South Carolina:

Building Strong and Thriving Families

Title IV-E Prevention Plan
FFY 2027-2031



DSS
SOUTH CAROLINA
DEPARTMENT *of* SOCIAL SERVICES

ADMINISTRATION FOR CHILDREN & FAMILIES
Children's Bureau | 330 C Street, S.W., Washington, DC 20201
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October 30, 2026

Anthony Catone
Director
South Carolina Department of Social Services
1535 West Confederate Avenue
Columbia, South Carolina 29201

Dear Director Catone:

Thank you for submitting South Carolina's title IV-E prevention program 5-year plan.

Plan Approval

We are pleased to notify you that South Carolina's title IV-E prevention program 5-year plan has been found to be in compliance with applicable federal statutory and regulatory requirements. South Carolina's title IV-E prevention program 5-year plan is approved as outlined below. An amendment must be submitted any time there is a substantial change to information in the approved plan.

South Carolina's 5-year plan is effective from October 1, 2026, through September 30, 2031. Please maintain this approval letter as a part of the final, approved plan.

Approval of Services Under the Title IV-E Prevention Program
Pursuant to sections 471(e)(1) and 471(e)(5)(B)(iii) of the Social Security Act (the Act), states may claim reimbursement for services and programs provided in accordance with promising, supported, or well-supported practices as rated by the Title IV-E Prevention Services Clearinghouse. In addition, section 471(e)(5)(B)(iii)(II) of the Act requires the state to describe how each program and service will be evaluated through a well-designed and rigorous evaluation strategy (unless waived for a well-supported practice rated by the Title IV-E Prevention Services Clearinghouse) and continuously monitored. The Children's Bureau has approved the following allowable programs and services as part of South Carolina's plan:

Brief Strategic Family Therapy
Parent-Child Interaction Therapy
Parents as Teachers
Healthy Families America
Motivational Interviewing
Multidimensional Family Therapy
Attachment and Biobehavioral Catch-Up Infant

Multisystemic Therapy
Functional Family Therapy
Homebuilders
Nurse Family Partnership
Intercept
Naltrexone: FDA-Approved Medication for Opioid Use Disorder
Methadone Maintenance Therapy: FDA-Approved Medication for Opioid Use Disorder
Buprenorphine: FDA-Approved Medication for Opioid Use Disorder
Family Centered Treatment
Iowa Parent Partner Approach
Triple P – Positive Parenting Program – Group
Triple P – Positive Parenting Program – Standard
Trust-Based Relational Intervention – Caregiver Training

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 public assistance 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 as or later than that of the title IV-E prevention program 5-year plan, depending on when submitted and the approval granted. For state title IV-E agencies, a public assistance cost allocation plan amendment must be submitted addressing title IV-E prevention program administrative costs in accordance with applicable regulations at 45 CFR 95.509(a)(3).

Approval of Request for Waiver of Evaluation Requirements
Pursuant to section 471(e)(5)(C)(ii) of the Act, the requirement for a well-designed and rigorous evaluation of any well-supported practice rated by the Title IV-E Prevention Services Clearinghouse may be waived if the evidence of effectiveness of the practice is deemed compelling and the continuous monitoring requirements of section 471(e)(5)(B)(iii)(II) are met. The Children's Bureau approves South Carolina's request for waiver of the evaluation requirement for the following approved services:

Brief Strategic Family Therapy
Parent-Child Interaction Therapy
Parents as Teachers
Healthy Families America
Motivational Interviewing
Multidimensional Family Therapy
Homebuilders
Multisystemic Therapy
Attachment and Biobehavioral Catch-Up Infant
Functional Family Therapy
Nurse Family Partnership
Intercept
Naltrexone: FDA-Approved Medication for Opioid Use Disorder

Methadone Maintenance Therapy: FDA-Approved Medication for Opioid Use Disorder
Buprenorphine: FDA-Approved Medication for Opioid Use Disorder

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 the Department of Health and Human Services for each child who receives title IV-E prevention services. South Carolina has 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. Title IV-E prevention program data submission timelines are provided in Technical Bulletin #2.

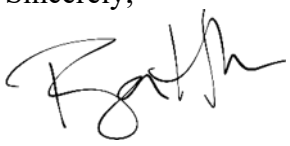
Payer of Last Resort
In approving the title IV-E prevention program 5-year plan, we remind states that section 471(e)(10)(C) of the Act requires that title IV-E is the payer of last resort for services allowable under the title IV-E prevention program. This means that if public or private program payers (such as private health insurance or Medicaid) would pay for a service allowable under the title IV-E prevention program, those payers 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 questions or concerns you may have, please contact the Children's Bureau at ivepreventionprogram@acf.hhs.gov.

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

Sincerely,



Ryan Hanlon
Associate Commissioner
Children's Bureau

Enclosures: Plan Submission Certification, Program Reporting Assurance, Request for Waiver of Evaluation Requirements, Assurance of Trauma-Informed Service Delivery

cc: Title IV-E Prevention Program Resource Mailbox, ivepreventionprogram@acf.hhs.gov;
Regional Office Resource Mailbox, Children's Bureauregion4@acf.hhs.gov;
Dianne Kelly, Regional Program Manager;
Janice Realeza, ACF Office of Grants Management;
Sona Cook, ACF Office of Grants Management.

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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.

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.

Background

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 quality, 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 administer programs and services that help 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 (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.

The Family First Prevention Services Act (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.

Family First went into effect at an opportune time for South Carolina as the Department was then and currently is undergoing tremendous system transformation. By building upon the solid foundations established through the State's first approved five-year prevention plan, 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.

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 states to 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 financial participation for these services.

South Carolina believes that by (a) anticipating the underlying needs driving the involvement of children and families with the child welfare system, and by (b) scaling up evidence-based interventions, and through (c) the development of more adaptive family strengthening pathways

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

(e.g. via traditional child welfare involvement or community pathways), SCDSS can better achieve meaningful and measurable improvements in child safety, permanency and child and family well-being as well as reduce rates maltreatment and mitigate risk factors associated with foster care entry. With this in mind, South Carolina is committed to continuing 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.

This new five-year plan sets forth the state's vision for developing an adaptive and responsive continuum or prevention services to strengthen South Carolina's children and families.

The table below identifies the interventions that South Carolina is including in its Prevention Plan. These evidence-based prevention programs have been rated by the Title IV-E Clearinghouse. Each intervention is described in the following subsections.

Table 1. South Carolina's Title IV-E Prevention Services Interventions

Targeted Prevention Services	
Well-Supported	
Brief Strategic Family Therapy	Multisystemic 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®
Multidimensional Family Therapy	Naltrexone: FDA-Approved Medication for Opioid Use Disorder
Attachment and Biobehavioral Catch-Up – Infant	Methadone Maintenance Therapy: FDA-Approved Medication for Opioid Use
Buprenorphine: FDA-Approved Medication for Opioid Use Disorder	
Supported	
Family Centered Treatment	
Promising	
Iowa Parent Partner Approach	Triple P– Positive Parenting Program – Standard (Level 4)
Triple P– Positive Parenting Program – Group (Level 4)	Trust-Based Relational Intervention-Caregiver Training

To this end, the Department is electing to continue to implement the optional Title IV-E Prevention Program authorized by Family First. SCDSS believes that by seizing this opportunity, the Department and its 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.

The following chapters of this plan comport with the Administration for Children and Families program instruction ACF-ACYF-CB-PI-24-10 issued on December 20, 2024.

Chapter 1: Service Description, Oversight

Well-Supported Interventions

Brief Strategic Family Therapy		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-Supported
	Book, manual, or other documentation consistent with the Clearinghouse	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.
	Identified service category(ies)	Mental Health Programs and Services, Substance Use Programs and Services, In-home Parent Skills-Based Programs
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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. 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. BSFT is currently available in Charleston, Spartanburg, Greenville, Lexington, and Dorchester counties. BSFT will be implemented in accordance with the BSFT model standards issued by either the Brief Strategic Family Therapy Institute or the Family Therapy Training Institute. 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). SCDSS may scale implementation to additional counties based on the needs of the agency and the needs of South Carolina's children and families. **AND** Continuous monitoring will adhere to all requirements associated with the BSFT model as appropriate.
	Description of how the state selected services	BSFT was selected for inclusion in this plan due to its applicability to serve teens and improve behavioral health and prosocial behaviors of service participants as well as to improve family functioning. A historical analysis of children receiving Family Preservation services found that approximately 56% meet the age criteria for BSFT. 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 flexibility of where it can be delivered, specifically in homes.
	Identified target population(s) specific to the state of jurisdiction	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.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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, 2015). In another study, significant overall improvements in family functioning were achieved (Santisteban, 2003).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Brief Strategic Family Therapy (BSFT) as a well-supported evidence-based practice (EBP) following its review of five eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child and adult well-being. Given this strong empirical foundation showing that BSFT positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver** of the evaluation requirements for this intervention

Multisystemic Therapy

Pre-Print Section	Requirement	Supporting Information
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	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.
	Identified service category(ies)	Mental health programs and services, Substance use programs and services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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. Multisystemic Therapy (MST) is currently implemented in the Upstate, Midlands, and Lowcountry regions of the state. SCDSS will work with community partners and other state agencies to include the South Carolina Department of Juvenile Justice (SCDJJ), to explore areas for scalability or capacity building. As of 2025, MST is included in the SC Medicaid State Plan and will only be covered under IV-E as a payor of last resort. **AND** Continuous monitoring will adhere to all requirements associated with the MST model as appropriate.
	Description of how the state selected services	South Carolina's historical analysis of the children receiving Family Preservation found that 23% of children in family preservation services met the age criteria for the model with

		a subset having concurrent juvenile justice involvement. This makes MST an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibility of where it can be delivered (e.g. homes, schools).
	Identified target population(s) specific to the state of jurisdiction	Youth between the ages of 12 and 17 who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement and their families.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child well-being outcomes*: Outcomes for children participating in MST include improved behavioral and emotional functioning, reductions in delinquent behavior, and reduced likelihood of out-of-home placement *Adult well-being outcomes*: Outcomes for adults participating in MST include improved positive parenting practices and improved family functioning.
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated MST as a well-supported EBP following review of 16 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being. Given this strong empirical foundation showing that MST positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Parent Child Interaction Therapy		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description	Well-supported, supported, or promising rating by the Clearinghouse	Well-Supported

and oversight	Book, manual, or other documentation consistent with the Clearinghouse	Manual: Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011.* PCIT International, Inc.
	Identified service category(ies)	Mental Health Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	In Parent Child Interactional Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent- child relationship. PCIT is currently provided by the South Carolina Department of Behavioral Health and Developmental Disabilities (SCBHDD) Office of Mental Health (OMH) and is available in nine centers across the state. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the PCIT model as appropriate.
	Description of how the state selected services	PCIT was selected because of its strength in reducing problematic behaviors in children ages 2–7, improving caregiver confidence, and preventing future maltreatment. It is also highly compatible with the needs of dually involved families who may be navigating DSS involvement alongside behavioral health or early childhood service systems. A historical analysis of Family Preservation services found that approximately 38% meet the age criteria for PCIT and many of these would benefit from a structured mental health intervention.

	Identified target population(s) specific to the state of jurisdiction	Families with children between the ages of 2-7 who experience emotional and behavioral problems that are frequent and intense.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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 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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	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. Given this strong empirical foundation showing that PCIT positively impacts child safety,

		permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Functional Family Therapy		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-Supported
	Book, manual, or other documentation consistent with the Clearinghouse	Alexander, J.A., Waldron, H.B., & Robbins, M.S., & Neeb, A. (2013). *Functional Family Therapy for Adolescent Behavior Problems.* American Psychological Association
	Identified service category(ies)	Mental Health and Substance Abuse Prevention and Treatment Programs
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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. FFT is currently implemented in the Upstate, Midlands, and Low Country regions of the state. SCDSS does not currently contract for FCT but may leverage service availability through state agencies for dually involved youth. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the FFT model as appropriate.

	Description of how the state selected services	A historical analysis of the children receiving Family Preservation services found that approximately 29% meet the age criteria for FFT with a subset having concurrent juvenile justice involvement. This makes FFT an appealing intervention for South Carolina because of emphasis on older children and youth, cross-system treatment focus, and the flexibility of where it can be delivered (e.g. homes, schools).
	Identified target population(s) specific to the state of jurisdiction	Children and adolescents between 11- 18 years old who experience problem behaviors such as conduct disorder, violent acting-out, and substance abuse.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated FFT as a well-supported EBP following review of 9 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being. Given this strong empirical foundation showing that FFT positively impacts child safety,

		permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Parents as Teachers		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	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).
	Identified service category(ies)	In-Home Parenting Skills-Based Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Parents as Teachers (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. PAT is currently available in 27 counties in South Carolina and is implemented by local affiliates of the South Carolina Office of First Steps (SCFS), the state office for the PAT program in South Carolina, in accordance with

		Parents as Teachers National Center Inc. standards. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the PAT model as appropriate.
	Description of how the state selected services	Historical analysis of South Carolina's children receiving Family Preservation services shows that approximately 43% meet the age criteria for PAT. Moreover, 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 to expand in-home parenting services to parents of young children. PAT is also a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. These data, paired with the strong PAT provider infrastructure and partnership through the South Carolina Office of First Steps (SCFS), compelled SCDSS to include PAT in its service array.
	Identified target population(s) specific to the state of jurisdiction	Families with children 0-5 or as approved by the model purveyor and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Parents as Teachers (PAT) as a well-supported evidence-based practice (EBP) following its review of 6 eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being. Given this strong empirical foundation showing that PAT positively impacts child safety and well-being and the outcomes outlined in Section 1, South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Homebuilders Intensive Family Preservation and Reunification Services		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping Families Together: The HOMEBUILDERS Model.* New York, NY: Taylor Francis.
	Identified service category(ies)	In-Home Parenting Skills-Based Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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. 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 is currently implemented in the Upstate, Midlands, and Low Country regions of the state. As of 2025, Homebuilders is included in the SC Medicaid State Plan and will only be covered under IV-E as a payor of last resort. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the HOMEBUILDERS® model as appropriate.
	Description of how the state selected services	The State selected HOMEBUILDERS® as a core Title IV-E prevention service based on a comprehensive review of state needs, evidence of effectiveness, and alignment with South Carolina's strategic priorities for strengthening families and preventing unnecessary foster care placements. HOMEBUILDERS® was further selected due to its Well-Supported rating in the Title IV-E Prevention Services Clearinghouse and its strong evidence base demonstrating reductions in out-of-home placements, improvements in family functioning, and increased child safety. The model's fidelity requirements, crisis-oriented structure, and 24/7 availability align with the State's goals of providing timely,

		high-impact services to families experiencing acute challenges. Finally, the selection of HOMEBUILDERS® supports the State's broader prevention strategy, which emphasizes family preservation, equitable access to evidence-based interventions, and the use of high-quality, measurable services that improve safety, permanency, and well-being. The model's demonstrated outcomes, strong evidence rating, and alignment with South Carolina's prevention goals make it an essential component of the State's Title IV-E Prevention Plan.
	Identified target population(s) specific to the state of jurisdiction	Families with children 0-18 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.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated Homebuilders as a well-supported EBP following review of 3 eligible studies that indicated favorable effects in the target outcomes of child and adult well-being. Given this strong empirical foundation showing that Homebuilders positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1.

		South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Healthy Families America		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	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.
	Identified service category(ies)	In-Home Parenting Skills-Based Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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. The 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 is currently implemented in South Carolina's Upstate region. SCDSS will work with community partners and sister agencies to explore areas for scalability or capacity building. If coverage gaps exist, SCDSS will work with community partners to determine appropriate procurement mechanisms to support additional implementation. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND**

		Continuous monitoring will adhere to all requirements associated with the HFA model as appropriate
	Description of how the state selected services	A historical analysis of the children and families receiving Family Preservation services 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 removal and/or child fatalities is support the uptake of in-home parenting services.
	Identified target population(s) specific to the state of jurisdiction	Families with children 0-5.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated HFA as a well-supported EBP following review of 22 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being. Given this strong empirical foundation showing that HFA positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Nurse-Family Partnership		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Nurse Family Partnership. (2020). *Visit-to-visit guidelines* Consistent with current training and certification per Nurse Family Partnership per https://www.nursefamily partnership.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).
	Identified service category(ies)	In-Home Parenting Skills-Based Services

	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	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 is currently implemented in Oconee, Pickens, Greenville, Spartanburg, and York Counties. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the NFP model as appropriate
	Description of how the state selected services	NFP is a well-suited intervention to serve South Carolina's foster youth who are pregnant and parenting. Presently, there is a sizable NFP network in specific regions of South Carolina. NFP may also be appropriate for non-custodial first-time parents with SCDSS for peri and post-partum support.
	Identified target population(s) specific to the state of jurisdiction	Young, first- time, low- income mothers through their child's first two years expectant and parents on behalf of an unborn child.
	Information on how providing the services is expected to improve	*Child safety outcomes*: Safety outcomes for children participating in NFP include reduction in maltreatment and abuse. NFP has demonstrated effects of reducing the likelihood

	specific outcomes for children and families	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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated NFP as a well-supported EBP following review of 10 eligible studies that indicated favorable effects in the target outcomes of child safety, child well-being, and adult well-being. Given this strong empirical foundation showing that NFP positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Motivational Interviewing		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service	Well-supported, supported, or promising rating by the	Well-supported

description and oversight	Clearinghouse	
	Book, manual, or other documentation consistent with the Clearinghouse	Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change (3rd ed.).* Guilford Press or other standardized MI training platforms and or protocols.
	Identified service category(ies)	Mental Health, Substance Use Programs and Services, In Home Parenting Skills-Based Programs (Cross-Cutting)
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Motivational Interviewing (MI) is an evidence-based counseling and engagement approach designed to facilitate behavior change and improve physiological, psychological, and lifestyle outcomes. Grounded in collaboration and respect for client autonomy, MI helps individuals reflect on their personal goals and examine how current behaviors may hinder progress toward those goals. Through structured, client-centered strategies, practitioners support individuals in articulating their own motivations for change and reinforce the belief that change is both possible and achievable. Consistent with the State's previously approved Title IV-E Prevention Plan, SCDSS is seeking continued authorization from the Children's Bureau to employ Motivational Interviewing (MI) not only as a substance use treatment intervention, but also as a structured engagement strategy that strengthens family participation across multiple service domains. MI will continue to be used to enhance motivation and support active involvement in substance use services, parenting skills interventions, mental health treatment. By positioning MI as both a therapeutic intervention and a crosscutting engagement tool, SCDSS ensures alignment with federal evidence-based requirements while reinforcing its commitment to fidelity, family voice, and measurable outcomes across the prevention service array.

		MI is also used to facilitate needs identification, resource navigation, case coordination, and the delivery of economic and concrete goods/supports, tutoring, mental health services, life skills training, and parenting programs. Through this integrated MI-informed approach, SCDSS aims to increase family engagement, address ambivalence toward change, reduce risk factors, prevent further child welfare involvement, and promote long term family stability The Department implements MI through contracts with local service providers who use MI across all service contacts and/or in conjunction with the delivery of in-home parenting supports, behavioral health services, tutoring, concrete goods, and life skills training. MI is typically delivered in families' homes or community settings, ensuring services are accessible and tailored to family needs. Dosage and intensity vary based on family circumstances and case goals, and MI remains a consistent engagement approach throughout the duration of service involvement. MI is available to SCDSS-authorized families through contracted service providers, including Family Resource Connection and Preservation Services (FRCPS), Enhanced FRCPS, and Family Resource Centers, with services offered statewide to strengthen uniform access and ensure MI functions as a central engagement and intervention strategy across the system. Implementation is structured to maintain fidelity to the MI model. Providers receive training, supervision, and ongoing support to ensure consistent delivery across settings. All contracted providers use an SCDSS-approved fidelity monitoring platform grounded in the Motivational Interviewing Treatment Integrity (MITI) and/or Motivational Interviewing Skill Code (MISC) tools.

		SCDSS will work with relevant stakeholders to assess scalability and increase accessibility, including exploring opportunities to expand MI as the central engagement and intervention strategy across additional service delivery types and settings. **AND** Continuous monitoring will adhere to all requirements associated with the MI model as appropriate to include the use of the MITI or other MI related QI tool.
	Description of how the state selected services	SCDSS selected MI for inclusion in its service array based upon needs reflected in agency data that warrant cross-cutting interventions to address families' mental health, material needs, and caregiver substance use. SCDSS believes that through the provision of MI, the department can address root causes and risk factors of maltreatment to prevent foster care entry for a variety of families with varying needs. Moreover, MI has been shown to be a practical intervention for precipitating diverse types of behavior change. Although MI originated in the field of substance abuse, model developers William Miller and Stephen Rollnick have encouraged the evolution of the model's use to address a wide range of behavior changes. The third and most recent edition of the MI manual, which is listed on the Title IV-E Prevention Services Clearinghouse, describes MI as a model with wide applications in diverse fields, and the authors purport to have "broadened the application of MI to behavior change more generally, no longer limited to addictive behaviors." Additionally, in December 2025, SCDSS conducted a preliminary point-in-time analysis of administrative data to assess outcomes associated with MI delivered through FRCPS

		and found that more than 90 percent of children who received the service did not experience subsequent foster care involvement. While not all children had reached the full 12- or 24-month evaluation window, these early findings are encouraging.
	Identified target population(s) specific to the state of jurisdiction	Families and/or caregivers with children birth to 17 years old and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	Initially developed for the treatment of substance abuse and addiction disorders, MI is now used in a variety of ways, including as means to promote engagement and success in services and interventions. MI has a robust evidence base in improving adult well-being outcomes. 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. (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, in 2019, a systematic review of MI delivered specifically to families in child welfare was published (Hall, Sears, & Walton, 2020). This review cites studies indicating 84 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.
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Motivational Interviewing as a well-supported evidence-based practice (EBP) following its review of 75 eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child and adult well-being. Given this strong empirical foundation showing that Motivational Interviewing positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention

Intercept		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	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.
	Identified service category(ies)	In-Home Parenting Skills-Based Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and	Intercept, developed by Youth Villages, is an integrated, intensive family-centered intervention designed to stabilize youth and caregivers by addressing behavioral, emotional, and environmental challenges within the home.

	refine and improve practices	The program primarily serves children and adolescents ages 4 to 18, with services tailored to prevent out-of-home placement and promote permanency through intensive in-home support. Out-of-home care includes, but is not limited to, foster care, residential treatment, or group home settings. Intercept services may last four to nine months. 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 Intercept is currently available in York, Lancaster, Richland, Lexington, Kershaw, Chester, Fairfield, Spartanburg, Anderson, and Greenville counties, providing coverage across diverse regions of the state. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the Intercept model as appropriate.
	Description of how the state selected services	SCDSS identified Intercept as a critical intervention to address the complex challenges faced by families with children under 18 who are at risk of out-of-home placement. Service selection was informed by routine analyses of

		intakes, substantiated investigations, and open Family Preservation and Foster Care cases, which consistently highlight overlapping concerns related to children's behavioral and emotional needs, school functioning, family conflict, and caregiver capacity. Historical data demonstrate that these factors are among the most significant drivers of child welfare involvement and placement instability. Further, insights from foster care entry data routinely identify child behavioral concerns—particularly among older youth—as a notable reason for placement, underscoring the need for an intensive, family-centered model capable of stabilizing children in their homes and communities. Intercept was selected because of its strong alignment with these identified needs, its evidence-supported capacity to reduce placement disruptions, and its ability to deliver individualized services across diverse family contexts. By choosing Intercept, SCDSS ensures that service implementation is directly responsive to the state's data-driven understanding of family needs, while reinforcing its commitment to evidence-aligned practice and prevention-focused outcomes.
	Identified target population(s) specific to the state of jurisdiction	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.
	Information on how providing the services is expected to improve specific outcomes for children and families	*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).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse rated Intercept® as a well-supported EBP following review of two (2) eligible studies that indicated favorable effects in the target outcomes of child permanency.

		Given this strong empirical foundation showing that Intercept® positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Multidimensional Family Therapy		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Liddle, H. A. (2007). *Multidimensional Family Therapy: Therapist's treatment manual*. Center for Treatment Research on Adolescent Drug Abuse, University of Miami.
	Identified service category(ies)	Mental Health Programs and Services, Substance Use Programs and Services, In-Home Parent Skill-based Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Multidimensional Family Therapy (MDFT) focuses on addressing the needs of adolescents and young adults with substance use, delinquency, mental health, and emotional problems. MDFT is an integrated therapy model that incorporates and supports parents, families, and community partners (e.g., child welfare, schools). MDFT seeks to enhance coping, problem solving, and communication skills; stabilize mental health issues; reduce youth substance use; and improve school achievement among adolescents and young adults. MDFT also aims to improve parenting skills, parental functioning, family communication, attachment, and to reduce parenting stress. MDFT is currently available in 15 counties across all four regions of South Carolina delivered by South Carolina Department of

		Behavioral Health and Developmental Disabilities (DBHDD), Office of Mental Health (OMH). This existing footprint provides a strong foundation for phased expansion and coordinated service delivery. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the MDFT model as appropriate.
	Description of how the state selected services	Given the complex needs of adolescents served by SCDSS -many of whom present with co-occurring behavioral health challenges, substance use, family conflict, school disengagement, and multi-system involvement—MDFT offers a strong, evidence-supported intervention aligned with FFPSA's goals of preventing foster care entry and stabilizing families. MDFT has demonstrated effectiveness in improving family functioning, reducing substance use and delinquent behaviors, strengthening parenting capacity, and increasing school engagement, all of which are core drivers of child welfare involvement. Its flexible, home- and community-based model is well-suited to the realities of SCDSS-involved families, and its demonstrated success across behavioral health, juvenile justice, and child welfare-relevant populations makes it an appropriate and scalable option for South Carolina's prevention continuum. Incorporating MDFT into the FFPSA Prevention Plan allows SCDSS to address high-risk adolescent needs with a rigorously tested, family-centered model that supports safety, stability, and long-term well-being.

	Identified target population(s) specific to the state of jurisdiction	Families with children or adolescents 9 - 18 years of age, who display substance use, delinquency, mental health, academic/vocational and/or emotional challenges.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child well-being outcomes*: In a comparative randomized controlled trial (RCT) evaluating MDFT, adolescent group treatment, and a psychoeducational multifamily intervention (Liddle et al., 2001), adolescents receiving MDFT demonstrated significantly greater improvements in academic performance than those in the comparison conditions. At the one year follow up, 76% of MDFT participants had passing grades, compared with 60% of youth in group treatment and 40% in the multifamily intervention. Similarly, in an RCT focused on younger adolescents (Rowe et al., 2003), MDFT again outperformed group treatment. Youth receiving MDFT showed greater improvements in academic and conduct grades, as well as larger reductions in school absences, findings that were replicated in subsequent analyses (Liddle et al., 2004; Liddle et al., 2009).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Multidimensional Family Therapy (MDFT) as a well-supported evidence-based practice (EBP) following its review of seven eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being. Given this strong empirical foundation showing that MDFT positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Attachment and Biobehavioral Catch-Up- Infant

Pre-Print Section	Requirement	Supporting Information
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Dozier, M., & the Attachment and Biobehavioral Catch-up Team. (2024). *Attachment and Biobehavioral Catch-up for infants (ABC-I): ABC-I manual.* University of Delaware, Newark.
	Identified service category(ies)	Mental Health Programs and Services; In-home Parent Skill-based Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Attachment and Biobehavioral Catch-up – Infant (ABC-I) is designed to help caregivers of children ages 6–24 months who have experienced early adversity. ABC-I aims to promote responsive caregiving to help infants develop secure, organized attachments and self-regulation capabilities. ABC-I is provided by skilled clinicians, called parent coaches. Coaching sessions include in-the-moment and video feedback to foster the caregiver's abilities to follow the infant's lead, respond to infant's distress in nurturing ways, and recognize and reduce frightening behaviors. ABC-I is available in 5 counties and is currently implemented by the South Carolina Infant Mental Health Association (SCIMHA). SCDSS plans to partner with SCIMHA to serve families with children at risk of foster care entry through this well-supported intervention. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate. **AND** Continuous monitoring will adhere to all requirements associated with the ABC-I model as appropriate.

	Description of how the state selected services	An analysis by the SCDSS Office of Accountability, Data, and Research found that as of December 2025, approximately 18.7% of children in foster care and 21.8% of children in family preservation were aged 2 or under.
	Identified target population(s) specific to the state of jurisdiction	Caregivers of infants ages 6-24 months who have experienced early adversity.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child well-being outcomes:* Well-being outcomes for children include improved behavioral and emotional functioning, specifically improvements in attachment and emotional dysregulation. In a comparative study of ABC versus another intervention, children whose foster parents had completed the ABC intervention showed significantly fewer avoidant attachment behaviors than children whose foster parents completed another intervention (Dozier et al., 2009). Another study using two randomized control trials found ABC to significantly reduce anger dysregulation among children referred to child protective services who remained with birth parents (Labella et al., 2020). *Adult well-being outcomes*: Improvements in adult well-being include positive parenting practices and family functioning. Bick and Dozier (2013) found that parents' ability to perceive a child's signals and effectively respond to these signals was improved for foster mothers in the ABC intervention, compared with mothers in the comparison intervention. Thorpe et al. (2022) found ABC to effective in reducing maladaptive parental beliefs about infant crying, suggesting more effective responses to infant distress.
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Attachment and Biobehavioral Catch Up - Infant as a well-supported evidence-based practice (EBP)

		following its review of five eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being. Given this strong empirical foundation showing that Attachment and Biobehavioral Catch Up - Infant positively impacts child safety, permanency, well-being, and adult well-being and the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Buprenorphine: FDA-Approved Medication for Opioid Use Disorder		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Medications for opioid use disorder: For healthcare and addiction professionals, policymakers, patients, and families (HHS Publication No. PEP21-02-01-002)*
	Identified service category(ies)	Substance Use Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Buprenorphine: FDA-Approved Medication for Opioid Use Disorder (Buprenorphine MOUD) is designed for individuals who have an opioid use disorder. The treatment aims to reduce opioid withdrawal and cravings and support patients to decrease or end opioid dependence. Buprenorphine MOUD is part of a comprehensive treatment plan that includes ongoing medical management visits where providers can offer brief supportive counseling, such as stress management, empathetic listening, and progress tracking; assess drug or alcohol use; monitor side effects; provide referrals to psychosocial and other support

		services; follow up on referrals; and involve family members, when appropriate. Buprenorphine is currently accessible in all 46 counties across South Carolina through an established network of DATA-waived prescribers, community behavioral health providers, and integrated primary care settings. This existing statewide infrastructure positions South Carolina to implement MOUD-B within the FFPSA prevention continuum without requiring the creation of new service delivery systems. Families referred through SCDSS will be able to access services through local providers already operating within their communities, ensuring timely engagement, continuity of care, and minimal disruption to family stability. To strengthen access and coordination, SCDSS will partner closely with the South Carolina Office of Substance Use Services (OSUS) and its network of treatment providers. Through this collaboration, partner support of referral pathways, provider engagement, and cross-system communication will ensure that caregivers involved with the child welfare system can rapidly connect to MOUD-B. This coordinated approach allows families affected by opioid use disorder to receive evidence-based interventions that promote safety, stability, and long-term recovery. By leveraging the state's existing MOUD infrastructure, SCDSS will enhance access to buprenorphine for families at risk of foster care involvement. This implementation strategy strengthens South Carolina's prevention system by addressing a prevalent driver of maltreatment—caregiver substance use—through a proven, scalable, and widely available intervention. SCDSS will focus its oversight on the referral process and the coordination of care delivered

		through community-based partners. This includes ensuring that families are connected to qualified buprenorphine providers in a timely manner, verifying that communication pathways between medical providers and SCDSS-funded supports are functioning, and reviewing documentation that reflects engagement, care coordination, and linkage to supportive services. Through this shared approach, SCDSS respects the clinical authority of medical providers while maintaining its responsibility to monitor service access, cross-system collaboration, and the overall integrity of the prevention service array. IV-E will serve as payor of last resort. Providers will be required to file a claim and keep denials on record prior to seeing reimbursement from the IV-E Agency.
	Description of how the state selected services	A substantial proportion of child maltreatment reports in South Carolina identify caregiver substance use as a primary factor contributing to abuse and neglect, underscoring the need for effective, evidence-based interventions that directly address opioid use disorder. Buprenorphine is an FDA-approved, evidence-based medication for OUD with a strong research base demonstrating its effectiveness in reducing illicit opioid use, improving treatment retention, and stabilizing individuals with moderate to severe OUD (Mattick et al., 2014). These outcomes directly align with FFPSA's goals of preventing foster care entry by strengthening caregiver functioning and promoting child safety and well-being. Buprenorphine is delivered through office-based medical providers and community health systems across South Carolina, allowing for accessible, flexible, and family-centered treatment that integrates medical care, behavioral health supports, and recovery services. This established infrastructure

		creates a strong foundation for scalable implementation within the child welfare prevention continuum. Given its proven effectiveness, accessibility, and alignment with the needs of families affected by OUD, buprenorphine represents a suitable and practical intervention for inclusion in the state's FFPSA Prevention Plan. Integrating buprenorphine into prevention services enhances South Carolina's capacity to address one of the most prevalent drivers of maltreatment—caregiver substance use—by supporting parental stabilization and improving the conditions necessary for children to remain safely in their homes.
	Identified target population(s) specific to the state of jurisdiction	Buprenorphine MOUD is designed for individuals who have an opioid use disorder and expectant parents on behalf of an unborn child..
	Information on how providing the services is expected to improve specific outcomes for children and families	*Adult and child well-being outcomes*: In a large retrospective cohort study of 14,463 Medicaid-covered maternal–infant dyads, treatment with buprenorphine during pregnancy was associated with significantly improved maternal and neonatal outcomes. Pregnant individuals receiving buprenorphine experienced lower rates of severe maternal morbidity, preterm birth, and neonatal intensive care unit (NICU) admission compared with those who did not receive medication for opioid use disorder. These differences were statistically significant, underscoring the protective effect of buprenorphine on both maternal stability and early child health. Overall, the study found a meaningfully reduced risk of adverse pregnancy and infant outcomes among those treated with buprenorphine relative to untreated individuals. This evidence reinforces buprenorphine as a critical intervention for improving child well-being by reducing preventable complications associated with untreated opioid

		use disorder in pregnancy (Krishnapura SR, McNeer E, Loch SF, et al., 2025).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Buprenorphine MOUD as a well-supported evidence-based practice (EBP) following its review of two eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being. Given this strong empirical foundation showing that MOUD positively impacts child safety, permanency, well-being along with the outcomes outlined in Section 1. South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Methadone Maintenance Therapy: FDA- Approved Medication for Opioid Use Disorder		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Medications for opioid use disorder: For healthcare and addiction professionals, policymakers, patients, and families (HHS Publication No. PEP21-02-01-002)*
	Identified service category(ies)	Substance Use Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Methadone Maintenance Therapy: FDA-Approved Medication for Opioid Use Disorder (MMT MOUD) is designed for individuals who have an opioid use disorder. MMT MOUD aims to reduce the use of heroin and other opioids. Methadone is part of a comprehensive treatment plan, which includes counseling and other behavioral health services.

		Methadone Maintenance Therapy (MMT) is available across South Carolina through a network of federally regulated Opioid Treatment Programs and some county level alcohol and drug abuse authorities, that operate in all regions of the state. This established infrastructure positions South Carolina to implement MMT within the Family First prevention continuum without the need to create new clinical service delivery systems. Families referred through SCDSS will be able to access methadone services through existing Opioid Treatment Programs (OTPs) located within or near their communities, supporting timely engagement, continuity of care, and minimal disruption to family stability. The structured nature of OTPs—including supervised dosing, integrated behavioral health supports, and routine monitoring—provides a consistent and reliable treatment environment for caregivers with opioid use disorder. To strengthen access and coordination, SCDSS will partner closely with the South Carolina Office of Substance Use Services (OSUS) and its network of providers. Through this collaboration, community-based providers may assist in addressing barriers such as transportation, care navigation, and linkage to supportive services. This coordinated approach helps families affected by opioid use disorder receive evidence-based treatment that promotes safety, stability, and long-term recovery. By leveraging the state's existing MMT infrastructure and formalizing collaboration with OSUS, SCDSS will streamline access to methadone for families at risk of foster care involvement. This implementation strategy strengthens South Carolina's prevention system by addressing one of the most prevalent drivers of maltreatment—caregiver substance use—through a proven, highly structured, and widely available intervention.

		Integrating MMT into the prevention service array supports caregiver stabilization, reduces crisis-driven behaviors associated with untreated opioid use disorder, and improves the conditions necessary for children to remain safely in their homes. IV-E will serve as payor of last resort. Providers will be required to file a claim and keep denials on record prior to seeking reimbursement from the SCDSS.
	Description of how the state selected services	Methadone Maintenance Therapy is included in the Prevention Plan based on its long-established effectiveness in improving adult stability and strengthening the caregiving environment for families affected by opioid use disorder. Caregiver substance use remains one of the most common contributors to child maltreatment in South Carolina, often leading to impaired supervision, unsafe home conditions, and crisis-driven decision-making. Untreated OUD is associated with high relapse rates, withdrawal-related instability, and significant disruptions in daily functioning—all of which directly increase the risk of child welfare involvement. Evidence-based methadone service reduces these risks by stabilizing the parent, suppressing illicit opioid use, and improving retention in care. A comprehensive review of randomized clinical trials found that methadone is significantly more effective than non-medication approaches in keeping individuals engaged in treatment and reducing heroin use, demonstrating its value as a foundational intervention for individuals with moderate to severe OUD (Faggiano et al., 2003). These improvements in parental stability translate into safer caregiving environments, fewer crisis events, and enhanced capacity for parents to meet their children's physical and emotional needs. Incorporating MMT into the state's prevention service array strengthens

		South Carolina's ability to address one of the most prevalent drivers of maltreatment—caregiver substance use—through a proven, highly structured, and widely available intervention that supports family preservation and child well-being.
	Identified target population(s) specific to the state of jurisdiction	Individuals who have an opioid use disorder and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Adult and child well-being outcomes*: Research shows that methadone helps people with opioid use disorder stay in treatment and significantly reduce their use of heroin and other illicit opioids. When parents receive methadone, they are far more likely to remain engaged in treatment and maintain stability, compared to approaches that do not use medication. Staying in treatment and reducing opioid use are two of the most important factors that support a parent's ability to safely care for their children. For caregivers, untreated opioid use disorder often leads to unpredictable behavior, withdrawal symptoms, health crises, and time spent seeking drugs—all of which can interfere with supervision, emotional availability, and the ability to meet a child's basic needs. Methadone reduces these patterns by preventing withdrawal, lowering cravings, and helping parents regain daily stability. As parents use fewer illicit opioids, they experience fewer crises, are better able to maintain routines, and can focus more consistently on caregiving responsibilities (Mattick et al., 2009).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Methadone Maintenance Therapy as a well-supported evidence-based practice (EBP) following its review of two eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being.

		Given this strong empirical foundation showing that MMT positively impacts child safety, permanency, and well-being along with the outcomes outlined in Section 1., South Carolina **is requesting a waiver of the evaluation requirements** for this intervention.

Naltrexone Maintenance Therapy: FDA- Approved Medication for Opioid Use Disorder		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Well-supported
	Book, manual, or other documentation consistent with the Clearinghouse	Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Medications for opioid use disorder: For healthcare and addiction professionals, policymakers, patients, and families (HHS Publication No. PEP21-02-01-002)*
	Identified service category(ies)	Substance Use Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Naltrexone: FDA-Approved Medication for Opioid Use Disorder (Naltrexone MOUD) is designed for individuals who have an opioid use disorder. The treatment aims to reduce opioid cravings and prevent return to opioid dependence. Naltrexone MOUD is part of a comprehensive treatment plan that includes ongoing medical management visits where providers can offer brief supportive counseling, such as stress management, empathetic listening, and progress tracking; assess drug or alcohol use; monitor side effects; provide referrals to psychosocial and other support services; follow up on referrals; and involve family members, when appropriate. Naltrexone is currently accessible across South Carolina through an established network of medical providers, community behavioral health agencies, and integrated primary care

		settings that offer both oral and extended-release injectable formulations. This existing statewide infrastructure positions South Carolina to implement N-MOUD within the Family First prevention continuum without requiring the creation of new service delivery systems. Families referred through SCDSS will be able to access naltrexone through local providers already operating within their communities, promoting timely engagement, continuity of care, and minimal disruption to family stability. To strengthen access and coordination, SCDSS will partner closely with the South Carolina Office of Substance Use Services (OSUS) and its network of providers. This collaboration will support referral pathways, provider engagement, and cross-system communication to help caregivers involved with the child welfare system rapidly connect to N-MOUD. This coordinated approach helps families affected by opioid use disorder receive evidence-based interventions that promote safety, stability, and long-term recovery. By leveraging the state's existing MOUD infrastructure SCDSS will enhance access to naltrexone for families at risk of foster care involvement. This implementation strategy strengthens South Carolina's prevention system by addressing one of the most prevalent drivers of maltreatment—caregiver substance use—through a proven, scalable, and widely available intervention that supports family preservation and child well-being. IV-E will serve as payor of last resort. Providers will be required to file a claim and keep denials on record prior to seeking reimbursement from SCDSS.
	Description of how the state selected services	Naltrexone is included based on its demonstrated ability to support adult stability and reduce opioid use among

		individuals with opioid use disorder, thereby strengthening the caregiving environment for children. Untreated OUD is associated with elevated risks of overdose, impaired parental functioning, and significant household instability—factors that increase the likelihood of child maltreatment and foster care involvement. Evidence-based services using naltrexone, particularly extended-release formulations, help mitigate these risks by blocking the euphoric effects of opioids, reducing relapse, and supporting sustained abstinence. A 2024 secondary analysis of adolescents and young adults receiving extended-release naltrexone found significantly lower rates of opioid use compared to treatment-as-usual, with adolescents demonstrating a 48% reduction in opioid-use days and young adults a 26% reduction, underscoring the medication's capacity to stabilize functioning and reduce crisis events within families. These improvements in parental consistency, safety, and daily functioning translate into more predictable caregiving, fewer high-risk situations, and enhanced capacity to meet children's developmental and emotional needs. Incorporating naltrexone into the state's prevention service array strengthens South Carolina's ability to address caregiver substance use—a prevalent driver of maltreatment—through an intervention with documented impacts on family stability and well-being (Mitchell SG, Fletcher JB, Monico LB, et al., 2024).

	Identified target population(s) specific to the state of jurisdiction	Individuals who have an opioid use disorder and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Adult and child well-being outcomes*: Research on oral naltrexone shows that the medication can help adults with opioid use disorder avoid relapse and maintain abstinence when they take it consistently and have strong support systems in place. Oral naltrexone works by blocking the effects of opioids, which removes the "reward" associated with relapse and helps individuals stay focused on recovery. Studies have found that when caregivers receive structured support—such as observed dosing, family involvement, or regular follow-up—they are more likely to stay on the medication and experience better outcomes, including fewer relapses and more days without opioid use. For SCDSS, these findings are especially relevant: when caregivers are supported in taking oral naltrexone as prescribed, they are more likely to maintain daily stability, avoid crisis-driven behaviors, and provide consistent supervision and care for their children. Improved adherence to oral naltrexone can therefore strengthen the caregiving environment, reduce safety risks associated with relapse or overdose, and support the conditions necessary for children to remain safely with their families (Minozzi et al., 2011).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	The Title IV-E Prevention Services Clearinghouse has designated Naltrexone MOUD as a well-supported evidence-based practice (EBP) following its review of two eligible studies. These studies consistently demonstrated favorable effects on key target outcomes related to child well-being. Given this strong empirical foundation showing that MOUD positively impacts child safety, permanency, and well-being along with the outcomes outlined in Section 1., South Carolina

		is requesting a waiver of the evaluation requirements for this intervention.

Supported Interventions

Family Centered Treatment		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Supported
	Book, manual, or other documentation consistent with the Clearinghouse	*The Wheels of Change—Family Centered Specialists Handbook and Training Manua*l is implemented in conjunction with the *Family Centered Treatment® Design and Implementation Guide.* Painter, W. E., & Smith, M. M. (2004). *Wheels of Change—Family centered specialists handbook and training manual.* Institute for Family Centered Services. Wood, T. J. (2018). *Family Centered Treatment® design and implementation guide* (Rev. ed.). Family Centered Treatment Foundation Inc.
	Identified service category(ies)	In-home parent skill-based programs and services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Family Centered Treatment® (FCT) is a home-based trauma treatment. FCT is designed for families who are at-risk of dissolution or in need of reunification. It is also designed to serve youth who move between the child welfare, behavioral health, and juvenile justice systems. During treatment, FCT practitioners aim to help families identify their core emotional issues, identify functions of behaviors in a family systems context, change the emotional tone and behavioral interaction patterns among family members, and develop secure relationships by strengthening attachment

		FCT is currently available to pilot counties in the Upstate and Midlands regions of the state. SCDSS will consider scaling this service post-implementation depending on outcomes and service availability in other areas. FCT is delivered by a provider trained and certified by the purveyor of FCT, the Family Centered Treatment Foundation. Initial implementation began in May 2025 in Richland and Greenville counties. Referrals are currently tracked through a SharePoint list maintained by DSS, with plans to transition data collection and monitoring to CAPSS following scaled implementation. FCT practitioners are expected to complete Level I certification within their first year and to adhere to FCT's model fidelity requirements, including structured supervision, training, and data submission to the purveyor. Agencies must apply and be licensed before implementing FCT. An agency becomes licensed by submitting an application providing evidence of the management, training, supervision, and data collection infrastructure to support the delivery of FCT. The agency must demonstrate fidelity to the model to maintain licensure. SCDSS is developing dashboards to track fidelity, reach, and outcome indicators for FCT. These dashboards will align with those used for other prevention services and will support CQI meetings between SCDSS, and the provider. Dashboards will eventually transition to use CAPSS data. Pinnacle and FCTF also maintain data collection, storage, and reporting functionality with respect to capacity, fidelity, reach, and family satisfaction and outcomes. SCDSS will work with relevant stakeholders to determine scalability and improved accessibility as appropriate.

		AND Continuous monitoring will adhere to all requirements associated with the Intercept model as appropriate.
	Description of how the state selected services	FCT was selected for inclusion in South Carolina's prevention plan because its flexible, family-driven structure allows services to be tailored to the unique intensity, safety concerns, and crisis-response needs of families working to prevent out-of-home placements and reduce maltreatment risk. Many families involved with SCDSS experience complex behavioral and emotional challenges—such as escalating conflict, caregiver stress, youth behavioral dysregulation, or instability across home and school settings—that require an intervention capable of adjusting in real time to the family's circumstances. FCT is especially valuable for families with fluctuating needs, co-occurring challenges, or patterns of instability that cannot be addressed through static service models.
	Identified target population(s) specific to the state of jurisdiction	Families with youth who are at-risk for out-of-home placements, have trauma exposure, have histories of delinquent behavior, or are working toward reunification. It is also designed to support youth who move between the child welfare, behavioral health, and juvenile justice systems.
	Information on how providing the services is expected to improve specific outcomes for children and families	Bright et al. (2018) found that youth who participated in FCT had significantly lower risk of adult conviction and incarceration compared to those who received care in group homes. Sullivan et al. (2012) found that adjudicated youth receiving FCT experienced reduced post-treatment number and duration of placements compared to youth placed in residential treatment. These studies were conducted in usual care settings with diverse youth populations and suggest positive effects in domains relevant to child welfare prevention,

		particularly permanency and placement at home.
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	An evaluation strategy for FCT can be found in Appendix A

Promising Interventions

Trust-Based Relational Intervention – Caregiver Training		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Promising
	Book, manual, or other documentation consistent with the Clearinghouse	*TBRI practitioner training notebook and resource manual.* Karyn Purvis Institute of Child Development. Purvis, K., Cross, D. R., & Hurst, J. R. (2013) *TBRI Practitioner Instructor Workbook* and the TBRI slide deck. Karyn Purvis Institute of Child Development. (2020)
	Identified service category(ies)	Mental Health Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Trust-Based Relational Intervention® – Caregiver Training (TBRI-Caregiver Training) is an intervention for caregivers of children who have faced abuse, neglect, and/or other trauma. This program is designed to be highly interactive and is delivered in-person by certified practitioners. TBRI-Caregiver Training uses an attachment-based and trauma-informed approach. It aims to provide parents and caregivers with the tools needed to meet the needs of these children. The training emphasizes three core principles: (1) *TBRI Connecting Principles*, which focus on building trust and positive relationships between caregivers and children; (2) *TBRI Empowering Principles*, which focus on addressing

		children's physical and environmental needs and building children's self-regulation skills; and (3) *TBRI Correcting Principles*, which focus on building children's social competencies. TBRI® is an actively implemented, well-established model with a provider and is used statewide as a core trauma-responsive practice. The provider employs certified TBRI® Practitioners and integrates TBRI® principles across all components of service delivery. The organization currently provides TBRI®-based supports to children that have been adopted to prevent dissolution, children and youth receiving Adoption Preservation Services, private family coaching, and consultation with partner agencies seeking to adopt or strengthen TBRI® implementation.
	Description of how the state selected services	TBRI® is included based on its demonstrated ability to strengthen caregiver–child attachment, improve behavioral and emotional regulation, and stabilize families experiencing complex trauma—core drivers of adoption disruption and subsequent foster care entry. Children who enter adoptive placements after experiencing early adversity often present with trauma-related needs that, when unsupported, contribute to escalating family stress, relational breakdown, and crisis events that place the child at heightened risk of re-entry into the child welfare system. Evidence-based relational interventions such as TBRI® directly address these risks by equipping caregivers with trauma-responsive strategies that build trust, reduce conflict cycles, and increase the child's felt safety and capacity for connection. Studies of TBRI® have shown significant reductions in challenging behaviors, improvements in attachment security, and enhanced caregiver confidence—outcomes that are strongly associated with placement stability and long-term permanency.

		South Carolina's existing statewide infrastructure through a provider provides an ideal platform for scaling TBRI® as a prevention service. The provider network already delivers trauma-informed supports across counties, maintains a trained workforce, and operates within a coordinated service array designed to strengthen family functioning before crises escalate. This alignment ensures that adoptive families receive early, accessible, and evidence-aligned support that reduces the likelihood of placement dissolution and prevents unnecessary foster care entry. Incorporating TBRI® into South Carolina's prevention service array reinforces the state's commitment to preserving permanency for adoptive families and mitigating one of the most preventable pathways into foster care—adoption instability driven by unmet trauma needs. By leveraging a well-established statewide platform and an intervention with documented impacts on attachment, behavior, and caregiver capacity, South Carolina strengthens its ability to promote safety, stability, and well-being for children and families (Purvis K, Cross DR, et al., 2014).
	Identified target population(s) specific to the state of jurisdiction	Parents and/or caregivers of children between the ages of 0 to 17 years old who have experienced adversity, early harm, toxic stress, and/or trauma.
	Information on how providing the services is expected to improve specific outcomes for children and families	Children with trauma histories—particularly those adopted from foster care or other high-risk environments—often present with significant behavioral challenges and trauma-related symptoms that place them at elevated risk for family stress and system involvement. The study by Purvis et al. (2015) provides strong evidence that trauma-informed caregiver training grounded in TBRI® principles produces meaningful improvements for this population. In a sample of at-risk adopted children, participation in TBRI® caregiver

		training was associated with significant reductions in both externalizing and internalizing behavior problems, demonstrating the model's capacity to stabilize child functioning and reduce behaviors that commonly contribute to placement disruption or maltreatment risk (Purvis et al., 2015). The study also found substantial decreases in trauma symptoms following caregiver participation in TBRI® training, including reductions in anxiety, depression, anger, and post-traumatic stress indicators (Purvis et al., 2015). These improvements reflect TBRI's effectiveness in addressing the core developmental impacts of early adversity by enhancing caregiver attunement, strengthening attachment, and promoting co-regulation. For prevention systems, these outcomes are highly relevant: reductions in trauma symptoms and behavioral dysregulation directly support family stability, improve caregiver capacity, and mitigate risk factors associated with child welfare involvement. The evidence demonstrates that TBRI® is a promising, trauma-responsive intervention for children with complex developmental trauma and the caregivers who support them.
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	An evaluation strategy for TBRI can be found in Appendix B

Iowa Parent Partner Approach		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Promising
	Book, manual, or other documentation consistent with the Clearinghouse	Iowa Department of Human Services. (2018). *Iowa Parent Partner Approach handbook: Governing philosophy, policy, & protocol.*

	Identified service category(ies)	In-home Parent Skills-based Programs and Services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	The Iowa Parent Partner Approach pairs “Parent Partners” with parents whose children have been removed from the home. It also pairs Parent Partners with parents who can only reside with their children under special conditions set by the courts. Parent Partners are parents who were formerly involved with the child welfare system and who have achieved reunification with their children. They are selected based upon their interpersonal skills, successes, and proven ability to overcome obstacles. To be eligible, Parent Partners must have maintained reunification with their children for at least 1 year. Parent Partners 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 help the family acquire needed resources. The goal is to support reunification and reduce recurrence of child maltreatment. The Iowa Parent Partner Approach is currently available in Greenville County. SCDSS will work with community partners and state agencies to explore areas for scalability or capacity building. If coverage gaps exist, SCDSS will work with state agencies to determine appropriate procurement mechanisms to support additional implementation. Parent Partners support families in understanding and completing their child welfare case plans, maintaining communication and visits with SCDSS, advocating for resources, and staying connected to their

		family's strengths as they work toward reunification. Implementation of the Iowa Parent Partner Approach will be continuously monitored by SCDSS through utilization of a complex system of monitoring that evaluates contractual parameters and establishes benchmarks for intervention impact. Model fidelity and program outcomes are reported by providers to SCDSS at contractually defined intervals. SCDSS will lead regularly cadenced CQI meetings to refine and improve practice and implementation.
	Description of how the state selected services	SCDSS chose the Parent Partner Approach because it improves family engagement, strengthens trust, and helps parents connect with someone who truly understands their experience. The approach supports trauma-informed, family-centered practice and aligns with the agency's mission to improve safety, permanency, and well-being. Other states have shown that Parent Partners help increase reunification, reduce time in care, and support better long-term outcomes—making it a strong strategy for strengthening results for South Carolina families (Chambers et al., 2019).
	Identified target population(s) specific to the state of jurisdiction	Parents with children birth to 17 years old.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child permanency*: A 2019 study found that children of program participants were less likely to experience removal within 12 months of reunification and were more likely to return home from foster care placement than those of non-participants (Chambers et al, 2019).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	An evaluation strategy for the Iowa Parent Partner Approach can be found in Appendix C

Triple P – Positive Parenting Program – Group (Level 4)

Pre-Print Section	Requirement	Supporting Information
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Promising
	Book, manual, or other documentation consistent with the Clearinghouse	Turner, K. M. T., Markie-Dadds, C., & Sanders, M. R. (2010). *Facilitator's manual for Group Triple P (3rd ed.).* Triple P International Pty Ltd.
	Identified service category(ies)	Mental Health Programs and Services; In-home parent skill-based programs and services
	Description of how the state plans to implement each service including how implementation will be continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	Triple P – Positive Parenting Program – Group (Level 4) ("Triple P-Group") is a group-based parenting intervention. Triple P-Group is for parents who are interested in promoting their child's development or who are concerned about their child's behavior problems. Group sessions typically focus on topics such as positive parenting, helping children develop, managing misbehavior, and planning ahead. Practitioners then provide individual feedback on progress using positive parenting strategies and goal setting. Working with the model purveyor- Triple P America, a philanthropic partner- The Duke Endowment, an evaluator- University of South Carolina Institute for Families in Society, a program implementor- Children's Trust Fund of South Carolina, and a technical assistance provider- The Coalition for Evidence Based Policy, SCDSS will be expanding the full Triple P system in South Carolina, starting with Lexington and Orangeburg counties. To support the expansion of this promising program, SCDSS will develop processes for identification and authorization of candidates for Triple P – Positive Parenting Program – Group (Level 4) (Group Triple P) through both the traditional and community pathway.

		Group Triple P is currently implemented through contracted service providers managed by the Children's Trust Fund of South Carolina (Children's Trust) and is available in eight counties across the Upstate and Lowcountry-Colleton, Cherokee, Spartanburg, Hampton, Greenville, Berkeley, Charleston, and Beaufort. Through the novel collaborative partnership outlined above, SCDSS and partners will expand availability of Standard Triple P starting in Lexington and Orangeburg Counties, building on the strong foundation laid by Children's Trust and their network of contracted service providers. Implementation of the Group Triple P traditional and community pathway will be continuously monitored by SCDSS through utilization of a complex system of monitoring that evaluates contractual parameters and establishes benchmarks for intervention impact. Model fidelity and program outcomes will be reported by providers to SCDSS at contractually defined intervals. SCDSS will lead regularly cadenced CQI meetings to refine and improve practice and implementation.
	Description of how the state selected services	A randomized control trial in South Carolina found that communities that implemented Triple P had lower rates of substantiated cases of maltreatment, fewer out-of-home placements, and fewer hospital treated injuries from maltreatment when compared to control counties that were matched on child maltreatment rates, poverty rates, and county size (Prinz et al, 2009).Given the promising outcomes of Group Triple P and the opportunity to expand availability of the full Triple P system in South Carolina, SCDSS seeks to add Standard Triple P to the array of evidence based interventions for authorized candidates.

	Identified target population(s) specific to the state of jurisdiction	Families with children (up to 12 years) who exhibit behavior problems or emotional difficulties and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child well-being outcomes*: Several studies have shown favorable findings in improvement of children's behavioral and emotional functioning. Specifically, parents receiving Group Triple P reported significantly lower levels of child behavior problems (Leung et al, 2013). *Adult well-being outcomes*: A review of 18 eligible studies showed improvements in positive parenting practices, parental/caregiver mental or emotional health, and family functioning. Caregivers participating in Group Triple P showed lower parental stress, dysfunctional discipline style, and parental conflict scores (Leung et al, 2013).
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	An evaluation strategy for the Triple P- Positive Parenting Program – Group (Level 4) can be found in Appendix D

Triple P – Positive Parenting Program – Standard (Level 4)		
Pre-Print Section	**Requirement**	**Supporting Information**
Section 1. Service description and oversight	Well-supported, supported, or promising rating by the Clearinghouse	Promising
	Book, manual, or other documentation consistent with the Clearinghouse	Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2013). *Practitioner's manual for Standard Triple P (2nd ed.).* Triple P International Pty Ltd.
	Identified service category(ies)	Mental Health Programs and Services; In-home parent skill-based programs and services
	Description of how the state plans to implement each service including how implementation will be	Triple P – Positive Parenting Program – Standard (Level 4) ("Triple P-Standard") is a parenting intervention for families with concerns about their child's moderate to severe

	continuously monitored to ensure fidelity, determine outcomes achieved, and refine and improve practices	behavioral problem. As a part of Triple P-Standard, parents engage in one-on-one sessions with a practitioner. These sessions focus on promoting child development, managing misbehavior, and implementing planned activities and routines to encourage independent child play. Working with the model purveyor- Triple P America, a philanthropic partner- The Duke Endowment, an evaluator- University of South Carolina Institute for Families in Society, a program implementor- Children's Trust Fund of South Carolina, and a technical assistance provider- The Coalition for Evidence Based Policy, SCDSS will be expanding the full Triple P system in South Carolina, starting with Lexington and Orangeburg counties. To support the expansion of this promising program, SCDSS will develop processes for identification and authorization of candidates for Triple P – Positive Parenting Program – Standard (Level 4) (Standard Triple P) through both the traditional and community pathway. Standard Triple P is currently implemented through contracted service providers managed by the Children's Trust Fund of South Carolina (Children's Trust) and is available in three counties in the Upstate- Greenville, Spartanburg, and Cherokee. Through the novel collaborative partnership outlined above, SCDSS and partners will expand availability of Standard Triple P starting in Lexington and Orangeburg Counties, building on the strong foundation laid by Children's Trust and their network of contracted service providers. Implementation of the Standard Triple P traditional and community pathway will be continuously monitored by SCDSS through utilization of a complex system of monitoring that evaluates contractual parameters and establishes benchmarks for intervention impact. Model fidelity and program outcomes

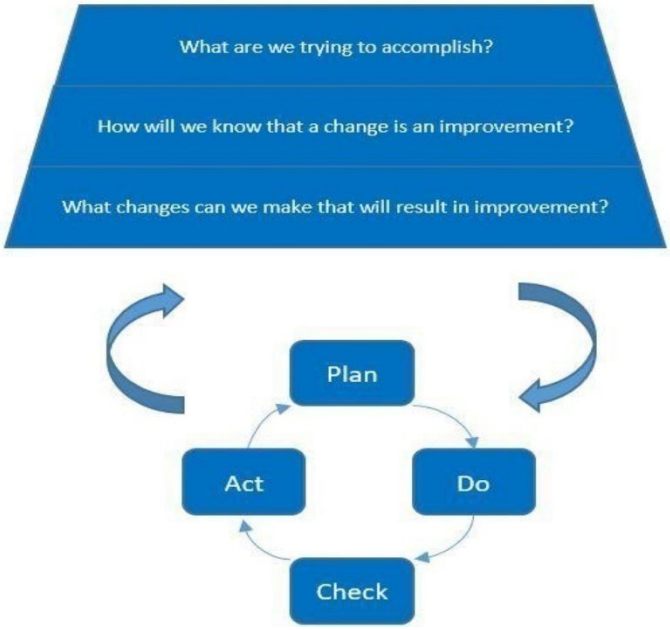
		will be reported by providers to SCDSS at contractually defined intervals. SCDSS will lead regularly cadenced scheduled CQI meetings to refine and improve practice and implementation.
	Description of how the state selected services	A randomized control trial in South Carolina found that communities that implemented Triple P had lower rates of substantiated cases of maltreatment, fewer out-of-home placements, and fewer hospital treated injuries from maltreatment when compared to control counties that were matched on child maltreatment rates, poverty rates, and county size (Prinz et al, 2009).Given the promising outcomes of Standard Triple P and the opportunity to expand availability of the full Triple P system in South Carolina, SCDSS seeks to add Standard Triple P to the array of evidence based interventions for authorized candidates.
	Identified target population(s) specific to the state of jurisdiction	Families with children (up to 12 years) who exhibit behavior problems or emotional difficulties and expectant parents on behalf of an unborn child.
	Information on how providing the services is expected to improve specific outcomes for children and families	*Child well-being outcomes*: Behavioral and emotional functioning *Adult well-being outcomes*: Positive parenting practices; Parent/caregiver mental or emotional health
Section 2. Evaluation	Evaluation Strategy or Evaluation Waiver Request	An evaluation strategy for the Triple P- Positive Parenting Program – Standard (Level 4) can be found in Appendix D

CQI Strategy for Evidence-Based Practices

South Carolina has created a statewide CQI structure and processes for the Prevention Plan that aligns with South Carolina's overall new strategic direction for program improvements This process is led by the agency's CQI team in the Division of Quality Assurance and CQI. 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 (PDCA) Cycle.

Figure 1. CQI Model for Improvement

This CQI model is being used in other statewide CQI activities and will be used for the CQI process for all of the selected well-supported interventions.



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 addresses a common set of cross-cutting research questions.

Research questions for well-supported EBPs may include but are not limited to:

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) As appropriate, 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)?*

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?

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?

CQI Implementation Team(s)

Guided by core research questions, South Carolina has established a central CQI team responsible for reviewing EBP specific data, monitoring fidelity and outcome measures, and adjusting as needed to support effective service delivery for children and families. This structure helps ensure that CQI activities remain aligned with emerging data trends and that each program is able to identify performance strengths, challenges, and opportunities for targeted PDCA cycles that reflect the program's unique context.

During the initial phase of implementation, the CQI team primarily focused 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 allows for any adjustments to be made in order to promote implementation success. In later phases, South Carolina has established data metrics based on the Framework that are used by the CQI team to understand if there are barriers to EBP service delivery and to evaluate whether outcomes are being achieved. This allows the CQI team to make data-informed decisions and adjustments as needed.

As EBP implementation continues DSS program staff, with support from the Office of Accountability, Data, and Research and the Office of Quality Assurance and CQI, meets periodically with regional implementation EBP implementation teams 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.

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 team relies 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 tracks service delivery information such as the referral dates, eligibility, progress in treatment, and service completion.

CQI EBP fidelity monitoring

South Carolina's approach to CQI EBP fidelity monitoring is intentionally designed to promote the delivery of evidence-based services with integrity, produce outcomes consistent with the research base, and generate objective information that strengthens statewide prevention efforts over time. All treatment and service providers receiving reimbursement for EBP delivery are required to collect, maintain, and report statistical data and implementation information needed for program monitoring and evaluation. As part of this structure, South Carolina is implementing annual fidelity monitoring processes for each EBP offered to families. These reviews allow SCDSS to cross-check provider performance against model-specific fidelity standards, supporting dosage, engagement patterns, documentation, supervision practices, and intervention techniques that align with expectations established by model developers and national clearinghouses. In addition to fidelity checks, SCDSS will routinely analyze outcome data to verify that results align with the research questions and intended impacts of each model, such as reductions in maltreatment risk, improvements in caregiver functioning, or stabilization of youth behavioral and emotional needs. When outcomes diverge from expected patterns, CQI teams will work to identify and understand root causes, implement corrective actions, and support providers. The overarching goal of this evaluation structure is to generate objective, actionable insights that inform agency-wide decisions, guide resource allocation, and help more families receive consistent, effective, and high-quality interventions across the state. By grounding decisions in fidelity data, performance trends, and measurable outcomes, SCDSS will continuously refine its prevention service array to better meet the needs of children and families in South Carolina.

Chapter 2: Evaluation Strategy and Waiver Request

Pre-Print Section II

South Carolina's prevention plan is built on the belief that a strong, evidence-aligned service array must be paired with rigorous, ongoing evaluation to help families receive consistent, effective, and high-quality interventions. The plan as a whole establishes a unified framework for selecting, implementing, and monitoring evidence-based and evidence-informed services, while the evaluation strategies support the assessment of each model in a manner appropriate to its evidence level. For interventions rated as "well-supported," South Carolina seeks waivers because the research base is already robust; evaluation efforts will therefore focus on verifying model adherence and that outcomes in South Carolina align with national findings. For "supported" and "promising" practices, the state will conduct structured implementation evaluations to understand how each intervention fits within the broader prevention ecosystem, how families experience services, and how effectively each model addresses the specific risks and needs of South Carolina's children and caregivers.

Across all EBPs, South Carolina will evaluate model adherence, provider performance, and family outcomes to support service delivery as intended and that families receive consistent, high-quality treatment regardless of provider or region. These evaluations will help the agency determine which interventions are most effective for which populations, how services should be scaled or adapted, and where additional supports or training may be needed. Ultimately, the prevention plan and its evaluation strategy work together to create a learning system—one that uses objective data, fidelity monitoring, and continuous quality improvement to strengthen decision-making and expand access to interventions that help more families remain safely together. Please see **Appendix A** for individual evaluation plans.

Chapter 3: Monitoring Child Safety

Pre-Print Section III
Federal/Statutory References 471(e)(5)(B)(ii)

Section 471(e)(5)(C)(ii) requires states to include in their title IV-E prevention program five-year plan information regarding how the state agency oversees and intervenes in the safety of children receiving programs through periodic risk assessments.

Monitoring Risk and Safety within the Traditional Pathway

Initial and ongoing assessments of safety and risk are a critical part of the work of the Department's child welfare staff. To adequately monitor the safety of children during the 12-month period, the Department will continue to leverage and enhance existing practices by systemically administering the Family Advocacy and Support Tool (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.

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 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 members of the child and family team.

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	FAST: - Review and consider Intake SDM findings - Complete safety items at initial contact - Following initial completion, Investigations Supervisor will review and finalize the FAST
Family Preservation Cases	Family Preservation Case Manager	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
Adoption Preservation Cases	Adoption Preservation Case Manager	CANS - Every 90 days
Pregnant and Parenting Youth in Foster Care	Foster Care Case Manager	CANS - Every 90 days CFTM: See Foster Care CFTM timelines

Safety Monitoring within the Community Pathway

Federal regulation requires that a *Prevention Programs and Services Five Year Plan* must describe how the state agency oversees the intervenes in the safety of children receiving programs through periodic risk assessments but does not define or prescribe specific tools, measures, or protocols. Safety assessment differs from risk assessment in that it assesses the child's present danger, and the interventions currently needed to protect the child. In contrast, risk assessment looks at the likelihood of future maltreatment incidents without considering severity.

Child abuse and neglect prevention services are pre-emptive and pro-active by definition and designed to target risks of future abuse and neglect. South Carolina is seeking to avoid additional surveillance by the Department of families involved in prevention services. Contracted service providers under the Community Pathway will observe and evaluate families during service provision to discern novel changes in family functioning, need, and/or overall risk during every engagement with families as a standard protocol to fulfill this requirement. Each provider is considered a mandated reporter, and as such, required by law to make a report to SCDSS of suspected abuse or neglect.

To ensure providers are adequately trained to monitor initial and ongoing safety and risk, SCDSS will require that all community providers serving children through the Community Pathway, 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, supporting appropriate intervention by SCDSS when necessary.

While many of the models outlined herein are family-based and involve routine engagement with the child, SCDSS will include in all community pathway contracts language related to pertinent prevention plan oversight/child safety monitoring, with particular attention to EBPs that are primarily provided to the parent on behalf of the child

For families in continued need of Community Pathway services 12 months after the date of service, SCDSS will work with providers to promote continued service eligibility and claiming as appropriate by re-reviewing risk factors and other collateral information. SCDSS will review each plan to make sure all requirements are met before determining that a child and family are eligible for continued Title IV-E prevention services and claiming.

Chapter 4: Consultation and Coordination

Pre-Print Section IV
Federal/Statutory References 471(e)(5)(B)(iv) and (vi)

The Department recognizes the critical importance of engaging and coordinating with community partners, key stakeholders, and other members of South Carolina's family and child well-being system. These partnerships have been essential to developing and scaling programs, ensuring sustainability, and building a continuum of evidence-based services that supports families statewide. To advance the state's first five-year prevention plan, SCDSS convened a Prevention Services Workgroup in 2019 with representation from a broad range of agencies and organizations, including the Department of Mental Health (DMH), First Steps, Child Advocacy Centers, Project BEST, DAODAS, SCPHCA, DHHS, DOE, NYAP, SCYAP, Justice Works Behavioral Health Services, CYDC, SAFY, SCIMHA, BHSA (County 301s), CRP, A Child's Haven, Epworth Children's Home, PAFCAF, South Carolina Children's Trust, the Continuum of Care (COC), and the Department of Children's Advocacy (SCDCA), as well as members of the Joint Citizens and Legislative Committee on Children (JLCC) and other community partners. The workgroup also included SCDSS leads from multiple initiatives—Thriving Families Safer Children, FAST/CANS implementation, Guiding Principles & Standards Practice Model, CFSR/PIP, and the Michelle H Consent Decree promoting alignment, communication, and cross-project collaboration.

The Prevention Services Workgroup played a central role in planning and decision-making for Family First by cataloging existing EBPs across South Carolina, analyzing data to understand the candidacy population, and recommending interventions that best met the needs of children and families for inclusion in the Prevention Plan. One of the most critical supports developed was an inventory of family preservation services, enabling SCDSS to contract with a diverse network of providers capable of delivering evidence-based, family-focused services statewide. These services strengthen parental capacities and address root causes of child maltreatment through therapeutic and concrete supports helping maintain children safely in their homes and prevent out-of-home placements. To build an effective continuum of resources, the Department prioritized leveraging all available funding opportunities and pursuing public-private partnerships to secure resources for lasting transformation, while the workgroup identified cross-sector funding strategies to supplement Family First reimbursement.

An innovative offshoot of the workgroup was a task force focused on developing Family First EBP capacity-building grants to expand provider networks, standardize service delivery statewide, and equip providers with training to implement interventions such as Brief Strategic Family Therapy (BSFT), Homebuilders, and Family Centered Treatment (FCT) underscoring the Department's commitment to high-quality, evidence-based services. Additionally, SCDSS launched an EBP Provider Workgroup dedicated to implementing BSFT, PAT, Homebuilders, Intercept, and Motivational Interviewing across the state, reflecting the Department's pledge to empower Family Preservation case managers with effective engagement strategies and practice methodologies.

When developing the first Community Pathway Plan Amendment, SCDSS partnered closely with South Carolina First Steps (SCFS), which administers the PAT program, through ongoing planning meetings to expand PAT access for families with child welfare involvement.

Subsequently, while developing amendments for FCT and MI CP, SCDSS worked with providers and the Opt-In Steering Committee, a group of key community stakeholders composed of more than 50% lived experts, with the remainder representing local Community-Based Organizations and advocacy organizations to promote the collaborative development of these new services.

As the current five-year plan builds on the foundation of the previous approved plan, expanding eligibility and reorganizing its format, SCDSS took a targeted approach to stakeholder engagement, consulting with provider partners, lived experts, and sister agencies (Children's Trust of SC, SCDJJ, Office of Mental Health, Office of Substance Use Services) throughout development.

SCDSS remains committed to expanding family and youth voice in system development and implementation, including individuals with lived experience such as birth parents, kin caregivers, and youth. Their inclusion is central to long-term systemic change, practice improvement, and effective service delivery.

As SCDSS is the Title IV-B State Agency, if a family is receiving services under the Title IV-B State Plan, SCDSS will work to align and coordinate services between families and caregivers though systemic collaboration, case consultation, or through child and family team meetings.

Chapter 5: Child Welfare Workforce Support & Training

Pre-Print Section V
Federal/Statutory References 471(e)(5)(B)(vii), 471(e)(5)(B)(vii)

Training and Supporting the Evidence-Based Program Provider Agency Workforce

All interventions under this plan must be evidence-based and delivered in a trauma- informed manner. The Department will continue to 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.

Training and Supporting the Child Welfare Agency Workforce

CHILD WELFARE ACADEMY (CWA) PRE-SERVICE CERTIFICATION TRAINING

South Carolina DSS offers the Child Welfare Academy (CWA) Pre-Service Certification Training as part of its commitment to redefining child welfare certification for new case managers and team leaders within Child Welfare Services. This program aligns with the agency's Guiding Principles and Standards (GPS) Practice Model and other key initiatives.

Core Objectives

- Augment casework readiness and enhance the transfer of knowledge to new case managers.
- Strengthen support from peers and team leaders from the outset.
- Reduce staff attrition and improve retention.

PROGRAM DETAILS

The CWA Pre-Service Certification Training is grounded in experiential learning and emphasizes the GPS practice model. The 11-week program combines 24 days of virtual Instructor-Led Training (ILT) with 28 days of On-the-Job Training (OJT), creating a blended learning experience.

During the OJT phase, learners engage in real-world tasks, gain insight into county office operations, and progressively assume casework responsibilities. A key component is the Learner Support Team, which includes a peer support member, a performance coach, and the team leader. This team guides learners through the transition from shadowing client visits to managing casework independently.

PHASE 2 AND BEYOND

After completing pre-service certification, case managers and team leaders advance to Phase 2: Post-Service Training. This phase deepens the knowledge gained during certification and is mandatory within the first year of employment.

CHILD WELFARE ACADEMY (CWA) INTAKE CERTIFICATION TRAINING

The CWA offers Intake Certification Training for Intake case managers and team leaders. This three-week program includes 12 days of instructor-led training and On-the-Job Training (OJT), with a focus on the GPS Practice Model and the Structured Decision-Making Tool.

ONGOING TRAINING OPPORTUNITIES

To promote 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 must undertake 20 hours of child welfare specific training annually for professional development.

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 instructor-led training, 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 promoting 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 support the provision of appropriate services 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 Promote 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 providing training that develops a workforce with 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, SCDSS provides self-paced courses through the National Adoption Competency Mental Health Training Initiative (NTI). These courses are designed to strengthen the child welfare system's ability to address mental health needs and improve permanency and well-being outcomes for children, youth, and families involved in foster care, adoption, or guardianship.

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 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 for the Traditional Pathway

SCDSS has developed Family First specific training required of all non-custodial case workers titled *Eligibility, Planning, and Services for Evidence-Based Referrals via CAPSS*. Through the training, course participants are provided with an overview of the skills necessary to determine eligibility, effectively plan, and make appropriate referrals in accordance with the provision of Family First. Additionally, the training supports the familiarization of the work force in establishing a service goal, child specific prevention plan, eligibility, and making referrals to evidence-based services through CAPSS.

Training to Refer and Link Families with Appropriate Interventions for the Traditional Pathway

The Department enhanced training on service linkage to needs with services; training SCDSS staff to take information from the assessment tools, CFTMs, and family preference to identify services that fit the needs of children and families. Additionally, as mentioned above SCDSS developed Family First specific training to support workers in streamlining the referral and linkage of families to appropriate interventions.

Training to Conduct Risk and Safety Assessments for the Traditional Pathway

The Department has CANS and FAST assessment training for child welfare staff promoting 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.

Training to Identify Candidates; Assess Risk Factors and Develop Prevention Plans for the Community Pathway

SCDSS Family Support Navigation Program staff undergo comprehensive training to assist in the identification of potential candidates for prevention services and assess imminent risk accurately. This training includes instruction on evaluating relevant risk factors, analyzing collateral information, and understanding family needs to determine whether families could benefit from specific community pathway services and to develop Child-Specific Prevention Plans (CSPPs) tailored to each family's circumstances. Their training emphasizes trauma-informed care, cultural competency, and engagement strategies to build trust and collaboration with families and how to coordinate with providers effectively. For families who choose to participate in prevention services, Navigators provide the community pathway provider with a letter of authorization that includes the CSPP.

Community partners under this pathway are also trained in the referral process and overall eligibility to support the collection of appropriate information to provide to SCDSS in the candidacy determination process, identification of appropriate referrals, and subsequent authorization for services.

SCDSS will provide robust training and supervisory guidance for the Family Support Navigation Program Manager, as they will play an essential role in making critical decisions about candidacy and eligibility for services, service matching, and plan development

Training to Refer and Link Families with Appropriate Interventions for the Community Pathway

Family Support Navigators will be trained in all available Community Pathways, and when appropriate, will refer families to additional Community Pathway interventions according to eligibility and need. Family Support Navigators will use the DSS-approved process to make referrals, issue authorizations, and develop and share CSPPs.

Training to Conduct Risk and Safety Assessments for the Community Pathway

In addition to training on specific policies, procedures, tools, and assessments, Community Pathway providers receive SCDSS-approved Mandated Reporter training prior to serving families. These trainings help staff respond to appropriate reporting of suspected child abuse or neglect and enhance the likelihood of appropriate intervention from the SCDSS when necessary.

Similarly, SCDSS Family Support Navigators receive SCDSS-approved Mandated Reporter training.

Chapter 6: Prevention Caseloads

Pre-Print Section 7 (Prevention caseloads)

Traditional Caseload Standards

Caseload size is an important factor in 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 1. Child Welfare Caseload Standards

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

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.

Community Pathway Caseload Standards

For the families, engaged through the community pathway and without an open child welfare case, the caseload size will follow the standards set forth by the specific model or identified through service type best practices. Caseload limits by intervention for the community pathway are outlined below:

Community Pathway Caseload Standards			
Well-Supported			
Intervention	Caseload Size	Intervention	Caseload Size
Brief Strategic Family Therapy	1:12 families	Multisystemic Therapy	1:6 families
Parent Child Interaction Therapy	1:25 direct contact hours per week	Functional Family Therapy	1:12 families
Parents as Teachers	1:18 families	Homebuilders	1:3 families
Healthy Families America	1:20 families	Nurse-Family Partnership	1:30 families
Motivational Interviewing	1:20 families	Intercept®	1:6 families
Multidimensional Family	1:12 families	Attachment and	1:26 families

Therapy		Biobehavioral Catch-Up – Infant	
Naltrexone: FDA-Approved Medication for Opioid Use Disorder	Prescribing providers must adhere to caseload best practices recommended by the American Society of Addiction Medicine (ASAM), as well as all regulations established by the South Carolina Department of Public Health and the licensure and scope of practice requirements of the South Carolina Department of Labor, Licensing, and Regulation.		
Methadone Maintenance Therapy: FDA-Approved Medication for Opioid Use			
Buprenorphine: FDA-Approved Medication for Opioid Use Disorder			
Supported			
Intervention		Caseload	
Family Centered Treatment		1:6 families	
Trust-Based Relational Intervention- Caregiver Training		1:15 families	
Promising			
Intervention		Caseload	
Iowa Parent Partner Approach	1: 15 families	Triple – Positive Parenting Program – Standard (Level 4)	1:15 direct contact hours per week
Triple – Positive Parenting Program – Group (Level 4)	1:15 families per group		

Note: Caseload size exceptions may be made if approved in writing by the model purveyor or other regulatory, licensing, or governing body.

DSS will outline in contractual agreements that Community Pathway providers are required to adhere to caseload standards as set forth by the respective model purveyor and will be required to submit to SCDSS in writing, notification if caseloads are exceeded during the contract period and a corrective action to bring practitioners into alignment with establish caseload sizes. Caseload compliance will also be monitored via contract monitoring for contracted community pathway providers. If caseloads are exceeded, then the provider will be placed on a corrective action plan and payments made may be considered ineligible for reimbursement and/or subject to recoupment.

Chapter 7: 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 all requisite information in CAPSS/CCWIS for each Family Preservation, Investigation, Adoption Preservation, 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 has developed a technical solution to capture the requisite information which sits outside of the CCWIS system, but within SCDSS, and will allow the agency fully to access the required Title IV-E and IV-B prevention plan data. When a case is referred to a community pathway service, 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 track expenditures and monitor relevant case 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 community pathway providers. All contracted service providers will be required to maintain this authorization with the CSPP in the family's record.

Additionally, SCDSS will include language in all community pathway contracts and agreements that SCDSS shall have the right to examine, make copies, excerpts, or transcripts from all records which will help SCDSS fulfill its responsibility to examine collateral information related to service provision, fidelity monitoring, and proper oversight of the prevention programs.

Chapter 8: Child and Family Eligibility for the Title IV-E Prevention Program

Pre-Print Section 9 – 471(e)(5)(B)(x)

Background Data

With the development of its first five-year prevention plan, SCDSS conducted an in-depth administrative data analysis focused on maltreatment typology, report determinations, and subsequent actions to better understand the disposition of children and families. This initial analysis enabled SCDSS to refine and narrow the scope of its target population for candidacy. Through subsequent amendments, SCDSS continued to iterate on candidacy definitions, taking a data-driven approach to prevention that enhanced timely and responsive services for families.

For the purpose of this new five-year plan, in 2025 SCDSS replicated a similar analysis using SFY 2019 data (pre-FFPSA implementation) as a baseline. These goals were to:

a) identify trends in maltreatment and case disposition over time, and

b) assess the potential impact of practice changes and the expanded availability of evidence-based services under FFPSA.

Baseline Data SFY 2019-2020 (Pre-FFPSA Implementation)	
Intake Disposition	Number
Total Hotline Calls	54,515
Accepted for CPS investigation	33,188 (61%)
Not Accepted (identifiable needs, referred to voluntary prevention services)	10,010 (18%)
Not Accepted (no further action)	11,320 (21%)
Case Type and Disposition	Number
Number of founded investigations	8,943 (26.9%)
Number of families receiving family preservation during the entire report period	14,647
Number of families receiving family preservation on the last day of the report**	6,642
Number of children & youth served in foster care during the entire report period	8,088
Number of children & youth served in foster care on last day of report*	4,356

Year-over-Year Data Comparison - SFYs 2021-2024				
Intake Disposition	21-22	22-23	23-24	24-25
Total Hotline Calls	67,671	67,955	68,155	67,925
Accepted for CPS investigation	36,749 (54%)	37,131 (55%)	36,896 (54%)	36,391 (54%)
Not Accepted (identifiable needs, referred to voluntary prevention services)	13,834 (21%)	13,572 (20%)	13,831 (20%)	12,728 (19%)
Not Accepted (no further action)	17,088 (25%)	17,252 (25%)	17,428 (26%)	18,806 (28%)
Case Type and Disposition	Number			
Number of founded investigations	8,779	8,557	7,660	7,072
Number of families receiving family preservation during the entire report period	13,209	12,082	10,547	9,631
Number of families receiving family preservation on the last day of the report**	5,613	4,606	3,759	3,139
Number of children & youth served in foster care during the entire report period	7,113	6,980	6,579	6,284
Number of children & youth served in foster care on last day of report*	4,066	3,795	3,441	3,476

A Shift Towards Prevention: Demonstrating Positive Impact

The year-over-year analysis from SFYs 2021–2024, compared to the SFY 2019 baseline, highlights several key indicators of improvement in all areas:

Key Indicator: Reduction In Founded Investigations	
Baseline (2019)	SFY 2024-2025
8,943	7,072 (↓21%)
Impact: A 21% decrease in founded investigations may suggest that prevention efforts and early interventions are reducing the risk of maltreatment.	

Key Indicator: Decrease in Foster Care Utilization	
Baseline (2019)	SFY 2024-2025
Children served in foster care during the entire report period	
8,088	6,284 (↓22%)
Children in foster care on the last day of the report	
4,356	3,476 (↓20%)
Impact: Fewer children entering or remaining in foster care may indicate that family preservation and prevention services are helping families remain safely together or being used as a method to support reunification.	

Key Indicator: Shift Toward Voluntary Prevention Services	
Baseline (2019)	SFY 2024-2025
Screen-outs referred to voluntary prevention services	

10,010 (18%)	12,728 (19%)
Impact: A growing proportion of families are being diverted from formal investigations to voluntary prevention services, reflecting a proactive approach to addressing needs before maltreatment occurs, reducing risk factors, and improving practices in delineating neglect from unmet need.	

Key Indicator: Decline in Families Receiving Family Preservation Services	
Baseline (2019)	SFY 2024-2025
14,647	9,631 (↓34%)
Impact: This decrease aligns with fewer founded investigations and reduced foster care placements, suggesting that early prevention services, especially during the investigative stage, are reducing the need for intensive post-investigation interventions by addressing risk factors or cases are closing cases sooner due to needs being met.	

This data demonstrates positive systemic impacts from the combination of practice changes and the availability of Family First-funded evidence-based services. These strategies have led to fewer founded investigations, reduced foster care placements, and increased use of voluntary prevention services indicating that families are receiving support earlier and more effectively, which aligns with the goals of Family First and SCDSS's prevention-focused strategies. However, while these efforts have positively impacted the safety, permanency, and well-being of children and families, we know that children who have an open child welfare service line remain at elevated risk of foster care entry, with approximately 30% of children in foster care having family preservation services immediately prior to their entry into care. This underscores the importance of anticipating emerging risks and adapting strategies to address evolving needs.

Emerging Trends and other areas of consideration

Building on this understanding, we also recognize emerging trends which present new challenges. Across the country, child welfare systems are experiencing an increase in the number of teenagers entering foster care due to complex behavioral challenges that disrupt family stability. These challenges often arise from ongoing parent-child conflicts and issues of intrapersonal dysfunction. As a result, youth are displaying higher levels of maladaptive behavior, struggling with self-regulation, and exhibiting poor impulse control. In many instances, these behaviors lead to issues such as truancy, running away, or being deemed incorrigible, placing additional stress on families and drawing attention from schools, courts, or law enforcement. Recognizing the need to respond swiftly, SCDSS proposes to include those with or at risk of juvenile justice involvement as a community pathway, so that families can receive critical evidence-based services to prevent foster care entry. A cross-agency data match between SCDSS and SCDJJ reinforces this urgency: as of January 22, 2026, approximately 121 (4%) of foster children had active involvement with the South Carolina Department of Juvenile Justice, representing about 15% of foster children between ages 9–17.

Similarly, in calendar year 2025, SCDSS saw 127 children entering foster care due to child behavior problem, diagnosed condition, or inadequate access to mental health services. With the age distribution as follows:

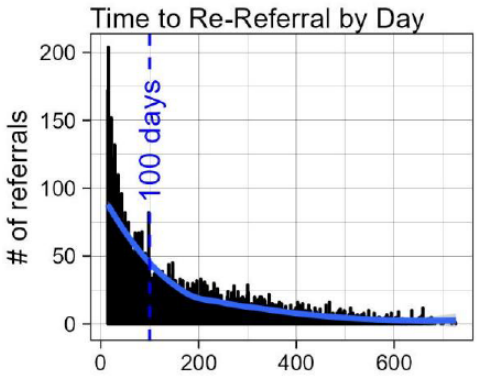
Children Entered Foster Care in CY 24 for BH Reason (N=127)		
Age 0-5	**Age 6-12**	**13-17**
5 (3.9%)	36 (28.3%)	86 (67.7%)

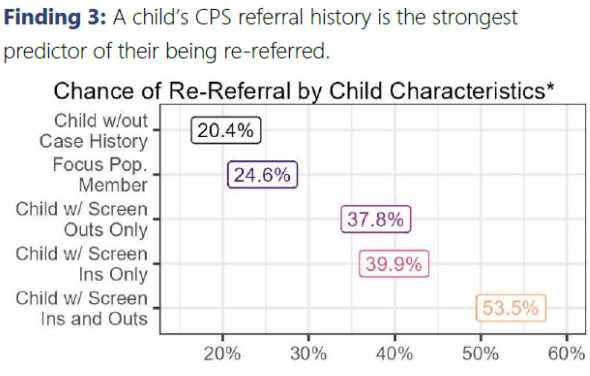
Moreover, in 2022, SCDSS conducted an in-depth analysis of teens entering foster care which included detailed reviews of cases in Anderson, Greenville, and Spartanburg. This analysis found that in more than half of the cases reviewed, many of the youth entered care primarily due to behavioral challenges and also found that many of these entries were due to law enforcement, the court system, and even at the request of the parent or caregiver.

Additionally, SCDSS is especially interested in identifying strategies to support children who have been adopted through the foster care system. In 2024, one hundred and seven (107) children were served through SCDSS' adoption preservation services or adoption preservation placement services. These services are geared at initially providing case management and coordination of community-based services to support the family unit with the goal of supporting their long-term permanency. When community-based services are unable to meet the need of the family, or the youth requires a formal placement outside of the home to preserve long-term permanency, SCDSS offers adoption preservation placement services. During this same period, approximately nine (9) of the one hundred and seven (107) youth required adoption preservation placement services with four (4) receiving adoption preservation services prior to escalating to requiring placement and the other five (5) requiring immediate placement upon seeking support.

Lastly, to further strengthen prevention efforts by understanding specific risk factors associated with unmet need, SCDSS partnered with Chapin Hall at the University of Chicago in 2025 to analyze statewide administrative data and identify families most at risk for future child welfare involvement. This analysis incorporated intake data from the SCDSS Office of Accountability, Data, and Research, which found that in calendar year 2023, 14,356 intakes, representing 21% of all reports, were "screened out with need," meaning they met one of three imminent risk criteria that make a family eligible for preventive services. The study further revealed that approximately 24% of families whose initial reports were not accepted for abuse or neglect return to SCDSSS within 3 to 24 months with an accepted report. Families with identified risk factors face the greatest likelihood of child welfare involvement and potential foster care entry within the first 100 days following a report if unmet need and risk factors continue to linger which without appropriate intervention may result in higher imminent risk for foster care. Moreover, this risk is elevated when accounting for prior involvement with child welfare.

Screened-Out with Need (N=14,356)	
Unmet Basic Needs	**4,786 (33%)**
Caregiver Struggling to Meet a Child's Special, Educational, or Behavioral Needs	**9,877 (69%)**
Caregiver Substance Misuse or Abuse	**3,296 (23%)**





The risk of unmet needs, demonstrably apparent in SCDSS administrative data, is reflected in the

field. Housing instability, lack of access to childcare, and unemployment are affiliated with increased child welfare involvement. A review of relevant literature reveals that waitlists to access subsidized childcare are associated with an increase in maltreatment investigations (Klevens, 2015). Self-reported housing instability is associated with increased risk for neglect (Warren, 2015), and each additional eviction filing (per 100 occupied units in a block group) is associated with a 2% increase in maltreatment reports (Bullinger, 2021). Households experiencing a foreclosure filing in the next 6-12 months are at a 70% greater risk of CPS investigation (Berger, 2015) and increases in current and prior year mortgage foreclosures are associated with increases in investigated and substantiated maltreatment (Frioux, 2014). A 1% increase in the county unemployment rate is associated with a 20% increase in substantiated neglect reports (Brown, 2020). This paired with the aforementioned fact that approximately 30% of foster children had a prior family preservation case highlight that these children are at an elevated risk.

Child welfare literature reinforces the positive impact of addressing unmet family need in improving child safety and reducing foster care entry. A literature review conducted by Chapin Hall of 24 studies meeting eligibility criteria consistent with the Title IV-E Prevention Services Clearinghouse found that meeting unmet basic needs has a causal effect on improvement of child maltreatment and child welfare outcomes, as well as child and adult well-being outcomes (Cusick et al, 2024).

These findings underscore the importance of providing upstream prevention services to resolve family crises before they escalate into abuse or neglect, thereby reducing the risk of foster care placement. In many of these cases children that have entered or re-entered foster may have been able to remain safely in their home with the provision of Title IV-E Prevention Services. One of SCDSS' strategic priorities for the new five-year Title IV-E Prevention Plan (2027–2031) is to build upon extant community pathways by implementing a more adaptive and responsive community pathway, enabling the Department to meet the evolving needs of children and families when they need it most. SCDSS believes that by doing so, more children will be able to remain safely in the home and that we can mitigate the traumas associated with child maltreatment and foster care entry.

Candidacy Population

There are two broad candidacy populations eligible for Family First prevention services:

1) Children who are determined to be at imminent risk for foster care entry; and
2) Pregnant or parenting youth who are in foster care.

Note: 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.

Note: In accordance with section 8.6B.4, *Title IV-E Prevention Services Program, Eligibility, Age*, of the Federal Child Welfare Policy Manual, prevention services may be provided to an expectant parent on behalf of an unborn child when the Title IV-E agency determines that the unborn child is a candidate for foster care and is at imminent risk of entering foster care.

Imminent Risk Criteria

In addition to meeting the population level candidacy criteria outlined above, the Department has determined that a child meeting any one of the following criteria would be at imminent risk for entering foster care:

A. All children under 18 named in an open Child Protective Services Investigation (not in Foster Care).
B. All children under 18 who are receiving Family Preservation services.
C. All children under 18 who have an open adoption preservation case or are at risk of experiencing a disrupted adoption (not in Foster Care).
D. All pregnant or parenting youth in foster care.
E. All children under 18 who are not a part of an open child protective services investigation, family preservation, adoption preservation, or foster care case and for whom at least one of the following risk factors is present or imminent:

    - Family needs assistance meeting basic food, clothing, safe sleep, and/or shelter needs.
    - Current caregiver substance misuse/abuse concerns.
    - The child has special educational, physical, or mental health needs, and the caregiver is struggling to meet those needs.
    - The child is involved with the juvenile justice system.
    - Otherwise determined by SCDSS to be at imminent risk of foster care entry.

When a child is determined to be eligible, the child, parent, and/or kin caregiver of the child may receive prevention services.

Candidacy Determination, Documentation, and the Child Specific-Prevention Plan

All children for whom the state will be claiming are determined to be at imminent risk of entering foster care by SCDSS. For families in continued need of prevention services 12-months after the date the first service, SCDSS will re-review candidacy and imminent risk criteria, make a candidacy determination, and create the child specific prevention plan.

Traditional Pathway (Active and Open Child Welfare Case not in Foster Care)

South Carolina utilizes the FAST/ CANS as a key resource for assessing family strengths, identifying needs, and guiding referrals to appropriate evidence-based interventions. These tools are not a standalone process, rather, a decision support tool that works in tandem with routine case practice, in partnership with the child and family team, to promote comprehensive and consistent support for families.

All children involved in investigations, family preservation, and adoption preservation services who are not in foster care begin with a status of “Pending Funding Eligibility.” Eligibility is automatically confirmed in CAPSS once a Family Permanency Plan is created, and the Goal Service is completed with an evidence-based service selection. Eligibility and services are documented on the Family Permanency Plan which also contains the Child Specific Prevention Plan.

The table below outlines the candidacy determination process for prevention services under the traditional Family First pathway.

Candidacy Population	Staff Determining Eligibility	Process of Determining Eligibility
Children under 18 (not in Foster Care) named in a CPS Investigation	Investigations Case Manager other designated IV-E agency staff	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 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 other designated IV-E agency staff	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 or other designated IV-E agency staff	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 other designated IV-E agency staff	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 other designated IV-E agency staff	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 with an existing Adoption Preservation Line	Adoptions Case Manager other designated IV-E agency staff	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.

SCDSS will follow the FAST/CANS periodicity schedule which requires periodic reassessment (i.e. reviewing every 90-days). As a part of the redetermination process, SCDSS will review the most recent score prior to the 12-month period. If new services need to be continued, the Case Manager will create a new CSSP for the new 12-month period which also serves as the

candidacy redetermination process.

Community Pathway (Children without an Active or Open Child Welfare Case)

Families eligible for the Community Pathway must have one or more of the designated risk factors that are specified in South Carolina's imminent risk criteria. Potential candidates may come to the attention of the Department from various sources including, screened out intake reports where risk factors are present, as well as referrals from law enforcement, the courts, public agencies, or through self-report. Given the community-focused nature of this pathway, contracted partners such as Family Resource Centers (FRCs) are authorized to engage in outreach efforts to families and provide information on appropriate available Title IV-E prevention services.

After potential candidates for Community Pathway Services are made known to SCDSS, SCDSS Family Support Navigators review relevant risk factors and available collateral information to determine whether the child meets the candidacy and imminent-risk criteria. If additional details are needed, SCDSS will request the supplemental information from the referral/outreach partner to support with the determination process.

Once a child is determined to be eligible, SCDSS Family Support Navigators will create the Child-Specific Prevention Plan which documents the child's eligibility, service recommendation, and authorization for services. Authorizing documentation will then be sent to the rendering service provider through the SCDSS approved referral process.

For families in continued need of Community Pathway services 12 months after the date the first service, DSS will work with providers to promote continued service eligibility and claiming as appropriate by re-reviewing risk factors and other collateral information. SCDSS will review each plan to make sure all requirements are met before determining that a child and family are eligible for continued Title IV-E prevention services and claiming.

The table below outlines the candidacy determination process for prevention services under the Community Pathway.

Candidacy Population	Staff Determining Eligibility	Process of Determining Eligibility
All children under 18 who are not a part of an open child protective services investigation, family preservation, adoption preservation, or foster care case who meet the imminent risk criteria defined on p. 91.	Family Support Navigators (IV-E Agency Employees)	After identifying potential candidates for Community Pathway services based on needs, Family Support Navigators assess risk factors to determine imminent risk, create the Child-Specific Prevention Plan for the child(ren) and refer potential candidates to the Service Provider for engagement using SCDSS' defined process.

If a child enters foster care or no longer meets the imminent risk criteria, the child will no longer be eligible for services under Title IV-E.

Appendix A: Family Centered Treatment

Note: The evaluation plans for the supported and promising interventions will be presented in detail in the sections that follow, with each model examined through a distinct approach. These tailored methodologies support the assessment of every intervention in a manner appropriate to its evidence designation, thereby reinforcing the agency's commitment to delivering consistent, high-quality services across the prevention ecosystem. These evaluations will only begin once the service is contracted for and implemented.

Introduction and Purpose of Process Evaluation

Family Centered Treatment (FCT) is a home-based, trauma-informed family therapy model designed to reduce maltreatment, increase family resilience, and improve child well-being. The model draws on the theoretical foundations of Eco-Structural Family Therapy and Emotionally Focused Therapy and targets emotional and behavioral patterns within the family system. Services include counseling, skills training, and resource coordination, and are delivered in the home or community with frequent face-to-face contacts. FCT clinicians maintain small caseloads to allow for intensive service delivery and strong relationship-building with families. A distinctive feature of the model is its emphasis on helping families value and sustain the behavioral changes they achieve in treatment.

FCT is currently rated as Supported by the Title IV-E Prevention Services Clearinghouse and Promising by the California Evidence-Based Clearinghouse (CEBC). Research studies have demonstrated favorable outcomes for youth and families involved in the juvenile justice and child welfare systems, including reductions in recidivism and improvements in behavioral functioning (Bright et al., 2018; Sullivan et al., 2012). Fidelity monitoring is a central feature of the model and is coordinated through the Family Centered Treatment Foundation (FCTF), which provides initial training, structured supervision protocols, and certification processes for participating providers.

SCDSS began a new implementation of FCT in May 2025, with services delivered by a provider in pilot counties in the Upstate and Midlands regions. The referral process is currently managed via a SharePoint list and will transition to the state's CAPSS administrative data system upon approval of the plan amendment. Referrals primarily originate from the Investigations and Family Preservation program areas, with rare referrals from Foster Care under specific conditions. Appropriateness for referral is guided by DSS's decision-support tools, which may include the FAST assessment.

This process evaluation is designed to fulfill the requirement from the Children's Bureau that states include a well-designed, rigorous evaluation strategy for all interventions. The evaluation will provide formative feedback on implementation progress, identify barriers and facilitators to effective service delivery, and assess readiness for a future outcome evaluation. It is not intended to meet Clearinghouse criteria for an outcome study but instead to lay the foundation for a future outcome study and to support DSS's internal CQI system. The evaluation plan draws on the DSS-approved evaluator CQI framework and reflects collaboration among DSS, Pinnacle Family Services, and the FCTF. Coordination with DSS's prevention and CQI teams will promote alignment with broader Family First prevention monitoring strategies.

Program Overview

FCT is an evidence-informed, home-based intervention that targets families with children at risk of out-of-home placement in need of intensive in-home services. The program is structured into four phases: Joining and Assessment, Restructuring, Valuing Change, and Generalization. FCT emphasizes family strengths and resilience, with the goal of helping families function effectively without ongoing reliance on formal services. Key program elements include 24/7 availability, in-home service delivery, and a focus on the function of behavior within the family system.

FCT incorporates elements of Eco-Structural Family Therapy (Lindblad-Goldberg & Northey, 2013) and Emotionally Focused Therapy (Johnson, 2004), which guide its emphasis on changing emotional and behavioral patterns within the family system. The model's effectiveness has been demonstrated in two published studies. Bright et al. (2018) found that youth who participated in FCT had significantly lower risk of adult conviction and incarceration compared to those who received care in group homes. Sullivan et al. (2012) found that adjudicated youth receiving FCT experienced improved behavioral outcomes and reduced post-treatment placements compared to youth placed in residential treatment. These studies were conducted in usual care settings with diverse youth populations and suggest positive effects in domains relevant to child welfare prevention.

In South Carolina, FCT is currently being delivered by a provider, which has been trained and licensed by the FCTF. Initial implementation began in May 2025 in Richland and Greenville counties. Referrals are currently tracked through a SharePoint list maintained by DSS, with plans to transition data collection and monitoring to CAPSS in fall 2026.

Families are referred to FCT from the Investigations and Family Preservation service lines. Eligibility is assessed using DSS's decision-making tools, including the FAST assessment. FCT practitioners are expected to complete Level I certification within their first year and to adhere to FCT's model fidelity requirements, including structured supervision, training, and data submission to the purveyor.

DSS is developing dashboards using SharePoint data to track fidelity, reach, and outcome indicators for FCT. These dashboards will align with those used for other prevention services and will support CQI meetings between DSS, Pinnacle, and the FCTF. Dashboards will eventually transition to use CAPSS data. Pinnacle and FCTF also maintain data collection, storage, and reporting functionality with respect to capacity, fidelity, reach, and family satisfaction and outcomes. These data tools will also serve as a foundation for the rapid improvement cycles planned as part of this evaluation.

Evaluation Questions

The process evaluation will explore the following research questions, aligned with the CQI framework and the goal of supporting strong implementation and outcome readiness:

1. How consistent and effective is the process to identify eligible children and families and refer them to FCT?
2. What are the rates of FCT service reach, including referral acceptance, family acceptance, dosage, and completion rates?

3. To what degree is FCT delivered with fidelity to the clinical model and to eligibility/referral protocols?
4. Are the capacity and infrastructure in place to support high-quality implementation of FCT?
5. What contextual or systemic factors support or hinder successful implementation of FCT?
6. What do families report about their experience with FCT, and what are the observed outcomes at discharge?

Evaluation Design and Methods

The process evaluation is grounded in implementation science and focuses on key domains from the DSS-approved evaluator CQI framework: reach, fidelity, capacity, and satisfaction. The process evaluation will also track implementation strengths and challenges.

- Reach: Use CAPSS, SharePoint, and provider records to assess number and percent of eligible families referred, accepted, enrolled, and completed; analyze referral flow and trends.
- Fidelity: Assess adherence to FCT's model using FCTF and Pinnacle system data and dashboards; track staff credentialing, supervision, and model component delivery.
- Capacity: Track staffing levels, caseloads, and clinician training and supervision rates using Pinnacle and FCTF records and implementation meeting notes.
- Implementation Strengths & Challenges: One follow-up activity (focus group or survey) will explore emerging barriers and facilitators.
- Satisfaction & Short-Term Outcomes: Assess family satisfaction, FAD and CPM-PTS completion and results, and closure outcomes using FACT data, surveys, and discharge documentation.

All data collection and analysis will be done in partnership with DSS staff, Pinnacle, and the FCTF and integrated into quarterly learning cycles.

Outcome Readiness Assessment

At the conclusion of the process evaluation period, the DSS-contracted evaluator will assess whether FCT is ready for outcome evaluation using the following criteria:

- Has FCT been delivered with model fidelity?
- Has the program served enough families to support a quasi-experimental design?
- Is there sufficient data quality and completeness to support rigorous outcome analysis?

The readiness review will include a power analysis and recommendations for proceeding with an outcome evaluation.

Data Management and Reporting

The evaluator will manage all evaluation data in accordance with DSS protocols and data sharing agreements. Administrative data will be de-identified, and qualitative data will be coded and stored securely. Biannual reports will summarize findings in the CQI domains. Final deliverables include a process evaluation report and outcome readiness assessment.

Phases and Activities

The process evaluation will unfold across several coordinated phases over the project period. In early implementation, the evaluation team will collaborate with DSS regional and county prevention services staff, the provider, and the FCTF to establish clear benchmarks for implementation aligned with the CQI framework. These benchmarks will guide monitoring and reporting throughout the process evaluation.

The evaluator will prepare and submit and finalize any necessary data sharing agreements with DSS, provider, and the FCTF. The evaluation team will also engage in ongoing implementation and strategic review meetings with DSS and partners to monitor progress and respond to emerging issues.

At least bi-annually, the team will conduct structured reviews of data across the CQI domains and will collaborate with DSS to select and carry out one targeted follow-up activity (such as a focus group or survey). These activities will provide deeper insight into identified issues and help refine implementation. The evaluation team will summarize findings from the data review and follow-up activity in a report with tailored recommendations.

Toward the end of the evaluation period, the evaluator will synthesize findings and deliver a final process evaluation report and an outcome readiness assessment. These reports will inform decisions about recommended improvements to implementation and whether and how to proceed with a future outcome study.

Limitations

There are several limitations to this process evaluation. First, FCT is still in the early stages of implementation in South Carolina, and the number of families served within the project period may be relatively small. This may limit the generalizability of findings and preclude meaningful disaggregation by county or population subgroups.

Second, the evaluation depends on the completeness and consistency of data from administrative systems (CAPSS and SharePoint) and fidelity tracking tools. While the planned transition from SharePoint to CAPSS should improve data infrastructure, temporary inconsistencies may arise. Ongoing validation and data quality monitoring will be essential.

Third, the qualitative components of the evaluation such as focus groups, or survey will be conducted at a limited scale and will focus on a narrow range of implementation topics. While these approaches are appropriate for the purpose of identifying and addressing implementation barriers, they may not reflect the full diversity of stakeholder perspectives.

Finally, this is a process evaluation and is not designed to estimate the causal effects of FCT on safety, permanency, or well-being outcomes. Instead, this evaluation focuses on implementation and readiness, providing a foundation for a future outcome study.

Table 2. Evaluation Matrix

CQI Domain	Evaluation Question	Indicators	Data Source(s)	Timing
Reach	How consistent and effective is the process to identify eligible children/families and refer them to FCT?	Existence of an articulated eligibility and referral protocol- % of children screened who meet eligibility criteria- % of eligible families referred- % of referred families accepted, enrolled, and completed- Timeliness of referral steps- Family demographics	CAPSS administrative data- SharePoint referral logs- DSS standards of practice	Ongoing
Fidelity	To what degree is FCT delivered with fidelity to the model?	% of certified staff- % of model components completed- % of supervision sessions completed- Use of fidelity tracking tools	FCTF data system- Provider training/supervision records- FCTF fidelity dashboards	Biannually
Capacity	Are there sufficient infrastructure and staff to deliver FCT with quality?	Number of trained/certified clinicians- Caseload sizes- Frequency of supervision and training sessions- Staffing levels	Provider training logs- Implementation meeting records	Ongoing
Implementation Strengths & Challenges	What contextual or systemic factors support or hinder FCT implementation?	Staff and stakeholder feedback on facilitators/barriers- Emerging issues from CQI meetings- Suggestions for improvement	Focus groups- Surveys- CQI meeting summaries	One activity every six months
Satisfaction & Short-Term Outcomes	What do families report about their experience with FCT, and what outcomes are observed at discharge?	FAD and CPM-PTS results over time- Family satisfaction surveys- Discharge status and post-treatment placement- Practitioner-reported goal progress	FACT system- Satisfaction surveys- Discharge documentation- FCTF reports	Biannual

Appendix B: Trust-Based Relational Intervention – Caregiver

Note: The evaluation plans for the supported and promising interventions will be presented in detail in the sections that follow, with each model examined through a distinct approach. These tailored methodologies will support the assessment of every intervention in a manner appropriate to its evidence designation, thereby reinforcing the agency's commitment to delivering consistent, high-quality services across the prevention ecosystem. These evaluations will only begin once the service is contracted for and implemented.

Introduction and Purpose of Process Evaluation

The Trust-Based Relational Intervention (TBRI) model provides a trauma-responsive, attachment-based framework for supporting children and families whose behavioral, emotional, and social challenges stem from adverse experiences. TBRI equips caregivers with practical strategies organized around three guiding principles—Connecting, Empowering, and Correcting—to build trust, strengthen self-regulation, and promote social competence.

Evaluation Questions

The process evaluation will explore the following research questions, aligned with the CQI framework and the goal of supporting strong implementation and outcome readiness:

1. How consistent and effective is the process to identify eligible children and families and refer them to TBRI?
2. What are the rates of TBRI service reach, including referral acceptance, family acceptance, dosage, and completion rates?
3. To what degree is TBRI delivered with fidelity to the clinical model and to eligibility/referral protocols?
4. Are the capacity and infrastructure in place to support high-quality implementation of TBRI?
5. What contextual or systemic factors support or hinder successful implementation of TBRI?
6. What do families report about their experience with TBRI, and what are the observed outcomes at discharge?

Evaluation Design and Methods

The process evaluation is grounded in implementation science and focuses on key domains from the DSS CQI framework: reach, fidelity, capacity, and satisfaction. The process evaluation will also track implementation strengths and challenges.

- Reach: Use CAPSS, SharePoint, and provider records to assess number and percent of eligible families referred, accepted, enrolled, and completed; analyze referral flow and trends.

- Fidelity: Assess adherence to TBRI's model using DSS and Flourishing Families SC system data and dashboards; track staff credentialing, supervision, and model component delivery.
- Capacity: Track staffing levels, caseloads, and clinician training and supervision rates using DSS and Flourishing Families records and implementation meeting notes.
- Implementation Strengths & Challenges: One follow-up activity (focus group or survey) will explore emerging barriers and facilitators.
- Satisfaction & Short-Term Outcomes: Assess family satisfaction; Tier 1, Tier 2, and Tier 3 completion and results, and closure outcomes using Flourishing Families data, surveys, and discharge documentation.

All data collection and analysis will be done in partnership with DSS staff and contracted provider and integrated into quarterly learning cycles.

Outcome Readiness Assessment

At the conclusion of the process evaluation period, the evaluator will assess whether TBRI is ready for outcome evaluation using the following criteria:

- Has TBRI been delivered with model fidelity?
- Has the program served enough families to support a quasi-experimental design?
- Is there sufficient data quality and completeness to support rigorous outcome analysis?

The readiness review will include a power analysis and recommendations for proceeding with an outcome evaluation.

Data Management and Reporting

The evaluator will manage all evaluation data in accordance with DSS protocols and data sharing agreements. Administrative data will be de-identified, and qualitative data will be coded and stored securely. Biannual reports will summarize findings in the CQI domains. Final deliverables include a process evaluation report and outcome readiness assessment.

Phases and Activities

The process evaluation will unfold across several coordinated phases over the project period. In early implementation, the evaluation team will collaborate with regional and county prevention services staff (as appropriate), and the provider to establish clear benchmarks for implementation aligned with the CQI framework. These benchmarks will guide monitoring and reporting throughout the process evaluation. The evaluation team will also engage in ongoing implementation and strategic review meetings with the provider to monitor progress and respond to emerging issues.

At least bi-annually, the team will conduct structured reviews of data across the CQI domains and will collaborate with the provider to select and carry out one targeted follow-up activity (such as a focus group or survey). These activities will provide deeper insight into identified issues and help

refine implementation. The evaluation team will summarize findings from the data review and follow-up activity in a report with tailored recommendations.

Toward the end of the evaluation period, the evaluator will synthesize findings and deliver a final process evaluation report and an outcome readiness assessment. These reports will inform decisions about recommended improvements to implementation and whether and how to proceed with a future outcome study.

Limitations

There are several limitations to this process evaluation. First, TBRI is still in the early stages of implementation in South Carolina, and the number of families served within the project period may be relatively small. This may limit the generalizability of findings and preclude meaningful disaggregation by county or population subgroups.

Second, the evaluation depends on the completeness and consistency of data from administrative systems (the provider and SharePoint) and fidelity tracking tools. Ongoing validation and data quality monitoring will be essential.

Third, the qualitative components of the evaluation such as focus groups, or survey will be conducted at a limited scale and will focus on a narrow range of implementation topics. While these approaches are appropriate for the purpose of identifying and addressing implementation barriers, they may not reflect the full diversity of stakeholder perspectives.

Finally, this is a process evaluation and is not designed to estimate the causal effects of TBRI on safety, permanency, or well-being outcomes. Instead, this evaluation focuses on implementation and readiness, providing a foundation for a future outcome study.

Table 2. Evaluation Matrix

CQI Domain	Evaluation Question	Indicators	Data Source(s)	Timing
Reach	How consistent and effective is the process to identify eligible children/families and refer them to TRBI?	Existence of an articulated eligibility and referral protocol- % of children screened who meet eligibility criteria- % of eligible families referred- % of referred families accepted, enrolled, and completed- Timeliness of referral steps- Family demographics	CAPSS administrative data- SharePoint referral logs- DSS standards of practice	Ongoing
Fidelity	To what degree is TBRI delivered with fidelity to the model?	% of certified staff- % of model components completed- % of supervision sessions completed- Use of fidelity tracking tools	Provider data system- Provider training/supervision records	Biannually

Capacity	Are there sufficient infrastructure and staff to deliver TBRI with quality?	Number of trained/certified clinicians- Caseload sizes- Frequency of supervision and training sessions- Staffing levels	Provider training logs- Implementation meeting records	Ongoing
Implementation Strengths & Challenges	What contextual or systemic factors support or hinder TBRI implementation?	Staff and stakeholder feedback on facilitators/barriers- Emerging issues from CQI meetings- Suggestions for improvement	Focus groups- Surveys- CQI meeting summaries	One activity every six months
Satisfaction & Short-Term Outcomes	What do families report about their experience with TBRI, and what outcomes are observed at discharge?	Tier 1, Tier 2, and Tier 3 and Family satisfaction surveys- Discharge status and post-treatment placement- Practitioner-reported goal progress	TBRI system- Satisfaction surveys- Discharge documentation- provider reports	Biannual

Appendix C: Iowa Parent Partner Approach

Note: The evaluation plans for the supported and promising interventions will be presented in detail in the sections that follow, with each model examined through a distinct approach. These tailored methodologies will support the assessment of every intervention in a manner appropriate to its evidence designation, thereby reinforcing the agency's commitment to delivering consistent, high-quality services across the prevention ecosystem. These evaluations will only begin once the service is contracted for and implemented.

Introduction and Purpose of Process Evaluation

The Iowa Parent Partner Approach offers a nationally recognized model for embedding lived experience into child welfare practice, pairing parents who have successfully reunified with their children as mentors to families currently engaged with the system. By providing peer support, advocacy, and hope, Parent Partners help families navigate case plans, strengthen engagement, and connect with resources that promote safety, permanency, and well-being.

Evaluation Questions

The process evaluation will explore the following research questions, aligned with the CQI framework and the goal of supporting strong implementation and outcome readiness:

1. How consistent and effective is the process to identify eligible children and families and refer them to PPA?
2. What are the rates of PPA service reach, including referral acceptance, family acceptance, dosage, and completion rates?
3. To what degree is PPA delivered with fidelity to the clinical model and to eligibility/referral protocols?
4. Are the capacity and infrastructure in place to support high-quality implementation of PPA?
5. What contextual or systemic factors support or hinder successful implementation of PPA?
6. What do families report about their experience with PPA, and what are the observed outcomes at discharge?

Evaluation Design and Methods

The process evaluation is grounded in implementation science and focuses on key domains from the DSS CQI framework: reach, fidelity, capacity, and satisfaction. The process evaluation will also track implementation strengths and challenges.

- Reach: Use CAPSS, SharePoint, and provider records to assess number and percent of eligible families referred, accepted, enrolled, and completed; analyze referral flow and trends.
- Fidelity: Assess adherence to PPA model using DSS and Specialized Alternatives for Families and Youth of South Carolina (SAFY) system data and dashboards; track staff credentialing, supervision, and model component delivery.

- Capacity: Track staffing levels, caseloads, and clinician training and supervision rates using DSS and SAFY records and implementation meeting notes.
- Implementation Strengths & Challenges: One follow-up activity (focus group or survey) will explore emerging barriers and facilitators.
- Satisfaction & Short-Term Outcomes: Assess family satisfaction; Peer Parents Trained, Peer Parents currently servicing families, referrals received, referrals accepted, parents served; and closure outcomes using SAFY data, surveys, and discharge documentation.

All data collection and analysis will be done in partnership with DSS staff and SAFY and integrated into quarterly learning cycles.

Outcome Readiness Assessment

At the conclusion of the process evaluation period, the DSS-contracted evaluator will assess whether PPA is ready for outcome evaluation using the following criteria:

- Has PPA been delivered with model fidelity as outlined by the Iowa Parent Partner Approach criteria?
- Has the program served enough families to support a quasi-experimental design?
- Is there sufficient data quality and completeness to support rigorous outcome analysis?

The readiness review will include a power analysis and recommendations for proceeding with an outcome evaluation.

Data Management and Reporting

The evaluator will manage all evaluation data in accordance with DSS protocols and data sharing agreements. Administrative data will be de-identified, and qualitative data will be coded and stored securely. Biannual reports will summarize findings in the CQI domains. Final deliverables include a process evaluation report and outcome readiness assessment.

Phases and Activities

The process evaluation will unfold across several coordinated phases over the project period. In early implementation, the evaluation team will collaborate with regional and county prevention services staff, and SAFY to establish clear benchmarks for implementation aligned with the CQI framework. These benchmarks will guide monitoring and reporting throughout the process evaluation.

The evaluation team will also engage in ongoing implementation and strategic review meetings with SAFY to monitor progress and respond to emerging issues.
At least bi-annually, the team will conduct structured reviews of data across the CQI domains and will collaborate with SAFY to select and carry out one targeted follow-up activity (such as a focus group or survey). These activities will provide deeper insight into identified issues and help refine implementation. The evaluation team will summarize findings from the data review and follow-up activity in a report with tailored recommendations.
Toward the end of the evaluation period, the evaluator will synthesize findings and deliver a final

process evaluation report and an outcome readiness assessment. These reports will inform decisions about recommended improvements to implementation and whether and how to proceed with a future outcome study.

Limitations

There are several limitations to this process evaluation. First, PPA is still in the early stages of implementation in South Carolina, and the number of families served within the project period may be relatively small. This may limit the generalizability of findings and preclude meaningful disaggregation by county or population subgroups.

Second, the evaluation depends on the completeness and consistency of data from administrative systems (SAFY and SharePoint) and fidelity tracking tools. Ongoing validation and data quality monitoring will be essential.

Third, the qualitative components of the evaluation such as focus groups, or survey will be conducted at a limited scale and will focus on a narrow range of implementation topics. While these approaches are appropriate for the purpose of identifying and addressing implementation barriers, they may not reflect the full diversity of stakeholder perspectives.

Finally, this is a process evaluation and is not designed to estimate the causal effects of PPA on safety, permanency, or well-being outcomes. Instead, this evaluation focuses on implementation and readiness, providing a foundation for a future outcome study.

Table 2. Evaluation Matrix

CQI Domain	Evaluation Question	Indicators	Data Source(s)	Timing
Reach	How consistent and effective is the process to identify eligible children/families and refer them to PPA?	Existence of an articulated eligibility and referral protocol- % of children screened who meet eligibility criteria- % of eligible families referred- % of referred families accepted, enrolled, and completed- Timeliness of referral steps- Family demographics	CAPSS administrative data- SharePoint referral logs- DSS standards of practice	Ongoing
Fidelity	To what degree is PPA delivered with fidelity to the model?	% of certified staff- % of model components completed- % of supervision sessions completed- Use of fidelity tracking tools	SAFY data system- Provider training/supervision records	Biannually
Capacity	Are there sufficient infrastructure and staff to deliver PPA with quality?	Number of trained/certified clinicians- Caseload sizes- Frequency of supervision and training	Provider training logs- Implementation meeting records	Ongoing

		sessions- Staffing levels		
Implementation Strengths & Challenges	What contextual or systemic factors support or hinder PPA implementation?	Staff and stakeholder feedback on facilitators/barriers- Emerging issues from CQI meetings- Suggestions for improvement	Focus groups- Surveys- CQI meeting summaries	One activity every six months
Satisfaction & Short-Term Outcomes	What do families report about their experience with PPA, and what outcomes are observed at discharge?	Monthly service and outcome reports, Family satisfaction surveys- Discharge status and post-treatment placement- Practitioner-reported goal progress	PPA system- Satisfaction surveys- Discharge documentation- SAFY reports	Biannual

Appendix D: Triple P (Level 4 Standard and Group)

Note: The evaluation plans for the supported and promising interventions will be presented in detail in the sections that follow, with each model examined through a distinct approach. These tailored methodologies will support the assessment of every intervention in a manner appropriate to its evidence designation, thereby reinforcing the agency's commitment to delivering consistent, high-quality services across the prevention ecosystem. Evaluation activities and data collection will be tailored to each Triple P level and variant while remaining aligned with the projects overall evaluation framework. These evaluations will only begin once the service is contracted for and implemented.

Introduction and Purpose of Process Evaluation

The Positive Parenting Program (Triple P) is an evidence-based, multi-level system designed to strengthen parenting skills, reduce child behavioral problems, and build family resilience. Children's Trust of South Carolina (SCCT) supports implementation of Levels 2, 3, and 4, with future expansion to Level 5 anticipated. All available formats and variants of these levels are supported, including Seminars, Discussion Groups, Standard, Group, and Primary Care.

SCCT's statewide Triple P Practitioner Network incorporates several core elements: Coordinated training and accreditation support, including tracking practitioner training completion, accreditation renewal, and ongoing professional development.

- Monthly site support calls with agencies and practitioners to support implementation, troubleshoot barriers, and improve data quality.
- Fidelity support, including fidelity coaching and session-level fidelity tools developed by SCCT to strengthen local QA processes.
- A centralized and customized statewide data system that captures service delivery, dosage, attendance, practitioner accreditation, satisfaction, and outcomes.
- Comprehensive reporting and dashboards to support continuous quality improvement (CQI), grant compliance, and implementation monitoring.
- Technical assistance (TA) on data use, implementation troubleshooting, practitioner support, and program strengthening.

SCCT has developed state-specific infrastructure and data collection processes to support fidelity monitoring, documentation of adaptations, and level-appropriate evaluation measures. Session-level fidelity tools, enhanced data fields, and differentiated data sets by level were created to ensure appropriate measurement without overburdening practitioners.

SCCT is currently developing an Implementation Guidance Manual, which will codify statewide processes, expectations, and support structures (forthcoming).

Target Population
Triple P is intended to support caregivers of children ages 0–16 who want parenting support, skill-building, and evidence-based strategies for improving child behavior and strengthening family functioning. In South Carolina, the intervention primarily reaches families facing behavior challenges with children, families experiencing stress, and caregivers seeking support from community-based providers.

The target population is reached through a diverse network of nonprofits, public agencies, family

support organizations, health systems, and community-based service providers who offer Triple P as part of their prevention and parent support services. There are no formal eligibility or screening criteria other than caring for a child within the supported age range and voluntarily engaging in services.

Contextually, South Carolina has significant statewide service gaps, particularly in rural regions with limited access to parent support services. Many communities also have multilingual and multicultural needs, and SCCT's statewide model aims to improve equity of access by supporting a broad provider network and flexible delivery formats (in-person, virtual, and hybrid). The population was identified based on statewide prevention priorities, ACEs/PCEs data trends, and ongoing data from child welfare and community partners indicating high need for evidence-based parenting supports.

Evaluation Goals and Rationale

SCCT's Triple P evaluation is hybrid, including both formative (real-time process and implementation data) and summative (outcome measurement, fidelity assessment, and model effectiveness) components.

The evaluation includes two complementary types of outcomes:
1. Participant Outcomes (Core Outcomes)
    - Changes in parenting self-efficacy and confidence
    - Improvements in parenting practices and use of Triple P strategies
    - Caregiver-reported improvements in child behavior and functioning

2. Participant Experience Measures
    - Satisfaction with Triple P sessions and content
    - Perceived usefulness and relevance of the strategies
    - Levels of engagement, attendance, and completion patterns

Together, these outcomes allow SCCT to measure both what changes for families and how families experience and value the support they receive.

The evaluation also examines:
- Implementation fidelity and practitioner adherence to Triple P model expectations
- Dosage, reach, and equity in access across communities
- The effectiveness of SCCT's training, technical assistance, and data system in supporting high-quality implementation
- Patterns of service delivery and practitioner capacity across diverse agency types

Primary evaluation audiences include SCCT leadership and staff, Triple P providers and practitioners, state partners (including DSS), funders, legislative stakeholders, and community partners.

Findings will be used for continuous quality improvement, statewide reporting, strategic decision-making, resource allocation, and future planning including potential expansion to additional Triple P levels.

Research Questions

Process & Reach

1. Who is being reached through Triple P services across South Carolina (demographics, geographic distribution, family needs)?
2. What is the dosage of Triple P services that families receive by level, format, practitioner, and site?
3. How frequently are Triple P services delivered, and what attendance or engagement patterns emerge?
4. How do families move through various levels or formats, and what does service flow look like?

Quality & Fidelity

5. Are practitioners delivering Triple P with adherence to fidelity standards, as measured through SCCT's fidelity tools and administrative data?
6. What types of adaptations, if any, are occurring in practice, and how do these align with Triple P guidance?

Participant Outcomes

7. Do caregivers show improvements in parenting self-efficacy, confidence, and skill use after participating?
8. Do caregivers report improvements in child behavior and functioning following services?
9. What levels of dosage and engagement are associated with meaningful improvements in parent-reported outcomes?

Participant Experience Measures

10. Are caregivers satisfied with Triple P services, and do they find the content useful and relevant?
11. What factors influence caregiver engagement, retention, and perceived value of the program?

Implementation & Equity

12. How does implementation vary across provider types, geographic regions, languages, or community contexts?
13. Are families in rural or historically underserved areas accessing services at comparable levels to families in urban areas?

System & Support

14. How effectively do SCCT's training, TA, site support calls, and reporting tools support practitioners in implementing the model?
15. What organizational or contextual factors influence successful implementation?

Narrative Theory of Change

South Carolina families experience stress, limited access to evidence-based parenting support, and challenges managing child behavior, particularly in rural and underserved areas. Practitioners and service agencies vary in capacity, resources, and expertise to deliver high-quality, evidence-based parenting programs. These factors contribute to preventable child welfare risks, including family conflict, harsh discipline, and child maltreatment.

Triple P is a globally recognized, evidence-based parenting system that has been shown to improve child behavior, increase parenting confidence, and strengthen family functioning across diverse communities. However, the model requires strong implementation infrastructure, consistent fidelity support, and accessible data systems to realize its impact at scale.

Children's Trust of South Carolina (SCCT) functions as the statewide backbone support

organization, providing direct support to Lead Implementing Agencies (LIAs) and practitioners across all Triple P levels (Levels 2–4, with expansion to Level 5 anticipated). This support includes training access, accreditation tracking, fidelity coaching, the statewide data system, reporting tools, and technical assistance. By replacing the earlier county-level backbone model with direct statewide support, SCCT strengthens consistency, equity, and quality across all local implementations.

The theory of change is:

1. If SCCT provides coordinated training, coaching, implementation guidance, and a centralized data system,
2. Then LIAs and practitioners will have the knowledge, skill, and structure needed to deliver Triple P with fidelity,
3. Then families will access consistent, high-quality Triple P services statewide,
4. Then caregivers will experience improved confidence, parenting practices, and child behavior,
5. Then child maltreatment risk factors will decrease, protective factors will increase, and communities will experience long-term improvements in child and family well-being.

This theory is grounded in Triple P's extensive evidence base of over 400 studies demonstrating improvements in parenting competence, child behavior, and family functioning and in implementation science research indicating that strong infrastructure, data systems, and fidelity supports are critical to sustained impact.

A. Key Issues / Problems Triple P Addresses

- Caregivers experience stress and limited strategies to manage child behavior.
- Many families lack access to evidence-based parenting support.
- Rural areas and underserved communities face major access and equity gaps.
- Practitioners and agencies vary in capacity, training, and consistency of delivery.
- Fragmented prevention supports lead to inconsistent quality and reach.
- Child maltreatment risk factors persist statewide (stress, low parenting confidence, harsh discipline).

B. Root Causes

- Limited availability of high-quality parenting programs statewide.
- Inconsistent workforce development and training pathways.
- Lack of centralized data systems for fidelity and outcome tracking.
- Varying organizational capacity for evidence-based implementation.
- Geographic barriers and resource limitations in rural areas.
- Low awareness of positive parenting strategies in communities.
- Insufficient coordination between service providers, funders, and model purveyors.

C. SCCT Strategies

Statewide Strategies Provided by Children's Trust

- Funding and coordination of training and accreditation.
- Practitioner and LIA coaching (implementation, fidelity, quality improvement).
- Access to a centralized data system for service tracking, fidelity data, and outcomes.
- Evaluation support, reporting tools, dashboards, and continuous quality improvement.
- Shared learning through webinars, communities of practice, and cross-site collaboration.
- Development of implementation guidance, templates, and technical assistance.
- Strong statewide branding and consistent messaging around Triple P.

- Coordination with model purveyors, state agencies, and funders.

Agency-Level Expectations Activated by Children's Trust Support
- Engage and educate community stakeholders and referral sources.
- Recruit, train, and retain Triple P practitioners.
- Implement agency-level guidelines that promote fidelity and high-quality delivery.
- Use data for monitoring, supervision, and quality improvement.
- Participate in statewide learning, coaching, and improvement processes.

D. Expected Outcomes
Strengthened LIA/Agency Outcomes
- Strengthened workforce development system (trained, supported practitioners).
- Strengthened quality and fidelity system through coaching and data monitoring.
- Strengthened data and outcomes system using statewide reporting and dashboards.
- Strengthened networking and shared learning systems across statewide providers.

Community-Level Outcomes
- A network of confident, competent practitioners delivering Triple P with fidelity.
- Engaged LIAs and multi-sector service organizations implementing the model.
- Increased reach, accessibility, and use of Triple P across communities.
- Consistent positive parenting messaging and improved visibility statewide.
- Increased parenting confidence, skill use, and self-sufficiency.
- Improved child behavior as reported by caregivers.

Long-Term Impact
- Sustained Triple P implementation across SC communities.
- Increased awareness and normalization of positive parenting.
- Decreased child maltreatment risk factors.
- Increased protective factors and family resilience.
- Improved child well-being statewide.
- State and national policies increasingly supportive of Triple P and prevention efforts.

Evaluation Framework
The evaluation of Triple P implementation in South Carolina is guided by a hybrid methodological approach that integrates:

1. Developmental Evaluation - supporting real-time learning, iterative improvement, and adaptation as SCCT, LIAs, and practitioners strengthen statewide Triple P implementation.

2. Participatory Evaluation – engaging LIAs, practitioners, and SCCT staff as active partners in shaping evaluation priorities, interpreting findings, and applying results to practice.

3. RE-AIM Framework – ensuring systematic assessment of:
    a. Reach (families served, equity in access)
    b. Effectiveness (caregiver outcomes, perceived usefulness)
    c. Adoption (agency and practitioner uptake)
    d .Implementation (fidelity, dosage, consistency)
    e. Maintenance (sustained delivery at practitioner, agency, and statewide levels)
4. Implementation–Effectiveness Hybrid Model – simultaneously measuring implementation

quality (fidelity, organizational readiness, workforce capacity) and effectiveness outcomes (caregiver-level change).

This blended approach allows SCCT to generate actionable information for continuous quality improvement (CQI), meet funder reporting requirements, and build a learning system around Triple P delivery statewide.

Process Evaluation Design
The process evaluation focuses on how Triple P is implemented across South Carolina, who is being reached, how fidelity is maintained, and what contextual factors shape implementation.

Process Evaluation Questions
The evaluation formally assesses all major domains of implementation:

1. Reach
    a. Who is being served (demographics, geography, needs)?
    b. How equitably are services accessed across urban, rural, and underserved communities?
2. Dosage
    a. What types and quantities of Triple P services are delivered across Levels 2–4?
    b. What attendance/engagement patterns exist across formats and LIAs?
3. Engagement
    a. What proportion of families attend sessions, complete services, or disengage early?
    b. What factors contribute to higher or lower engagement?
4. Fidelity
    a. To what extent do practitioners adhere to Triple P model expectations?
    b. What adaptations are occurring and are they appropriate?
5. Practitioner Capacity
    a. Workforce composition, training completion, accreditation status, retention.
6. Implementation Barriers & Supports
    a. Identified during site support calls, TA interactions, and qualitative feedback.
7. Equity in Implementation
    a. Geographic disparities, multilingual access, and service availability.
8. Organizational Readiness
    a. Assessed through the Partnership Assessment and prevention readiness measures.
9. Provider Network Functioning
    a. Engagement in the Triple P Practitioner Network, peer support, communication channels.
10. Data Quality & Timeliness
    a. Completeness, accuracy, and usability of administrative data entered into the statewide system.

Process Evaluation Design Approach

- Continuous administrative data analysis through SCCT's statewide Quickbase system
- Cross-agency comparisons (LIAs, practitioner types, service levels)
- Mixed methods, including qualitative insights from:
    - Site support calls
    - TA interactions
    - Practitioner feedback
    - Planned focus groups and interviews
- Triangulation of quantitative and qualitative data to validate findings

Outcome Evaluation Design
The outcome evaluation measures changes in caregiver-reported parenting outcomes and examines how implementation quality contributes to those outcomes.

- Outcome Domains Measured
- Caregiver Outcomes
- BPSE (Parenting Self-Efficacy)
- APQ-9 (Positive Parenting & Discipline Practices)
- Confidence using Triple P strategies
- Engagement in strategies learned
- Perceived usefulness of Triple P
- Satisfaction with services
- Protective Factors (PFS-2) – reflecting broader family needs and strengths beyond parenting skills

System Outcomes

- Practitioner workforce capacity
- Implementation consistency across LIAs
- Variation across geographic contexts
- Organizational readiness for child abuse prevention
- Provider network functioning

Outcome Evaluation Questions

1. Do caregivers demonstrate improved parenting self-efficacy after Triple P?
2. Do parenting practices improve (APQ-9) following participation?
3. Do caregivers feel more confident using Triple P strategies?
4. How useful and relevant do caregivers find Triple P content and supports?
5. What improvements are observed in protective factors?
6. How do outcomes vary by level, format, dosage, LIA, practitioner, or community?
7. What dosage appears sufficient for meaningful improvement?
8. How do system-level factors (fidelity, readiness, workforce, equity) influence outcomes?

Outcome Evaluation Design

- Retrospective pre–post measurement at program exit
- Benchmark comparisons aligned with expected Triple P outcomes by level/format
- Stratified analyses across LIAs, practitioner types, geographic regions
- Mixed-methods integration using both quantitative outcomes and qualitative user feedback
- Future capacity to add cost-effectiveness and ROI analyses once longitudinal data mature

Cost Analysis
SCCT conducts an ongoing cost analysis aligned with its role as a grant-making intermediary.
Current Cost Analysis Components

- Cost per family served
- Training and accreditation costs
- Program implementation costs per agency
- Value-added intermediary functions (TA, fidelity support, data system)

Future Cost Studies

- Cost-effectiveness analyses comparing costs to changes in key outcomes
- Benefit–cost (ROI) analyses, pending data maturity and external partnership opportunities

Research Design and Methods

Process Evaluation Research Design

- Descriptive study using administrative data
- Continuous monitoring of fidelity, reach, and engagement
- Comparison across agencies, practitioners, levels, and geographic contexts
- Mixed methods incorporating qualitative data from site engagement
- Triangulated interpretation to strengthen validity

Outcome Evaluation Research Design

- Retrospective pre–post survey design administered at service exit
- Benchmarking against Triple P model guidance
- Subgroup comparisons
- Descriptive and inferential analysis depending on sample size
- Qualitative user feedback, including future focus groups and structured interviews

Rationale for Design Selection

- Random assignment is not appropriate for a voluntary prevention program offered statewide.
- Quasi-experimental comparison groups are not feasible due to the community-wide nature of service delivery.
- Administrative data allow statewide, low-burden analysis, reducing reporting demands on LIAs and practitioners.
- The evaluation is intentionally designed to support continuous quality improvement, not to test model efficacy (already established through 400+ Triple P studies).
- Current resources do not support a randomized or quasi-experimental study; such work would require external evaluation partners.
- The hybrid implementation–effectiveness approach best supports SCCT's dual role as both a training/intermediary body and evaluation hub.

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