families receiving Family Preservation services statewide indicates there were approximately 28,053 children under the age of 18. When a child is determined to be eligible, the child, parent, and/or kin caregiver of the child may receive prevention services. Additionally, South Carolina CANS data identifies 20 youth fall into the category of pregnant and parenting while in foster care as of June 30, 2023. When a child is determined to be eligible, the child, parent, and/or kin caregiver of the child may receive prevention services. For those pregnant and parenting youth in foster care who also have open cases as parents, both the youth and their child are eligible to receive prevention services.

Imminent Risk Criteria

A child meets the criteria for candidacy for Family First when they are determined to be at imminent risk for removal if the identified risk and safety issues are not being addressed through the provision of needed specific preventative services. The Department reviewed administrative data to assist in defining the criteria for imminent risk for out of home placement and found the presence of the following characteristics in Family Preservation cases.

Families experiencing substance use disorder: Parental substance use disorders have been found to be a leading contributing factor associated with children entering care in South Carolina. From August to September of 2019, the Department conducted qualitative reviews of Family Preservation and Foster Care populations to evaluate the impact of the opioid epidemic and prevalence of substance usage. Findings indicated that 45% of all Family Preservation cases had a presence of substance use, 21% of which resulted in entry into care. At the close of calendar year 2022, there were 9,841 intakes with substance use screened in. This number includes substance-exposed newborns, exposure to an illegal drug-related activity, and caregiver substance abuse or misuse.

Families with prior child welfare involvement: Families who have had prior involvement with child welfare are at higher risk of foster care entry. The Department analyzed its Foster Care population to understand the extent to which children and families receiving Family Preservation Services later entered foster care. At least 30% of children in Foster Care in calendar year 2019 had a Family Preservation service directly prior to coming into or concurrent at entry into foster care. Moreover, this trend continued for calendar years 2020 (31% or 826 children and youth), 2021 (32% or 952 children and youth), and 2022 (31% or 911 children and youth). Additionally, children and families who exit to reunification are often referred to Family Preservation for transitioning and monitoring and are at risk for re-entry into foster care. In some instances, parents or caregivers receiving Family Preservation services were themselves in foster care.

Families with a history of domestic violence: Families with a history/presence of intimate partner violence and other forms of domestic violence are at risk of entry into care. As of June 2023, approximately 784 children in foster care reported having witnessed or being exposed to family violence according to the SCDSS Child and Adolescent Needs and Strengths (CANS).

Families in unsafe living conditions: The Department finds that unsafe housing, including homelessness, creates significant family instability, elevating parental stressors that contribute to maltreatment and safety concerns for children. As of June 2023, approximately 500 children with an open Family Preservation case reported having a rating of immediate needs (e.g., item score greater than 1) related to home condition, home maintenance, and residential stability on the SCDSS Family Assessment & Support Tool (FAST). For that same time period, 206 children (12.5%) reported having a similar rating (greater than 1) related to their Living Situation on the CANS.

Families with children 0-5: Families who have children that are age five and under in the home are at risk for foster care entry. Children in this age group are uniquely vulnerable and can experience long-lasting neurodevelopmental impacts of child maltreatment without appropriate intervention. In calendar 2022, there were 7,724 children, from birth to age 6, of a total 15,382 children involved in a substantiated investigation. Similarly, for children, birth to age 6 years, there were 7,667 children of 15,246 children with a substantiated maltreatment.

Informal kinship living arrangements: Kinship families caring for children who are not in foster care may need additional support to ensure children can remain with their families. SCDSS tracks and monitors the use of non-custodial kinship placement for children in Family Preservation Services. As of September 18, 2023, there were 1,404 children placed with a kinship caregiver in Family Preservation services.

Families with complex medical needs: Families with complex medical needs include various situations such as parents with medical challenges, medically fragile children, failure to thrive, and children with significant disabilities. Families with complex medical needs would significantly benefit from additional support to build their caregiver capacities and prevent entry into care. In calendar year 2022 there were 224 families with a substantiated investigation for medical neglect.

Children and youth with juvenile justice involvement: The Department and the South Carolina Department of Juvenile Justice (SCDJJ) conduct data matching on an on-going basis to determine the number and percentage of its children in foster care who have or had active cases with SCDJJ. Children in foster care who had been involved with SCDJJ at any point in time is approximately 24%. The Department created a proxy measure, based on its calculated ratios of children in foster care ages 10-17, to identify Family Preservation child populations that likely had concurrent involvement with SCDJJ prior to foster care entry. Using those ratios, the Department estimates that approximately 1,100 children ages 10-17 in open Family Preservation cases as of June 1, 2020 were also involved with SCDJJ.

Children who have been trafficked: Any child or youth under the age of 18 who is a victim of either labor or sex trafficking regardless of whether the perpetrator is a parent, guardian, or other person responsible for the child's welfare. In 2022, there were 111 youth involved in a substantiated investigation for human trafficking.

Families with identified risk of harm: In addition to the specific populations of children and families identified above, SCDSS will use the Family Advocacy and Support Tool to identify families with elevated risk of harm, which places their children at imminent risk of foster care entry.

Candidacy Determination

The Department will automatically flag eligible candidates based on imminent risk criteria embedded within the SCDSS intake and assessment tools. Once the workforce enters the assessment findings into the CAPSS data system, eligible candidates would then be identified for Family First in CAPSS using the IV-E eligibility wizard and Family Advocacy and Support Tool (FAST).

South Carolina will be using the Family Advocacy and Support tool (FAST) to assist in determining eligibility and subsequent referral to appropriate evidence-based interventions. Using the FAST, the investigator or case manager identifies the need for a service. Once the investigator or a case manager enters the child and family's specific assessment information into the FAST, and a specific service is identified in the family permanency plan, initial imminent risk is noted related to the candidacy determination, CAPSS will flag that youth and/or family as an eligible candidate.

The FAST, a multi-purpose planning and decision support tool, will assist the case manager with the comprehensive family assessment that is completed in conjunction with families and their child and family team. Using the FAST, the case manager, along with the child and family team, will ensure services are matched to identified needs. The FAST will also assist in tracking the family's progress in services and as a communication tool across the family and child serving partners.

The investigator or case manager will be in consultation with his/her supervisor during the functional assessment and candidacy determination process. Once candidacy eligibility has been determined, the investigator or case manager will consult with the supervisor to begin the development of the child specific prevention plan and service selection process as described in Section 4 of this Prevention Plan.

SCDSS case managers assess safety and risk on an on-going basis during every contact with a family, thus, imminent risk is continuously monitored and assessed as a part of routine case practice. If a DSS case is closed or the child enters care, they will no longer be eligible for prevention services under the traditional FFPSA pathway.

For families receiving services in their communities from SCFS Parents as Teachers (PAT), there are two separate determinations: PAT eligibility and Title IV-E Prevention Candidacy. SCFS will make the determination of a family's initial eligibility for PAT. SCDSS will make the determination of Title IV-E prevention candidacy. **PAT Eligibility**: Following a referral for services, a family's initial eligibility for PAT services will be determined by SCFS PAT or the local PAT providers using the SCFS PAT intake and screening process. PAT providers use standardized assessment tools to ensure consistent and reliable information throughout the life of the case, inclusive of but not limited to the Healthy Families Parenting Inventory (HFPI). Families eligible for the DSS SCFS PAT community pathway must have one or more of the designated risk factors that are specified in South Carolina's candidacy criteria, as identified above on pages 21-22. **Title IV-E Prevention Candidacy:** At the completion of PAT initial intake and assessment process, PAT submits documentation that includes the identified risk factor(s), the child's DOB and other relevant information. SCDSS then reviews this information to determine whether the family is at "imminent risk" and qualifies as a Title IV-E prevention candidate. Through this two-step process, SCDSS ensures families meet all requirements for accessing PAT services and for Title IV-E prevention services, planning, and claiming.

All children for which the state will be claiming, including those assigned to the community pathway are determined to be at imminent risk of entering foster care by the IV-E agency.

Figure 5. Candidacy Eligibility

Candidacy Population	Staff Determining Eligibility	Process of Determining Eligibility
Children under 18 (not in Foster Care) named in a CPS Investigation	Investigations Case Manager	Begins as "Pending Funding Eligibility". Automatic eligibility confirmation in CAPSS upon creation of Family Permanency Plan and completion of Goal Service with Evidence-Based service selection.
Children aged 0-5 being served by SCFS PAT, without an open investigation or SCDSS case	SCFS in conjunction with DSS.	SCFS Intake assists families in the completion of the PAT intake and risk factors assessment process and obtaining family consent. Risk factors and other child-specific information are shared with DSS who confirms eligibility and makes the determination of candidacy.
Children under 18 being referred to or receiving Family Preservation with 1 or more imminent risk criteria, which can be determined via three (*3) eligibility pathways:*		
1. Through an investigation	Investigations Case Manager	Begins as "Pending Funding Eligibility". Automatic eligibility confirmation in CAPSS upon creation of Family Permanency Plan and completion of Goal Service with Evidence-Based service selection.
2. Existing Family Preservation case	Family Preservation Case Manager and Supervisor	Begins as "Pending Funding Eligibility". Automatic eligibility confirmation in CAPSS upon creation of Family Permanency Plan and completion of Goal Service with Evidence-Based service selection.
3. Exiting Foster Care and entering Family Preservation	Foster Care Case Manager/Family Preservation Case Manager	Once transitioned to Family Preservation. Begins as "Pending Funding Eligibility". Automatic eligibility confirmation in CAPSS upon creation of Family Permanency Plan and completion of Goal Service with Evidence-Based service selection.
Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager	Begins as "Pending Funding Eligibility". Automatic eligibility confirmation in CAPSS upon creation of Family Permanency Plan and completion of Goal Service with Evidence-Based service selection.

Identifying Pregnant and Parenting Youth

SCDSS has included pregnant and parenting youth in foster care within the population to be served by IV-E prevention services. Case managers will assess each pregnant and parenting youth in foster care using the CANS to determine when a prevention plan is needed to support healthy parenting and avoid the need for their child being placed away from their care and into Foster Care. Providing an array of prevention services supports the youth and their children and helps reduce generational entry into foster care.

Eligibility Documentation

The Department's Child and Adult Protective Services System (CAPSS) automatically identifies l candidates at imminent risk of entering foster care when a Family Preservation Service case is created or during investigations. Through the Family Permanency Plan (FPP), caseworkers establish eligibility by adding specific goals and evidence-based services. The process requires the caseworker to explicitly link children as recipients or beneficiaries of the chosen Evidence-Based Practice (EBP) within the goal service. When adding these services, the caseworker must specify service details including start dates, select "Evidence-Based" as the service category, and choose the specific EBP subcategory. The system automatically updates the child's eligibility for Family First funding from "Pending" to "Eligible" once the evidence-based service has been identified and the child is listed as a beneficiary.

For pregnant and parenting youth in foster care, CAPSS continues to identify and document their eligibility for Family First services. The youth's CANS assessment helps determine appropriate service needs and informs the selection of evidence-based interventions through the FPP process.

For families served through the SCFS PAT Program, SCDSS will coordinate with the provider to ensure appropriate PAT eligibility documentation is completed and submitted as required. The PAT staff will assist families with the completion of the intake and risk factor screening process which assesses a wide variety of family needs. When one or more risk factors (listed on page 21-22 above) are identified, SCFS staff will provide SCDSS with the child's date of birth, along with identified risk factors that suggest the child could benefit from the PAT program. SCDSS will respond with a candidacy determination inclusive of the CSPP and provide a unique child identifier. The child's date of birth, unique identifier, and service dates are recorded as data points and will be used as the start date for service eligibility and claiming.

For families in continued need of PAT services 12 months after the date the prevention plan is completed, DSS will work with PAT providers to utilize the aforementioned PAT intake and assessment process to ensure that service eligibility and claiming continue as appropriate. SCDSS will review each plan and ensure all requirements are met by the PAT provider before determining that a child and family are eligible for IV-E prevention services and claiming. Copies of the intake and risk factor screening, and other PAT forms are attached and appear in the appendix of this document.

Section III: Title IV-E Prevention Services

Pre-Print Section I (Service Description and Oversight)

Evidence-Based Practices

There is an ever-growing body of empirically supported interventions that are prevention-focused and address the behavioral, social and emotional needs of child welfare-involved children and families. Family First requires that states utilize prevention services in the categories of mental health and substance use prevention and treatment and in-home parenting skills; and that they be evidence-based, trauma-informed and rated as “promising,” “supported” or “well-supported” by the title IV-E Prevention Services Clearinghouse, to receive federal reimbursement for these services.

South Carolina believes that by (a) anticipating the underlying needs driving the involvement of children and families when they enter the child welfare system, and by (b) rethinking the structure of services delivered throughout the system (i.e. via GPS practice model), and through (c) scaling up evidence-based interventions, SCDSS can better achieve meaningful and measurable improvements in child safety, permanency and child and family well-being. With this in mind, South Carolina is committed to introducing and expanding its use of evidence-based practices (EBPs) that are most likely to result in positive outcomes for children and families, and to measuring the impact of these approaches for the children and families.

Landscape of Evidence-Based Practices in South Carolina

In early 2020, the Department partnered with the University of South Carolina’s Institute of Families in Society and the South Carolina Department of Licensing, Labor, and Regulation (SCLLR) to develop and disseminate a survey to help the Department better understand the landscape of evidence-based practices, provider readiness, and provider self-efficacy with evidence-based practices across the state. The SCLLR disseminated the survey via email to all licensed professional counselors, marriage and family therapists, social workers, psychologist, psycho-educational specialists, addiction counselors, and physicians. Concurrently, the Department, Palmetto Association for Children and Families (PAFCAF), and the Behavioral Health Services Association (BHSA) made their network providers aware of the survey to expand the reach of dissemination.

Over 2,600 individuals responded to the survey, with approximately half reporting they were currently serving children, families, or caregivers. Of the 1,298 respondents currently serving children, families, or caregivers, their geographic distribution spans all counties and regions across the state. The resulting data indicated there are many evidence-based practices being provided across the state. Additionally, the survey provided insight into the characteristics of South Carolina’s child and family serving workforce, and illuminated various factors related to implementation challenges. Each of the survey findings have application that are integral to the successful implementation of prevention services.

The data show that South Carolina’s professional child and family serving workforce is well experienced, with around seventy percent of respondents having over five years of direct service experience, and that service providers are trained on several evidence-based and/or evidence- informed services. Service providers also helped to identify a number of shared implementation barriers for South Carolina. For example, while interventionists overall are confident about their competence and skill using EBPs, they often lacked support from their organization and had insufficient access to supervision. They also reported that EBPs are not integrated with their caseloads or other duties, which can lead to difficulties with fidelity and sustainability, and that there is a lack of on-going training for EBPs available.

Regarding availability of services, South Carolina has mental health, substance use, parenting

programs in each county of the state. Many of these are under review or rated in the Clearinghouse. The most often reported evidence-based practices available throughout the state are:

- Cognitive Behavioral Therapy (CBT),
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT),
- Parents as Teachers (PAT),
- Motivational Interviewing (MI),
- Triple P, and
- Dialectical Behavior Therapy (DBT).

Additionally, other interventions of utility to stabilize families and prevent foster care entry are or have been in place in South Carolina include:

- Parent-Child Interaction Therapy (PCIT),
- Cognitive Processing Therapy (CPT),
- Multisystemic Therapy (MST),
- Nurse-Family Partnership (NFP), and
- Functional Family Therapy (FFT).

The survey findings regarding available evidence-based service array and workforce considerations have helped the Department make informed decisions about its selection of key practices for inclusion in this Prevention Plan. Additionally, the survey was instrumental in pointing the Department to better understand capacity building and implementation needs in order to ensure sustainability of EBPs under this plan. These findings are critically important to South Carolina's implementation and addressed further in the implementation approach section of this document.

Recognizing the current need for intensive in-home services and gap in accessibility, the Department is investing FFTA funds to build capacity around 4 well-supported evidence-based programs across the state. Additional information related to capacity building can be found in the subsection titled *Implementation Approach.*

Training and Supporting the Child Welfare Agency Workforce

As noted previously, Family First requires the selection of prevention services that are trauma-informed and fall into one of three categories: a) Mental Health Prevention and Treatment Services, b) Substance Use Prevention and Treatment Services, and c) In-home parent skills training. In addition to the categorical requirements, interventions must be rated as either 1) Promising, 2) Supported, 3) Well-Supported. These ratings must be assigned by the Title IV-E Prevention Services Clearinghouse (Clearinghouse), or through an approved independent systematic review conducted via a state.

The table below identifies the interventions that South Carolina is including in its Prevention Plan. These evidence-based prevention programs align with the needs of the Department's target populations and have been rated by the Clearinghouse. Each intervention is described in the following subsections.

Figure 6. South Carolina's Proposed Interventions

Targeted Prevention Services	
Brief Strategic Family Therapy	Multisystemic Family Therapy
Parent Child Interaction Therapy	Functional Family Therapy

Parents as Teachers	Homebuilders – Intensive Family Preservation and Reunification Services
Healthy Families America	Nurse-Family Partnership
Motivational Interviewing	Intercept®

Mental Health and Substance Abuse Prevention and Treatment Services

Eligible mental health programs and services include those that aim to prevent, reduce, or eliminate behavioral and emotional disorders. Programs may be delivered to children and youth, adults, or families; can employ any therapeutic modality, including individual, family, and group therapy; and, may have any therapeutic orientation, such as cognitive, cognitive-behavioral, psychodynamic, structural, narrative, etc. Eligible substance abuse prevention and treatment programs and services include those that have an explicit focus on the prevention, reduction, treatment, remediation, and/or elimination of substance use, misuse, or exposure in general. Eligible programs and services can employ any therapeutic modality, including individual, family, or group and may have any therapeutic orientation, such as cognitive, cognitive-behavioral, psychodynamic, structural, narrative, etc.

All model information and ratings in the following section have been gathered from the Clearinghouse website which can be found at: https://preventionservices.abtsites.com/program. Since several programs concurrently serve both mental health and substance abuse services, the selected EBP services and the rationale for both are discussed in the section below.

Parent-Child Interaction Therapy (PCIT)

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability **

Mental Health Program and Services	Parent-Child Interaction Therapy (PCIT)*	Families with children between the ages of 2-7 who experience emotional and behavioral problems that are frequent and intense.	• Build close relationships between parents and their children using adaptive strategies • Help children feel safe and calm by fostering warmth and security between the child and parent • Improve parent-child communication • Increase children's organizational and play skills • Decrease in child's frustration and anger • Enhance child's self-esteem • Improve children's social skills	Fidelity: PCIT: Treatment Integrity Checklist (TIC). The basic clinical fidelity tools are included as part of the standard PCIT protocols which can be found at www.pcit.org. More detailed research measures of therapist competency and fidelity have been developed for studying skill acquisition and fidelity (CEBC website) Manual: Eyberg, S., & Funderburk, B. (2011) Parent-Child Interaction Therapy protocol: 2011. PCIT International, Inc.	N = 26
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Description: 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 that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach 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 are able to achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and caregivers.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 38% meet the age criteria for PCIT and many of these would benefit from a structured mental health intervention. PCIT aligns with two of South Carolina's imminent risk criteria of children 0-5 and families with complex psychological and/or behavioral health needs. South Carolina currently has existing, though limited capacity, to offer PCIT and will leverage Family First to build additional infrastructure and expand the availability

of PCIT over the next five years.

Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), and Multisystemic Therapy (MST)

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability **
Mental Health and Substance Abuse Prevention and Treatment Programs	Brief Strategic Family Therapy (BSFT)*	Families with children or adolescents 6 to 17 who display or are at risk of developing problem behaviors, antisocial peer associations, bullying, truancy, or drug use and dependency	• Reduction in behavior problems, while improving self-control • Reduce associations with antisocial peers • Reduce drug use • Develop prosocial patterns • Improvements in maladaptive patterns of family interactions • Improvements in family communication, conflict resolution, and child family bonding	Fidelity: The BSFT Therapist Adherence Form & Clinical Supervision Checklist Manual: Szapocznik, J. Hervis, O., & Schwartz, S. (2003). Brief Strategic Family Therapy for adolescent drug abuse (NIH Pub. No. 03-4751). National Institute on Drug Abuse	N = 0
	Functional Family Therapy (FFT)*	Children and adolescents between 11-18 years old who experience problem behaviors such as conduct disorder, violent acting-out, and substance abuse	• Eliminate youth referral problems (i.e. delinquency, oppositional behaviors, violence, substance use) • Improve prosocial behaviors (i.e. school attendance) • Improve family and individual skills	Fidelity: FFT web-based Client Services System (CSS) is used to monitor program fidelity. Quarterly ratings are used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model. Fidelity and Dissemination Adherence Scores Manual: Alexander, J.A., Waldron, H.B., & Robbins, M.S., &	N = 31

				Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association	
	Multisystemic Therapy (MST)*	Youth 12 to 17 with possible substance use issues who are at risk of out- of-home placement due to antisocial or delinquent behaviors and/or youth involved with juvenile justice systems	• Eliminate or reduce the frequency and severity of the youth's referral behavior(s) • Empower parents with skills and resources to independently address difficulties associated with the identified behavior(s)	Fidelity: The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a Therapist's adherence to the MST model as reported by the primary caregiver of the family. The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists. (CEBC website) Manual: Henggeler, S. W., Schoenwald, S. K., Borduin, C. M.,	N=33

				Rowland, M. D., & Cunningham, P. B. (2009). Multisystemic Therapy for antisocial behavior in children and adolescents (2nd ed.). Guilford Press.	
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Brief Strategic Family Therapy (BSFT)

Description: Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. There are three intervention components. First, counselors establish relationships with family members to better understand and 'join' the family system. Second, counselors observe how family members engage with one another in order to identify interactional patterns that are associated with problematic youth behavior. Third, counselors work in the present, using reframes, assigning tasks and coaching family members to try new ways of relating to one another to promote more effective and adaptive family interactions. BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes. BSFT counselors are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral interventions and family systems theory.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 56% meet the age criteria for BSFT. Data also show a percentage of active Family Preservation cases with concurrent juvenile justice involvement. BSFT aligns closely with South Carolina's imminent risk criteria of dually-involved youth, and could also address child substance use disorder. BSFT is an appealing intervention for South Carolina because of broad eligibly age range of child and youth populations, cross-system treatment focus, and the flexibly of where it can be delivered, specifically in homes. The most recent Child and Family Services Review (CFSR), for example, identified transportation as one of the common challenges to parents accessing available services and the in-home delivery format would address this barrier. South Carolina is in the process of building the infrastructure to offer BSFT over the next five years.

Functional Family Therapy (FFT)

Description: Functional Family Therapy (FFT) is a short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of three to six months. Master's level therapists provide FFT. They work as a part of an FFT-supervised unit and receive ongoing support from their local unit and FFT training organization.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 29% meet the age criteria for FFT with a subset having concurrent juvenile justice involvement. FFT aligns closely with South Carolina's imminent risk criteria of dually-involved youth, families with complex psychological and/or behavioral health needs, and could also address child substance use disorder. This makes FFT an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibly of where it can be delivered (e.g. homes, schools). South Carolina is in the process of building the infrastructure to offer FFT over the next five years.

Multisystemic Therapy (MST)

Description: Multisystemic Therapy (MST) is an intensive treatment for troubled youth delivered in multiple settings. This program aims 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. MST program addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of three to five months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 23% meet the age criteria for MST with a subset having concurrent juvenile justice involvement. MST aligns closely with South Carolina's imminent risk criteria of dually-involved youth, families with complex psychological and/or behavioral health needs, and could also address child substance use disorder. MST is a desired intervention for South Carolina because of emphasis on dual-system youth, co-occurring mental health and substance use problems, and the flexibly of where it can be delivered (e.g. homes, schools). MST has been offered in South Carolina in the past and is in the process of re-building the infrastructure to offer it over the next five years.

In selecting these interventions (e.g., BSFT, FFT and MST), South Carolina is choosing three interventions for older youth with behavioral challenges as a combined strategy to reduce entries into foster care and subsequently into congregate care. Data shows that far too many older youth who enter foster care are ultimately placed into congregate care. The constellation of these interventions is purposeful to bring extensive capacity to bear for these children and families and subsequently addresses one of the Department's priority outcomes through Family

First, to reduce entry and stay in congregate care.

In-Home Parent Skills-Based Programs

Eligible parent skill-based programs and services include those that are psychological, educational, or behavioral interventions or treatments, broadly defined, that involve direct intervention with a parent or caregiver. Direct intervention contact means that intervention services are provided directly to the parent(s) or caregiver(s); children may be present or involved but are not required to be present for a program to be eligible. Programs may be explicitly delivered as in-home interventions, or the skills learned by parents can be deployed in the home. All model information and ratings in the following section have been gathered from the Clearinghouse website which can be found at: preventionservices.abtsites.com/program

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability **
In-Home Parenting Skills-Based Services	Homebuilders – Intensive Family Preservation and Reunification Services*	Families with children (birth to 18) at imminent risk of placement into or needing intensive services to return from, foster care, group, or residential treatment, psychiatric hospitals, or juvenile rehabilitation facilities	Teach families the skills needed to prevent placement or successfully reunify with children	Fidelity: HOMEBUILDERS Fidelity Measures- includes specific indicators and performance measures found within the HOMEBUILDERS Implementation Guide. Each of the 20 HOMEBUILDERS Standards has multiple fidelity measures available at www.institutefamily.org. Furthermore, HOMEBUILDERS uses a quality enhancement system known as QUEST to assure quality through the development and continual improvement of the knowledge and skills needed to meet model fidelity and service outcomes. Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS	N = 5

				Model. New York, NY: Taylor Francis.	
	Parents as Teachers (PAT)*	Families with children 0-5	• Child Development and School Readiness • Family Economic Self-Sufficiency • Positive Parenting Practices (parent-child interactions) Reductions in Child Maltreatment	Fidelity: The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report. (CEBC) Manual: Parents as Teachers National Center, Inc. (2016). Foundational curriculum. Parents as Teachers National Center, Inc. (2014). Foundational 2 curriculum: 3 years through kindergarten. PAT Foundational Curriculum is available to support families birth to 3; PAT Foundational 2 Curriculum is available to support families 3 through Kindergarten. (Title IV-E Clearinghouse)	N=23
	Healthy Families America (HFA)*	Families with children 0-5	• Reduction in child maltreatment Improved parent-child interactions and	Fidelity: HFA requires implementing sites to utilize the HFA Best Practice Standards and to demonstrate fidelity to the standards	N=18

			children's social-emotional well-being • Increase school readiness • Promote child physical health and development • Increase access to primary care medical and community services • Decrease child injuries and emergency department use	through periodic accreditation site visits. There are 152 standards, and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model. Manuals: 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.	
	Nurse-Family Partnership (NFP)*	Young, first-time, low-income mothers beginning in early pregnancy through their child's first two years	• Measurable gains in individual self-worth of parents and children • Measurable gains in parental empathy and meeting their own adult needs in healthy ways • Utilization of dignified, non-violent disciplinary strategies and practices • Measurable gains in nurturing parenting beliefs, knowledge and utilization	Fidelity: Nurse-Family Partnership Model Elements. Nurses collect client and home visit data as specified by the Nurse-Family Partnership National Program Office, and all data is sent to the Nurse-Family Partnership National Program Office's national database. The Nurse-Family Partnership National Program Office reports out data to agencies to assess and guide program implementation, and agencies use these reports to monitor, identify and improve variances, and assure fidelity to the NFP model (CEBC).	N=6

			of skills and strategies as measured by program assessment interventions	Manual: Nurse Family Partnership. (2020). Visit-to-visit guidelines Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamilypartnership.org/ Core education about the Nurse-Family Partnership (NFP) model. New nurses also learn the Visit-to-Visit Guidelines, which provide a consistent content and structure for each of the 64 planned home visits. (CEBC).	
	Intercept®*	Children and youth ages 0-18 with emotional and/or behavioral problems or have experienced abuse or neglect and are at risk of entry or re-entry into out-of-home placement	Increased parental use of non-violent discipline, more effective parenting skills, higher levels of emotional support, greater understanding of trauma's impact on self and others in the short-term and lower incidence and severity of future maltreatment in the intermediate-term and lower entry into foster care over the long-term Improved child functioning over time (school status, involvement with justice system; older youth assessed on employment, pregnancy, and	Fidelity: Family Intervention Specialists complete comprehensive orientation including on the job training and four-day Clinical Foundations training, weekly consultation with a Licensed Program Expert (LPE) via GuideTree; LPEs attend yearlong training and coaching and are supervised by a Clinical Services Program Manager; Clinical Supervisors work with Specialists weekly; Youth Villages performs program model reviews utilizing a random selection of cases and completes a Balanced Scorecard measuring monthly census, staff caseload, staff tenure, percent of successful discharges, and number of critical incidents.	SCDSS is working directly with Youth Villages (Intercept Purveyor) to build capacity in Intercept.

			parenting)	Finally, Youth Villages conducts quarterly meetings with state leadership to discuss implementation issues. Manual: Goldsmith, T. (Ed.). (2007). *Youth Villages clinical protocols treatment manual*. Youth Villages. Youth villages clinical protocols treatment manual in provided online through the Clinical Portal.	
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Homebuilders – Intensive Family Preservation and Reunification Services

Description: Homebuilders provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Homebuilders practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. Homebuilders practitioners then collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety. Homebuilders utilizes research-based intervention strategies including Motivational Interviewing, a variety of cognitive and behavioral strategies, and teaching methods intended to teach new skills and facilitate behavior change. Practitioners support families by providing concrete goods and services related to the intervention goals, collaborating with formal and informal community supports and systems, and teaching family members to advocate for themselves. Homebuilders services are concentrated during a period of 4 to 6 weeks with the goal of preventing out-of-home placement and achieving reunification. Within Homebuilders, therapists typically have small caseloads of 2 families at a time. Families typically receive 40 or more hours of direct face-to-face services. The family's therapist is available to family members 24 hours per day, 7 days per week. Treatment services primarily take place in the client's home. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience.

Rationale: Homebuilders aligns with many of the South Carolina's imminent risk criteria, and specifically can be utilized with families with prior child welfare experience or who are transitioning to family preservation from foster care. Because of the broad applicability to a wide range of children, youth and families, with the specific focus on family preservation and prevention of foster care entry, South Carolina intends to invest heavily in building the infrastructure to offer Homebuilders statewide.

Parents as Teachers (PAT)

Description: Parents as Teachers (PAT) is an intervention aimed at families with children 0-5 years old. PAT is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. Parent educators must also attend five days of PAT training.

Rationale: South Carolina's analysis of the children receiving Family Preservation services, as of June 2020, show that approximately 43% meet the age criteria for PAT. Moreover, analysis also show that children ages five and under are more likely than older children and youth to enter foster care after a finding of maltreatment. South Carolina believes that one strategy to reduce foster care entries is by expanding in-home parenting services to parents of young children. PAT is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there is an established PAT provider infrastructure and partnership through the states' Head Start program. Family First provides additional resources to expand the reach of PAT statewide.

Healthy Families America (HFA)

Description: Healthy Families America (HFA) is a home visiting program for new and expectant families with children 0-5 years old who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Each HFA site can determine which family and parent characteristics it targets.

Rationale: South Carolina's analysis of the children and families receiving Family Preservation services, as of June 2020, show that approximately 8% are one year of age or under and a subset meet the age criteria for HFA. Five-year fatality trends also show that children under one year of age account for over half of all maltreatment-related child fatalities. South Carolina believes that one strategy to reduce severe physical abuse resulting in child fatalities is by expanding in-home parenting services to new and expectant parents. HFA is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there is an established HFA provider infrastructure but with limited providers, primarily in the Greenville, SC area. Family First provides an additional opportunity to expand the reach of HFA statewide.

Nurse Family Partnership (NFP)

Description: Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses for young, first-time, low-income mothers beginning in early pregnancy through their child's first two years. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother. NFP aims for 60 visits that last 60-75 minutes each in the home or a location of the mother's choosing. For the first month after enrollment, visits occur weekly. Then, they are held bi-weekly or on an as-needed basis.

Rationale: NFP is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. NFP also aligns well with the imminent risk criteria of children 0-5 and families of children with complex medical needs. Presently, there is a sizable NFP network in specific regions of South Carolina with a good partnership for data sharing.

Intercept®

Description: Intercept®, developed by Youth Villages, is an integrated, intensive in-home parenting skills program used to safely prevent children from entering out-of-home care or to reunify them with family as quickly as possible if a period of out-of-home care is necessary. Out-of-home care includes, but is not limited to, foster care, residential treatment, or group home settings. Intercept is appropriate for children ranging in age from birth to 18, with services lasting four to nine months (typically, four to six months for prevention or six to nine months for reunification). Family Intervention Specialists work with both the child and the caregivers to address issues impacting the stability of the family, meeting an average of three times weekly in the home or community, depending on family need, and providing 24-hour on-call crisis support. Family Intervention Specialists have small caseloads of four to five families and provide trauma-informed care. Intercept works in all the areas that surround the child – family, school, peer group, neighborhood – providing evidence-based and research-informed interventions. Following a detailed case conceptualization process, Family Intervention Specialists collaborate with other providers, schools, case workers, courts, and other community supports to formulate individualized treatment plans. The treatment plans are reviewed bi-weekly with Licensed Program Experts, assuring fidelity with the program model. Family Intervention Specialists receive extensive, ongoing training from the Licensed Program Experts to continually improve their skills. Progress with children and families is measured through ongoing assessment and review. The comprehensive treatment approach includes advocating extensively to access community resources and linking to long-term, ongoing support. This program provides services to children and youth from birth to age 18 who 1) have emotional and/or behavioral problems, or 2) have experienced abuse and/or neglect. Intercept targets youth at high risk of entering foster care or other out-of-home placements.

Rationale: SCDSS recognizes the need for Intercept® to address the multiple issues of families with children under 18 years of age. Routinely, DSS examines its intakes, substantiated investigations, and open service lines in Family Preservation and Foster Care for trends from a wide array of internal data sources to gain a deeper understanding of the populations it serves.

Although DSS is still in the early stages of utilizing the FAST assessment, it has proven to be a valuable tool to guide decisions about services and planning. Administered initially during the investigation and subsequently updated as the family receives services through Family

Preservation, the FAST assessment has yielded a wealth of information about the families and their children. Using an analysis on all open Family Preservation Services (July 1, 2023), DSS learned that collectively a quarter of families had issues related to the child's behavior and emotional needs within the home and school environment. FAST ratings greater than zero were used to indicate the child's and/or family's needs. Examples include 15% of the children had identified needs with school behavior, 25% with school attendance, and 21% with school achievement. Many of the same families, no doubt, had needs crossing multiple items but, at a minimum, 25% had an identified need in school related items. (Data was not unduplicated across items). Families were also faced with children having significant behavioral needs (22%), often secondary to acute or chronic trauma (Adjustment to trauma 13%). Similarly, forty-three percent (43%) of families were identified as having a need for help with family conflict. Twenty-three percent (23%) needed help with knowledge of their family and children's needs.

Evidence to support SCDSS need for Intercept® was also seen in data routinely collected on Foster Care. DSS tracks by calendar year the reasons why children and youth enter care. For the last two calendar years (2022 and 2023), the behavior of the child was identified as the 6th most common reason for a child or youth entrance into foster care. As might be expected, the number was slightly higher for teenagers (7%) entering care due to behavior issues. South Carolina intends to provide Intercept® as a family reunification intervention as well. In these situations, the referral process will be initiated 60 days prior to planned reunification so the service can begin prior to the case being transferred to Family Preservation for ongoing support and monitoring. DSS will fund 100% of Intercept® for families engaged while their foster case is open. IV-E claiming will only begin once the Family Preservation case is open.

Motivational Interviewing

Motivational Interviewing

Description: Motivational Interviewing (MI) is an evidence-based treatment that addresses engagement, motivation, and ambivalence to change. It emphasizes using a directive, patient-centered style of interaction to promote behavioral change by helping patients explore and resolve ambivalence. As an evidence-based counseling approach, health care providers and other clinicians use MI to help patients adhere to treatment recommendations. While MI was originally used to help treat substance dependency, research related to the impact and efficacy of Motivational Interviewing has shown considerable success promoting family engagement and participation in case planning and service interventions including in-home parenting skill-building, and mental health treatment.

For families with an open investigation or open Family Preservation case receiving FRCPS services, Motivational Interviewing will be used as an engagement intervention with families in need of substance abuse prevention and support services, in-home parenting skill-based, and/or mental health prevention and treatment services to promote their participation in services, motivation, and commitment to change through the Family Resource Connection and Preservation Service.

MI is a conversational approach designed to help people with the following:

- Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs)
- Express in their own words their desire for change (i.e., "change-talk")
- Examine their ambivalence about the change
- Plan for and begin the process of change

- Elicit and strengthen change-talk
- Enhance their confidence in taking action and noticing that even small, incremental changes are important
- Strengthen their commitment to change

Rationale: SCDSS intends to use Motivational Interviewing (MI) for treatment of substance use within the Family Resource Connection and Preservation service and to promote engagement and address ambivalence towards change for families receiving services for parenting skills, mental health concerns, and other services. Family Resource Connection and Preservation is a community-based service delivered by contracted service providers in the family's home or community.

As it relates to families with substance use disorders, recent data from the SCDSS Division of Accountability, Data, and Research, utilizing the SDM tool for intakes, reveals that 15,163 or 23% of all SCDSS intakes in calendar year 2023 were related to substance abuse. This data, extracted from CAPSS on May 1, 2024, provides a comprehensive view of substance abuse-related intakes. Of these 15,163 intakes:

- 1,785 (3%) involved substance-affected newborns
- 10,408 (16%) involved exposure to illegal drugs
- 3,227 (5%) involved caregiver substance misuse or abuse

Further support for the use of MI in SCDSS is also noted through the Department's use of the FAST. Through an analysis on all open Family Preservation Services FAST assessments (July 1, 2023), DSS learned that 39% of its families had a rating greater than 0 in caregiver substance use. A score of 1 or higher is indicative of some level of difficulties associated with substance use. Seventeen percent (17%) had a rating greater than one, suggesting a need for immediate therapeutic intervention.

Similarly, evidence for the need for Motivational Interviewing was also seen in data routinely collected on Foster Care. DSS tracks by calendar year the reasons why children and youth enter care. For the last two calendar years (2022 and 2023), drug abuse by the parent ranked 3rd as to why the child or youth entered care (e.g., 416 children or youth in calendar year 2022 and 404 children or youth in 2021.

While MI's efficacy is grounded originally in substance abuse treatment, research has shown MI an effective tool to engage families and enhance their motivation to participate in services to support families and reduce foster care entry. In a literature review regarding MI practices, 12 of 16 articles documented MI's value of improving multiple outcomes, including parenting skills, parent and child mental health, retention in services, substance use, and recidivism in child welfare involvement.

As stated previously, Motivational Interviewing will be implemented within the Department's Family Resource Connection and Preservation Service (FRCPS) and available to families who have an open Investigations or Family Preservation Service line and a need as identified in the FAST assessment. MI will serve to increase families' engagement and successful completion of the child specific prevention plan and increase participation in a broad range of services and supports to prevent child removal.

Motivational interviewing is the core of Family Resource Connection and Preservation Services.

All Family Resource Specialists Family Resource Specialists within the FRCPS program will receive training by an approved MI trainer. FRCPS staff will utilize MI to support and team with families to achieve the goals in their Child Specific Prevention Plan. Within the FRCPS program, MI will be used to engage the family in planning and delivery of services by wrapping the family with in-home parenting, homemaker services, career exploration, substance use disorder support, and concrete service delivery. DSS will partner with a motivational interviewing trainer to ensure all services will be trained and delivered to fidelity utilizing Motivational Interviewing practice standards.

DSS investigations and Family Preservation case managers will determine the need for a referral to FRCPS using the families completed FAST, during collaboration with the family and in case consultations with their Team Lead. Criteria for referral to Family Resource Connection and Preservation Services includes a rating of 2 or 3 on any item in the following domains on the FAST: Family Functioning, Advocacy and Capacity or Caregiver Needs.

During an investigation, the Investigations Case Manager completes a FAST assessment. If FRCPS is identified as an appropriate service, the DSS investigations case manager will document the need in the child's prevention plan and refer the family to Family Resource Connection and Preservation Services (FRCPS).

During a Family Preservation case, if a family is already involved with FRCPS from a referral during the Investigation, the DSS case manager may continue to monitor and update the child's prevention plan until the case is closed. If the family has an open Family Preservation case and the Family Preservation Case Manager identifies the need for FRCPS with the family's updated FAST assessment and in collaboration with the family, they may make a referral to FRCPS at that time. The Case Manager, Team Lead, and family team will meet regularly to determine whether FRCPS is meeting the goals and objectives in the family's Family Permanency Plan. Efforts to successfully complete services before case closure must be made by the family team.

Service Type	Intervention	Target Population	Program Goals	Fidelity Measure	EBP Availability **
Engagement strategy to promote engagement for families needing substance abuse prevention and treatment support, parenting skills, and/or mental health prevention or support.	Motivational Interviewing *	Caregivers of children referred to the child welfare system Has been used with adolescents	• Enhance internal motivation to change • Reinforce this motivation • Develop a plan to achieve change	Fidelity: MI has multiple tools available to ensure fidelity. SCDSS is considering the Motivational Interviewing Treatment Integrity (MITI) instrument, as a fidelity measure uses coaching to work toward proficiency through observation, note review, or role playing. A final decision for a fidelity tool will be	N = 46

				determined in conjunction with DSS Data-CQI. Manual: Miller, W. R., & Rollnick, S. (2012). Motivational Interviewing: Helping people change (3rd ed.). Guilford Press	
*Clearinghouse Rating: Well-Supported **# of Counties (N=46) with one or more provider					

Future Service Considerations

As South Carolina continues to develop its prevention continuum, SCDSS will monitor changes to the Title IV-E Prevention Services Clearinghouse and will seek opportunities to expand South Carolina's service array as the Clearinghouse grows. Specifically, South Carolina has a strong provider community offering TF-CBT (N=597 providers across the state), which is currently rated as "promising" by the Clearinghouse and requires a rigorous evaluation to receive federal Family First reimbursement. At this time, the Department does not plan to conduct an evaluation but will continue to monitor the rating status of TF-CBT. Once it achieves a "well-supported" rating, the Department plans to add this intervention to its Family First prevention services continuum and integrate it into the overall Family First Continuous Quality Improvement (CQI) process. A similar approach will also be used with two additional interventions with strong support in South Carolina: Attachment, Bio-Behavioral Catch-Up/ABC (N = 124) and Family Centered Treatment (N= 74).

Trauma-Informed Service Delivery

The Department's transformation efforts are steeped in its mission, vision and newly developed practice model (GPS) and commitment to ensuring that all services delivered to youth and families are family-centered, individualized and strengths-based, culturally responsive, and trauma- informed. Integration of South Carolina's trauma-informed framework into practice requires ongoing training and coaching for internal staff and contracted providers of the evidence-based practices included in this Prevention Plan. Training of the workforce is currently underway and will be spread and sustained through the statewide implementation of the GPS and Family First. Additionally, South Carolina is initiating a procurement process with contracted providers to ensure that all practice and services delivered are conducted in adherence to the GPS and using trauma-informed practices across the state. Through this practice, the Department will ensure that the services provided via Family First are responsive to the widespread impact of trauma and the potential paths for recovery. As SCDSS and its partners craft a service array that fully integrates knowledge of trauma and seeks to actively resist re-traumatization, the Department will monitor its implementation of the GPS and service delivery using new or revised policy and procedures, routine and structured contract reviews and continuous quality improvement strategies that are also trauma-informed.

Implementation Approach

South Carolina has a strong array of high-quality evidence-based programs and providers in its state to ensure effective implementation. Many of the EBPs selected for this Prevention Plan are well established in South Carolina, including its home-visiting programs (HFA, PAT, NFP).

In 2008, the Duke Endowment endorsed and funded a number of evidence-based programs (PCIT, MST, TF-CBT, Triple P, etc.). The investment in this type of service array has supported a capable provider base and jurisdictional preparedness for implementing South Carolina's selected EBPs to fidelity.

To further implementation efforts, the Department administered a statewide survey to the workforce and provider community to prepare for and assist the state with Family First implementation. Survey findings revealed many strengths amongst South Carolina's workforce and provider network, but also significant challenges related to workforce and provider training, ongoing supervision and support and fidelity monitoring. The Department will rely on its Family First Prevention Services workgroup to address survey findings and assist with implementation and operationalization of this Prevention Plan inclusive of the evidence-based practices identified above. This group will meet on an on-going basis to discuss implementation challenges, utilizing feedback loops to bolster communications between SC DSS, community partners/providers, and stakeholders and leveraging existing and new infrastructures to monitor and review appropriateness of referrals, model fidelity, and outcomes. The scope of this workgroup will also focus on overall service array, information sharing of service-related initiatives, and bring together partners of South Carolina's shared Child and Family Well-Being System.

Additionally, a core implementation strategy will be to provide capacity building grants, funded through FFTA, to promote the high-quality scale up of evidence-based practices in this Prevention Plan. South Carolina has an especially strong interest in building the capacity of intensive in- home services and family focused interventions such as: a) Homebuilders, b) Brief Strategic Family Therapy, and c) Intercept. The capacity building grants will be targeted initially to these interventions. These grants will allow providers to receive the requisite training for effective implementation of these models. Provider partners will also be eligible for a limited number of grants to support the ongoing costs of implementation and enable them to implement with model fidelity. The program area in partnership with model purveyors, implementation teams consisting of pilot sites, and provider partners will work through any technical or adaptive challenges during initial implementation and on an ongoing basis.

South Carolina Department of Social Services is currently implementing pilot sites with two evidence-based programs (EBP): BSFT and Homebuilders. To manage and monitor EBP implementation, SCDSS, with assistance from Chapin Hall, convenes a bi-weekly implementation workgroup comprised of local Department administrators and/or designees, EBP providers, and representatives from SCDSS Accountability, Data, and Research, (ADR) and QA/CQI. While SCDSS's system of record has not yet been fully developed to capture the information for these two EBPs and future EBPs, SCDSS has been capturing information on those pilot sites in Excel spreadsheets. Data is reviewed bi-weekly with the providers and local Department leadership for the purposes of managing referral utilization and continuous quality improvement, to aid in understanding the implementation of the programs, to capture barriers through the discussions and to decide and /or include, where necessary, additional information for a more informed understanding of the programs. Findings from the EBP implementation workgroup are also utilized to make real-time adjustments to program operations and delivery and to inform SCDSS IT of data and IT development needs in CAPSS.

To maximize EBP availability, the Department is also working closely with the Department of Juvenile Justice to build capacity in Multi-Systemic Therapy and Functional Family Therapy. SCDSS plans to review implementation data and outcomes related to implementation by the Department of Juvenile Justice.

Finally, to continue to balance the number of interventions being rolled-out across the state, the Department will employ a phased approach to implementing the selected EBPs. Prioritization of additional EBPs will be determined based upon the emerging needs of candidates as well as the infrastructure in South Carolina. The Department will continue to work with its technical assistance providers at the Capacity Building Center for States and at Chapin Hall to successfully implement its Prevention Plan.

In addition to the implementation strategies described here, Section 6: Evaluation Strategy delineates how the Department will ensure fidelity of implementation and monitor outcomes. The Department will also describe how South Carolina will use continuous quality improvement to learn from these monitoring activities to refine and improve service delivery on an on-going basis.

Section IV: Child-Specific Prevention Plan

As previously stated, the Department believes that safety, permanency and well-being outcomes increase when families play a central role in their case plan development and decision-making process. Family voice in their own planning results in children spending less time involved with child welfare, and families are more successful when they are involved in creating their own plan and goals. Families who identify their strengths and build on them draw confidence from that experience and are better able to build their capacity to provide protection and stability in their households.

Process for assessing need and developing child-specific prevention plans for families

To initiate a child-specific prevention plan, the case manager and supervisor will make the decision as to whether Family First services (e.g., EBPs) fit the needs of a child/family based upon the review of available assessment findings. To assess family needs, SCDSS will use the Family Advocacy and Support Tool (FAST), Child and Family Teaming, and supervision between the Investigations and Family Preservation case manager and the team leader.

The FAST is a multi-purpose decision support tool developed to assist in family case planning, service matching, on-going safety and risk, and the monitoring of service outcomes. The FAST provides an understanding of a child and family's strengths, needs, and risk factors, all of which will help inform the child-specific prevention plan.

While the FAST is a supportive tool to help guide decision-making, SCDSS values partnering with families and their support teams to assess needs and to make child specific prevention plan and case planning decisions. The Department's implementation of Child and Family Team Meetings (CFTM) is another important method of engaging families receiving Family Preservation services in the case planning process, inclusive of the child-specific prevention plan. A CFTM includes the family's formal and informal supports, child welfare staff, friends, and family members. Using a strengths-based approach, the team identifies the reason for involvement and works collaboratively to build a plan that addresses the family's underlying needs. The child and family in partnership with the family's child and family team will utilize the assessment information and the child and family team's findings and recommendations to identify service needs that the family identifies as supportive to mitigating the risk of future maltreatment and strengthening parent capacity to prevent foster care placement. The culmination of this process is used to develop and inform the Department's child-specific

prevention plan within the Family Permanency Plan and to continue with the functional assessment process.

For candidates with open investigations (and not in Foster Care), the Department will utilize the FAST during the investigation phase of a case. Using the FAST, the Investigation Case Manager will determine eligibility for prevention services – e.g., whether the child meets the definition and characteristics of a "candidate for care" for Family First. The Investigation Case Manager will document the need for prevention services in the Family Permanency Plan. Services will be authorized by the average duration of identified services as defined by the EBP or as otherwise determined by the Department.

Similarly, the Department uses the Child and Adolescent Strengths and Needs (CANS) assessment for youth in foster care. Therefore, the CANS will be used with pregnant and parenting youth in foster care to inform the development and selection of prevention services within the youth's case plan.

For eligible families being served through the community pathway by SCFS PAT, the PAT provider will coordinate with community partners and stakeholders who can link the family with those prevention services and community resources that effectively and safely address their needs.
As noted previously, the PAT staff will assist families with the completion of the intake and risk factor screening process which assesses a wide variety of family needs. When one or more risk factors (listed on page 21-22) above) are identified, PAT staff will submit to DSS through its secure process, the child's date of birth, along with identified risk factors that suggest the child could benefit from the PAT program. SCDSS will review the risk factors, candidacy requirements, determine if the child is at imminent risk, and develop the CSSP. SCDSS will respond with a candidacy determination in the Letter of Determination and Authorization which is inclusive of the CSPP.

Following the intake process, the local PAT providers administer a series of screening and assessment tools with the child and family, including the Healthy Families Parenting Inventory Risk Assessment (within 45 days of intake and every 6 months thereafter), followed by the Adult-Child Interactive Reading Inventory (ACIRI), as developmentally appropriate, within 45 days of intake Ages and Stages Questionnaire – 3 (ASQ-3), Ages and Stages-Social Emotional-2 (ASQ-SE-2) within 90 days, as developmentally appropriate, and the Life Skills Progression within 120 days of intake. The family's progress in PAT services will be tracked and monitored utilizing the Family Goal Record as well as the Healthy Families Parenting Inventory. Copies of the intake and risk factor screening tools, Healthy Families Parenting Inventory, and other PAT forms are attached and appear in appendix of this document.

If the family remains engaged and in need of PAT services after 12 months from the date the prevention plan is completed, SCDSS will work with PAT providers to ensure that services, eligibility, and claiming continue as appropriate. SCDSS will review and ensure all requirements of IV-E prevention planning are met by the PAT provider before determining that a child and family are eligible for IV-E prevention and claiming.

Figure 7. Candidacy/Eligibility and Documenting the Child-Specific Prevention Plan

Candidacy Population	Staff Determining Eligibility	Tools/Methods to assess need	Staff Responsible for Developing or Updating Prevention Plan	Documentation Form used for Child-Specific Prevention Plan
Children & Families without an open Investigation or Family Preservation case and who are served by the SCFS Parents as Teachers (PAT) Program				
Children with one or more imminent risk criteria who are receiving PAT services in the community	SCDSS Family Support Navigators (Prevention)	PAT Family Intake and Family Information Record	*SCDSS Family Support Navigators*	***Letter of Determination and Authorization for Services***
Children in an open investigation and not in Foster Care				
Children in an open investigation	Investigations Case Manager and Supervisor	FAST Assessment and Automatic CAPSS Candidacy Identification; No individual risk factor tracking required	*Case Manager creates FPP, adds goals with EBP services, links children as beneficiaries, completes referral form; Supervisor reviews and authorizes services*	*Family Permanency Plan with authorized EBP service and completed FFPSA referral*
Children & Families being referred to or receiving Family Preservation Services				
To Family Preservation via Investigations	Investigations Case Manager and Supervisor	FAST Assessment and Automatic CAPSS Candidacy Identification; No individual risk factor tracking required	*Case Manager creates FPP, adds goals with EBP services, links children as beneficiaries, completes referral form; Supervisor reviews and authorizes services*	*Family Permanency Plan with authorized EBP service and completed FFPSA referral*
In Family Preservation criteria	Family Preservation Case Manager and Supervisor	FAST Assessment, Automatic CAPSS Candidacy Identification, CFTMs; No individual risk factor tracking required	Case Manager creates FPP, adds goals with EBP services, links children as beneficiaries, completes referral form; Supervisor reviews and authorizes services	Family Permanency Plan with authorized EBP service and completed FFPSA referral

To Family Preservation via exit from Foster Care	Foster Care Case Manager and Supervisor and/or Family Preservation Case Manager and Supervisor	C Case Closure CANS, Automatic CAPSS Candidacy Identification, Transition/Special Call CFTM, Updates FAST within 14 days of opening the Family Preservation Service line.	Case Manager updates FPP, adds goals with EBP services, links children as beneficiaries, completes referral form; Supervisor reviews and authorizes services (Court orders considered) .	Family Permanency Plan Updated with authorized EBP service and completed FFPSA referral
Pregnant and parenting youth in Foster Care				
Pregnant and parenting youth in foster care	Foster Care Case Manager and Supervisor	CANS Assessment, Automatic CAPSS Candidacy Identification, CFTMs	Case Manager creates FPP, adds goals with EBP services, links youth as beneficiaries, completes referral form; Supervisor reviews and authorizes services	Family Permanency Plan with authorized EBP service and completed FFPSA referral

Integrating the child-specific prevention plans within the CAPSS system

The Family Permanency Plan is a comprehensive case planning tool that is currently being enhanced within the DSS CAPSS system to include the child-specific prevention plan. The child-specific prevention plan is entered and updated into CAPSS Family Permanency Plan (FPP) following the administration of the FAST by the Investigations and/or Family Preservation Case Manager. When needs are identified during the investigation, the Investigation Case Manager initiates the CFTM process. At the close of the initial and ongoing CFTM, the Investigations or Family Preservation Case Manager, with support from their supervisors, finalizes and enters the FPP into CAPSS. The FAST and FPP are then reviewed and updated within CAPSS at each subsequent CFTM that follows.

As previously mentioned, child and family team meetings continue throughout the family's involvement in both family preservation and foster care cases.to monitor and inform case planning and decision-making. CFTMs and case planning provide continued opportunities for ongoing review of child and family needs using assessment tools (e.g., FAST and CANS, respectively), every 90 days. At the 12-month mark, children's candidacy will be re-determined based on a review of the on-ongoing FAST or CANS and service needs. Case Managers, with support from their supervisors, will be responsible for redetermination of eligibility of Family First services. Once the redetermination has been made, Case Managers, with support from their supervisors, will be responsible for updating the Family Permanency Plan, and its child-specific prevention plan, and entering it into CAPSS.

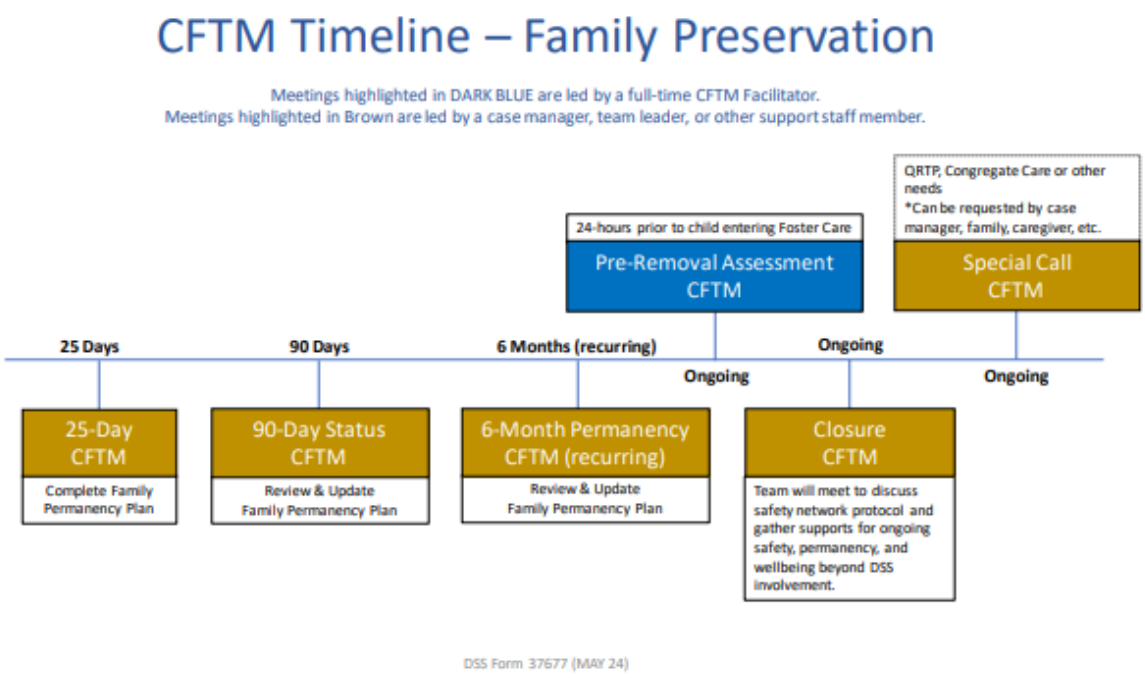
For families being served via the community pathway, the Letter for Determination and Authorization for Services, inclusive of the child's specific prevention plan, will be stored in the PAT data system, outside of the SCDSS CAPSS system. Only the child's date of birth, sex, race, unique

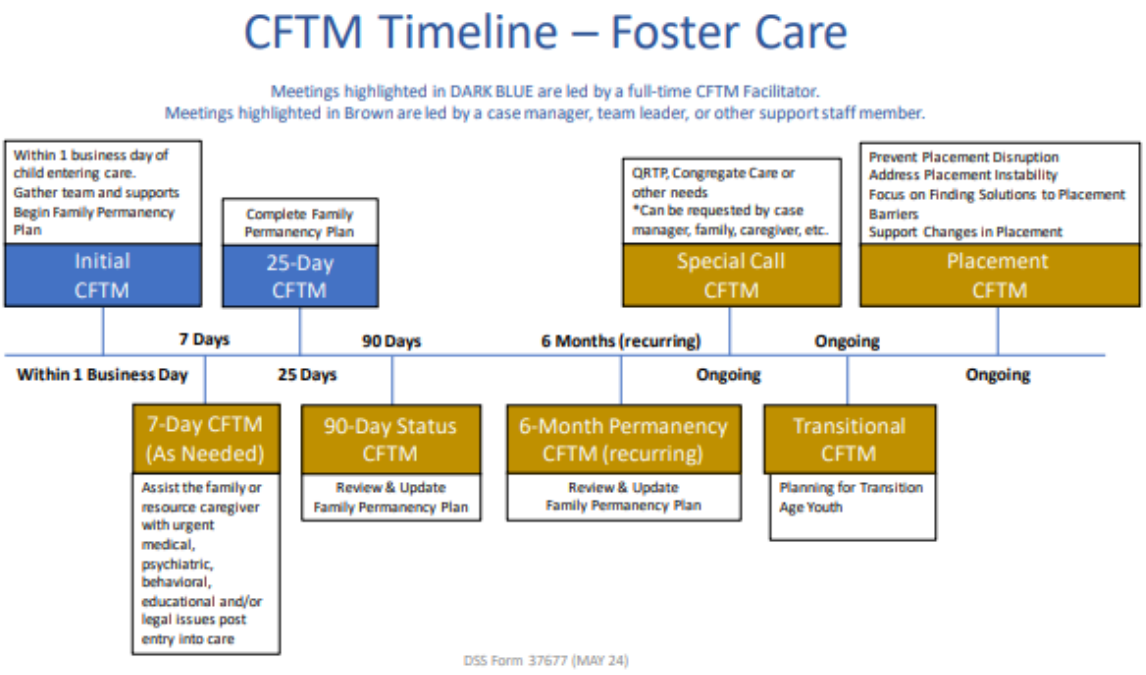
identifier and other required Family First data elements will be stored with SCDSS.

Service referral, linkage, and oversight

Linkage (service referrals) to available Family First services will follow the Child and Family Team meeting (CFTM) where the Family Permanency Plan, and its child-specific prevention plan, is developed. Information gathered from the FAST or CANS and the CFTM will guide case managers and families to determine appropriate services. Matching services to individualized needs are an important part of this process and is a pillar of the child and family teaming structure. The family's referrals, linkages and participation in services will be monitored by the family's case manager.

Ongoing engagement with the child, family, family supports, and providers through the CFTM will ensure appropriateness of services. In keeping with the GPS practice model, the family is present and actively involved in the monitoring and updating of the family's prevention plan. Changes to service planning efforts and prevention plan will be updated regularly in the Family Prevention Plan based on the evolving needs of the family. Below are the Family Preservation and Foster Care CFTM Timelines highlighting opportunities to measure progress and review and update goals, all of which will be documented in the Family Permanency Plan and its child-specific prevention plan.





In addition to the CFTMs, the case manager monitors the family's safety and progress with the Family Permanency Plan, and its child-specific prevention plan, on a monthly basis. Monthly updates to the Family Permanency Plan include:

- The child's and family's engagement with services
- Progress made by the child and family as it relates to the reasons for Department's involvement, including the actions and services required to strengthen the family and assuring the safety, permanency and well-being for the child
- Needs and strengths identified through formal and informal assessments
- Safety or risk concerns identified by the Case Managers assessments and goals to address those concerns.
- Child's adjustment to agency involvement

For investigations

The investigations case manager monitors the family's safety and progress through face-to-face contact and with supervisory consultations, as defined below:

- Initial contact (identify services) within first 24 hours of receiving case
- Face-to-face contact with child or youth within 20 days (continue to assess for safety)
- Monitoring continues through supervisory consultations as outlined in policy until a determination is made.

Section V: Monitoring Child Safety

Pre-Print Section 3 (Monitoring Child Safety and Risk)

Initial and ongoing assessments of safety and risk are a critical part of the work of the Department's child welfare staff. In order to adequately monitor the safety of children during the 12-month period, the Department will leverage and enhance existing practices by systemically administering the FAST safety and risk items every 90-days. As with ongoing monitoring of

family strengths and needs, the Department will monitor ongoing risk through 1) completing a formal risk assessment and 2) informally assessing risk on an ongoing basis during face-to-face observations and during regularly scheduled CFTMs.

During initial contact with the family, the Investigations Case Manager, collaborating with their supervisor, will review the SDM completed at intake, collaborate with the family, and complete the safety items of the FAST for all cases in order to identify any acute safety risks or needs. As new information becomes available, the full FAST will be updated throughout the course of the Investigation. If a case is substantiated and a family enters into Family Preservation, the Family Preservation Case Manager will review and update the FAST after the implementation of services to assess the family's strengths, needs, and safety concerns. This assessment will help case managers determine if the child(ren)'s safety is compromised and whether action needs to be taken due to changes that have occurred within the family unit. The FAST contains information relevant to both safety and risk, but also helps to identify services a family may need. Based on the needs identified within the FAST assessment, case managers and supervisors will match services to identified needs. The FAST is re-administered every 90-days to monitor safety and risk while services are provided. The FAST helps case managers gather information, assess progress, and monitor safety and risk throughout the life of the case.

For pregnant and parenting youth in foster care, Foster Care Case Managers administer the CANS. For both Family Preservation and Foster Care cases, CFTMs are held no less than every 90 days and align with important case milestones offering regular opportunities for informal monitoring of risk and update of the FAST or CANS every 90 days as well.

As indicated above in the CFTM timeline for Family Preservation and Foster Care cases, the 90- day permanency CFTM provides an opportunity to assess family progress and monitor safety and risk using the FAST or CANS (completed within that same time frame). If services are needed for longer than the initial 12 months the CFTM, using the FAST or CANS, will determine the ongoing need to continue services and monitor case progress. A family's continued participation in services beyond 12 months will be determined jointly between the case manager and family in the CFTM.

Figure 8. Candidacy – Monitoring Risk and Safety for DSS Involved

Candidacy Population	Staff Responsible for Monitoring Risk and Safety	Monitoring Tools/Protocols and Timeframes for Administering Them
Children & Families in an open Investigation and not in Foster Care	Investigations Case Manager and Supervisor	FAST: - Review and consider Intake SDM findings - Complete safety items at initial contact - Following initial completion, Investigations Supervisor will review and finalize the FAST CFTM: occurs prior to or in conjunction with start of services
Family Preservation Cases with 1 or more imminent risk criteria	Family Preservation Case Manager and Supervisor	FAST - Review and update the FAST after entry into Family Preservation - Review and update the FAST every 90-days after implementation of services CFTM: See Family Preservation timelines

Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager and Supervisor	CANS - Every 90 days CFTM: See Foster Care CFTM timelines

Safety Monitoring within the Community Pathway

For families receiving services within their community through the PAT Program, the initial and ongoing monitoring of the child's safety will occur through the periodic assessments of family functioning as specified by the PAT program's design and conducted by the local PAT provider. PAT has formal assessments that are completed at specified intervals. Additionally, practitioners informally observe and evaluate family functioning, needs, and risks at all contacts with the family. The frequency of contacts with the local PAT provider occurs minimally twice a month but may occur more often based on family needs and length of time in the program.

The SCDSS will monitor local PAT providers' completion of the initial and ongoing child safety and risk assessments through review of the PAT provider data and outcome reports at monthly SCDSS-PAT implementation team meetings and through the Department's program monitoring.

To ensure providers are adequately trained to monitor initial and ongoing safety and risk, SCDSS requires all community providers, including those involved in the delivery of the PAT Community Pathway, to receive the "'Recognizing and Reporting Child Abuse and Neglect" mandated reporting training to support appropriate reporting of suspected child abuse or neglect by the local provider, ensuring appropriate intervention can occur from the IV-E agency when necessary.
SCDSS partners with the Children's Law Center to facilitate the standardized 'Recognizing and Reporting Child Abuse and Neglect' training. The training is designed for mandated reporters and professionals who have frequent contact with children. Through this training, participants learn how to identify mandated reporters according to South Carolina law, understand statutory requirements and protections, understand the role and responsibilities of mandated reporters, recognize the signs of possible abuse and neglect, and describe when to make a report of child abuse and neglect. This systematic approach to mandated reporter training ensures a consistent understanding of mandated reporting requirements. The Children's Law Center provides these trainings multiple times monthly, both virtually and in person, and training is also available by request.
Families receiving DSS IV-E prevention services for PAT undergo a comprehensive baseline assessment by the assigned local PAT provider within 45 days of enrollment. The PAT comprehensive assessment process utilizes an in-depth assessment framework developed by the national PAT program and SCFS. The assessment includes the Healthy Families Parenting Inventory and several other validated tools. The Healthy Families Parenting Inventory serves as the primary PAT risk assessment. In addition, PAT requires that families also receive monthly in-home visits by the PAT provider minimally, up to 24 visits annually. The frequency of visits may be increased as determined by clinical need. Findings from visits are documented by the local PAT provider in the PAT Personal Visiting Record. The goal of this comprehensive assessment framework is to identify risks, needs, and progress in key domains. PAT and related-services and subsequent monitoring are tailored to each family's unique circumstances.

As noted, PAT assessments and re-assessments are carried out as specified in the approved SCFS Program and Operational Guidelines - PAT section (Appendix B), with final assessments being conducted for families at risk of case closure and/or at closure. The local PAT provider administers the family risk assessment, the Healthy Families Parenting Inventory, within 45-days of enrollment and every six months thereafter until case closure.

At 12 months from the date of the initial service/prevention plan completion, the local PAT provider will reassess the child's risk for entering foster care using the PAT Healthy Families Parenting Inventory and PAT Goals Record. If the child's risk of entering foster care remains high at 12 months, despite the provision of services, the local PAT provider will repeat the Intake (authorization request and review process) and DSS Family First eligibility process of emailing SCDSS at the designated inbox or through another SCDSS approved business process with the child's date of birth and identified risk factors that suggest the child could continue to benefit from the PAT program. DSS will respond with a candidacy determination inclusive of the CSPP. SCDSS will review the child-specific prevention plan to ensure continued FFPSA eligibility, appropriate risk determination, and the appropriateness of continued PAT services.

DSS will monitor the date of completion of the initial intake and screening process, the child-specific prevention plan, subsequent assessments, the status of the 12-month plan, and if needed, renewal requests for continued EBP services.

To further monitor compliance and quality service delivery, DSS will require the periodic submission of PAT fidelity and outcomes data to the designated DSS team and its Office of Accountability, Data and Research (ADR). SCDSS conducts annual contract monitoring to ensure timely completion and updates of the prevention plan, ongoing safety and risk assessments, and service delivery. Additionally, SCDSS routinely includes language in its contracts and agreements that SCDSS shall have the right to examine, make copies, excerpts, or transcripts from all records which will ensure that SCDSS can fulfill its responsibility to examine the prevention plan as necessary based on these risk assessments and provide appropriate oversight.

Figure 9 Candidacy – Monitoring Risk and Safety for Community Pathway

Candidacy Population	Staff Responsible for Monitoring Risk and Safety	Monitoring Tools/Protocols and Timeframes for Administering Them
Child/parent without an open investigation or family preservation case served through SCFS PAT	South Carolina Office of SCFS PAT or local PAT provider	Parents as Teachers (PAT) - PAT Family Records - Findings from Healthy Families Parenting Inventory (HFPI) and other assessments of functioning and well-being - PAT Personal Visit Records

Section VI: Evaluation Strategy and Waiver Request

Pre-Print Section 2 (Evaluation strategy and waiver request)

South Carolina's Overall Approach to Evaluation and Continuous Quality Improvement (CQI) of Preventive Programs

Family First requires that each state continually assess if the EBPs provided to children and their families are achieving the desired outcomes. To accomplish this, each EBP service submitted in a state's Prevention Plan must include a well-designed and rigorous evaluation strategy. The Children's Bureau, however, may waive this requirement for a well-supported EBP if the state provides compelling evidence of the effectiveness of the EBP and meets the CQI

requirements. South Carolina is requesting a waiver of the evaluation requirements for each of these well- supported programs:

- Parent-Child Interaction Therapy (PCIT)
- Brief Strategic Family Therapy (BSFT)
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- Homebuilders – Intensive Family Preservation and Reunification Services (Homebuilders)
- Parents as Teachers (PAT)
- Healthy Families America (HFA)
- Nurse-Family Partnership (NFP)
- Motivational Interviewing (MI)
- Intercept®

All of these have empirical evidence that they improve outcomes in the domains of child safety, child permanency, child well-being, and/or adult well-being and the justification is described in the section below.

Compelling Evidence for EBP Effectiveness and Waiver Justification

Mental Health and Substance Treatment Programs and Services

The most common types of identified maltreatment in South Carolina over the last few years have been neglect and physical abuse. Of these, approximately two-thirds have been referred to Family Preservation and one-third resulted in foster care entry. Research suggests that two of the most salient contributors to neglect and/or physical abuse are untreated mental health and/or substance-related problems in a child and/or caregiver (CDC). PCIT, BSFT, FFT, MST and MI are efficacious interventions designed to address untreated mental health and/or substance- related problems.

Parent-Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT) PCIT is a program for two- to seven-year-old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. South Carolina's prevention plan aims to deliver PCIT to families with children ages two to seven that have identified stressors of child emotional behavior challenges. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 38% meet the age criteria for PCIT and some of these would benefit from a structured mental health intervention. Of South Carolina's 46 counties, 26 have one or more providers offering PCIT across the state and intends to build the infrastructure and expand the availability of the intervention over the next five years.

Evidence based justification: The Title IV-E Prevention Services Clearinghouse rated PCIT as a well-supported EBP following review of 21 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes: Outcomes for children participating in Parent Child Interaction Therapy include improving child behavioral and emotional functioning and reducing problematic behaviors, improving parent-child communication, increasing children's organizational and play skills and improving the child's self-esteem and social skills. Several different studies of PCIT have shown that participation improves child behavioral and emotional functioning in areas such

as child compliance, internalizing and externalizing behaviors, and overall reduction in problematic behaviors (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; Matos, 2009, Schuhmann, 1998; & Thomas, 2011).

Adult well-being outcomes: Outcomes for adults participating in Parent Child Interaction Therapy include improving parent-child communication and reducing the frequency of corporal punishment. PCIT has demonstrated efficacy in enhancing positive parenting behaviors like such as using encouraging commands and praise, and effective child- and parent-led play skills and reducing laxness and the frequency of corporal punishment (Bagner, 2007, 2010; Bjorseth, 2016; Leung, 2015, 2017; McCabe, 2009; & Thomas, 2011). At least one study showed that PCIT reduced parental stress, depression and anxiety (Leung, 2015, 2017).

Program delivery and fidelity monitoring: PCIT is delivered using a dyadic approach based on the following manual: Eyberg, S., & Funderburk, B. (2011) Parent-Child Interaction Therapy protocol: 2011. PCIT International, Inc. Parents are coached by a trained therapist in behavior-management and relationship skills. Parents or caregivers progress through treatment as they master specific competencies, thus there is no fixed length of treatment. Most families are able to achieve mastery of the program content in 12 to 20 one-hour sessions. PCIT has a rigorous fidelity monitoring infrastructure with a prescribed clinical tool called the Treatment Integrity Checklist (TIC) (PCIT International).

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) uses a structured family systems approach to treat families with children or adolescents (6 to 17 years) who display or are at risk for developing problem behaviors including substance abuse, conduct problems, and delinquency. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 56% meet the age criteria for BSFT. Data also showed a percentage of active family preservation cases with concurrent juvenile justice involvement. BSFT is an appealing intervention for South Carolina because of its broad eligibility age range of child and youth populations, cross-system treatment focus, and the flexibly of where it can be delivered, specifically in homes. The most recent Child and Family Services Review (CFSR), for example, identified transportation as one of the common challenges to parents accessing available services and the in-home delivery format would address this barrier. South Carolina is in the process of building the infrastructure to offer BSFT over the next five years.

Evidence based justification: The Title IV-E Prevention Services Clearinghouse rated BSFT as a well-supported EBP following review of 5 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes: Outcomes for children participating in Brief Strategic Family Therapy include reduction in behavior problems while improving self-control, reduction in associations with antisocial peers, reduction in drug use, the development of pro-social behaviors, improvements in maladaptive patterns, and improvements in communication, conflict resolution and family bonding. At least one study of BSFT has shown improved child well-being outcomes. Participation improved behavioral and emotional functioning by reducing externalizing behaviors (Horigian, 2015). Results of this study also showed reductions in delinquent behaviors such as the number of lifetime and past year arrests and incarcerations (Horigian, 2015).

Adult well-being outcomes: Outcomes for adults participating in BSFT include Improvement in maladaptive patterns of family interactions and improvement in family communication, conflict resolution, and family bonding. BSFT has demonstrated effects in improving adult well-being

outcomes. In one study, parents who participated in BSFT reported less alcohol use (Horigian, 2015b). In another study, significant overall improvements in family functioning were achieved (Santisteban, 2003).

Program delivery and fidelity monitoring: BSFT is typically delivered in 12 to 16 weekly sessions in community centers, clinics, health agencies, or homes. Invention delivery is based on the required manual: Szapocznik, J. Hervis, O., & Schwartz, S. (2003). Brief Strategic Family Therapy for adolescent drug abuse (NIH Pub. No. 03-4751). National Institute on Drug Abuse. BSFT counselors are required to participate in four phases of training and are expected to have training and/or experience with basic clinical skills common to many behavioral interventions and family systems theory. Fidelity monitoring includes counselor completion of The BSFT Therapist Adherence Form with monitoring by a clinical supervisor documented using the Clinical Supervision Checklist (CEBC, Robbins et al., 2011).

Functional Family Therapy (FFT)

FFT is a trauma-informed evidence-based therapeutic intervention for at-risk families and juvenile justice involved youth. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth who have been referred for behavioral or emotional problems. South Carolina's Prevention Plan aims to deliver FFT to youth ages 11-18 years old who have family stressors, emotional behavior disabilities; children at risk of voluntary placement; and pregnant and parenting youth in foster care. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 29% meet the age criteria for FFT with a subset having concurrent juvenile justice involvement. In addition, South Carolina has at least one provider of FFT in 31 of their counties across the state. This makes FFT an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibly of where it can be delivered (e.g. homes, schools). In addition to existing provider network, South Carolina is in the process of building the infrastructure to offer FFT over the next five years.

Evidence based justification: FFT is currently rated as Well-Supported on the Title IV-E Prevention Services Clearinghouse following review of 9 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being.

Child well-being outcomes: Outcomes for children participating in FFT include eliminating delinquency, oppositional behaviors, violence, and substance abuse. FFT also improves the child's prosocial behaviors. FFT has a proven track record in improving youth behavior and emotional functioning, and reducing youth alcohol and drug use (Celinska, 2013; Slesnick, 2009). Participation in FFT has been shown to significantly reduce delinquent behaviors and the likelihood of out-of-home placements resulting from them (Celinska, 2013, Darnell, 2015, & Slesnick, 2009).

Adult well-being outcomes: Outcomes for adults participating in FFT include enhanced family functioning and reduction in family conflict. FFT also has established efficacy in improving overall family functioning by reducing verbal aggression between family members (Slesnick, 2009).

Program delivery and fidelity monitoring: FFT is conducted in clinic and home settings. It can also be delivered in schools, child welfare facilities, probation and parole offices, aftercare systems, and mental health facilities. FFT is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth

and family, and generalizing changes to a broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of 3-6 months. Master's level therapists deliver the intervention based on the following manual: Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). Functional Family Therapy for Adolescent Behavior Problems. American Psychological Association. Therapists work as a part of a FFT-supervised unit and receive ongoing support from their local unit and FFT training organization.

FFT has a rigorous fidelity monitoring infrastructure. Contracted therapists providing FFT must show proof of training and fidelity to the model which includes three phases: clinical training, supervisor training, and maintenance phase. FFT has a web-based Client Services System (CSS), which is used to monitor program fidelity based on the Fidelity and Dissemination Adherence Scores. Quarterly ratings are then used to derive a Global Therapist Rating for each therapist, gauging therapists' adherence to and competence in the model (CEBC).

Multisystemic Therapy (MST)

MST is an intensive treatment for troubled youth delivered in multiple settings. This program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of- home placements, and illicit substance use. The target population for MST is youth, ages 12 to 17, and for the families of youth who are (1) at risk for or engaging in delinquent activity or substance misuse, (2) experiencing mental health issues, and (3) at risk for out-of-home placement. South Carolina's Prevention Plan aims to serve youth ages 12 to 17 years old who are at risk of out of home placement. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 23% meet the age criteria for MST with a subset having concurrent juvenile justice involvement. Moreover, 33 counties across South Carolina have at least one treatment provider utilizing MST within their service array. MST is a desired intervention because of its emphasis on dual-system youth, co-occurring mental health and substance use problems, the flexibly of where it can be delivered (e.g. homes, schools) and its existing presence in South Carolina. South Carolina will continue to support their infrastructure to offer MST over the next five years.

Evidence based justification: MST is currently rated "well-supported" as a Mental Health Program and as a Substance Abuse Program by the Title IV-E Prevention Services Clearinghouse following review of 16 eligible studies that indicated favorable effects in the target outcomes of child permanency and child and adult well-being.

Child permanency outcomes: MST has been shown to significantly reduce out-of-home placement for problematic youth behavior (Vidal et al., 2017).

Child well-being outcomes: Outcomes for children participating in MST include eliminating or reducing the frequency and severity of the youth's difficult behaviors. Numerous studies of MST show significant improvements in youth behavioral and emotional functioning. MST participation reduces problematic mental health symptoms associated with conduct problems, conduct disorder, oppositional defiant disorder, impulsiveness, Attention Deficit Hyperactivity Disorder, and other kinds of internalizing and externalizing behaviors (Asscher et al., 2013, 2014; Dekovic et al., 2012; Fonagy et al., 2018; Henggeler, 1997; Manders, 2013; Ogden, 2004; and Weiss, 2013). MST also has a proven track record for reducing substance misuse and a wide range on delinquent behaviors like property offenses, subsequent arrests and adjudications, and violent and non-violent crimes (Asscher, 2013; 2014; Borduin, 1995; Butler, 2011; Fonagy, 2018; Henggeler, 1997; and Vidal, 2017).

Adult well-being outcomes: Outcomes for adults participating in MST include empowering them with skills and resources to independently address difficulties associated with the identified behavior(s). Several studies of MST demonstrate improvements in positive parenting practices such a positive discipline, increased parental involvement, improvements in monitoring and supervision, and reductions in inconsistent discipline (Asscher, 2013; Borduin,1995, Fonagy, 2018). MST has also been shown to improve parent/caregiver mental and emotional health and overall improvements in family functioning, family satisfaction, family cohesion and family communication (Borduin, 1995; Fonagy, 2018).

Program delivery and fidelity monitoring: MST is delivered based on the following manual: 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.). Guilford Press. The invention addresses the core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, his or her family, and school and community. The intervention strategies are personalized to address the identified drivers. The program is delivered for an average of 3-5 months, and services are available 24/7, which enables timely crisis management and allows families to choose which times will work best for them. Master's level therapists from licensed MST providers take on only a small caseload at any given time so that they can be available to meet their clients' needs.

MST has a rigorous fidelity monitoring infrastructure and includes measures for the therapist and the supervisor. The Therapist Adherence Measure Revised (TAM-R) is a 28-item measure that evaluates a Therapist's adherence to the MST model as reported by the primary caregiver of the family. The Supervisor Adherence Measure (SAM) is a 43-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST therapists (CEBC).

In-Home Parenting Skill-Based Services

Many parents involved with the child welfare system lack an understanding of child developmental needs (Landers et al., 2020). Research shows that parenting interventions that strengthen parental knowledge and skills, will lead to better child well-being outcomes and reduce incidents of maltreatment. (Barth, 2015; Berliner et al., 2015; Glascoe & Leew, 2010; Huebner, 2002; & Luby et al., 2016). South Carolina is selecting a comprehensive in-home parenting service array in order to build skills and knowledge across all child and youth developmental levels. These include Homebuilders, PAT, HFA, and NFP.

Homebuilders – Intensive Family Preservation and Reunification Services (Homebuilders)

Homebuilders provides intensive, in-home counseling, skill building and support services for families who have children (0-18 years old) at imminent risk of out-of-home placement or who are in placement and cannot be reunified without intensive in-home services. Because of the broad applicability to a wide range of children, youth, and families with the specific focus on family preservation and prevention of foster care entry, South Carolina intends to invest heavily in building the infrastructure to offer Homebuilders statewide. At present, there are five (5) providers in the state offering the Homebuilders intervention. South Carolina will continue to build providers to support their infrastructure to offer Homebuilders across the state over the next five years.

Evidence based justification: Homebuilders is one of the oldest Intensive Family Preservation Services (IFPS) programs in the United States (Institute for Family Development). The intervention is currently rated "well- supported" as an In-Home Parenting Skill-Based Service by

the Title IV-E Prevention Services Clearinghouse following review of 3 eligible studies that indicated favorable effects in the target outcomes of child permanency and adult well-being.

Child permanency outcomes: Participation in Homebuilders enhanced child permanency by preventing out-of-home placement directly after the intervention and at six and twelve months out (Walton, 1993). Additional research found that Homebuilders also improved reunification and family stability at the conclusion of child welfare involvement (Walton, 1993; 1998).

Adult well-being outcomes: Homebuilders has demonstrated evidence in improving adult well-being outcomes such as overall economic and housing stability and food security (Westat, 2002).

Program delivery and fidelity monitoring: Homebuilders is delivered in the family's home. Services are provided when and where the family needs them, including other community locations (e.g. school). Homebuilders is delivered according to the following manual: Manual: Kinney, J., Haapala, D. A., & Booth, C. (1991). Keeping Families Together: The HOMEBUILDERS Model. New York, NY: Taylor Francis. Practitioners conduct behaviorally specific, ongoing, and holistic assessments that include information about family strengths, values, and barriers to goal attainment. Homebuilders practitioners collaborate with family members and referents in developing intervention goals and corresponding service plans. These intervention goals and service plans focus on factors directly related to the risk of out-of-home placement or reunification. Throughout the intervention the practitioner develops safety plans and uses clinical strategies designed to promote safety. Homebuilders services are concentrated during a period of 4 to 6 weeks with the goal of preventing out-of-home placements and achieving reunifications. Providers are required to have a master's degree in social work, psychology, counseling, or a closely related field or a bachelor's degree in social work, psychology, counseling, or a closely related field with at least 2 years of related experience. The Homebuilders model includes fidelity measures designed to track specific indicators and performance measures (CEBC, Institute for Family Development). South Carolina, and their designated Homebuilders providers, will work together with The Institute for Family Development, to obtain Homebuilders Program Quarterly Reports for each provider offering Homebuilders services. The Institute for Family Development offers technical assistance support and oversees compliance monitoring for each provider offering the Homebuilders program. They ensure the provider is delivering the Homebuilders model with fidelity and regularly evaluate service outcomes. To assess overall performance, they produce quarterly reports for each provider. South Caroline will use a subset of data in the quarterly reports for purposes of continuous monitoring. These include measures most aligned with South Carolina's practice model (Guided Principles & Standards/GPS) and current five-year strategic plan and consist of the following:

- **Outcome measures**- placement prevention, safety concerns addressed, no new CPS reports, and improved family functioning
- **Family engagement measures**- percentage of families engaged, client ratings of cultural humility, and client ratings of family centered service delivery
- **Model fidelity measures**- immediate response to referrals, 24/7 availability, service intensity-direct contact hours, service intensity-frequency of contact, and contact with referent.

Parents as Teachers (PAT)

PAT is a home-visiting parent education program that teaches new and expectant parents skills

intended to promote positive child development and prevent child maltreatment. Enrollment may begin with the pregnant mom in foster care and continue through when the child enters kindergarten (i.e. prenatal to age 5). PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. South Carolina's Prevention Plan aims to deliver PAT to families that have identified stressors of being new parents and/or struggling with childcare responsibility, as well as pregnant or parenting youth in foster care. South Carolina's analysis of the children receiving Family Preservation services as of June 2020, show that approximately 43% meet the age criteria for PAT. Moreover, analysis also show that children ages five and under are more likely than older children and youth to enter foster care after a finding of maltreatment. South Carolina believes that one strategy to reduce foster care entries is by expanding in-home parenting services to parents of young children. Presently, there is an established PAT provider infrastructure and data capture partnership through the states' Head Start program. There are 23 counties throughout the state with at least one serviceprovider offering PAT. Family First provides an additional opportunity to expand the reach of PAT statewide.

Evidence based justification: PAT is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 6 eligible studies that indicated favorable effects in the target outcomes of child safety and child well-being.

Child safety outcomes: Participation in PAT has been shown to increase child safety by reducing the occurrence of substantiated incidents of abuse and neglect (Chaiyachati, 2018).

Child well-being outcomes: Outcomes for children participating in PAT include child development and school readiness. In two separate studies, participation in PAT was found to improve social functioning and cognitive functioning and abilities (Neuhauser, 2018; Wagner, 1999).

Program delivery and fidelity: The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. PAT is designed so that it can be delivered to diverse families with diverse needs, although PAT sites typically target families with specific risk factors. Families can begin the program prenatally with the pregnant mom as the candidate and continue through when their child enters kindergarten. Services are offered on a biweekly or monthly basis, depending on family needs and delivered using one of two age-based curriculums: PAT Foundational Curriculum is available to support families prenatal to 3; PAT Foundational 2 Curriculum is available to support families 3 through Kindergarten. Sessions are typically held for one hour in the family's home, but can also be delivered in schools, childcare centers, or other community spaces. Each participant is assigned a parent educator who must have a high school degree or GED with two or more years of experience working with children and parents. The PAT National Center requires that affiliates provide annual data on their fidelity to the program model through an Affiliate Performance Report (CEBC).

Healthy Families America (HFA)

HFA is a home visiting program for new and expectant families with children who are at-risk for maltreatment or Adverse Childhood Experiences. Enrollment may begin with the pregnant mom in foster care and continues up to 3 months after birth. South Carolina's analysis of the children and families receiving Family Preservation services as of June 2020, show that approximately 8% are one year of age or under and a subset them would meet the age criteria for HFA. Five-

year fatality trends also show that children under one year of age account for over half of all maltreatment-related child fatalities. South Carolina believes that one strategy to reduce severe physical abuse resulting in child fatalities is by expanding in-home parenting services to new and expectant parents. Presently, there is an established HFA provider infrastructure but with limited providers. There are 18 counties with at least one provider statewide. Family First provides an additional opportunity to expand the reach of HFA statewide.

Evidence based justification: HFA is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 22 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Child safety outcomes: Safety outcomes for children participating in HFA include reduction in child maltreatment and a decrease in child injuries and emergency department use. HFA has been shown to increase child safety by reducing incidents of neglectful behaviors, minor physical aggression, psychological aggression and frequency of severe and very severe physical abuse (Duggan, 2004; Mitchell-Herzfeld, 2005).

Child well-being outcomes: Well-being outcomes for children participating in HFA include improved parent-child interactions and social-emotional well-being, increase in school readiness, promotion of physical health and development and increase to primary care and community service access. Findings show that participation in HFA has been shown to improve behavioral and emotional functioning and improvement in cognitive functions and abilities (Caldera, 2007, Duggan, 2005, DuMont, 2010 & Kirkland, 2012).

Adult well-being outcomes: HFA also has a robust set of research documenting improvements in adult well-being. HFA participation has been linked to enhanced parenting practices, improved parent/caregiver mental or emotional health, reductions in parental stress and overall improvements in family functioning and reductions in domestic violence (Bair-Merritt, 2010, Duggan, 2004; DuMont, 2008; & McFarlane, 2013).

Program delivery and fidelity: HFA is delivered in the family's home and providers follow the following manuals: 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. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed. Each HFA site is able to determine which family and parent characteristics it targets. Enrollment may begin with the pregnant mom in foster care and continue up to 3 months after birth. Most families are offered services for a minimum of 3 years and receive weekly home visits at the start. After 6 months, families receive visits less frequently depending on their needs and progress. All HFA home visiting staff must have a minimum of a high school diploma or equivalent and are required to attend a four-day core training and receive supplemental wrap-around training.

HFA has required fidelity monitoring requirements. Implementing sites utilize the HFA Best Practice Standards and demonstrate fidelity to the standards through periodic accreditation through site visits. There are 152 standards, and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model (CEBC).

Intercept®

Intercept®, developed by Youth Villages, is an integrated, intensive in-home parenting skills program used to safely prevent children from entering custody or to reunify them with family as quickly as possible if a period of out-of-home care is necessary. Intercept is appropriate for children ranging in age from birth to 18, with services lasting four to nine months (typically, four to six months for prevention or six to nine months for reunification). South Carolina's analysis of the children and families receiving Family Preservation services as of March 2023 shows that approximately 10,747 children and youth would meet the age criteria for Intercept®. Presently, there is an established Intercept® provider infrastructure in one county (e.g., York), with a goal for expansion in 2024.

Evidence based justification: Intercept® is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of two eligible studies that indicated favorable effects in the target outcome of child permanency.

Child permanency outcomes: Permanency outcomes for children participating in Intercept® include reduction in child placement into out-of-home care and timely exit to permanency for children in care. (Huhr, 2020a & 2020b; Huhr, 2021).

Program delivery and fidelity: Intercept® is delivered in the family's home or community setting. Specialists utilize an online clinical database of evidence-based and research-informed interventions and resources called the Clinical Portal. The Clinical Portal aids in case conceptualization and development of treatment plans. The overall desired outcomes are threefold:

1. Program Model – The foundation of the results-oriented framework is a strong program model, which starts with model principles, specifies key program elements as well as adherence measures for each program element, and identifies instrumental and long-term outcomes expected from model implementation. The annual Program Model Adherence Review includes survey data from youth, families, staff, supervisors, and referral sources as well as an extensive document review that includes clinical records, staff development plans, and training materials. Scores generated by the review pinpoint program areas that may need to be strengthened in order for families to achieve the expected outcomes.
2. Performance Improvement – Using a Balanced Scorecard (Kaplan & Norton, 1996) approach, the Performance Improvement activity refers to a monthly process of examining leading and lagging indicators in both clinical and operational areas. Measures include average monthly census, staff caseload, staff tenure, percent of successful discharges, and number of critical incidents. Monthly review of these key metrics by all levels of staff allows an opportunity to ensure the program is operating 'within the guardrails' and to troubleshoot any issues that might be occurring.
3. Ongoing Outcome Evaluation – Although the monthly Performance Improvement process and the annual Program Model Adherence Review provide evidence that the program implementation is within model parameters, measuring outcomes on an ongoing basis is the only way to determine whether the program is achieving the expected results. Outcomes are measured for youth who receive a minimum dose of services, which is defined as at least 60 days. Focusing on basic functional and behavioral outcomes, including living situation, educational progress, criminal justice involvement, and out of home placements, surveys are conducted at six, 12, and 24

months post-discharge to determine the extent to which progress was sustained after treatment.

A program model fidelity review is conducted yearly by Intercept® Clinical Services department to ensure clinical service delivery is consistent with the model.

Nurse-Family Partnership (NFP)

NFP is a home visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. NFP is intended to serve young, first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. Because of the emphasis on young first-time parents, NFP is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there are at least 6 counties having one or more providers within the NFP network.

Evidence based justification: NFP is currently rated "well-supported" as an In-Home Parenting Skill-Based Service by the Title IV-E Prevention Services Clearinghouse following review of 10 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being.

Child safety outcomes: Safety outcomes for children participating in NFP include reduction in maltreatment and abuse. NFP has demonstrated effects of reducing the likelihood of Child Protective Services (CPS) involvement (Mejdoubi, 2015).

Child well-being outcomes: Outcomes for children participating in NFP include fewer emotional disorders and behavioral problems, reduction in maltreatment and abuse, and improvement in overall health and well-being. Several studies have found that participation in NFP enhances cognitive functions and abilities and physical development and health (Kitzman, 1997, Robling, 2016 & Thorland, 2017).

Adult well-being outcomes: Outcomes for adults participating in NFP include gains in individual self-worth, improved empathy, and meeting their own needs in healthy ways. Adults also show measurable gains in nurturing parenting beliefs as well as knowledge and utilization of parenting skills and strategies. NFP also has at least one study demonstrating that participation in NFP increases the likelihood of caregiver months employed after birth (Olds, 2002).

Program delivery and fidelity: NFP is delivered by nurses through the core education about the Nurse-Family Partnership Model. New nurses learn the visit-to-visit guidelines, which provide a consistent content and structure for each of the 64 planned home visits (CEBC). The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother. NFP aims for 60 visits that last 60-75 minutes each in the home or a location of the mother's choosing. For the first month after enrollment, visits occur weekly. Then, they are held bi-weekly or on an as-needed basis.

NFP has a robust fidelity monitoring process. Nurses collect client and home visit data as specified by the National Program Office, and all data is sent to the Nurse-Family Partnership National Program Office's national database. The Nurse-Family Partnership National Program

Office reports out data to agencies to assess and guide program implementation, and agencies use these reports to monitor, identify and improve variances, and assure fidelity to the NFP model (CEBC).

Motivational Interviewing (MI)

Initially developed for the treatment of substance abuse and addiction disorders, Motivational Interviewing (MI) is now used in a variety of ways, including as means to promote engagement and success in services and interventions. MI is a method of counseling clients designed to promote behavior change and improve physiological, psychological, and lifestyle outcomes. MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. It aims to do this by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals. MI uses clinical strategies to help clients identify reasons to change their behavior and reinforce that behavior change is possible. These clinical strategies include the use of open-ended questions and reflective listening. MI can be used to promote behavior change with a range of target populations and for a variety of problem areas.

Evidence based justification: Motivational Interviewing (MI) is currently rated as "well supported" by the Title IV-E Prevention Services Clearinghouse as a Substance Abuse intervention following review of 75 eligible studies that indicated favorable effects in the target outcomes of adult well-being. As noted previously, The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rates MI as Well-Supported by research evidence with a medium relevance to child welfare in the categories of motivation and engagement programs. Similarly, a literature review of MI practice identified 12 of 16 articles that suggested MI's value of improving multiple outcomes, including parenting skills, parent and child mental health, retention in services, substance use, and recidivism in child welfare involvement[61]. These outcomes align with the targeted outcomes in SCDSS including increasing motivation to change across multiple areas of practice such as parent skill development, parent and child mental health, retention in services, substance use, and child welfare recidivism.

Adult well-being outcomes: MI has a robust evidence base as a substance misuse intervention. Several studies have demonstrated efficacy in reducing the quantity and frequency of alcohol use (Carey, 2006, Field, 2014, Gentilello, 1999, Marlatt, 1998, Rendall-Mkosi, 2013). There is also evidence demonstrating reduced use of other illicit substances (Stein, 2011).

MI is also "well supported" by the California Evidence-based Clearinghouse (CEBC) as both a Substance Abuse intervention and Motivation and Engagement program. CEBC does not provide specific information about the studies included in its review that contributed to its rating MI as "well supported" as a Motivation and Engagement program, but it does provide reference to four systematic reviews and meta-analyses summarizing existing literature on the effectiveness of MI (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Vasilaki, Hosier, & Cox, 2006; and Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). The most recent of these reviews, Lundahl et al. (2010) cites studies that overall indicate a significant effect of MI on client engagement and intention to change.

Finally, since the Title IV-E Clearinghouse last reviewed the evidence of MI in 2019, a systematic review of MI delivered specifically to families in child welfare has been published (Hall, Sears, & Walton, 2020). This review cites studies indicating positive effects for child welfare families engaged using MI compared to those not engaged using MI, including

increased likelihood to attend one-to-three substance use treatment sessions after referral, shorter lengths of time in out-of-home care, and a higher likelihood of children remaining with their parents at case closure.

Program delivery and fidelity: MI is typically delivered over one to three sessions with each session lasting about 30 to 50 minutes. Sessions are often used prior to or in conjunction with other therapies or programs. They are usually conducted in community agencies, clinical office settings, care facilities, or hospitals. While there are no required qualifications for individuals to deliver MI, training can be provided by MINT (Motivational Interviewing Network of Trainers) certified trainers. MI training by credentialed trainers use the practice manual, "Motivational Interviewing, Third Edition: Helping People Change" by Miller, W.R., & Rollnick, S. (2012), to standardize practice. MI has the Motivational Interviewing Treatment Integrity (MITI) instrument to measure fidelity to the MI model, and uses coaching to work toward proficiency through observation, note review, or role playing (CEBC).

Specifically in South Carolina, because of the evidence that MI increases engagement in services and motivation to change, as well as improves outcomes among child welfare families, the Department is seeking approval from the Children's Bureau to use MI not only for families in need of substance use treatment, but a broader population of Investigations and Family Preservation Cases, through the provision of the Department's new Family Resource Connection and Preservation Service (FRCPS). As previously noted in section two of this plan, parental substance use disorders are a leading factor associated with children entering care in South Carolina. While MI's efficacy was initially grounded in substance abuse treatment, DSS intends to use MI to engage families and enhance their motivation to participate in substance abuse services as well as mental health services or parenting skill services through FRCPS.

After building capacity in Motivational Interviewing through FRCPS and analyzing outcome data, the Department will explore in the future the feasibility of training Family Preservation and other child welfare staff in Motivational Interviewing. The Department anticipates that this will augment the GPS core practice skills of engagement and teaming with families to ensure appropriate planning and service matching. Currently, 46 of South Carolina's 46 counties have at least one MI provider across the state, making MI one of South Carolina's most commonly used interventions within the service array. Thus, the infrastructure already exists to further support MI as an intervention for Family First.

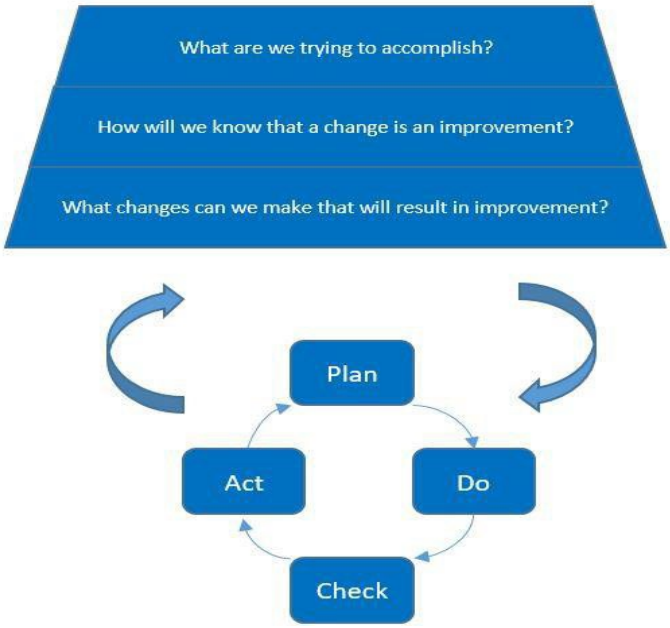
CQI Strategy for Proposed Well-Supported Interventions

South Carolina is creating a new statewide CQI structure and processes for the Prevention Plan that will be aligned with South Carolina's overall new strategic direction for program improvements. As part of this effort, South Carolina recently centralized its CQI infrastructure by reorganizing and aligning the divisions of Staff Development and Training; Accountability, Data, and Research; and Performance Management and Accountability under the Department's Director of Professional Development and Innovation. This newly formed formal and centralized approach has increased collaboration and communication by streamlining data, quality assurance, and workforce training into an active CQI process that is being leveraged to make recommendations for analysis and action steps to improve programs and outcomes for children and families.

South Carolina's CQI Strategy is based on the Model for Improvement, a widely used framework for CQI that consists of three fundamental questions and the Plan-Do-Check-Act (PDSA) Cycle.

(Figure 3, adapted from Langley et al., 2009). This CQI model is being used in other statewide CQI activities and will be used for the CQI process for all nine of the selected well-supported intervention.

Figure 9. CQI Model for Improvement



All CQI processes will be guided by A Measurement Framework for Implementing and Evaluating Prevention Services (Framework) developed by Chapin Hall at the University of Chicago (2020). The Framework lays out metrics to understand the ***reach*** of the proposed interventions, to monitor the ***fidelity*** of the proposed interventions, and to assess if the intervention-specific and overall Family First desired ***outcomes*** are achieved. The CQI process for well- supported interventions will address a common set of cross-cutting research questions.

Research questions for well-supported EBPs

1) Research questions for **reach**:
   a) Are Family First candidate children/families being identified and referred to EBP services?
   b) Are referred children/families receiving EBP services?
   c) What are the characteristics of referred children/families receiving EBP services and do they differ from referred children/families not receiving services?
   d) What is the length of time from referral to the start of services for children/families?
   e) Are children/families completing services?
   f) Are there regional variations in EBP referrals, service receipt, and service completion?
2) Research questions for **fidelity**:
   a) Do the referred children/families meet the eligibility requirements for each specific EBP model?
   b) Are the EBP services delivered as prescribed by each specific EBP model and guiding manual/curriculum (e.g., fidelity to the model)?
   c) How many EBP service sessions took place and is this consistent with the

EBP model?

3) Research questions for **outcomes**:
   a) *Child and family well-being outcomes:*
      i) Do children/families that *receive* an EBP service experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP *(this will be developed based on the EBP-specific program goals)?*
      ii) Do children/families that *complete* an EBP service experience better mental health, substance abuse, and parenting outcomes as prescribed by each EBP (*this will be developed based on the EBP-specific program goals*)?
   b) *Child safety outcomes:*
      i) Does EBP service *receipt* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii) Does EBP service *completion* reduce maltreatment? Are children re-referred for suspected child maltreatment within 12 months of EBP service completion? Within 24 months?
   c) *Child permanency outcomes:*
      i) Does EBP service *receipt* reduce foster care entry? Do children enter foster care within 12 months of the child-specific prevention plan start date? Within 24 months?
      ii) Does EBP service *completion* reduce foster care entry? Do children enter foster care within 12 months of EBP service completion? Within 24 months?

CQI Implementation Team(s)

Using core research questions to guide the CQI process, South Carolina will establish regionally based CQI teams responsible for reviewing EBP specific data, monitoring fidelity and outcome measures and making necessary adjustments to ensure that services are effective and meet the desired outcomes for children and families (see Figure 4). This will ensure that CQI efforts are regionalized and that each program is able to identify the performance successes and challenges and implement PDCA cycles that are tailored to their specific context.

During the initial phase of implementation, the CQI teams will primarily focus on the process and data related to the implementation of EBPs to inform how services are being implemented and the status of implementation drivers and supports. This will allow for any adjustments to be made in order to ensure implementation success. In later phases, South Carolina will establish data metrics based on the Framework to generate quarterly reports that will be used by the CQI teams to understand if there are barriers to EBP service delivery and to evaluate if outcomes are being achieved. This will allow CQI teams to make data-informed decisions and adjustments as needed.

As EBP implementation continues the Office of Family and Community Services, with support from the Office of Accountability, Data, and Research and the Office of Quality Assurance and CQI, meets once a month minimally with regional implementation EBP implementation teams (figure 10) to review performance and outcome data for each of the well-supported interventions. These regional teams are comprised of child welfare county directors, program coordinators and frontline team leaders from each locality in the region, representatives from provider agencies, and community organizations. Teams are responsible for identifying areas in

need of improvement in EBP service delivery as well as selecting and implementing CQI activities designed to achieve the improvements needed and monitoring the results of those activities.

Figure 10. Regional Implementation Teams

Region	Counties in Region
Upstate	Abbeville, Anderson, Cherokee, Greenville, Greenwood, Laurens, Newberry, Pickens, Spartanburg, and Oconee
Midlands	Aiken, Bamberg, Barnwell, Chester, Richland, Edgefield, Fairfield, Kershaw, Lancaster, Lexington, McCormick, Saluda, Union, and York
Low Country	Allendale, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg
Pee Dee	Chesterfield, Clarendon, Darlington, Dillon, Georgetown, Florence, Horry, Lee, Marlboro, Marion, Sumter, and Williamsburg

CQI data sources

To answer research questions, the CQI teams will rely on data metrics and reports generated from CAPSS, the data system that houses all child welfare information, and the South Carolina provider portal. CAPSS includes all administrative data on the children and families referred to or receiving services (child-specific plans) and their child welfare system involvement (e.g., child maltreatment screening and investigations; as well as foster care entries and exits). CAPSS also includes IV-E reports regarding eligibility for financial related determinations or needed determinations for claiming purposes. The provider portal will track all service delivery information such as the referral dates, eligibility, progress in treatment, and service completion.

CQI EBP fidelity monitoring

All treatment/service providers who receive reimbursement from South Carolina for EBP service delivery are required to collect, maintain, and report statistical data and information as requested for the purpose of program monitoring and evaluation. South Carolina plans to develop an annual fidelity monitoring on-site and/or virtual case review process for each of the EBP services provided to families. The review process will be developed in consultation with each of the EBP purveyors, and include verification of the required certifications/trainings, documentation of the prescribed fidelity measures, approved manual, trauma-informed delivery, and tracking of model- specific program goals.

Section VII: Child Welfare Workforce Training and Support

Pre-Print Sections 5 and 6 (Child welfare workforce support and training)

Training and Supporting the Evidence-Based Program Provider Agency Workforce

As discussed earlier in the prevention plan, all interventions must be evidence-based and trauma- informed. The Department will build upon and expand its existing provider network and their capacity to provide the evidence-based practices proposed in this plan. South Carolina has an accomplished and skilled workforce that is capable of effectively implementing and maintaining EBPs with support from the entire child and family well-being system.

The Department recognizes the need for ongoing training for providers to support continuous learning and growth. As SCDSS expands the array of services offered, providers of evidence-based and evidence-informed services will be required to operate from trauma-informed frameworks that meet the necessary training, credentialing, and fidelity monitoring requirements associated with each model.

The Department will also support South Carolina's transition to the use of evidence-based practices through capacity building grants and other fiscal and/or technical supports to ensure that both public and private workers and clinicians have the opportunity to collaborate through peer-learning and other training opportunities.

Training and Supporting the Child Welfare Agency Workforce

In recent years, SC DSS unveiled its Child Welfare Academy (CWA) Pre-service Certification Training, in collaboration with, the University of South Carolina's Center for Child and Family Studies, and Affintà Consulting. This two-year project aimed to redefine child welfare certification for new case managers and team leaders within Child Welfare Services. Training curriculums are aligned with the agencies adopted Guiding Principles and Standards (GPS) Practice Model and other initiatives. The core objectives of this program are:

- Augmenting casework readiness and enhancing the transfer of knowledge to new case managers.
- Bolstering support from peers and team leaders from the outset.
- Curtailing staff attrition and ensuring retention.

PROGRAM DETAILS

The updated nine-week training certification training is rooted in experiential learning and emphasizes the GPS practice model. Participants experience a blend of virtual classroom sessions spanning 18 days and an On-the-Job Training (OJT) phase lasting 25 days. Throughout the OJT phase, learners are exposed to real-world tasks, gaining insights into county office operations and progressively assuming more casework duties. A crucial component is the learning support team, which includes a peer, a performance coach, and the team leader. This team aids in the learner's transition, from shadowing tasks in clients' homes to taking on more casework duties.

PHASE 2 AND BEYOND

Following the completion of the pre-service certification, case managers and team leaders advance to Phase 2: Post-service training. This phase deepens the insights garnered in the certification training and is mandatory within the first year of employment.

Furthermore, in November 2021, the CWA introduced the Intake Certification Training tailored for Intake case managers and team leaders. This three-week program includes 12 days of instruction-led training and OJT activities, with a special focus on the GPS Practice Model and the Structured Decision-Making Tool.

ONGOING TRAINING OPPORTUNITIES

To ensure continued proficiency, Staff Development and Training (SD&T) rolled out the CWA Training Course Catalog. It serves as a comprehensive guide for Child Welfare Services professionals, detailing various training programs available. Post their first year, employees are mandated to undertake 20 hours of training annually to maintain their child welfare certification.

SD&T remains dedicated to equipping the CWS workforce with the latest in child welfare practices. This commitment is evident in the ongoing in-service training programs that cater to both mandatory and elective courses. Offered in collaboration with SCDSS and other partner entities, these programs range from webinars and podcasts to self-paced courses helmed by seasoned professionals. These sessions not only reinforce the foundational principles of GPS but also address the continual need for building competency, enhancing resilience, and fostering leadership capabilities.

South Carolina's Guiding Practices and Standards (GPS) Practice Model and Workforce Training

As mentioned earlier in this document, the Guiding Principles and Standards (GPS) Practice Model provides the values, principles and core practice skills used by Child Welfare staff to provide quality case management services. The overarching goal of the GPS Practice Model is to guide staff in ensuring the safety, stability, permanency, and well-being of the children and families. GPS provides an integrated and standardized framework for children and families which incorporates the following guiding principles: family-centered, trauma-informed, individualized and strengths-based, culturally responsive; and the following core practice skills: engagement, teaming, functional assessment, planning, intervening, tracking and adapting. Through quality coaching and the utilization of a strengths-based approach, case managers will be monitored and evaluated to ensure that appropriate services are delivered to children and families throughout the duration of the families' involvement with the Department. The GPS Practice Model is the foundation for all Child Welfare Certification training and In-service learning opportunities for child welfare staff. The Department began training on the GPS Practice Model through various forums since 2021. Included in the rollout was transfer of learning and coaching opportunities to support staff with implementation and integration of the GPS Practice Model into daily operations including how these practices apply in prevention services today.

Training to Ensure Trauma-Informed Care

Trauma-Informed care is integral to the Department's transformation strategy and a foundational principle within its GPS Practice Model. The Department recognizes that building a trauma-informed framework into its practice will require ongoing training and coaching beyond its Child Welfare Certification training. As such, the Department's Training Office is committed to ensuring that its workforce has a stronger understanding of how trauma impacts and is central to a family's experience with the child welfare system and to teaching the skills necessary to recognize and mitigate child and family trauma reactions and build resiliency. In addition to the GPS Practice Model, the Department's Foundations training series will now include an eight-module trauma- informed training for case managers and supervisors. Moreover, SCDSS is also committed to addressing the impact of workforce trauma and secondary traumatic stress through the implementation of the University of Kentucky's nationally recognized Safety Science framework with their child welfare supervisory workforce.

Since 2023, SCDSS has been implementing Therapeutic Crisis Intervention (TCI with case managers and their leadership. TCI presents a trauma-informed crisis prevention and intervention model designed to help staff prevent potential crises, deescalate crises when they occur, and assist children to learn adaptive ways to handle feelings of frustration, failure, anger, and hurt. TCI training provides immediate emotional and environmental support in a way that reduces the stress and risk and teaches better, more effective ways to deal with stress and painful feelings.

Family First Specific Training

The Department created a Family First webpage and has been communicating with staff and providers to incorporate training and update on Family First legislation. The webpage also provides updates to staff and the community regarding South Carolina's efforts to broaden the prevention continuum.

Training to Identify Candidates; Assess and Develop Prevention Plans

Current DSS training for the Family Preservation workforce will be enhanced to include information about how to identify candidates for Family First services based on the identified risk criteria. Simultaneously, the Department is seeking ways to automate candidate identification within the CAPSS system and assist the case manager and supervisor with service recommendations based on needs identified by the Family Advocacy and Support Tool (FAST) or Child and Adolescent Needs and Strengths (CANS) assessments.

Because supervisors will play an essential role in making critical decisions about candidacy and eligibility for services, service matching, and plan development, the Department will ensure robust training for supervisory guidance on these decisions. Additionally, provider agency staff under the contractual Family Resource Connection and Preservation Services (FRCPS) Program will work in tandem with existing Family Preservation staff. Families with an open investigation or open family preservation case will still receive case management services by a member of the SCDSS Child Welfare Services staff. FRCPS is a service provided in conjunction with case management services, not in place of. FRCPS staff will be provided training on their roles and responsibilities within an Investigation or Family Preservation case and receive approved Motivational Interviewing training.

Similarly, PAT SCFS Parent Educators are required to attend an extensive multi-day training on model implementation and curriculum training with a nationally certified PAT trainer. Upon conclusion of training, a parent educator is certified to provide PAT services. All parent educators must renew their certification annually. PAT documentation covered during initial training includes PAT intake requirements and forms, including the PAT Intake and Family Information Records, Visiting Record, Goal Record and the Family Service Record & Exit Summary. At the PAT State Office, SCFS PAT also provides local PAT providers training on additional PAT screening and risk assessment tools, such as the Healthy Families Parenting Inventory (HFPI), along with a family-centered assessment known as the Life Skills Progression (LSP), Ages and Stages/Ages & Stages Social-Emotional, and the Adult-Child Interactive Reading Inventory. Utilizing these tools and processes, PAT staff are best positioned to assess family needs and strengths, match appropriate services, and evaluate ongoing progress to achieve stated goals as identified in the Family Goal Record. All PAT tools, services, and required assessments are trauma-informed.

In addition to training on PAT-specific policies, procedures, tools, and assessments, SCFS PAT affiliates also ensure local PAT providers receive the 'Recognizing and Reporting Child and Abuse and Neglect' training as outlined above. These trainings help to ensure PAT staff respond to appropriate reporting of suspected child abuse or neglect to ensure appropriate intervention can occur from the SCDSS when necessary.

Training to Refer and Link Families with Appropriate Interventions

The Department enhanced training on service linkage to align with the new Family First service array; training DSS staff to take information from the assessment tools, CFTMs, and family preference to identify services that fit the needs of children and families. Similarly, DSS is coordinating within CAPSS to automate matching between reported needs and available services.

Training to Conduct Risk and Safety Assessments

The Department has enhanced current CANS and FAST assessment training for child welfare staff ensuring alignment with the GPS Practice Model. Existing Child Welfare Certification training includes a unit on assessment tools and understanding underlying conditions. Additionally, the SCDSS Assessment and Planning Team began conducting FAST/CANS Refresher training for DSS staff in January 2023. Refresher trainings, held monthly, are geared toward enhancing staff knowledge surrounding how to complete the CANS and FAST tools. Training also focuses on topics that case managers and team leaders tend to struggle with while completing the assessment while in the field. The Assessment and Planning team has continued to sponsor monthly coaching sessions for team leaders to assist them with supporting their direct staff members every 2nd Thursday of the month.

Section VIII: Prevention Caseloads

Pre-Print Section 7 (Prevention caseloads)

Caseload size is an important factor in ensuring effective case management for families and children receiving prevention services. For traditional FFPSA (families with active child welfare involvement) South Carolina has determined that the prevention caseload sizes can be maintained at their current rates given that candidates for prevention services will be limited to children who receive Family Preservation services, Investigations, and youth in Foster Care who are pregnant and parenting. The table below outlines the Department's caseload standards.

Figure 11. Child Welfare Caseload Standards

Case Type	Staff-to-Case Ratio
Investigations	1:12 families
Family Preservation	1:15 families
Foster Care	1:15 children

For the SCFS/PAT families, engaged through the community pathway and without an open child welfare case, the caseload size will follow the standards set forth in the SCFS Program and Operational Guidelines.

Case Type	Staff-to-Case Ratio
SCFS/PAT	1:18 families

A parent educator may carry a maximum caseload of 18 active families. Smaller caseloads may be necessary based upon the intensity of services provided (ex: weekly home visits) or as determined by individual family needs. Any exceptions to the identified caseload size must be approved by South Carolina First Steps Director of Parenting.

- **First-year** parent educators working **32 or more** hours per week should serve a minimum of ten (10) families and no more than fifteen (15).
- **Second year**, and beyond experienced parent educators working **32 or more** hours per week should serve a minimum of fifteen (15) families and no more than eighteen (18).
- **First year** parent educators working **less than 32** hours per week should serve a minimum of eight (8) families and no more than twelve (12).
- **Second year**, and beyond experienced parent educators working **less than 32** hours per week should serve a minimum of ten (10) families and no more than fifteen (15)

Each supervisor or lead parent educator may be assigned up to 12 Parent Educators, regardless of whether the parent educators are full or part time employees.

DSS will ensure that contractual agreements outline that SCFS will include in its quarterly reports the number of staff in compliance or out of compliance with the establish caseload standards. SCFS will also report to DSS immediately when staff are out of caseload size compliance and take appropriate measures to bring the parent educators into compliance.

Caseload Management and Oversight

SCDSS Child Welfare Operations, which includes the Director of CW Operations, Regional Directors, County Directors, Adoption Administrators and frontline supervisors, regularly oversee and monitor caseload standards through ongoing CQI practices and regular agency-wide performance monitoring. Additionally, SCDSS will expect all EBP providers to uphold the staffing and caseload requirements specified by each intervention and in accordance with the intervention fidelity.

Section IX: Assurance on Prevention Program Reporting

Pre-Print Section 8 (Assurance on prevention program reporting)

Appendix (x) contains the Department's assurance as required by ACFY-CB-PI-18-09 Attachment I, which the Department will comply with all the prevention program reporting requirements put forward by the Children's Bureau. The reporting requirements to date are contained in the Title IV-E Prevention Program Data Elements, Technical Bulletin #1. Consistent with this guidance and subsequent guidance, the Department will provide the following information for each child receiving services under the Title IV-E Prevention Program:

- Basic demographic information (e.g. age, sex, race, ethnicity)
- The child's identification as candidate or pregnant/parenting youth
- The child's foster care status, as applicable prior to receiving services, and at 12 and 24 months after receiving services
- Service types provided to the child and/or family
- The duration of services provided
- Total expenditures for each of the services provided to the child and/or family

DSS will capture the FAST/CANS and Family Permanency Plan in CAPSS/CCWIS for each Family Preservation, Investigation, and Expectant or Parenting Youth in foster care along with all other IV-E and IV-B data required for on-going federal child welfare cases.

For families served through the community pathway, DSS will develop a technical solution to capture the requisite information which will sit outside of the CCWIS system, but within SCDSS, and will allow the agency full access to the required Title IV-E and IV-B prevention plan data. When a case is referred to the SCFS PAT Program, the DSS team will use identifying information and risk factors to confirm eligibility for services and search CAPSS/CCWIS to search for an existing AFCARS ID and/or assign a new ID to serve as the child's unique identifier if none exists. Once eligibility is confirmed, DSS will utilize the technical solution to provide authorization of services and expenditures and monitor case management data to support federal audits, reviews, and other monitoring activities.

SCDSS will be responsible for making all initial and subsequent authorizations for community pathway services and providing notification via the Letter of Determination and Authorization for Services to SCFS community pathway providers. SCFS will be required to maintain this authorization with the CSPP in the family's record.

SCDSS will ensure it complies with 471(e)(5)(B)(ii) of the Act, which states that the title IV-E agency must ensure that it can fulfill its responsibility to examine the prevention plan as necessary based on periodic risk assessments and provide oversight through its community pathway. SCDSS will do so through two processes, first through program oversight and second through contract monitoring. SCFS will provide DSS staff with access to its systems to review case records, reports or other informational materials as needed to monitor compliance with all Title IV-E prevention requirements as needed.

The DSS designated team along with its QA/QI team will also monitor and follow-up with SCFS/PAT each month through an established Implementation Workgroup and quarterly through the transmission of PAT fidelity and outcomes data reports to DSS to ensure all required tasks are being completed. In addition, the DSS designated team and QA/QI team will conduct annual random case file reviews to verify requirements are being met.

Additionally, SCDSS will include language in its community pathway contract and agreements that SCDSS shall have the right to examine, make copies, excerpts, or transcripts from all records which will ensure that SCDSS can fulfill its responsibility to examine the prevention plan as necessary based on these risk assessments and provide appropriate oversight).

Process for Ongoing PAT Service Delivery:

The PAT Family Intake Record and the ongoing PAT Goal Record will be stored in the SCFS Information Technology System and completion dates will be logged in the DSS data tracking platform. Family progress or a lack thereof is documented monthly on the PAT Goal Record or whenever there is a change in risk or safety concerns. If safety concerns arise, the PAT Parent Educator is a mandated reporter and will be required to notify DSS.

Appendix A: South Carolina Family First Prevention Services Act Logic Model

	Inputs	Outputs	Outcomes	Impact
Infrastructure	• Policy identifying Family First processes • IT capacity to identify, track and monitor FF candidates • CQI prevention infrastructure	• Procedures and standards • CAPPS capacity to monitor FF cases • Data to inform need for course corrections • Fidelity monitoring	• Alignment of policy & practice • Data driven decision-making	As the number of children and **families served by Family Preservation increases**, the number of children entering **foster care decreases**. • Increased prevention services provided • Increased safety • Increased child and family well-being • Reduced foster care entry • Reduced foster care re-entry
Practice Supports	• GPS Practice Model • Enhanced CFTM process • FAST/CANS • Pre-service and veteran staff training • Model of Supervision • Coach Approach • Motivational Interviewing MINT Training	• Clear vision, values, guiding principles, and skills • Network of support engagement • Comprehensive assessment of needs & strengths • Ability to match services to needs • Prepared workforce with ongoing supports	• Individualized and strength-based plans • Professional workforce	
Collaboration & Coordination	• University of South Carolina partnership • FFPSA Prevention Services Workgroup • DSS Training Initiative Planning Team • GPS Practice Model Implementation Team • South Carolina Office of First Steps • Department of Juvenile Justice • Department of Mental Health	• State Agency, university partner, community provider, advocacy group, and persons with lived child welfare experience contributing to candidacy, • service array, and planning efforts	• Shared vision and prevention plan for South Carolina	
Services/ Interventions	• Intercept® • Motivational Interviewing • Multisystemic Family Therapy • Functional Family Therapy • Nurse-Family Partnership • Homebuilders • Healthy Families America • Parents as Teachers • Parent Child Interaction Therapy • Brief Strategic Family Therapy	• Evidence-based prevention service array • Matching of services to needs • Improved service capacity statewide • Improved family engagement, completion of services, and satisfaction with services	• Family First candidates improved mental health, decreased substance abuse, and strengthened parenting skills based on identified needs	
Candidates & Families	Children ages 0-18 and their parents/caregivers: • Served by Family Preservation • Served by Investigations • Foster youth pregnant or parenting	• Improved access to evidence-based practices for Parents with children age 0-5, Family Preservation, Adoption, Guardianship, and Pregnant and Parenting Youth	• Engagement in prevention services • Sustained and supported families	

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