STATE OF NEVADA
FAMILY FIRST PREVENTION SERVICES ACT (FFPSA)
PREVENTION PLAN

Resubmitted by the State of Nevada, Department of Health and Human Services, Division of Children & Family Services

To the U.S. Department of Health & Human Services, Administration for Children & Families, Children's Bureau

May 31, 2023, Revised July 24, 2023

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Acknowledgments

Nevada DCFS would like to thank the many people across the state who contributed to the initial and resubmitted Prevention Plan, including Clark County, Washoe County, Rural Nevada, and DCFS Child Welfare Program staff and their partners. Many individuals served on workgroups and reviewed tools, indicators and data collection plans, eligibility flowcharts, draft language, and more, and DCFS is grateful for their time and contributions. A special thank you to the youth, families, workers, universities, and community-based organizations who shared their priorities and expertise for this plan and are critical to its successful implementation. This plan is just one piece of Nevada's larger approach to supporting all children, youth, and families to be safe, healthy, and thriving in their homes and communities and our local partnerships and communities are critical to our shared success.

DCFS gratefully acknowledges the assistance provided by colleagues across the country through the sharing of Children's Bureau-approved prevention plans and associated materials and technical assistance regarding model-specific fidelity monitoring and reporting approaches.

Support for the development of the Prevention Plan was provided by The Institute for Innovations & Implementation at the University of Maryland, Baltimore, and Innovations Institute at the University of Connecticut School of Social Work. Kathryn Baxter, JD, MPS; Deborah Harburger, MSW; F. Tony Bonadio, PhD; and, Michael Schlossman, PhD, co-authored this plan with DCFS, with critical input from Sheila Pires, MPA at Human Services Collaborative and other colleagues.

Introduction

The State of Nevada Department of Health and Human Services Division of Child and Family Services (DCFS) is pleased to submit this updated Family First Prevention Services Act (FFPSA) Title IV-E Prevention Plan. This plan reflects the commitment of the State of Nevada and its partners to prevent the need for children to enter foster care; provide high quality, evidence-based interventions and services to youth and families; and strengthen the skills of the state's child welfare workforce.

FFPSA, passed as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), presents exciting opportunities for Nevada to align federal child welfare funding with its vision: to have safe, healthy, and thriving kids in every Nevada community.[1] This plan incorporates changes made in response to feedback provided by the Children's Bureau to Nevada's initial plan, submitted in August 2021. It also reflects the work that has occurred over the past 21 months and is responsive to changing data and priorities in each region.

In 2005, DCFS established its Case Management Practice Model[2] to create a principle-based framework across the state for case management. The practice model is based on six core Systems of Care principles: community-based services and supports; child and family involvement; interagency collaboration; cultural competence; individualized and strengths-based care planning; and accountability.[3] These principles and the associated key practice area skills (engagement, teaming, assessment, planning, intervening, and tracking/adapting) have positioned Nevada to be successful in implementing FFPSA. Over the past decade, Nevada has made great strides in ensuring that practices across both services and jurisdictions are aligned with the practice model.

Nevada's expanding services continuum, increased interagency collaboration, and revised practice model have led to reductions in the number of youth entering foster care in recent years. There was a 21% reduction in the number of children removed and placed into foster care across the state from State Fiscal Year (SFY) 2019 to 2022 (from 3,382 to 2,681) and the statewide removal rate per 1,000 children decreased from 5.22 to 3.57 from SFY2015 to SFY2022.[4] Nevada already serves most of the families involved with the foster care system in family-based settings: on 7/31/22, **93.1% of all children in foster care were living in a family-based setting** (i.e., foster family home, trial home visit, or pre-adoptive home). However, Nevada recognizes that challenges persist, exacerbated by the COVID-19 pandemic. The average length of stay for children in foster care has increased from 13 months to 19 months from SFY2016 to SFY2022 and the average number of children in foster care during a given month decreased by only 8% from SFY 2019 to SFY 2022 (4,479 versus 4,131), despite a larger reduction in the number of children entering care.

Nevada is poised to build upon a strong infrastructure and values base to provide services and support to children and families sooner to avoid entries into foster care. Nevada intends to **expand access to and availability of quality, effective, and comprehensive services,** building on an already robust continuum of

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[1]Nevada Department of Health & Human Services, Division of Child and Family Services. (2020). *5 Year Strategic Plan: 2020-2025*. Available from DCFS:
http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/DCFSStrategicPlan-10-12-20.pdf

[2]Nevada Department of Health & Human Services, Division of Child and Family Services. (2005). *Policy 0203: Case Management Practice Model*. Available from DCFS:
http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Policies/CW/0203_Case_Management_Practice_Model(1).pdf

[3] Child Welfare Information Gateway. (n.d.) *Guiding Principles of Systems of Care.* Available from the Children's Bureau: https://www.childwelfare.gov/topics/management/reform/soc/history/principles/

[4] Unless noted, all data come from the Nevada DCFS Data Book, as of 7/31/22.

child and family services,[5] to promote safety, permanency, and well-being and support children, youth, and families within their own homes and communities.

This prevention plan reflects careful, intentional, and collaborative planning. The COVID-19 pandemic not only diverted resources from planning activities but resulted in a significantly changed fiscal landscape for child welfare services in the state. As such, **Nevada's plan focuses on building upon the state's current infrastructure and leveraging current resources and community partnerships** while leaving open opportunities to make significant modifications to the service array in the future. Nevada will explore modifications to this plan as the state's fiscal outlook changes and as additional well-supported models are added to the Title IV-E Prevention Services Clearinghouse.

Child Welfare Structure in Nevada

The Division of Child and Family Services (DCFS) Family Programs Office is the Title IV-E Agency for the State of Nevada. DCFS is one of five Divisions of the State of Nevada Department of Health and Human Services. The other four Divisions include the Division of Public and Behavioral Health, Division of Welfare and Supportive Services, the Aging and Disabilities Services Division, and the Division of Health Care Finance and Policy (i.e., Medicaid). DCFS includes child welfare services, children's mental health services, juvenile justice services, and victim's services for the State of Nevada.

Nevada is one of two states with a **hybrid child welfare system**, with child welfare services partially administered by the State and partially administered by counties. A child welfare agency is defined as:

> "1. In a county whose population is less than 100,000, the local office of the Division of Child and Family Services; or
> 2. In a county whose population is 100,000 or more, the agency of the county, which provides or arranges for necessary child welfare services."[6]

There are two counties that meet the population threshold described in the law: Clark County (home of Las Vegas) and Washoe County (home of Reno). Over 70% of the state's population resides in Clark County, 15% live in Washoe County, and the remainder of the population is spread among the state's 15 rural and frontier counties. Child welfare services are provided by the county Department of Family Services (DFS) in Clark County, the county Human Services Agency (HSA) in Washoe County, and the State of Nevada DCFS in the rural and frontier counties ("Rurals"). Therefore, **this plan refers to Clark, Washoe, and Rurals as the three regions of child welfare services in Nevada.**

Outcomes

Pre-Print Section 1

The following logic model presents the vision for Nevada's FFPSA Prevention Services implementation. It outlines the types of infrastructure and implementation supports necessary to ensure successful installation, implementation, and sustainability of the FFPSA Prevention Services; describes the population of children, youth, and families who may be eligible to receive prevention services; outlines the FFPSA prevention services proposed under this plan; and describes the priority outcomes. Further detail on the specific models, populations to be served, and the outcomes tracked in the sections that follow.

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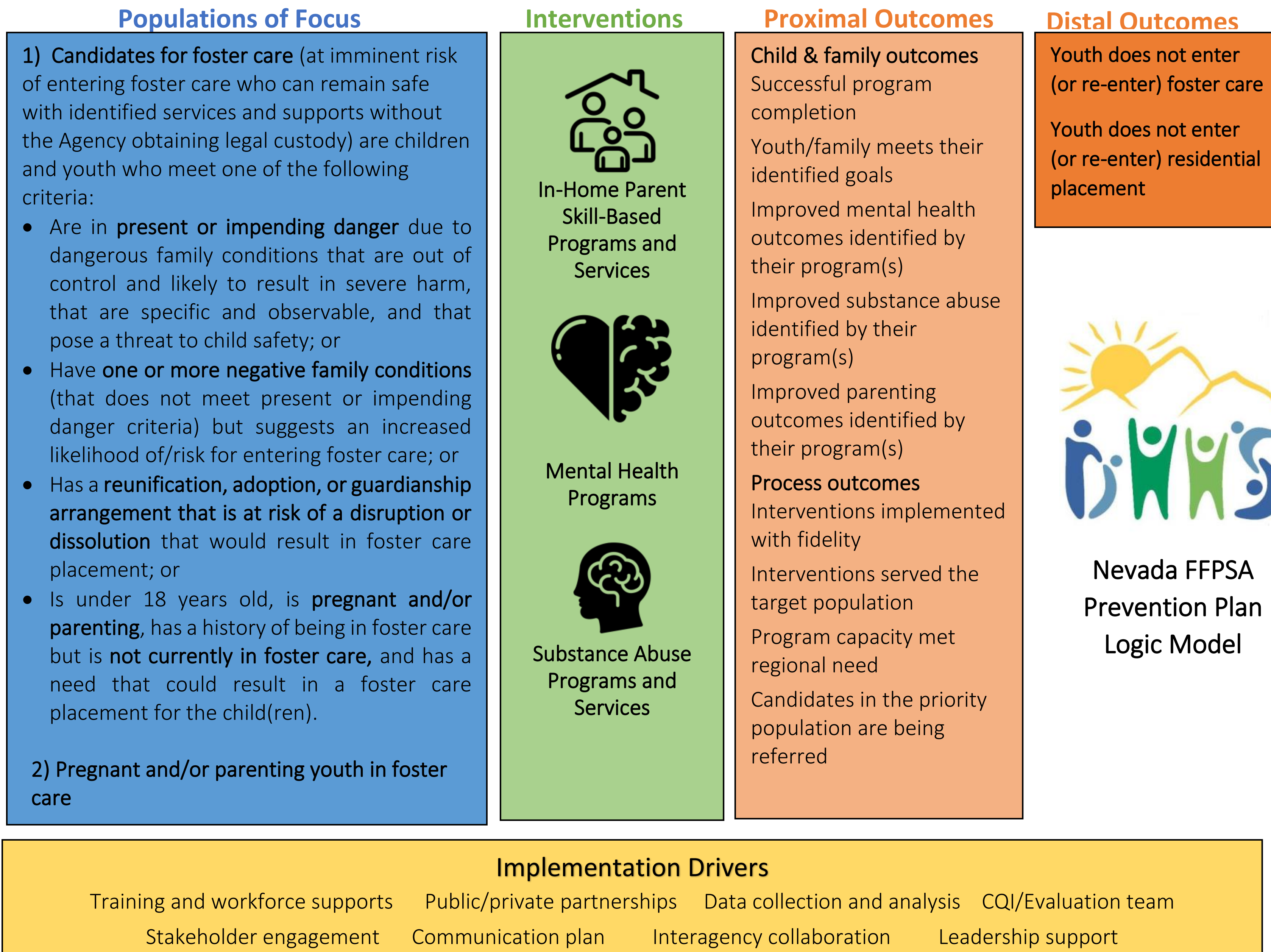
[5] Nevada Department of Health & Human Services, Division of Child and Family Services. (2019). *2020-2024 Child and Family Services Plan*. Available from DCFS: http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/NV_CFSP_2020-2024_FINAL(1).pdf

[6] Nevada Revised Statute § 432B.030.

Figure 1. Logic Model for Nevada's Family First Prevention Services Act (FFPSA) Prevention Plan



Candidacy Definition

Pre-print Section 9

In accordance with Section 50711 of FFPSA, Nevada is identifying two populations of children (along with their parents and kin caregivers) who are eligible for Title IV-E Prevention Services:

- A child who is a candidate for foster care (as defined in section 475(13) of the Social Security Act) but can remain safely at home or in a kinship placement with receipt of services or programs; and,
- A child in foster care who is a pregnant or parenting foster youth.

Identifying Candidates for Foster Care

Nevada will serve children who are at an increased likelihood and risk of entering foster care and can be safely served with the provision of prevention services. These services will address identified safety, permanency, and/or well-being needs of the child related to mental health and substance abuse prevention and treatment services and/or parenting programs necessary to prevent the child from entering foster care.

Consistent with 42 U.S.C. § 675(13), Nevada defines a "candidate for foster care" as a child who:

a) **Is at imminent risk of entering foster care and**
b) **Can remain safely at home[7] or in a kinship placement with receipt of [FFPSA] services or programs.**

Nevada analyzed historical data to identify common characteristics of youth who enter the state's foster care system to identify the characteristics of youth who are likely at "imminent risk" of foster care placement (Table 1).

Table 1. Most Frequent Factors Present At Time of Removal, Youth Entering Foster Care, SFY2022[8]

Removal Reason or Factor Present at Time of Removal	Number of children with factor present^	Percentage of removals with this factor[9]
Neglect	2,004	74.7%
Parent(s)' Drug/Alcohol Use or Abuse[10]	869	32.4%
Domestic Violence	356	13.3%
Homeless/Inadequate Housing	337	12.6%
Incarceration of Parents	276	10.3%
Emotional Abuse	208	7.8%

Based on this analysis, Nevada identified several categories of children who are candidates for foster care. Neglect was present in a majority of removals and caregiver substance use or abuse was present in almost one-third of removals. (Note: These data analyzed the factors that were present at the time of removal,

[7] The statute states that this term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in foster care placement. See 42 U.S.C. § 675(13).

[8] Source for data: Nevada Division of Child and Family Services, *Data Book as of July 31, 2022*, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Programs/Data/DCFS_Data_Book_ADA_for_July_2022_updated_11.9.2022.pdf.

[9] Note: Children and youth may have multiple factors present. Percentages were calculated using the total number of children removed in SFY2022 (2,681).

[10] This figure is calculated from the sum of the following categories: parent(s) drug abuse, parent(s) meth use, parent(s) alcohol abuse, parent(s) opioid use, parent(s) marijuana use, and prenatal drug exposure.

even if that individual factor was not the primary reason for removal.)

DCFS consulted with child welfare leadership from Clark and Washoe Counties and the Rural Region to identify characteristics of youth and families who may be "screened out" during the initial intake assessment because they are not facing an imminent safety threat, but who may return to the child welfare system with more severe problems that require "screening in" or even removal from the home. Based on this data analysis and the input from State and regional child welfare leadership, Nevada developed the following criteria for "imminent risk" (**Error! Reference source not found.**).

FIGURE 2: DEFINITION OF IMMINENT RISK OF ENTERING FOSTER CARE

In Nevada, a child who is in **imminent risk of entering foster care** is a child who:

- Is in **present or impending danger** due to dangerous family conditions that are out of control and likely to result in severe harm, that are specific and observable, and that pose a threat to child safety;

or

- Has **one or more negative family conditions** listed below (that does not meet present or impending danger criteria) but suggests an increased likelihood of and risk for entering foster care:
    - An infant with prenatal substance exposure;
    - A caregiver who has a mental health and/or substance misuse disorder or other challenging condition or circumstance that impacts the caregiver's capacity or ability to function and care for the child;
    - Domestic violence or intimate partner violence in the home;
    - Significant, unmanaged child behavioral challenges that the caregiver is unable to address and/or that pose a threat to the safety of other individuals in the home;
    - A screened-in child abuse or neglect case eligible for an assessment and services under Differential Response;
    - Experiencing human trafficking; and/or
    - The sibling or child of a child identified as in imminent risk of entering foster care or already in foster care for whom there are safety or well-being concerns;

or

- Has a **reunification, adoption, or guardianship arrangement that is at risk of a disruption or dissolution** that would result in foster care placement;

or

- Is under 18 years old, is **pregnant and/or parenting**, has a history of being in foster care but is **not currently in foster care,** and has a need that could result in a foster care placement for the child(ren).

(Note: As described below, youth who are pregnant and/or parenting who are currently in foster care are not considered at imminent risk of entering foster care and do not require a separate assessment for candidacy to be able to receive services.)

Assessing for FFPSA Prevention Services Candidacy

There are four different times when youth and families may be assessed to determine whether they meet the definition of a "candidate for foster care" (i.e., at imminent risk of entering foster care, see **Figure 2**, and able to remain safely at home with services), and thus are eligible to receive FFPSA prevention services.

The Title IV-E agency will make all eligibility determinations, regardless of whether services will ultimately be managed through the "traditional pathway" or the "community pathway." Community providers play no role in the candidacy determination process. (See Figure 3 for a visual overview of the candidacy determination process).

1) Candidacy assessment based on present or impending danger: A child who is in present or impending danger but who can remain safe with necessary services and supports is eligible to receive FFPSA prevention services. Nevada will evaluate for present or impending danger under its current policies using existing tools (i.e., the Present Danger Assessment, the Nevada Initial Assessment, and the Safety Plan Determination).

a. *Present danger:* If the Present Danger Assessment (PDA) identifies present danger, the caseworker will work with their supervisor and the family to create a present danger plan and will document that the child has been assessed for candidacy, can be safe under a present danger/safety plan, and is eligible to receive FFPSA prevention services.

b. *Impending danger at close of Nevada Initial Assessment (NIA):* If the PDA does not identify present danger but the NIA identifies impending danger, the NIA worker will transfer the case for ongoing services and will document that the child has been assessed for candidacy, can remain safe under a safety plan, and is eligible to receive FFPSA prevention services.

c. *Impending danger based on PCFA or PCPA*: If the Protective Capacity Family Assessment (PCFA) or Protective Capacity Progress Assessment (PCPA) identifies impending danger but can be safe under a present danger/safety plan, the permanency worker will implement the safety plan and document that the child has been assessed for candidacy, can remain safe under the safety plan, and is eligible to receive FFPSA prevention services.

2) Candidacy assessment based on a negative family factor(s): This candidacy assessment will occur in situations where a worker determines that there is no present danger or impending danger, but the family is at-risk for foster care based on one or more of the following negative family conditions or factors:

- An infant with prenatal substance exposure;
- A caregiver who has a mental health and/or substance misuse disorder or other challenging condition or circumstance that impacts the caregiver's capacity or ability to function and care for the child;
- Domestic violence or intimate partner violence in the home;
- Significant, unmanaged child behavioral challenges that the caregiver is unable to address and/or that pose a threat to the safety of other individuals in the home;
- A screened-in child abuse or neglect case eligible for an assessment and services under Differential Response;
- Experiencing human trafficking; and/or
- The sibling or child of a child identified as in imminent risk of entering foster care or already in foster care for whom there are safety or well-being concerns.

There are two main points in the intake and assessment process at which this determination could occur:

a. *Following intake*: Under Nevada's current policies and procedures, intake reports with no present or impending threat are treated as "Information Only." In implementing FFPSA, child welfare agency workers will conduct an additional screening to determine whether the family meets one or more of the other criteria within the candidacy definition. The worker will use the "Families First Prevention Services Foster Care Candidacy Tool" in Nevada's Comprehensive Child Welfare Information System (Unified Nevada Information Technology for Youth, hereinafter "UNITY") for this eligibility determination. (See the Appendix for a copy of the tool.)

b. *Following completion of the NIA*.
Under Nevada's current policies and procedures, when a caseworker completes the NIA process and finds no present or impending danger, the child's case is closed. In implementing FFPSA, the NIA worker will conduct an additional screening to determine whether the child and family meets one or more of the identified negative family factors within the candidacy definition. The worker will use the "Families First Prevention Services Foster Care Candidacy Tool" in UNITY for this eligibility determination. (See the Appendix for a copy of the tool.)

If the worker identifies negative family factors or conditions and the family is eligible for FFPSA, the worker will document that the child has been assessed for candidacy, can remain safe under a prevention plan, and is eligible to receive FFPSA prevention services.

3) Candidacy assessment to support and maintain permanency: A child who is at risk of entering or re-entering foster care due to a possible disruption of a permanent living arrangement (including reunification, guardianship, or adoption), but who can remain safe with necessary services and supports without agency custody is eligible to receive FFPSA prevention services. This candidacy assessment occurs either (a) after a child's reunification with family (based on need(s) identified in the PCFA or PCPA) and case closure or (b) after a child's permanent placement with relative or fictive kin on a guardianship or a post-adoptive placement. During this process, the child welfare agency is made aware of problems and the potential risk of disruption to the child's permanency. The worker (either the family's worker, if the family is actively working with the child welfare agency, or an assigned worker) will assess needs and determine candidacy; this process may use the family's definition of risk of disruption.

4) Candidacy assessment for pregnant and/or parenting youth who is not currently in foster care: Youth and young adults up to age 18 who are pregnant and/or parenting may be considered at imminent risk of entry into foster care based on their child welfare history. This candidacy assessment may be provided to a youth or young adult who

a. is under age 18;
b. was previously in foster care;
c. is pregnant and/or parenting; and
d. needs additional support and services to prevent their child from entering foster care.

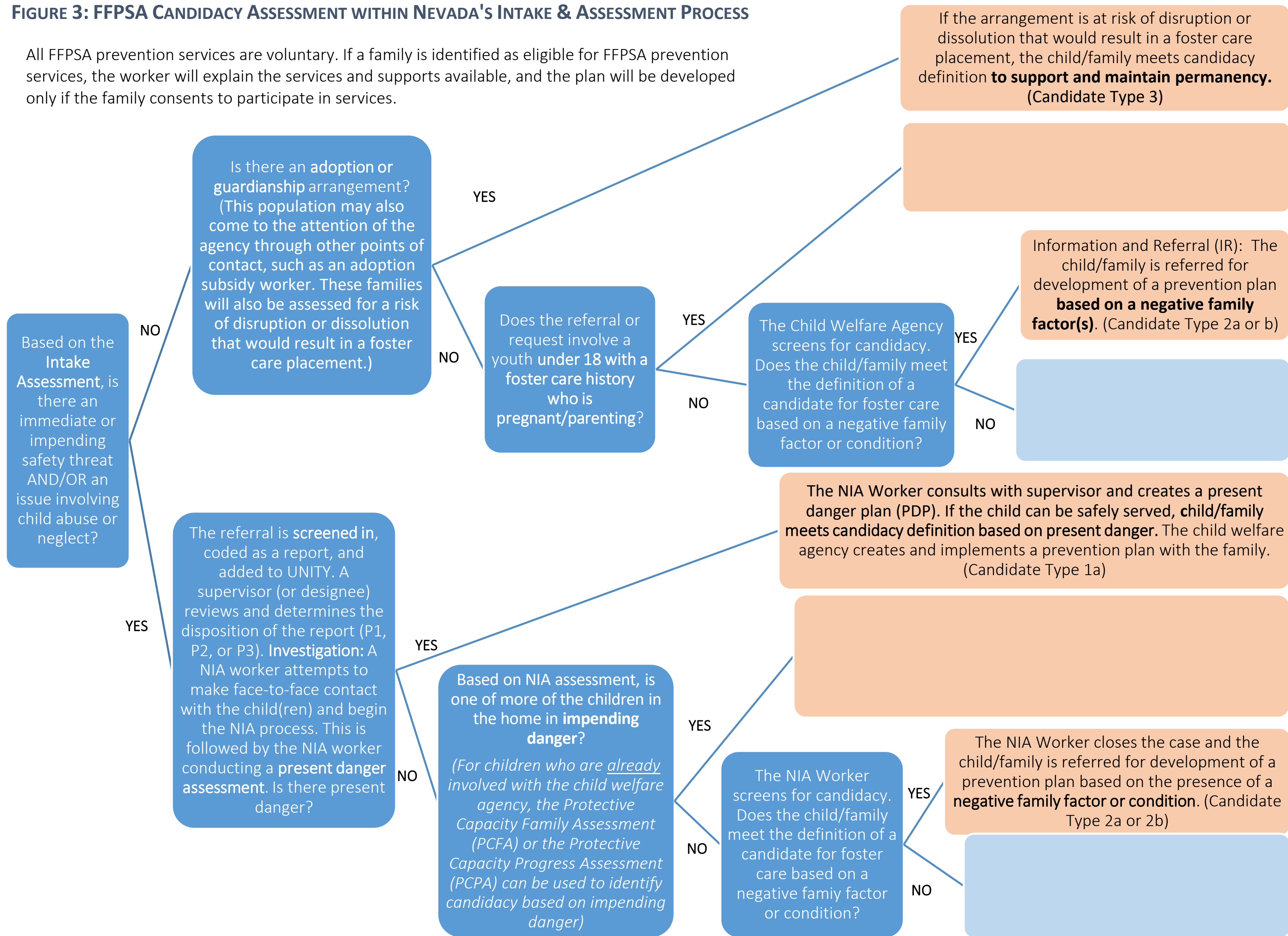
A youth who meets these eligibility criteria may receive prevention services during pregnancy to increase the likelihood of the positive outcomes of services and decrease the risk of their child entering foster care.

Pregnant or Parenting Foster Youth

Youth in foster care who are pregnant and/or parenting may obtain additional supports through FFPSA prevention services without conducting a candidacy assessment. Nevada will utilize a combination of workforce training and data analysis to identify youth currently in foster care who are pregnant and/or parenting, who may benefit from an assessment to identify additional needs and services. The child welfare jurisdictions will monitor this population and maintain records to include the number of pregnant/parenting foster youth, demographics of these youth, their referrals to prevention services, and their use of prevention services.

FIGURE 3: FFPSA CANDIDACY ASSESSMENT WITHIN NEVADA'S INTAKE & ASSESSMENT PROCESS

All FFPSA prevention services are voluntary. If a family is identified as eligible for FFPSA prevention services, the worker will explain the services and supports available, and the plan will be developed only if the family consents to participate in services.



Prevention Services

Pre-print Section 1 (continued)

Program Selection

The process of selecting a service array for inclusion in Nevada's IV-E Prevention Services Plan included two major initiatives: a comprehensive survey to assess the current service array and a review of historical data regarding service needs. In combination, these efforts provided qualitative and quantitative information about which services should be included in the prevention plan, particularly given the state's emphasis on building upon current infrastructure and leveraging existing resources and practices.

Assessing the Service Array

In 2019 and early 2020, DCFS conducted a survey of county, state, and private entities (e.g., community service providers) that serve the child welfare population and those that provide mental health, substance abuse, and in-home parent skill-based programs to identify current capacity and future interest in providing prevention services to Nevada's priority populations. Nevada slightly modified a survey (with permission) that Kentucky had developed and used in its own FFPSA planning.

The survey was designed to solicit information from community service providers and sister agencies in the Department of Health and Human Services regarding:

- Current capacity to provide services to Nevada children and families;
- Current implementation of evidence-based practices (EBPs);
- Populations of children and families served (currently and possible future expansion);
- Continuous quality improvement (CQI) practices;
- Capacity to provide services/programs that are trauma-informed;
- Geographic location of current services and possible expansion;
- Types of payment accepted;
- Potential to expand capacity to provide well-supported, supported, and promising programs; and,
- For residential providers, ability to meet the criteria of a Qualified Residential Treatment Program (QRTP).

After the survey was completed, DCFS held discussions with each of its sister agencies to better understand their provider networks and capacity and gauge their interest in collaborating to meet the goals of FFPSA. In addition, each of the regions (Clark, Washoe and Rurals) reached out to their respective providers to gauge capacity and interest. These discussions and the survey provided foundational input about providers' and sister agencies' experiences with a range of programs, as well as their interest in expanding existing services or implementing new services, that guided the selection of programs within this plan.

In addition, Nevada noted that further expansion of the service array, particularly to meet substance abuse and behavioral and mental health needs, was a need identified in the state's 2018 Child and Family Services Reviews. Nevada's prevention plan aligns with these identified needs by including at least one prevention service within each service area (i.e., mental health, substance abuse, in-home parent skill building) and by allowing each region to prioritize the service expansion that is aligned with their community's needs and their implementation capabilities.

Analyzing Data to Understand Service Needs

The second step in selecting the services and programs to include in this plan included a review of historical data to identify trends in service needs and reasons for removal of children from their homes and

placement into foster care. Nevada's data analysis focused on understanding the needs in the three categories of FFPSA prevention services: mental health services, substance abuse services, and in-home parent skill-building.

Mental Health Needs of Children and Families

Data indicated that mental health needs of a child are present in a small but notable portion of the entries into Nevada's child welfare system. From calendar years 2020-2022, children were either relinquished to or voluntarily placed with the agency because the child needed services to address a mental illness or emotional disturbance (see Table 2**Error! Reference source not found.**).[11]

TABLE 2 CHILD WELFARE RELINQUISHMENTS BASED ON A CHILD'S MENTAL HEALTH NEEDS OR EMOTIONAL DISTURBANCE (CALENDAR YEARS 2020-2022)

	Clark	Washoe	Rurals
CY2020	78	15	1
CY2021	108	62	4
CY2022	67	4	0

Nevada also assessed the impact of parent/guardian mental health needs on placement within the child welfare system. Nevada's practice model identifies an impending danger when one or both parents'/caregivers' emotional, developmental, and/or cognitive abilities seriously impairs their ability to care for the children. The findings showed that a parent or guardian's mental health contributed to an unsafe condition in a considerable number of Nevada's child welfare cases. In SFY2022, of the 2,681 children deemed "unsafe" based on the NIA, 831 of the children were deemed unsafe due to the mental health of their parent or caregiver – approximately 31% of the total. (See Table 3 for additional details.)

TABLE 3 CHILDREN DEEMED "UNSAFE" DUE TO THE MENTAL HEALTH OF A PARENT OF CAREGIVER (SFY 2022)

	Age 0 - 5	Age 6 - 10	Age 11 - 15	Age 16+	All Children
Clark County	364	126	97	17	604
Washoe County	65	32	18	3	118
Rural Region	52	31	25	1	109
Total	481	189	140	21	831

Substance Abuse Treatment Needs of Families

Like most states, substance abuse treatment needs for both caregivers are prevalent across Nevada's child welfare system. In SFY2022, 32% (n=869) of all children entering foster care had an identified parental substance abuse treatment need at the time of entry (parent's alcohol abuse, drug abuse, marijuana use, meth use, opioid use, and/or prenatal drug exposure). This may be an undercount of families in need of substance abuse treatment or services, as additional needs may become apparent after prevention services start being provided.

Parent Skill Building Needs of Families

Nevada's practice model identifies an impending danger threat when one or both parent(s)/caregiver(s) lack parenting knowledge, skills, and/or motivation in a way that affects child safety. A lack of parental skills rising to this level of risk was present for a large percentage of the 2,709 children deemed "unsafe" based

[11] This analysis of the impact of children's mental health on entry into foster care was mandated by Assembly Bill 387, which was passed in the 2019 Nevada Legislative Session.

on the NIA in SFY2022 (see Table 4: **Children Identified as "Unsafe" with a Parental Skill Need (SFY202** below). **Overall, about three-quarters of children and youth who were deemed unsafe (76%) had an identified need related to parental skills, knowledge, and/or motivation**.

When broken down by age and jurisdiction, these rates ranged from approximately 38% to 89% of children for the given group; for nearly all age groups regardless of jurisdiction, this rate was almost at or above 50%. As might be expected due to the developmental, physical safety, and well-being needs of young children, the rate of families with this indicated need was highest for families with children under 6 years old—for all jurisdictions combined, 79% of "unsafe" children in this age group had a need related to parental skills, knowledge, and/or motivation. Overall, these data demonstrate that Nevada has a significant need for services and programs that develop parental skills as a strategy to reduce foster care entry. These data indicate that 2,046 children might have met the definition of candidate for foster care based on this criterion in SFY2022.

TABLE 4: CHILDREN IDENTIFIED AS "UNSAFE" WITH A PARENTAL SKILL NEED (SFY2022)

Region	Age 0 - 5			Age 6 - 10			Age 11 - 15			Age 16+			All Children		
	n	Total	%	n	Total	%	n	Total	%	n	Total	%	n	Total	%
Clark County	910	1014	90	335	398	84	250	310	81	78	106	74	1573	1828	86
Washoe County	156	262	60	69	128	54	39	66	59	5	7	71	269	463	58
Rural Region	102	195	52	44	105	42	50	102	49	8	16	50	204	418	49
Total	**1168**	1471	79	**448**	631	71	**339**	478	71	**91**	129	71	**2046**	2709	76

The data presented throughout this plan support Nevada's candidacy definition. Furthermore, they indicate a need for a variety of mental health, parenting, and substance abuse treatment services and supports that may prevent entry into foster care for many Nevada children.

Selected Prevention Services

Nevada identified a range of services that would meet these needs and produce related outcomes. In the year following the initial FFPSA Prevention Plan submission, Nevada reviewed updated data (presented above) and engaged in further discussions across regions and with providers, child welfare workers, and community agencies. The Family Programs Office also led a modified Results Based Accountability process to choose programs based on their respective leverage (how much impact will it have on desired outcomes?), reach (is it feasible and affordable?), and lift (is it realistic based on workforce and other implementation considerations?).[12] These processes resulted in further refinement of the list of prevention services that Nevada will be offering to eligible children and families.

The list of services for inclusion primarily includes programs that have been implemented in at least one region in the state, which is consistent with Nevada's strategy to build on existing resources and programs. **All services are well-supported and are trauma-informed** (see below and the Appendix for the *State Assurance of Trauma-Informed Service Delivery).* Additionally, all services meet the categories of allowable Title IV-E prevention services and are time-limited in nature. *Note: Some programs may be proposed for*

[12] Adapted from Friedman, M. (2015). *Trying Hard is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities.* PARSE Publishing.

use across categories and/or may also be listed under workforce training.

Table 5: Nevada's Proposed Title IV-E Prevention Services

Program/ Service	Title IV-E Prevention Services Clearinghouse Rating	Title IV-E Prevention Services Clearinghouse Program/Service Area			Title IV-E Prevention Services Clearinghouse Outcomes	Evaluation Waiver Requested	Proposed Region(s) of State		
		Mental Health	Substance Abuse	In-Home Parent Skill-Based			Clark	Washoe	Rural
Family Check-Up (FCU)	Well-Supported	X		X	**Adult well-being:** Positive parenting practices Parent/caregiver mental or emotional health **Child well-being:** Behavioral and emotional functioning	Yes. See Appendix			X
Motivational Interviewing (MI)[13]	Well-Supported	X	X	X	**Adult well-being:** Parent/caregiver substance use	Yes. See Appendix	X	X	X
Parents as Teachers (PAT)	Well-Supported			X	**Child safety:** Child welfare administrative reports **Child well-being:** Social functioning **Adult well-being:** Positive parenting practices	Yes. See Appendix		X	X
Parent-Child Interaction Therapy (PCIT)	Well-Supported	X			**Child safety:** Child welfare administrative reports **Child well-being:** Behavioral and emotional functioning **Adult well-being:** Positive parenting practices Parent/caregiver mental or emotional health	Yes. See Appendix	X		X

[13] Although Motivational Interviewing is listed as well-supported for the substance abuse program category only, Nevada requests the Children's Bureau's approval for MI's use in all three categories (mental health, substance abuse, and in-home parent skill based). Nevada is proposing additional measures to assess outcomes for MI in addition to Adult well-being: Parent/caregiver substance use, as outlined below.

As illustrated in Table 5, **DCFS is requesting the Children's Bureau's approval to provide the following services in one or more parts of the state:**

- **Family Check-Up**
- **Motivational Interviewing**
- **Parents as Teachers**
- **Parent-Child Interaction Therapy**

The following summary table (Table 6) and service details that follow are designed to provide current plans for implementation, which are subject to change based on the needs of the communities.

TABLE 6: SUMMARY OF SERVICES BY REGION

Clark County	Washoe County	Rural Region
• Motivational Interviewing (MI) • Parent-Child Interaction Therapy (PCIT)	• Motivational Interviewing (MI) • Parents as Teachers (PAT)	• Family Check-Up (FCU) • Motivational Interviewing (MI) • Parents as Teachers (PAT) • Parent-Child Interaction Therapy (PCIT)

Nevada is requesting an evaluation waiver for each of these programs (see appendix). Table 7 below identifies both the broad proximal outcomes and the specific outcome(s) that will be measured for each program. All outcomes will be measured in all regions implementing the program. Further details on these outcomes—including the processes and tools/measures that will be used to track and evaluate the outcomes identified for each program—are provided in the Evaluation section.

TABLE 7. OUTCOMES BY EVIDENCE-BASED PROGRAM

Selected program/service	Proximal outcome(s), as noted in the logic model	Specific outcome(s)
Family Check-Up (FCU)	Improved adult well-being	Positive parenting practices
		Parent/caregiver mental or emotional health
	Improved child well-being	Behavioral and emotional functioning
Motivational Interviewing (MI)	Improved adult well-being	Parent/Caregiver Substance Use or Misuse
	Successful program completion	Longer enrollment Fewer early dropout
Parent-Child Interaction Therapy (PCIT)	Improved adult well-being	Positive parenting practices
		Parent/caregiver mental or emotional health
	Improved child well-being	Behavioral and emotional functioning
	Improved child safety	Child welfare administrative reports
Parents as Techers (PAT)	Improved child safety	Child welfare administrative reports
	Improved child well-being	Social functioning
	Improved adult well-being	Positive parenting practices

The following tables provide information on each of the four programs/services being proposed for inclusion in Nevada's plan. The tables outline the level of evidence, service description and category, region(s) proposed for implementation, population of focus, implementation plan, expected outcomes, fidelity monitoring plan, reason for inclusion, and evaluation approach.

TABLE 8: FAMILY CHECK-UP	
Level of evidence	Well-Supported
Version Used	Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019). *Family check-up in early childhood: An intervention manual* (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon.
Service description	Family Check-Up is a brief, strengths-based model targeting parenting skills and family management practices to improve outcomes for children. The model has three major components: (1) an initial interview; (2) an ecological family assessment that includes multiple tools to better understand the family; and (3) tailored feedback based on the assessment results to recommend follow-up services (e.g., clinical or support services).
Service category	Mental health programs and services In-home parent skill-based programs and services
Region(s)	Rural
Population of Focus	Families with children ages 2 through 17 who meet one or more of these criteria under the candidacy definition: • Present or impending danger • Caregiver with unmanaged mental health/substance misuse disorder • Screened in case eligible for Differential Response • Reunification, adoption, or guardianship arrangement at risk of disruption (if parent/caregiver mental health or parental skill needs are the cause of the disruption risk) • Pregnant or parenting youth with past foster care experience (if their child is at least 2 years old) • Sibling or child of an identified child/youth (if the identified child/youth is at risk of foster care placement due to one of the situations above)
Implementation plan	The Rural region has contracted with a provider for training and evaluation for FCU. The provider is undergoing additional training and certification through FCU to become a certified trainer, meaning they will be able to provide training, supervision, and oversight to identified providers throughout the Rural Region. Eight to 10 individuals can be trained and certified per cohort. The Rural region has identified qualified providers through its Clinical Program and community providers to participate in certification. There is an approved contract in place and the first cohort can be trained within 60 days.
Expected outcomes	Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health Child well-being: Behavioral and emotional functioning
Fidelity monitoring plan	Family Check-Up will use two major measures to monitor and assess fidelity: • COACH fidelity assessment (annual) • Required certification attained and training completed (semi-annual) See "Program Specific Fidelity Monitoring and Proximal Outcomes" for additional details regarding fidelity monitoring.
Reason for inclusion	Family Check-Up is a well-supported mental health service that addresses positive parenting practices. Protective caregiver capacity is a key component of Nevada's practice model; improving caregivers' protective capacity will allow more children and youth to stay safely in their own families and homes rather

	than enter child welfare, which is an approach consistent with the goals of FFPSA. Family Check-Up was selected as a prevention service that could support caregivers in improving their parenting skills and thus prevent removals to child welfare for children in the target population.
Evaluation approach	Nevada is requesting an evaluation waiver for this service. See the Appendix for Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

TABLE 9: MOTIVATIONAL INTERVIEWING	
Level of evidence	Well-Supported
Version Used	Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.
Service description	Motivational Interviewing (MI) is an adaptable counseling approach designed to support behavior change in a variety of problem areas. MI helps participants to articulate goals and uses clinical strategies to identify how their current problem behaviors are interfering with those goals. MI sessions can be provided in a wide variety of settings and usually involve one to three sessions that last about 30-50 minutes each. MI can be provided in conjunction with other services or interventions and incorporated into various screening, assessment, and care planning activities.[14]
Service category	Substance abuse programs and services *Consistent with other approved state FFPSA Plans (e.g., California, Washington DC), Nevada requests approval from the Children's Bureau to use Motivational Interviewing for mental health programs and services and in-home parent skill-based programs and services in addition to substance abuse programs and services. MI will be implemented as both 1) a standalone evidence-based service integrated with case management practices to advance individualized goals identified in the child-specific prevention plan, including to reduce substance abuse, regardless of whether families are participating in any other EBPs and 2) an adjunctive evidence-based service, when appropriate, to improve appropriate selection of additional services and EBPs and ensure that each family has the dedicated support and motivation to sustain engagement in intensive service interventions, bolstering individual and family treatment outcomes.
Region(s)	Clark, Washoe, Rural
Population of Focus	Children of all ages who are candidates for foster care or pregnant/parenting foster youth and their parents/caregivers
Implementation plan	Nevada already trains all its child welfare caseworkers in Motivational Interviewing as a strategy for engagement in treatment and care planning, including to engage in and complete substance abuse treatment as well as to support effective mental health treatment and parent skill building. MI will continue to be included in caseworkers' training. The state also intends to expand training to community providers to increase capacity so the service can be offered to prevention plan-eligible youth with MI included in their

[14] MINT. (2019). *Understanding Motivational Interviewing.* Available from Motivational Interviewing: https://motivationalinterviewing.org/understanding-motivational-interviewing

	prevention plan. In this way, Nevada will develop its capacity to offer MI through both agency staff and community providers.
Expected outcomes	Adult well-being (Parent/caregiver substance use) Increased engagement in and reduced early dropout from other services and programs (as approved in other state FFPSA plans, e.g., California, Washington DC)
Fidelity monitoring plan	Nevada has a current plan for tracking fidelity for MI, which includes using the Behavior Change Counseling Index (BECCI). At the same time, Nevada is exploring the use of LYSSN, an AI-based fidelity monitoring system designed for MI, based on recommendations from other states. See "Program Specific Fidelity Monitoring and Proximal Outcomes" for additional details regarding fidelity monitoring.
Reason for inclusion	Motivational Interviewing is a well-supported program that has a strong evidence base in enhancing motivation for behavior change, including related to substance use. It can be used by itself or in combination with other treatments and can be used to help motivate and engage caregivers. Parental substance use and abuse is a common factor at the time of removals in Nevada child welfare cases. Based on the state's current use of MI, Nevada sees opportunities to use the service for children with prevention plans with mental health and/or parental skill building needs, as well as for substance abuse needs.
Evaluation approach	Nevada is requesting an evaluation waiver for this service. See the Appendix for Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

TABLE 10: PARENTS AS TEACHERS	
Level of evidence	Well-Supported
Version Used	Parents as Teachers National Center, Inc. (2016*). Foundational curriculum.* Parents as Teachers National Center, Inc. (2014). *Foundational 2 curriculum: 3 years through kindergarten.*
Service description	Parents as Teachers (PAT) is a home visiting program that focuses on building parents/caregiver skills in areas such as positive child development and child maltreatment prevention. Trained parent educators work with caregivers in their homes or in community spaces, such as schools or childcare centers. Services are usually offered in one-hour sessions either biweekly or monthly. PAT includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks. The goals of PAT are to increase parent knowledge of early childhood development and improve parent practices; provide early detection of developmental delays and health issues; prevent child abuse and neglect; and increase children's school readiness and success.[15]
Service category	In-home parent skill-based programs and services
Region(s)	Washoe, Rural

[15] Parents as Teachers National Center, Inc. (2021). *About the evidence-based home visiting model.* Available from Parents as Teachers: https://parentsasteachers.org/evidencebased-home-visiting-model#aboutebm

Populations of Focus	Parents/caregivers of children ages 0 to 5 (consistent with the model eligibility) who meet one or more of Nevada's prevention services criteria under the candidacy definition: • Present or impending danger • Infant with prenatal substance exposure • Significant, unmanaged child behavioral challenges • Screened in case eligible for Differential Response • Human trafficking experience • Reunification, adoption, or guardianship arrangement at risk of disruption (if parental skills needs are the cause of the disruption risk) • Pregnant or parenting youth with previous experience in foster care • Sibling or child of an identified child/youth (if the identified child/youth is at risk of foster care placement due to one of the criteria above)
Implementation plan	In Washoe County, WCHSA has entered into an agreement with the University of Nevada, Early Head Start (UNR, EHS) to provide the PAT curriculum to eligible families. UNR, EHS has obtained affiliate status with the PAT purveyor and is required to submit annual CQI reports to PAT to maintain that status. The agreement with UNR, EHS outlines the requirement to provide services with fidelity and CQI processes that align with the requirements to maintain affiliate status with the PAT purveyor. Internal policies and procedures will be developed to outline referral processes as well as ongoing documentation of services and updates on required CQI processes every six months. In the Rural counties, PAT is administered through the Division of Public and Behavioral Health, which has indicated interest in expanding its PAT provider capacity. The Rural counties will collaborate with DPBH to seek expansion opportunities to offer the service to prevention plan-eligible youth and families.
Expected outcomes	Child safety: Child welfare administrative reports Child well-being: Social functioning Adult well-being: Positive parenting practices
Fidelity monitoring plan	PAT uses two methods to monitor and assess fidelity: • Affiliate Performance Report and Essential Requirements Measures (annual) • Required certification attained and training completed (semi-annual) See "Program Specific Fidelity Monitoring and Proximal Outcomes" for additional details regarding fidelity monitoring.
Reason for inclusion	PAT is a well-supported program with evidence showing a reduction in child welfare administrative reports and improvements in key indicators of child well-being. It is already being provided in part of the state and is an effective home visiting intervention, including for those individuals who are not first-time parents or who do not become eligible for services until after the birth of their child. Parent educators only need a high school diploma or GED and the required training.
Evaluation approach	Nevada is requesting an evaluation waiver for this service. See Appendix for Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

TABLE 11: PARENT CHILD INTERACTION THERAPY (PCIT)	
Level of evidence	Well-Supported
Version Used	Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011*. PCIT International, Inc.
Service description	Parent-Child Interaction Therapy (PCIT) is a treatment model that coaches caregivers in key parenting skills such as child-centered play, communication, and problem-solving. The program uses "bug-in-the-ear" technology to allow PCIT-trained therapists to offer live coaching to parents as they manage their child's behavior. Treatment includes two phases with different treatment goals for each phase. The program usually lasts for between 12-20 one-hour sessions, though the length will differ based on each family's needs.[16]
Service category	Mental health programs and services
Region(s)	Clark, Rurals
Population of Focus	Children and youth ages 2 to 7 (and their caregivers and, as appropriate, their siblings) who meet one or more of these criteria under the candidacy definition: • Present or impending danger • Caregiver with unmanaged mental health/substance misuse disorder • Significant, unmanaged child behavioral challenges • Screened in case eligible for Differential Response • Reunification, adoption, or guardianship arrangement at risk of disruption (if parent/caregiver mental health needs are the cause of the disruption risk) • Pregnant or parenting youth with previous experience in foster care experience • Sibling or child of an identified child/youth (if the identified child/youth is at risk of foster care placement due to one of the criteria above)
Implementation plan	PCIT is currently being implemented in Clark County by contracted community providers. Clark County has identified a community provider with a PCIT Certified Practitioner, as well as other providers that are prepared to become certified. Clark County will establish partnerships with these providers to ensure prevention-plan eligible families can access these services. In the Rural region, DCFS will be contracting for training through a PCIT International-approved trainer (likely University of Oklahoma) to train their clinicians who will be delivering this service.
Expected outcomes	Child well-being: Behavioral and emotional functioning Adult well-being: Positive parenting practices Adult well-being: Parent/caregiver mental or emotional health
Fidelity monitoring plan	PCIT will use two methods to monitor and assess fidelity: • Treatment Integrity Checklist (annual) • Required certification attained and training completed (semi-annual) See "Program Specific Fidelity Monitoring and Proximal Outcomes" for additional details regarding fidelity monitoring.

[16] PCIT International. (2018). *What is Parent-Child Interaction Therapy (PCIT)?* Available from PCIT International: http://www.pcit.org/what-is-pcit.html

Reason for inclusion	PCIT is a mental health intervention with a strong evidence base to address children's mental health issues and caregiver skills, as demonstrated by its well-supported rating in both the Title IV-E Prevention Services Clearinghouse and the California Evidence-Based Clearinghouse and evidence-based rating by the Washington State Institute for Public Policy for families in child welfare. Unmet mental health needs of children is a common factor in child welfare placements in the state. A lack of parent skills and knowledge is also a common issue that leads to child welfare involvement within the state. PCIT was selected as a prevention service that could address both of these factors that lead to child welfare removals for children in the population of focus.
Evaluation approach	Nevada is requesting an evaluation waiver for this service. See the Appendix for Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, with supporting documentation.

Consultation and Coordination

Pre-print Section 4

Consistent with FFPSA, Nevada engaged in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers. Nevada engaged in consultation with other state agencies responsible for administering health programs and with other public and private agencies and community-based organizations to ensure the development of a comprehensive continuum of care for children who are candidates for foster care and their parents or caregivers. Nevada completed a multi-pronged needs assessment to determine the existing service array that could be used for FFPSA prevention services and the capacity for expansion of current service providers and services provided. The needs assessment included a provider survey, which was introduced with two one-hour live webinars to allow for questions and comments from community and state providers. Nevada received a total of 51 surveys (38 from community-based and state service providers and 13 from congregate care providers). Nevada also held a virtual "town hall" with specialized and advanced foster care providers to answer questions about IV-E eligibility and QRTP status and readiness.

Additionally, DCFS held structured meetings with State of Nevada Divisions and Agencies to enhance state collaboration on FFPSA. The Department of Health and Human Services (DHHS) is comprised of five Divisions: DCFS, Aging and Disabilities Services (ADSD), Health Care Financing and Policy (Medicaid), Public and Behavioral Health (DPBH), and Welfare and Supportive Services (DWSS). The DCFS FFPSA team met with all Divisions, as well as projects within those divisions, including children's mental health (DCFS), System of Care (DCFS), Mobile Response (DCFS), home visiting, maternal health, and rural children's mental health (DPBH).

Nevada prioritized services and programs that a) meet the needs of the candidates for foster care and their families and b) aligned or were able to be coordinated with other child and family services provided across the state. Of the four programs and services included in the plan, all four currently are available in at least part of Nevada. Nevada's FFPSA Prevention Plan leverages existing infrastructure and prioritizes initiatives to enhance quality home- and community-based services. The diversity of the programs selected is

reflective of the differences in demographics, accessibility of services, and other factors across the three regions.

As described in the Monitoring Child Safety section of this plan, Nevada's IV-E agency will be partnering closely with the community providers that will be providing oversight and management of some plans of children and families receiving prevention services. The IV-E agency will be providing training to the providers on mandatory reporting and FFPSA-required activities, such as prevention planning, documentation, and required CQI activities. This will be formally documented in contracts with providers and oversight will be maintained through audits, record sampling, and/or comprehensive record reviews. All prevention plans will be provided to the IV-E agency along with all related screenings or other documentation. Nevada intends to have all prevention plans submitted to the IV-E agency electronically, so they are easily accessed as needed.

Nevada will coordinate the services described in this plan with other child and family services provided to the child and the parents or kin caregivers of the child provided under the state plans in effect under subparts 1 and 2 of part B of Title IV. DCFS as the IV-E agency will continue to coordinate with contracted IV-B providers to ensure that any services provided through both IV-B and IV-E funds are clearly tracked and appropriately charged based on eligibility and funding constraints and parameters. IV-B providers who are not providing IV-E prevention services will be given information on the prevention services, including names of providers and eligibility criteria for services, as part of Nevada's larger outreach and communications plan. IV-B providers who are also providing separate IV-E services will receive more extensive training on the FFPSA requirements, in addition to intervention-specific requirements, as appropriate.

Evaluation Strategy

Pre-print Sections 2 and 8

Nevada recognizes the importance of well-designed continuous quality improvement (CQI) processes to support the effective implementation of evidence-based programs into the existing service array and to ensure that the proximal and distal outcomes are reached for youth and families. Nevada's DCFS Family Programs Office (FPO) has worked diligently with state and regional leadership, service providers and purveyors, and national experts to develop detailed CQI and fidelity monitoring processes for each of the proposed programs that include data collection and analysis, reporting timelines, processes for data review, and procedures for getting data into the hands of decision makers. These processes will allow key stakeholders to monitor both the implementation process and outcomes and enable service providers and leadership to make data informed decisions regarding strategies to address identified barriers to implementation. Most importantly, they allow key stakeholders to ensure that youth and families are receiving the high-quality services that they need for achieving optimal outcomes.

As described previously, DCFS is proposing to initially implement **four Well-Supported** (Table 5) programs to meet the specific needs of youth and families identified for prevention services in Nevada. DCFS plans to add additional programs to expand their service array following the successful implementation of these initial programs. Given that all four programs have been rated as Well-Supported by the Title IV-E Prevention Services Clearinghouse, DCFS is requesting waivers for the rigorous evaluation requirement for all four programs (see Appendix for the evaluation waivers).

Nevada formed an **Evaluation Oversight Committee (EOC)** that reports to a larger, existing statewide CQI group and developed comprehensive CQI and fidelity monitoring plans for each EBP to monitor effective implementation of FFPSA programs and ensure that all federal reporting requirements are met.

The CQI and fidelity monitoring activities for each program will be conducted regionally by each participating jurisdiction with oversight by the EOC. Programs will vary as to whether they are implemented statewide or regionally. When implemented regionally, each region is responsible for coordinating CQI and fidelity monitoring, either internally or through a contracted entity, with DCFS FPO ultimately responsible. The DCFS FPO will provide oversight via the EOC to ensure that CQI and fidelity monitoring are designed to answer overarching questions regarding the quality of implementation and service delivery as well as the extent to which program and system-level outcomes are being reached. Overall, the goal of all CQI and fidelity activities is to ensure that youth and families receive high quality services in a timely manner that meet their needs and lead to positive outcomes.

CQI Oversight Structure and Processes

As discussed, Nevada created the EOC to oversee CQI and fidelity monitoring activities across all Nevada FFPSA programs. The EOC is a subcommittee of and reports to the Statewide Quality Improvement Committee (SQIC), an existing committee comprised of leadership and decision-makers who meet bi-monthly to review policy and make decisions regarding statewide service implementation. All authority remains with the Title IV-E Agency, but the EOC supports broad accountability for the CQI and fidelity monitoring activities across regions.

The EOC is facilitated by FPO leadership with support from other state-level staff with appropriate knowledge of both the FFPSA plan and evaluation design and methods. Additional members include regional child welfare leadership (including representatives from all three regions), individuals with expertise in program evaluation and CQI, and internal staff with technical knowledge of or experience managing Nevada's child welfare database and information systems. FPO is responsible for coordinating meetings with regional stakeholders and evaluators and presenting information from those meetings to the SQIC.

The EOC is charged with regularly monitoring the implementation of approved CQI and fidelity monitoring plans and will ensure that the required administrative data from UNITY are provided on a timely basis. The EOC will communicate regularly with evaluators about how planned CQI and fidelity monitoring activities are unfolding and any alterations to those plans that might need to occur due to unanticipated developments. Specific responsibilities for the EOC include:

- Maintain regular communication with jurisdiction and program leadership as well as evaluators regarding CQI and fidelity monitoring processes.
- Support program evaluators in accessing administrative data required for statewide CQI reporting.
- Review CQI and fidelity data reports provided by program evaluators designed to track drivers and barriers to implementation of each program.
- Collaborate with program and jurisdiction leadership to develop data-informed recommendations for addressing implementation barriers.
- Monitor the outcomes of implementation strategies used to address barriers to ensure that they are having the desired impact and adjust strategies when needed.
- Review CQI and evaluation plans for newly proposed evidence-based programs interested in being amended to the state FFPSA plan.
- Ensure that all federally required data are being reported in an appropriate and timely manner to the Children's Bureau.
- Present overall findings and recommendations based on CQI and fidelity data review to the SQIC.

The EOC began meeting monthly to support the development of the CQI and fidelity monitoring plans and will continue to meet monthly for at least the first six months following the approval of the FFPSA Plan to

support the initial implementation of CQI and fidelity monitoring plans for each program. Once the EOC determines that the proposed data elements can be collected (as described below), meeting frequency will be adjusted to quarterly to align with data reporting schedules (see below). As new programs are proposed for FFPSA, EOC representatives from associated jurisdictions and FPO leadership will review CQI and evaluation plans to ensure that they meet the requirements for FFPSA. EOC representatives will share reports, successes, barriers, and proposed strategies with SQIC on at least a quarterly basis and may be called upon to present data and recommendations to other decision-making groups when necessary. Overall, the EOC will ensure that data is being collected, reported, reviewed, and used to make decisions to support the successful implementation of all FFPSA programs.

Continuous Quality Improvement and Fidelity Monitoring

The FPO, through the EOC, has developed a plan for thorough CQI processes for each of the FFPSA programs and for the state as whole. The goal of the CQI process is to **use data to inform planning and monitor the implementation of programs to ensure that youth and families are receiving high-quality services that achieve targeted proximal and distal outcomes.** The widely used Plan-Do-Check-Act (PDCA) framework will be utilized to guide the process of identifying implementation barriers and successes and executing plans to improve or continue effective service delivery. The PDCA cycle involves an iterative process of developing strategies to address identified barriers (Plan); implementing these strategies (Do); gathering data and reviewing findings to determine if changes are having the intended effect (Check); and standardizing changes across programs when they are found to be effective (Act). This process will be guided and supported by the EOC, which will communicate regularly with service providers and evaluators to review data reports, identify barriers and facilitators to implementation, develop plans and strategies to address barriers, and check to ensure that strategies are having their intended effect. Additionally, the EOC will provide regular updates to decision-makers at the SQIC and provide updates and recommendations for changes to policy or future planning.

FIGURE 4. PLAN-DO-CHECK-ACT FRAMEWORK

The EOC will convene quarterly meetings with representatives from all programs and evaluators to facilitate this PDCA cycle. As part of the Planning step, data collected through UNITY, as well as data collected by program evaluators, will be reviewed to identify regional and statewide patterns of barriers to and opportunities for successful implementation. The EOC will collaborate with program and regional leadership to develop strategies to address the identified barriers and take advantage of opportunities to improve implementation within and across jurisdictions. Additionally, this group will serve as a learning community in which programs and regions can share knowledge and strategies that they have found to be successful.

Strategies developed during these meetings will be documented. Documentation will include the identified barrier or opportunity for improve implementation, the agreed upon strategy aimed to address the barrier or opportunity, the intended outcome of the strategy, the data needed to monitor those outcomes, and a benchmark that would indicate that the strategy was successful. Regional and program leadership will be responsible for implementing strategies on the program level and gathering the required data to assess the effectiveness of the strategy. Outcomes for strategies will be checked at subsequent meetings to see if the strategies have had the intended effect. If strategies are effective, they will be retained as the new

standard. If they are not, appropriate revisions or new strategies will be developed, and the process will be repeated.

To support consistency in CQI activities across programs, each program will be required to collect and report data to answer overarching CQI questions that are tied to core Process and Child & Family Outcomes identified in the logic model as key to succeeding in addressing youth and families' needs. These measures will include, but are not limited to, the number of referrals, number of enrolled youth and families, time between referral and enrollment, length of stay in program, and discharge reason (see Table 12). These data will be analyzed on a quarterly basis and aggregate reports will be provided to the EOC prior to meetings.

TABLE 12. PROCESS AND CHILD & FAMILY OUTCOMES ACROSS PROGRAMS

Process Outcomes	Aligned CQI Questions	Data Elements
Interventions served the target population Program capacity met regional need Candidates in the target population are being referred. Interventions implemented with fidelity (see Table 10 below on Program-Specific Fidelity Measures)	What are the demographic and need characteristics of the youth and families being referred to the program? Do the identified needs of the referred families align to the target outcomes of the program? What are the referral sources for the program? How long, in days, does it take from referral to enrollment of the family in the program? What are the barriers to youth who are referred to being enrolled promptly? Are there youth with identified needs who are not being referred to an appropriate FFPSA program?	Referral Date Referral Source Enrollment Date Youth Sex Youth DOB Youth Race/Ethnicity City/Location Risk Assessment
Child & Family Outcomes	**Aligned CQI Questions**	**Data Elements**
Successful program completion Youth/family meets their identified goals	How long, in days, are youth and families being enrolled in the program? What are the reasons youth and families are being discharged from the program? Are youth and families disengaging from services prematurely? If so, what are the reasons for disengagement? Did youth and families show improvements in areas they identified as important?	Discharge Date Discharge Reason Program-Specific Proximal Outcomes (see table below)

Table 13 provides an overview of the frequency and data source of the planned reporting requirements for all CQI and fidelity monitoring activities. As mentioned, the agreed upon standard metrics for CQI will be reported on a quarterly basis. Reports will be submitted on program-specific fidelity measures on a semi-annual or annual basis depending on the measure. These reports will be sent to the EOC and reviewed during the EOC's quarterly meeting with evaluators and leadership. Finally, annual outcome reports will be completed for each program that will include program-specific proximal and distal outcomes.

Data for CQI and fidelity monitoring processes will be collected through UNITY, as well as through program level data collection efforts. Specifically, service providers will enter data related to referrals, enrollment, discharges, and distal outcomes into the UNITY system via an external application. The EOC will support evaluators in getting access to this administrative data in a timely manner so that they can provide aggregate data reports to the EOC before quarterly meetings. Program evaluators will be responsible for collecting and reporting on program-specific fidelity measures and program-specific proximal outcomes. Evaluators will work directly with the program sites and the purveyors of interventions to ensure there is adequate training in the collection of program-specific assessment tools and other data metrics.

TABLE 13. DATA SOURCES AND FREQUENCY FOR PLANNED REPORTING REQUIREMENTS

Reporting Frequency	Data Elements	Data Source
Quarterly Reporting	Referral Source	UNITY
	Enrollment Date	
	Youth Sex	
	Youth DOB	
	Youth Race/Ethnicity	
	Youth Sexual Orientation, Gender Identity, and Expression (SOGIE)	
	City/Location	
	Discharge Date	
	Discharge Reason	
Semi-Annually or Annually	Program Specific Fidelity	Program-specific data systems
Annually	Program Specific Proximal Outcomes (see Table 15)	Programs will collect
	Proximal Outcome: Living Situation at time of discharge	UNITY
	Distal Outcome: Youth living situation 12 months post-discharge	
	Distal Outcome: Re-entry into DCFS 12 months post-discharge	
	Distal Outcome: Youth living situation 24 months post-discharge	
	Distal Outcome: Re-entry into DCFS 24 months post-discharge	

During the initial year of implementation, the CQI process will primarily focus on monitoring that the populations of focus are being served, that families are being engaged in a timely manner, and that programs are being implemented with fidelity. This will allow Nevada and service providers to be proactive in identifying barriers and facilitators to the initial implementation processes and making plans for addressing any identified problems. In subsequent years, the EOC will begin to examine proximal and distal outcomes for each program as well.

Proximal and distal outcomes will be reported annually to the EOC, and the EOC will then report on these outcomes to the SQIC, who can support statewide policy and procedure development that can improve program delivery. Table 13 shows the standard proximal and distal outcomes that will be reported for all four FFPSA programs. Distal outcomes include youth living situation and DCFS involvement at 12- and 24-

months post-discharge while proximal outcomes include youth living situation at discharge and program-specific outcomes. Program-specific proximal outcomes will also be reported to the EOC on an annual basis. The section below on Program Specific Fidelity Monitoring and Proximal Outcomes (see tables below), provide details regarding the program-specific proximal outcome domains and their operationalization.

Program Specific Fidelity Monitoring and Proximal Outcomes

As noted above, program evaluators will be responsible for collecting and analyzing fidelity data and program-specific proximal outcomes. All four proposed programs have specific metrics for monitoring whether the program is being implemented as intended. This table lists the program-specific fidelity measures that the EOC will track on a semi-annual or annual basis depending on the measure.

TABLE 14: PROGRAM-SPECIFIC FIDELITY MONITORING

EBP	Instrument/Measure
Family Check-Up	• COACH fidelity assessment (annual) • Required certification attained and training completed (semi-annual)
Parents as Teachers	• Affiliate Performance Report and Essential Requirements Measures (annual) • Required certification attained and training completed (semi-annual)
Parent-Child Interaction Therapy	• Treatment Integrity Checklist (annual) • Required certification attained and training completed (semi-annual)
Motivational Interviewing*	• Behavior Change Counseling Index (BECCI) (annual) • Required certification attained and training completed (semi-annual)

*Nevada is currently planning to use the BECCI, but the EOC is exploring the use of a new developed AI-driven fidelity monitoring system for Motivational Interviewing.

Additionally, each program will collect data on specific proximal outcomes that are tied directly to the needs of the youth and families that they are intended to serve. These proximal outcomes align with the outcome domains found to be impacted by each program in the review by the FFPSA Clearinghouse and which are reflected in the state's Logic Model. Table 15 provides details regarding each of these program-specific proximal outcomes, including the specific construct, how it will be measured, and the Clearinghouse domain to which it relates. Details regarding the collection of fidelity and outcome measures for each program are presented below, and additional information regarding the evidence for each program is presented in the Waivers Request section. These metrics will be included in the EOC's Plan-Do-Check-Act Framework to ensure that high-quality services are being delivered and intended outcomes are being reached.

Family Check-Up

Family Check-Up (FCU) is a parent-coaching intervention that assesses family strengths and challenges and offers a tailored parent training program focused on teaching parents positive behavior support, healthy limit setting, and relationship building. Based on the review of evidence by The Clearinghouse, FCU has been found to be effective in increasing positive parenting skills. Nevada will utilize the FCU program with families who can benefit from increased parenting skills.

The standardized tool developed by the FCU purveyors will be used in a pre-post design to assess improvements in positive parenting skills for families enrolled in the FCU to assess if the FCU is effective in addressing this need for families in Nevada. In addition to improving positive parenting skills, Nevada is interested in assessing if FCU has a positive impact on child behavior and emotional functioning and caregiver emotional or mental health. Therefore, the Eyberg Child Behavior Index (ECBI) and the Parenting Stress Index (PSI) will be collected pre- and post-treatment to assess child behavior and emotional functioning and caregiver emotional or mental health, respectively.

In addition to tracking program-specific proximal outcomes, the COACH rating system, designed specifically for FCU, will be used to monitor fidelity. The COACH rating system will be collected by an FCU-certified trainer and clinician who will be supporting the implementation of FCU in Nevada and is also the program evaluator. The evaluator will report COACH data to the EOC on at least an annual basis. Data on the number of staff receiving required trainings in FCU will be sent to the EOC semi-annually.

Motivational Interviewing

Motivational Interviewing (MI) is an adaptable counseling and engagement approach designed to support behavior change in a variety of problem areas. A review of research by The Clearinghouse shows that MI has been particularly effective at reducing parental substance abuse, however MI has also been shown to increase engagement and participation in other services, reducing early discharge and increasing successful completion of programs. Like other states using MI as part of their FFPSA plan (e.g., Washington D.C.), Nevada will primarily examine the impact of MI on caregiver engagement in case management services and their participation in other programs. As noted above, MI will be implemented two ways:

1) as a standalone evidence-based service integrated with case management practices to advance individualized goals identified in the child-specific prevention plan, including but not limited to reducing substance abuse, regardless of whether families are participating in any other EBPs; and

2) as an adjunctive to any of the other evidence-based programs and services within the FFPSA plan, when appropriate, to ensure that each family has the dedicated support and motivation to sustain engagement in intensive service interventions, bolstering individual and family treatment outcomes.

In both of these implementations, it will be the case workers who are implementing MI. The primary difference will be that if youth are enrolled in any other EBPs within this FFPSA plan, length of stay and discharge from those EBPs will also be tracked as indicators of the effectiveness of MI. Overall, MI will be used to increase engagement in case management or all other EBPs within this plan.

Research supports broader use of MI as an effective strategy for increasing caregivers' motivation to make difficult behavioral changes. For these reasons, all three jurisdictions in Nevada will train their case managers to use MI for a broader population of youth and caregivers who are receiving case management. Youth and families may also be using other EBP interventions proposed in this plan, and case managers will employ MI to increase the likelihood of engagement in those EBPs. Specifically, MI is expected to improve retention and engagement in case management and other EBPs. As a measure of engagement in services, lengths of stay for youth/families who receive MI should be more likely to fall within the standards of a particular EBP. Likewise, the percentage of youth being discharged from case management and other EBPs due to loss of contact or refusing further services should be lower for youth and families that receive MI. Discharge reason and length of stay for case management and the other EBPs are already part of the main CQI items that will be extracted from UNITY and reported to the EOC on a quarterly basis. Additionally, progress towards individualized goals identified in the child-specific prevention plan will be tracked through the UNITY system to determine if youth and families who are receiving MI are staying engaged in case

management until their goals are reached. When relevant, MI's impact on caregiver substance abuse will be measured using administrative risk assessment data which will be reviewed to identify repeated reports of caregiver substance use.

Data tracking the dosage of MI and examining its potential impact on these outcomes will be reported to the EOC annually. Supervisory and CQI staff in each jurisdiction will be responsible for sharing this data with the EOC.

MI does not have a set certification process or standard fidelity monitoring tools. Nevada is currently planning to utilize the Behavior Change Counseling Index (BECCI), a tool designed to measure the skills in behavior change counseling more generally—that was recently used in a child welfare context by Washington State—as its measure of MI fidelity. The BECCI will be used to ensure that MI is implemented consistently and FPO will be responsible for ensuring that those data are shared with the EOC on an annual basis. Nevada is also in the process of exploring other, potentially more efficient, methods of tracking MI fidelity. Based on feedback from other states using MI, Nevada is exploring the feasibility of using an artificial intelligence (AI)-based fidelity monitoring system designed for MI, called LYSSN. The LYSSN platform uses AI to code MI skills based on recorded MI sessions. These sessions can be test cases used as part of ongoing training or upload recordings of actual sessions. If it is determined that LYSSN provides a feasible and more efficient method of fidelity monitoring, Nevada may transition from their current plan of using the BECCI to implementing LYSSN. Nevada also will report on a semi-annual basis to the EOC on the number of staff attending trainings on MI that are currently being offered by the Nevada Partnership for Training (NPT) at the University of Nevada, Las Vegas and the University of Nevada, Reno.

Parents As Teachers

Parents as Teachers (PAT) is a home visiting program that seeks to promote positive child development and prevent child maltreatment by improving parental knowledge, attitudes, and behaviors as well as fostering children's social and emotional development. A review of research by The Clearinghouse has found that PAT has been effective at increasing child safety and reducing maltreatment reports (see Request for Waiver section). Consistent with the goals of PAT, Nevada also plans to assess the impact of PAT on child social functioning and positive parenting skills.

PAT evaluators in both regions will use a combination of administrative data from UNITY and standardized assessment tools to assess these outcomes. Evaluators will use administrative data to examine the number of substantiated reports of abuse/neglect and recurrence of abuse/neglect for families involved in PAT to assess the impact on child safety. Child social functioning will be assessed using the Ages & Stages Questionnaire (ASQ-3) and Ages & Stages Questionnaire: Social-Emotional (ASQ-SE) with a pre- post design to assess changes during treatment. Finally, positive parenting skills will be assessed using the Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO), a tool designed to assess developmental parenting behaviors including affection, responsiveness, encouragement, and teaching behaviors.

PAT has its own fidelity metrics that are required to be collected by agencies to maintain their affiliate status and are compiled into an annual Affiliate Performance Report. PAT will be delivered by outside agencies that are PAT affiliates, and they will be required to collect the key indicators of fidelity needed for this report. CQI personnel at the local level will review these reports, compare the results to internal agency benchmarks, and forward reports on fidelity monitoring to the EOC on an annual basis. They will also track and report data to the EOC on required certifications attained and trainings completed.

Parent Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is a parent-coaching intervention for families with young children (2-7 years old) that strives to improve the parent-child relationship and caregiver parenting skills in order to better address children's developmental needs. A review of research by The Clearinghouse finds that PCIT has been effective at improving child behavioral and emotional functioning, increasing positive parenting practices, and improving parent/caregiver mental health. Nevada will use a battery of standardized measures to assess change in these key outcomes, including the Eyberg Child Behavior Index (ECBI; i.e., child behavioral functioning), the Parent Stress Index (PSI; i.e., caregiver mental/emotional well-being), and the Dyadic Parent-Child Interaction Coding System (DPICS; i.e., positive parenting behaviors). The ECBI and PSI will be collected using a pre- post design to track changes over the course of treatment; while the DPICS is collected multiple times throughout the course of treatment to assess how the parents are progressing during treatment.

PCIT requires practitioners or supervisors to collect fidelity monitoring data. PCIT's main measure of fidelity, the Treatment Integrity Checklist, calculates an integrity score to gauge the quality of the delivery of the two main PCIT phases of treatment: Child-Directed and Parent-Directed interactions. This checklist is used to rate to what degree clinicians complete specific PCIT tasks within a session. The Treatment Integrity Checklist (TIC) will be completed through either self-report by the clinician following the end of a session or by a supervisor or another certified PCIT clinician through a session observation. CQI staff will be responsible for ensuring the collection of fidelity data in each jurisdiction and will review fidelity monitoring data regularly and report it to the EOC on at least an annual basis. They will also track and report data to the EOC semi-annually on required certifications attained and trainings completed.

TABLE 15. PROGRAM-SPECIFIC PROXIMAL OUTCOMES

Program	Domains	Measurement Tools and Expected Outcomes
Family Check-Up (FCU)	1) Adult well-being: Positive parenting practices 2) Child well-being: Behavioral and emotional functioning 3) Adult well-being: Parent/caregiver mental or emotional health	1. **FCU Assessment** - Parenting skills and behavior section including subscales such as: Setting limits, Monitoring of Peer Relationships and Parent Self-Efficacy 2. **Eyberg Child Behavior Inventory (ECBI)** – Problem and intensity scale of behavioral problems 3. **Parental Stress Index (PSI)** - Improvement on one or more of the Competence, Attachment, and Role Restriction subscales
Motivational Interviewing (MI)	1) Adult well-being: Parent/caregiver substance use *Additional Outcome Areas:* 2) Increased engagement and participation in case management or other services 3) Increased likelihood of staying in case management until goals are met	1. **Caregiver Substance Use:** Risk assessment completed by case manager 2. **Engagement in EBPs** –more families enrolling in EBPs and other services 3. **Individualized Goals**-more families meeting goals on individualized treatment plan prior to discharge 4. **Discharge reason** – fewer families being discharged due to loss of contact/refusing further services. 5. **Length of stay** – Lengths of stay that are consistent with the standards of a particular EBP

	4) Retention in case management or other EBPs 5) Engagement in treatment services	
Parents as Teachers (PAT)	1) Child safety: Child welfare administrative reports 2) Child well-being: social functioning 3) Adult Well-being: Positive Parenting Practices	1. Substantiated reports of abuse or neglect 2. **ASQ: SE (Ages and Stages Questionnaire: Social-Emotional Development)** and the **ASQ-3** (Development, language, cognitive subscales) 3. **Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCILO)**. Measures parenting behaviors including affection, responsiveness, encouragement, and teaching behaviors.
Parent-Child Interaction Therapy (PCIT)	1) Child well-being: Behavioral and emotional functioning 2) Adult well-being: Positive parenting practices 3) Adult well-being: Parent/caregiver mental or emotional health	1. **Eyberg Child Behavior Inventory (ECBI)** – Problem and intensity scale of behavioral problems 2. **Dyadic Parent-Child Interaction Coding System (DPICs):** Measures Child-Directed Interactions (CDI) and Parent-Directed Interactions (PDI) 3. **Parental Stress Index (PSI)** - Improvement on one or more of the Competence, Attachment, and Role Restriction subscales

Justification for Waiver Request for Well-Supported Programs

As noted, **all four programs selected have been rated as Well-Supported by The Clearinghouse.**

Nevada requests a waiver of the rigorous evaluation requirements for each of the programs: Family Check-Up, Parents as Teachers, Parent-Child Interaction Therapy, and Motivational Interviewing.

Each of these programs has shown

1) evidence of alignment with Nevada's candidacy populations;
2) compelling evidence of improved outcomes related to child permanency, child safety, child well-being, and adult well-being; and
3) effectiveness and applicability across diverse populations consistent with the population of Nevada.

CQI and fidelity monitoring activities for these well-supported programs will be conducted as described above. The following provides compelling evidence to support waiver requests for each of these programs.

Family Check-Up

Nevada is requesting an evaluation waiver for Family Check-Up (FCU), a parent-coaching intervention that assesses family strengths and challenges and offers a tailored parent training program focused on teaching parents positive behavior support, healthy limit setting, and relationship building. FCU is a flexible program that uses rapport building and motivational interviewing initially to develop a better understanding of the family, along with an ecological family assessment that includes videotaped observations of family interactions. After the initial assessment, parent management training (the Everyday Parenting Program) is used, with the number of direct contact hours ranging from 3 to 15 depending on the assessed level of family needs.

Alignment with Candidacy Populations. Findings from the Nevada Initial Assessment (NIA) in SFY2022 showed that a lack of parenting skills and knowledge were a common reason for both younger and older children being identified as "unsafe," and at risk of home removal. FCU's flexible design and strength-based approach should facilitate a robust implementation and ultimately lead to improvements in parenting and healthier families.

Favorable Evidence for Adult Well-Being. The Title IV-E Prevention Services Clearinghouse considers FCU a Well-Supported program, and this assessment is based on a review of 22 studies. While there is no evidence of effects on child behavioral and emotional functioning or parent/caregiver mental or emotional health, there were four favorable findings supporting the program's effect on positive parenting practices, and two of these favorable findings came from two high-quality randomized controlled trials with long follow-up periods that were rated by The Clearinghouse (see Table 16 below). One of these studies (Shaw, 2006) found that there was greater parental involvement in the FCU group compared to the treatment as usual group.[17] The other study (Hiscock, 2018) found that FCU reduced over-involved/protective parenting. [18] Two additional randomized controlled trials, rated as having moderate quality, found that FCU improved parents' use of positive reinforcement (Lunkenheimer et al., 2008) and proactive parenting strategies (Shelleby et al., 2012)[19][20]. FCU's documented ability to improve parenting practices and knowledge make it an important part of the state's plan to reduce out-of-home placements.

Effectiveness Across Diverse Populations. Across these four studies with positive effects for FCU, study populations were racially and ethnically diverse as well as diverse in terms of socio-economic status. For example, the study by Shaw et al. (2006) was conducted in Pittsburgh, PA, where the study population was 48.3% African American, suggesting that FCU can work effectively with non-white groups. Further, several of these studies recruited participants through Women, Infants, and Children (WIC) Nutritional Centers which resulted in study samples from economically marginalized populations. The California Evidence-Based Clearinghouse has also rated FCU as Well-Supported and highlights additional evidence of the effectiveness of FCU with families from middle and lower socioeconomic status as well as both rural and urban settings. FCU's ability to serve families with children from age 2 through 17—along with its ability to be integrated into diverse service settings—make it an important and widely applicable prevention service for Nevada.

TABLE 16. SUMMARY OF TITLE IV-E CLEARINGHOUSE FINDINGS FOR FAMILY CHECK-UP

Outcome	Effect Size & Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.04 1	3 (23)	1659	Favorable: 0 No Effect: 23 Unfavorable: 0

[17] Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-Year effects of the Family Check-Up in early childhood. *Journal of Consulting and Clinical Psychology, 74*(1), 1-9. https://doi.org/10.1037/0022-006x.74.1.1.

[18] Hiscock, H., Gulenc, A., Ukoumunne, O. C., Gold, L., Bayer, J., Shaw, D., Le, H., & Wake, M. (2018). Preventing preschool mental health problems: Population-based cluster randomized controlled trial. *Journal of Developmental and Behavioral Pediatrics, 39*(1), 55-65. https://doi.org/10.1097/DBP.0000000000000502.

[19] Shelleby, E. C., Shaw, D. S., Cheong, J., Chang, H., Gardner, F., Dishion, T. J., & Wilson, M. N. (2012). Behavioral control in at-risk toddlers: The influence of the Family Check-Up. *Journal of Clinical Child & Adolescent Psychology, 41*(3), 288-301.

[20] Lunkenheimer, E. S., Dishion, T. J., Shaw, D. S., Connell, A. M., Gardner, F., Wilson, M. N., & Skuban, E. M. (2008). Collateral benefits of the Family Check-Up on early childhood school readiness: indirect effects of parents' positive behavior support. *Developmental Psychology, 44*(6), 1737.

Child well-being: Cognitive functions and abilities	-0.01 0	1 (4)	659	Favorable: 0 No Effect: 4 Unfavorable: 0
Child well-being: Educational achievement and attainment	-0.14 -5	1 (1)	538	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Positive parenting practices	0.11 4	4 (24)	1955	Favorable: 4 No Effect: 20 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.08 3	2 (8)	1560	Favorable: 0 No Effect: 8 Unfavorable: 0

Motivational Interviewing

Nevada is requesting an evaluation waiver for Motivational Interviewing (MI), an adaptable counseling approach designed to support behavior change in a variety of problem areas. MI helps participants to articulate goals and uses clinical strategies to identify how their current problem behaviors are interfering with those goals. MI sessions can be provided in a wide variety of settings and usually involve one to three sessions that last about 30-50 minutes each. MI can be provided in conjunction with other services or interventions and incorporated into various screening, assessment, and care planning activities.[21]

Alignment with Candidacy Populations. Almost one-third (32%) of all children entering foster care had an identified parental substance abuse treatment need present at the time of removal. Likewise, of the 3,325 children deemed "unsafe," caregiver mental health contributed to this assessment approximately one-third of the time. Further, as previously mentioned, parenting skills need has also been found to be a significant driver for youth and family involvement with DCFS in Nevada. When implemented effectively, MI uses skills and practices to increase caregivers' motivation to make difficult behavioral changes, including reducing substance use and/or reducing negative parenting behaviors, by increasing engagement and participation in other services and interventions. Nevada proposes to use MI to help motivate and engage caregivers by targeting these factors directly and enhancing the impact of other interventions.

Favorable Evidence for Substance Abuse and Parental Engagement in Treatment. The Title IV-E Prevention Services Clearinghouse considers MI a Well-Supported program, and this assessment is based on a review of 30 studies with an additional 45 reviewed for risk of harm. MI can be used by itself or in combination with other treatments as an intervention to help motivate and engage caregivers. As
Table **17** below shows, there were 16 favorable findings for MI when used to target parental substance abuse, including several with relatively large effect sizes (e.g., 0.30), and few unfavorable findings. For example, a 2015 randomized trial looked at the impact of a therapist-delivered and computer-delivered MI on risky drinking and substance use behaviors for a group of people discharged from a hospital emergency room. The study found that both therapist and computer-delivered MI reduced alcohol consumption measured at 3 and 12 months post-intervention, while also reducing prescription drug use at 12 months.[22]

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[21] MINT. (2019). *Understanding Motivational Interviewing.* Available from Motivational Interviewing: https://motivationalinterviewing.org/understanding-motivational-interviewing

[22] Cunningham, R. M., Chermack, S. T., Ehrlich, P. F., Carter, P. M., Booth, B. M., Blow, F. C., . . . Walton, M. A. (2015). Alcohol interventions among underage drinkers in the ED: A randomized controlled trial. *Pediatrics, 136*(4), e783-e793. doi:10.1542/peds.2015-1260.

In addition, a couple of studies conducted in a child welfare setting have found that MI increases the likelihood that parents initiate drug treatment programs.[23]

The California Evidence-Based Clearinghouse for Child Welfare considers MI a well-supported intervention for both adult substance abuse treatment and as a "motivation and engagement program" that, more broadly, increases "the involvement of youth and/or families in child welfare or related services." Results from a randomized trial by Chaffin and colleagues (2011) for families with chronic and severe child welfare histories supports MI's ability to enhance the impact of other child welfare interventions. The study analyzed the impact of PCIT versus treatment as usual with and without an MI enhancement at the beginning of the program to encourage parents to commit to changing their behavior and take advantage of the treatment program to come. Parents who received the PCIT preceded by MI were the least likely to have a new child welfare episode compared to other treatment options[24]. Likewise, a 2011 randomized trial of child welfare-involved parents in a rural area found that participants were more likely to enroll and be retained in treatment when they were placed in a skill-based parenting program enhanced with MI (in comparison to treatment as usual, which was a home-based mental health service). The study did not detect differences in child welfare reports overall during service provision, though domestic violence reports declined in the treatment group.[25] As these studies illustrate, MI has been successfully used in a range of child welfare contexts, though a recent (2019) literature review noted a need for further studies examining child welfare outcomes such as reunification and parent/child mental health.[26]

Effectiveness Across Diverse Populations. MI has been successfully adapted to individuals from diverse backgrounds, showing positive outcomes among non-white populations and in different countries. Recent studies have also found favorable outcomes for Hispanic young adults and Native American adolescents.[27, 28] In a state with great regional, ethnic, and racial diversity, MI's demonstrated ability to serve a diverse clientele makes it an important addition to the range of prevention and community-based services Nevada is proposing.

TABLE 17. SUMMARY OF TITLE IV-E CLEARINGHOUSE FINDINGS FOR MOTIVATIONAL INTERVIEWING

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Substance use	-0.01 0	5 (33)	1634	Favorable: 0 No Effect: 33 Unfavorable: 0

[23] Schaeffer C. M., Swenson C. C., Tuerk E. H., Henggeler S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse & Neglect*, 37, 596-607.
[24] Chaffin, M., Funderburk, B., Bard, D., Valle, L. A., & Gurwitch, R. (2011). A combined motivation and parent–child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology*, *79*(1), 84.
[25] Silovsky J., Bard D., Chaffin M., Hecht D. B., Burris L., Owora A., Lutzker J. (2011). Prevention of child maltreatment in high risk rural families: A randomized clinical trial with child welfare outcomes. *Children and Youth Services Review*, 33, 1435-1444
[26] Shah, A., Jeffries, S., . . . and White-Chapman, N. (2019). Partnering With Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Families in Society: The Journal of Contemporary Human Services, 100(1), 52-67.
[27] Cherpitel, C. J., Ye, Y., Bond, J., Woolard, R., Woolard, R., Villalobos, S., Bernstein, J., Bernstein, E., & Ramos, R. (2016). Brief intervention in the emergency department among Mexican-origin young adults at the US-Mexico border: Outcomes of a randomized clinical trial using promotores. *Alcohol and Alcoholism, 51*(2), 154-63.
[28] Gilder, D. A., Geisler, J. R., Luna, J. A., Calac, D., Monti, P. M., Spillane, N. S., . . . Ehlers, C. L. (2017). A pilot randomized trial of Motivational Interviewing compared to psycho- education for reducing and preventing underage drinking in American Indian adolescents. *Journal of Substance Abuse Treatment, 82*, 74-81.

Adult well-being: Parent/caregiver mental or emotional health	0.000	3 (5)	1464	Favorable: 0 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver substance use	0.166	15 (109)	6066	Favorable: 16 No Effect: 91 Unfavorable: 2
Adult well-being: Parent/caregiver criminal behavior	-0.010	2 (7)	1610	Favorable: 0 No Effect: 7 Unfavorable: 0
Adult well-being: Family functioning	0.104	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver physical health	0.000	4 (10)	2158	Favorable: 0 No Effect: 10 Unfavorable: 0
Adult well-being: Economic and housing stability	-0.020	1 (1)	777	Favorable: 0 No Effect: 1 Unfavorable: 0

Parents as Teachers

Nevada is requesting an evaluation waiver for Parents as Teachers (PAT), a home visiting program that seeks to improve parental knowledge, attitudes, and behaviors as well as children's social and emotional development. PAT's home visit parent educators bolster the parent-child relationship by working with parents to set goals, practice skills, and problem-solve childrearing challenges. Beyond conducting home visits, PAT also offers courses for expecting parents and organizes get togethers with other caregivers to create a supportive learning community. PAT is a comprehensive parent education model serving families with children from prenatal through kindergarten that has been around for 30 years and is well-researched.

Alignment with Target Candidacy Populations. Results from NIA found that for children identified as "unsafe" and at risk of home removal, between 49-86% of families had an identified parenting skill need. PAT's home visiting program has had demonstrated success in building caregivers' skills in ways that positively affect child outcomes and avoid unnecessary home removals. PAT has a flexible design that can be adapted to a variety of populations and has shown success in families from diverse backgrounds.

Favorable Evidence for Child Safety and Well-Being. The Title IV-E Prevention Services Clearinghouse considers PAT a Well-Supported program. Six studies were examined by the Clearinghouse measuring a range of outcomes. As Table 18 below shows, favorable findings were reported in the areas of child safety/maltreatment reports and social and cognitive functioning. One recent (2018) study included in the Title IV-E Clearinghouse findings examined a sample of 2,662 first-time mothers who had received the PAT curriculum and compared them to a propensity score matched comparison group eligible for the program who did not receive it.[29] The rate of child maltreatment was 22% lower for the group that received PAT than for the comparison group. More recent studies not included in the Clearinghouse have shown further evidence of PAT's effectiveness. A 2019 randomized controlled trial of PAT in Switzerland found that children receiving PAT demonstrated a higher level of adaptive behavior, cognitive skills, and developmental status.[30] This evidence buttresses the findings of a 1999 study reviewed by the

[29] Chaiyachati, B. H., Gaither, J. R., Hughes, M., Foley-Schain, K., & Leventhal, J. M. (2018). Preventing child maltreatment: Examination of an established statewide home-visiting program. *Child Abuse & Neglect, 79,* 476-484.

[30] Schaub, S., Ramseier, E., Neuhauser, A., Burkhardt, S., Lanfranchi, A. (2019). Effects of home-based early intervention on child outcomes: A randomized controlled trial of Parents as Teachers in Switzerland. *Early Childhood Research Quarterly, 48*, 173-185.

Clearinghouse that found significant effects of PAT on child social and cognitive development. Meanwhile, a 2019 report found that home visiting programs, including PAT, improved positive parenting practices and family functioning.[31] Additionally, The California Evidence-Based Clearinghouse has also identified PAT as promising in the area of prevention of child abuse and neglect. In sum, Title IV-E Clearinghouse findings and other recent literature suggest that adopting PAT will help Nevada achieve its proximal outcomes of increased family engagement and stability as well as improved child well-being—and contribute to a reduction in out-of-home placement.

Effectiveness Across Diverse Populations. PAT is currently provided in 35 states and 13 tribal communities, as well as internationally, and has been shown to be effective in diverse samples of youth and families. child social functioning, cognitive functions, and family functioning in a sample of predominantly Hispanic, Spanish-speaking youth in the United States[32]. Finally, it has shown to be effective in broad sample of 2,662 families with child welfare system involvement in the United States. Although race/ethnicity data were unavailable for this large sample, the study did include an economically diverse sample of families with roughly 40% of the sample having less than 12 years of education.[7] Taken together, these studies show the broad impact that PAT can have across ethnic, cultural, and socioeconomic groups, making it an ideal intervention to serve Nevada DCFS' diverse population of youth and families.

TABLE 18. SUMMARY OF TITLE IV-E CLEARINGHOUSE FINDINGS FOR PARENTS AS TEACHERS

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: Child welfare administrative reports	-0.05 -1	1 (4)	4560	Favorable: 2 No Effect: 2 Unfavorable: 0
Child permanency: Out-of-home placement	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.03 -1	1 (9)	375	Favorable: 0 No Effect: 8 Unfavorable: 1

[31] Sama-Miller, E., Akers, L., Mraz-Esposito-A., Coughlin, R. & Zukiewicz, M. (2019). *Home Visiting Evidence of Effectiveness Review: Executive Summary.* (OPRE Report #2019-93). Available from https://www.mathematica.org.
[32] Wagner, M. M., & Clayton, S. L. (1999). The Parents as Teachers program: Results from two demonstrations. *The Future of Children, 91*-115.

Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable: 1

Parent-Child Interaction Therapy (PCIT)

Nevada is requesting an evaluation waiver for Parent-Child Interaction Therapy, a mental health and parent support intervention for families with young children (2-7 years old). PCIT works with parents whose children exhibit behaviors such as frequent defiance and aggression to try to improve the parent-child relationship and caregiver parenting skills to better address children's developmental needs. PCIT coaches caregivers in Child-Directed Skills that emphasize listening to the child and following their lead in play activities. The second phase of PCIT focuses on imparting Parent-Directed Skills such as effective commands and other behavior management strategies that help create a supportive family environment. PCIT provides live coaching of caregivers as they interact with their children and, thus, offers them immediate feedback to help them improve. The program is deliverable in an office or home environment, as well as online.

Alignment with Candidacy Populations. PCIT has a strong evidence base—as demonstrated by its Well-Supported rating in both the Title IV-E Prevention Services Clearinghouse and the California Evidence-Based Clearinghouse, and evidence-based rating by the Washington State Institute for Public Policy for families in child welfare. Results from the NIA found that unmet mental health needs of children and a lack of parenting skills and knowledge were common reasons for children being identified as "unsafe" and at-risk of home removal. Moreover, the findings showed that the group with the greatest number of families with an identified parenting need were children under 6 years old.

Favorable Evidence for Child and Adult Well-Being. The Title IV-E Prevention Services Clearinghouse considers PCIT a Well-Supported program, and this assessment is based on a review of 36 studies (an additional 6 were reviewed for risk of harm). As the table below shows, there were 20 favorable findings for PCIT's effect on positive parenting practices, 18 favorable findings for the program's effect on child behavioral and emotional functioning, and 4 favorable findings for parent/caregiver's mental or emotional health—with no unfavorable findings in any of these domains. Nine different randomized controlled trials, utilizing diverse samples within the United States and internationally, have found that participation in PCIT significantly improved child behavior and emotional functioning as well as social functioning. Of those nine studies, four were rated as High quality with the remaining five rated as Moderate quality by The Clearinghouse. In addition, eight of these nine studies also demonstrated significant impacts on positive parenting behaviors, with two studies also showing improvements in caregiver mental and emotional health.

Effectiveness Across Diverse Populations. In addition to the overall strong research base, PCIT has been shown to be effective with multiple diverse populations. A randomized controlled trial compared the effectiveness of a culturally modified version of PCIT for Mexican American families with young children who had a clinically significant behavior problem to regular PCIT and to treatment as usual.[33] The results of a 6- to 24-month follow up found that regular PCIT improved parenting practices in several Dyadic Parent Child Interaction Coding System (DPICS) measures such as child-led play "do" skills" (effect size of 1.56) and "don't" skills (effect size of 0.96). While in this study, regular PCIT did not have a significant effect on child

[33] McCabe, K., Yeh, M., Lau, A., Argote, C. B., McCabe, K., Yeh, M., . . . Argote, C. B. (2012). Parent-Child Interaction Therapy for Mexican Americans: Results of a pilot randomized clinical trial at follow-up. *Behavior Therapy, 43*(3), 606-618. doi:10.1016/j.beth.2011.11.001

emotional and behavioral health measures, it is notable that the culturally adapted version of PCIT did demonstrate a favorable impact on child conduct problems. Likewise, another recent study reviewed by the Clearinghouse found that, for a sample of Chinese families, PCIT had a favorable impact on both child and parent/caregiver mental or emotional health.[34] PCIT's positive track record in a variety of cultural contexts and with non-white youth makes it an important part of Nevada's plan to improve prevention and community-based services to families with young children.

[34] Leung, C., Tsang, S., Ng, G. S. H., & Choi, S. Y. (2017). Efficacy of Parent-Child Interaction Therapy with Chinese ADHD children: Randomized controlled trial. *Research on Social Work Practice, 27*(1), 36-47.

TABLE 19. SUMMARY OF CLEARINGHOUSE FINDINGS FOR PARENT-CHILD INTERACTION THERAPY

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46 42	8 (25)	422	Favorable: 20 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.57 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10 Unfavorable: 0

Monitoring Child Safety

Pre-print Section 3

Just as Nevada monitors—without exception—the safety and risk of all children in the child welfare system on an ongoing basis, all children and families who receive FFPSA Prevention Services will be carefully monitored for service provision, progress, and outcomes. As outlined below, the process of monitoring safety differs somewhat for children who have a prevention plan administered by the child welfare agency and children who have a prevention plan administered by a community provider. However, all children receiving prevention services will have a minimum monthly in-person contact by the entity providing the prevention care planning. All children will be screened for safety at least every 90 days throughout the 12-month period, as discussed below.

Safety Monitoring for Children & Families Receiving Services through the Child Welfare System

All children in Nevada's child welfare system are monitored for safety through Nevada's SAFE/ Safety Intervention Permanency System (SIPS) Practice Model. Children who are eligible for prevention plan services based on the present or impending danger will be monitored under the SAFE/SIPS practice model. SAFE/SIPS uses the tools listed in the table below to assess safety periodically and re-examine the prevention plan to consider whether current services and supports are meeting the family's needs. As shown in the table below, a Present Danger Assessment (PDA) will be completed during the initial contact with the family and will be re-evaluated continuously throughout the Nevada Initial Assessment (NIA) process, which is completed within 30 calendar days if no present danger or impending danger is identified (sooner, if identified). The Safety Plan is documented and incorporated into the Protective Capacity Family Assessment (PCFA), which is administered within 60 days of case opening. The Protective Capacity Progress Assessment (PCPA) is completed every 90-120 days. The PCPA will be the tool that is re-administered throughout the time that the family is being served under a Prevention Plan. It includes a Safety Plan Determination to ensure that the safety plan is still appropriate and minimally intrusive and reviews whether case plan services are working effectively.

Table 20. Assessments used to monitor safety during provision of prevention plan services (for child-welfare involved families) as part of the SAFE/Safety Intervention Permanency System (SIPS) Practice Model

Assessment/Tool	Purpose	Timeline	Steps to maintain/ improve safety
Present Danger Assessment (PDA) (Part of the NIA process)	Identify whether present danger exists. If yes, develop a present danger plan to protect children who are unsafe.	Completed during initial contact with family (within 6 hours if present danger is identified at intake; within 24 hours if impending danger is identified at intake). Assessed continually throughout the NIA process.	A Present Danger Plan is created as soon as the present danger is identified.
Nevada Initial Assessment (NIA)	Determine whether maltreatment has occurred and whether children are in impending danger.	Completed within 15 business days if present danger is identified; three calendar days if impending danger is identified without present danger; 30 calendar days if no present danger or impending danger is identified.	Diminished Caregiver Protective Capacities that are identified serve as the initial basis of the Protective Capacity Family Assessment (PCFA). The determination regarding impending danger is used in the Safety Plan Determination to determine whether an in-home safety plan may be implemented.
Safety Plan Determination and Meeting (Part of the NIA process)	Determine whether children in impending danger (as assessed by the NIA) can be served using an in-home Safety Plan.	The Safety Plan is documented in UNITY within 24 hours of the Safety Plan Determination Meeting. Also incorporated into the PCPA (see below).	A Safety Plan is developed to manage and control impending danger in an appropriate, minimally intrusive way.
Protective Capacity Family Assessment (PCFA)	Engage caregivers to develop individualized case plan goals focused on enhancing Caregiver Protective Capacities.	The PCFA is administered within 60 days of case opening. The case plan must be drafted within 45 calendar days of service provision.	A permanency worker conducts weekly oversight of the safety plan, communicates weekly with the safety managers (if applicable), coordinates with community service providers to confirm the provision of safety services, and determines if adjustments to the Safety Plan are needed.
Protective Capacity Progress Assessment (PCPA)	Assess whether impending danger is still present. Complete a Safety Plan Determination to ensure the safety plan is still appropriate and minimally intrusive. Ensure that case plan services are working effectively.	Completed every 90-120 days and before all court reviews.	Update the safety plan and/or case plan as needed based on the assessment.

Safety Monitoring for Children and Families Not Receiving Services through the Child Welfare System

As outlined in the "Candidacy Definition" section, after the child welfare agency determines candidacy, prevention-plan eligible children and families with no present or impending danger who do not have a current child welfare worker will have their prevention plan administered by a community service provider.

Nevada has developed a prevention services policy that provides requirements for providers (agency staff and community providers) who provide FFPSA prevention services, as outlined in the Pre-Print. The state will adapt and build on existing policies and procedures, as permanency workers already coordinate with community service providers that are delivering safety plan services to child welfare-involved youth. Nevada will partner with these community service providers and ensure that contracting documents specify the robust training and monitoring processes and actionable reporting procedures that will be implemented. Nevada will require community service providers to conduct a risk assessment every 90 days and at case closure providing assurance that the child and family are receiving services in accordance with their prevention plan and that there are no concerns of child maltreatment (and, if there are, that a report is made).

Community providers will receive training (online and/or in-person) that reviews all mandated reporting requirements. The training will help community providers understand when to make a report of suspected child abuse or neglect as a mandated reporter. A Risk Assessment Tool will be completed periodically by the community providers to identify when to contact the IV-E agency; when in doubt, the community provider will be expected to refer concerns to the IV-E agency consistent with mandatory reporting requirements. The community provider will complete this Risk Assessment Tool at least every 90 days. If the IV-E agency receives a report, they will conduct a formal intake assessment.

The IV-E agency will implement CQI and monitoring processes to ensure that in-person visits and prevention planning are occurring as required. Nevada anticipates that it will monitor the children, plans, and documentation particularly closely during the initial year(s) of a community provider contract. Each region will develop the oversight plans in collaboration with the community providers. If all activities are occurring as anticipated, Nevada will shift its oversight approach to mirror other child welfare CQI activities, including using audits and sampling to review files.

Re-Assessment of Risk for Foster Care

Nevada will continue to provide training to its child welfare workers on conducting risk re-assessments, including to determine if the risk of entering foster care remains high despite the provision of services and if the child continues to be a candidate for foster care.

All children and families who have received Prevention Services for 12 months will be reviewed for risk of entering foster care. Agency and community providers will engage with the family to identify which needs have been unmet, if any, and whether there remains a risk, with the IV-E Agency responsible for assessing risk. Nevada will use its existing risk and safety tools and definitions, as outlined above, in this process. If there is present or impending danger and the child is unable to remain safely in the home, the IV-E agency will follow existing protocols to place the child in foster care.

If the family has been receiving prevention services through the child welfare agency and there is no indication that the children are unable to remain safely in the home, the child welfare agency may authorize

additional Prevention Services through a community provider or close the case and, if necessary, refer the family to community providers for additional voluntary services.

If the family has been receiving prevention services through a community provider and there is no indication that the children are unable to remain safely in the home, the child welfare agency may authorize additional Prevention Services through the community provider or close the case and, if necessary, refer the family to community providers for additional voluntary services.

Continued services through a formal prevention services provider may be warranted, including possibly through the child welfare agency, particularly if the family is in the middle of receiving an intervention or treatment covered under FFPSA and closing the case would cause a disruption in service provision.

Prevention Caseloads

Pre-print Section 7

Under Nevada's Practice Model, manageable caseloads are key to ensuring that case workers can engage children and families in ways that are individualized, strength-based, and grounded in meaningful child and family involvement. Nevada does not have a set worker-to-child or family ratio for child welfare cases. Supervisors assign workers to children and families based on a variety of factors, including current caseloads, complexity of needs, and number of children involved. Nevada has been able to achieve improved outcomes with these flexible approaches to caseload size, including a statewide average of 95.48% of all caseworkers having monthly visits with children who are in foster care (the federal target is 95%). The following caseload data were reported in the 2022 Annual Progress Services Report:

Region	Information on Caseloads for Assessments
Clark County	Average number of CPS assessments per worker is 10-15.
Washoe County	Average number of open cases for assessment caseworkers is 9 with 7-8 new cases assigned per month. Average number of cases assigned to a permanency caseworker is 15.
Rurals/DCFS	Investigations per month range from 4-10 depending on vacancies. Average number of permanency cases is 22.

For youth who meet prevention plan eligibility requirements based on **present or impending danger, who are in voluntary jurisdiction of the court (18-21), who are at-risk for placement disruption and have a current worker, or who are foster youth who are pregnant and/or parenting,** the DCFS caseworker assigned to that youth will be responsible for managing and overseeing the youth's prevention plan. This structure will allow agency-employed caseworkers to ensure that the youth's prevention plan is well-coordinated and consistent. Caseloads for youth with prevention plans will be managed according to the same policies and procedures as those agency-involved youth who do not have a prevention plan.

For youth who meet eligibility requirements based on an identified candidacy factor, including any youth at risk for placement disruption who do *not* have a current caseworker, community service providers will be responsible for managing and overseeing the youth's prevention plan. This approach capitalizes on the capacity of these organizations to provide services to youth who are not in present or impending danger to prevent their entry or re-entry into foster care. Once the IV-E Agency has determined that a child meets the definition of a candidate for foster care, the agency will refer the child and family to a community provider for the development of a prevention plan. The selected community service provider will then carry

out the administrative functions related to the prevention services, including developing and maintaining the child's prevention plan, carrying out case management and supervision and risk assessments, and maintaining and reporting relevant data (CQI and/or evaluation data). The community provider will be completing documentation, including the prevention plan, progress updates, and risk assessments, in an external website portal that will feed the information during back into UNITY.

The agency will supervise the service provider's activities through the collection of evaluation and CQI data. Contracts and Memoranda of Understanding with these providers will clearly indicate standards for caseload management that are aligned with the relevant aspects of DCFS caseload policies. Providers will also be required to notify DCFS promptly about any changes that indicate the presence of a safety concern, maltreatment, or neglect. (See the "Monitoring Child Safety" section above.)

The community service provider will be responsible for overseeing caseload sizes. Parents as Teachers recommends that providers estimate a caseload of 20 families per full-time parent educator with a visit frequency of twice per month. PCIT, FCU and MI do not have recommended caseload sizes. Instead, it is incumbent on the supervisors to ensure that children and families are receiving high quality services that are in fidelity to the model. All community providers will monitor caseload numbers and use supervisor discretion taking into consideration experience of the individual providers, distance to the family's home, complexity of the family's situation, etc.

Child Welfare Workforce Support and Training

Pre-print Sections 5 and 6

Current Training Infrastructure

The State of Nevada partners with the University of Nevada, Las Vegas and the University of Nevada, Reno's Nevada Partnership for Training (NPT)[35] for pre-service and ongoing training to all counties to ensure a competent, skilled, and professional workforce. All new case workers complete the Nevada Child Welfare Training Academy Pre-Service Training (Academy) which is built upon a foundation of Nevada's Practice Model from Action for Child Protection (ACTION)[36] known as Safety Intervention Permanency System (SIPS) in Clark County, and the Nevada Safety Model in the rest of the state. The Academy includes training on the state's practice model as well as Motivational Interviewing, LGBTQ and cultural competency, commercial sexual exploitation of children, the Indian Child Welfare Act (ICWA), substance use disorders, trauma, mental health, father engagement, and domestic violence. Ongoing refresher trainings are required throughout state service to ensure continued competence in the practice model and up-to-date training as new research and practice emerge in child welfare.

Enhancements to Current Training Infrastructure through FFPSA

Nevada's child welfare workforce and contracted community providers are trained to assess children and families from a strengths-based perspective and to ensure that individualized services and supports are identified to help the families meet identified goals. The services identified in this prevention plan have been proven effective with diverse populations of children and families and FPO anticipates that many families receiving prevention services will benefit MI as well as one or more of the other EBPs. The existing child welfare practice, combined with a renewed emphasis on MI, will support workers to connect to families, including with initial and ongoing engagement. The EOC will be reviewing data to identify areas

[35] https://www.unlv.edu/socialwork/npt
[36] https://action4cp.org/

where there may be gaps in implementation which could be addressed through training and workforce development activities. Such activities could relate to the provision of trauma-responsive care, culturally and linguistically humble and responsive treatment, individualized care planning, and more. Data will be used to inform decision-making, including efforts to oversee and evaluate the initial and ongoing appropriateness of services provided at an individual and aggregate level.

The DCFS Family Programs Office and the FFPSA Leadership Team will work with NPT to develop and provide FFPSA-specific training to all child welfare staff, as well as to those community partners responsible for prevention plan development and management. NPT has hired designated staff to develop, implement, and monitor the FFPSA-specific trainings on behalf of the state.

Nevada has finalized an online mandatory reporter training that can be accessed by all mandated reporters (https://mandatedreportertraining.com/nevada/) and will be using its learning management system (NPTLearn) to offer online training on FFPSA-specific topics, including developing and monitoring prevention plans. NPTLearn is a fully functional child welfare workforce development platform.

The Title IV-E Agency will oversee FFPSA-specific training and coaching activities through its CQI process (detailed above) and each contracting entity will ensure that the providers meet all requirements, both initially and ongoingly. DCFS specialists will assume additional responsibilities to support initial and ongoing support for child welfare staff, including through oversight of NPT activities. The DCFS Family Programs Office Training Manager facilitates the Workforce Innovation Team (WIT), which is a collaborative of in-state Universities and representatives from the three regions. All executive leadership, managers, and supervisors have been trained in CoachNV, a statewide training campaign to instill a coaching framework. This approach is intended to support a learning environment and ensure a better prepared workforce. (See *Nevada Child Welfare Program Support Training Plan*, submitted as part of the Nevada CFSP 2020-2024, updated SFY2022).

FFPSA-specific training will be delivered through a curriculum that includes, but will not be limited to, the following topics:

- Conducting initial risk and intake assessments, including the FFPSA candidacy tool
- Assessing, documenting, and communicating eligibility and candidacy for prevention services
- Developing appropriate prevention plans
    - Using screening and assessment tools to inform prevention plan development
    - Understanding the service array available for prevention plans
    - Matching youth and families to appropriate services based on family and youth choice, strengths, and identified needs
- Delivering trauma-informed and evidence-based services
- Monitoring prevention plans and child safety
- Conducting risk re-assessments to determine if risk of entering foster care remains high despite the provision of prevention services

Additionally, Nevada plans to implement several models to enhance workforce support.

State, county, and community-service providers offering any of the programs and services included in the FFPSA prevention plan will be required to have the necessary training and certification required by the specific program model. Providers will be required to maintain the training and certification consistent with model requirements. These activities—and the oversight of them by FPO and the regions—will ensure that there is a competent, skilled, and professional workforce to deliver the trauma-informed and evidence-

based services. Furthermore, the child welfare and community-based workforce will have training on the specific EBPs to ensure that families are given appropriate referrals to services that will best meet their needs.

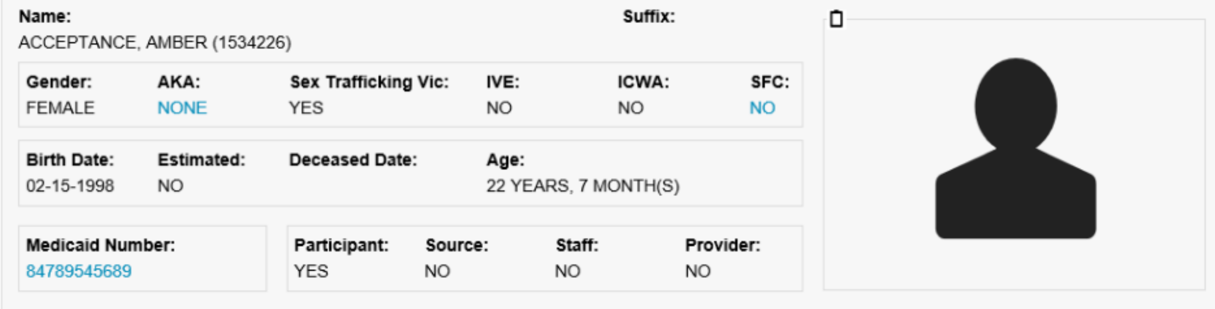
Appendices

Appendix A: Families First Prevention Services Foster Care Candidacy Tool
Appendix B: Attachment I – State title IV-E prevention program reporting assurance
Appendix C: Attachment II – State request for waiver of evaluation requirement for a well-supported practice and supporting documentation
Appendix D: Attachment III – State assurance of trauma-informed service-delivery
Appendix E: Attachment IV-State Annual Maintenance of Effort (MOE) Report
Appendix F: Attachment B to ACYF-CB-PI 18-09: State Title IV-E Prevention Program Five Year Plan Pre-Print

Appendix A: Families First Prevention Services Foster Care Candidacy Tool

Screen Capture of Draft Candidacy Tool in UNITY

Family First Eligibility Details



General

Name: ACCEPTANCE, AMBER (1534226)

Suffix:

Gender:	AKA:	Sex Trafficking Vic:	IVE:	ICWA:	SFC:
FEMALE	NONE	YES	NO	NO	NO

Birth Date:	Estimated:	Deceased Date:	Age:
02-15-1998	NO		22 YEARS, 7 MONTH(S)

Medicaid Number:
84789545689

Participant:	Source:	Staff:	Provider:
YES	NO	NO	NO

History

ASSESSMENT DATE	BEGIN DATE	END DATE	PARTICIPANT ID	PARTICIPANT NAME	REFERRAL ID	REFERRAL NAME	CASE ID	CASE NAME
02/02/2022	02/01/2022	01/31/2023	1534226	ACCEPTANCE, AMBER	3245680	ACCEPTANCE, MOM	8926761	ACCEPTANC MOM

New Record

Case*

ACCEPTANCE, MOM - 1310229: 01-01-2003 - ACTIVE

Participants

PARTICIPANT ID	PARTICIPANT NAME	BIRTH DATE	GENDER	ROLE
1534226	ACCEPTANCE, AMBER	09-12-2010	CHILD	F
1534227	ACCEPTANCE, BILL	08-08-2008	CHILD	M
1534227	ACCEPTANCE, CINDY	11-01-2006	CHILD	F

Assessment Date	Service Begin Date	Service End Date	
03-05-2020	02-01-2022	01-31-2023	☐ Unable To Locate

1. There is present and/or impending danger — (•) Yes ( ) No

Candidacy Decision

FFPSA IV-E Eligible — (•) Yes ( ) No

2. There is one or more of the negative family conditions listed below

a. An infant with prenatal substance exposure — (•) Yes ( ) No

b. A caregiver who has mental health and/or substance misuse disorder or other challenging condition or circumstance — (•) Yes ( ) No

c. Domestic violence or intimate partner violence in the home — (•) Yes ( ) No

d. Significant, unmanaged child behavioral challenges — (•) Yes (•) No

e. A screened-in child abuse or neglect case eligible for an assessment and services under Differential Response — (•) Yes ( ) No

f. The sibling or child of a child identified as in imminent risk of entering foster care or already in foster care — (•) Yes ( ) No

3. A child has a reunification, adoption, or guardianship arrangement that is at risk of a disruption or dissolution — (•) Yes ( ) No

4. A child is under 18 years old, pregnant and/or parenting and was previously in foster care — (•) Yes ( ) No

5. A child is under 18 years old, pregnant and/or parenting and is currently in foster care — (•) Yes ( ) No

Explain

500 Characters

IVE-P Eligibility

History

DETERMINATION DATE	APPLICATION DATE	ASSESSMENT TYPE	STATUS	RESULT	AUTHORIZED PERSON
08/01/2021	08/01/2021	Initial	Active	Approved	Reddybabu Uppu

Existing Record: xxxxxxx

Determination Date: 08-01-2021

Application Date: 08-01-2021

Assessment Type: Initial

Determination Status: Active

Determination Result: Approved

Authorized Person Reddybabu Uppu

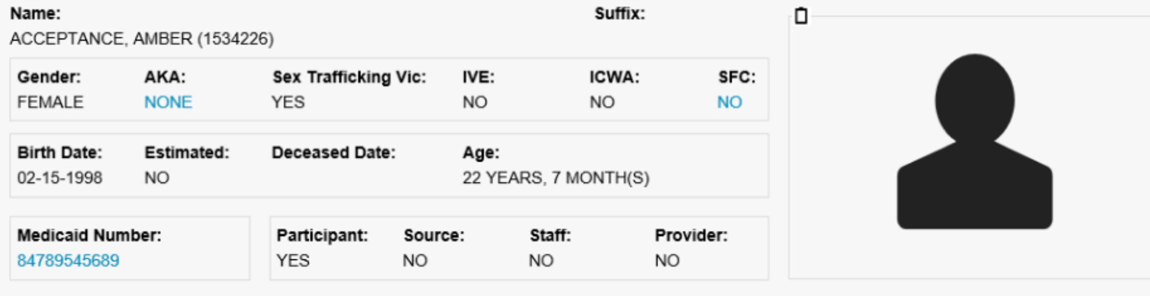
Careated:

UPPU, REDDYBABU - 02-22-2022 at 10:00 AM

Last Modified:

UPPU, REDDYBABU - 02-23-2022 at 11:12 AM

Risk Assessment Tool



General

Name:			Suffix:		
ACCEPTANCE, AMBER (1534226)					
Gender: FEMALE	**AKA:** NONE	**Sex Trafficking Vic:** YES	**IVE:** NO	**ICWA:** NO	**SFC:** NO
Birth Date: 02-15-1998	**Estimated:** NO	**Deceased Date:**	**Age:** 22 YEARS, 7 MONTH(S)		
Medicaid Number: 84789545689	**Participant:** YES	**Source:** NO	**Staff:** NO	**Provider:** NO	

Risk Assessment History

ASSESSMENT DATE	ASSESSED BY
02/01/2023	**Staff Name**
11/01/2022	**Staff Name**
08/01/2022	**Staff Name**

Detail

1. The child/family is currently receiving Family First prevention services — ○ Yes ○ No
2. The negative family condition(s) that made the child eligible for Family First prevention services still exists — ○ Yes ○ No

   a. An infant with parental substance exposure — ○ Yes ○ No

   b. A caregiver who has mental health and/or substance misuse disorder or other challenging condition or circumstance — ○ Yes ○ No

   c. Domestic violence or intimate partner violence in the home — ○ Yes ○ No

   d. Significant, unmanaged child behavioral challenges — ○ Yes ○ No

   e. A screened-in child abuse or neglect case eligible for an assessment and services under Differential Response — ○ Yes ○ No

   f. Experiencing human trafficking — ○ Yes ○ No

   g. The sibling or child of a child identified as in imminent risk of entering foster care or already in foster care — ○ Yes ○ No

2 A child has a reunification, adoption, or guardianship arrangement that is at risk of a disruption or dissolution — ○ Yes ○ No

3 A child is under 18 years old, is pregnant and/or parenting, has a history of being in foster care but is not currently in foster care — ○ Yes ○ No

4. A child is under 18 years old, pregnant and/or parenting and is currently in foster care — ○ Yes ○ No

5. There are concerns of abuse or neglect of a child in the home — ○ Yes ○ No

Have you made a report to a child welfare agency concerning the abuse and/or neglect? — ○ Yes ○ No

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