



LEADERSHIP LESSONS

TRANSFORMING CHILD WELFARE SYSTEMS

What are some considerations when bringing **evidence-based interventions to scale?**

Q&A with David Reed, Deputy Director of Child Welfare Services, Indiana Department of Child Services¹

Child protection agencies across the country are faced with the complex task of determining when children can be safely cared for at home, often with services and supports, and when they may need to be removed from their parents in order to ensure their safety. Since 2012, Indiana has used the state's Title IV-E waiver to offer a selection of evidence-based interventions to keep families safely together or reunify them. On top of the waiver, the federal *Family First Prevention Services Act of 2018*² supports evidence-informed interventions to help children safely remain at home by meeting families' service and treatment needs. David Reed, deputy director of the Indiana Department of Child Services (DCS), shares some lessons learned from the agency's work to build and implement an array of evidence-based interventions. He describes challenges in ensuring that the right services are provided to the right families at the right time, and discusses the agency's next steps.



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Has Family First accelerated prevention efforts already underway in Indiana?

Yes. Our agency has been emphasizing the importance of evidence-based prevention for a while, but Family First provides additional credibility and support for this orientation. We still remove too many children; in fact, for many years, Indiana struggled with very high rates of removal. In 2017, prior to Director (Terry) Stigdon coming to the department, Indiana had record numbers of children in care, and experienced an 89% increase in children in care from 2005 to 2017. We know that foster care as an intervention results in poor outcomes for those children, and we know we need to prioritize preserving families. We know the trauma that happens when a child is removed and the disruption in bonding that occurs. For years, we have been holding trauma symposiums and stating that we didn't want to remove children, but we haven't always been successful in applying what we learned and said to our frontline practice. Family First gives us more momentum and a funding tool to support and preserve families.

When did Indiana begin offering evidence-based mental health interventions?

We first rolled out a few evidence-based practices beginning in 2012 as part of our [Title IV-E waiver](#). We developed service standards and funded training to providers across the state on [Trauma-Focused Cognitive Behavioral Therapy](#), [Motivational Interviewing](#), and [Family Centered Treatment®](#). When one of our family case managers needed to make a referral, they engaged in service mapping by entering data on the child and family into our referral system. An automated "wizard" then recommended which model, if any, should be utilized for that family. We recognized this wasn't working. New staff and overburdened caseworkers trying to understand our extensive service array tended to go to the services that they knew best, or that took the least amount of time to secure (such as more generic home-based therapy or home-based casework). They didn't always understand the complex service mapping or have the time to go through it.

What changes in the referral process and service array have you made?

We looked for better ways to ensure selection of evidence-based models didn't require family case managers go through a complex service mapping process. The service provider that has the expertise, clinical knowledge, and training should be deciding what model makes the most sense for each family. Family case managers now write a single referral for services, and the provider assesses the family and determines which evidence-based intervention is most appropriate. We've learned that designing an effective referral process is just as important as what is included in the service array.

Our new approach is called [Indiana Family Preservation Services](#) because it's all about keeping families together and preventing removals whenever it is possible to safely do so. This is not primary prevention; it's preservation. Referrals are sent to the provider with the understanding that the provider's goal is to preserve that family by bringing in services — not by removing the child. The provider, in collaboration with the family, decides which evidence-based practice will be delivered and how much time is needed, focusing on the development of protective factors within the family while ensuring child safety during and after service delivery. DCS is focused on tracking outcomes at a provider level for a year after a family's case has closed with the department to determine whether the service was effective.

Are you currently contracting for other interventions supported by Family First?

We have [Healthy Families Indiana™](#) in every county in our state. We first introduced the Healthy Families model in Indiana over 25 years ago, and it has been available in each of our 92 counties for more than a decade. We serve about 10,000 families a year with the model and track outcomes, which have been phenomenal. However, there are two key challenges with Healthy Families and Family First: 1) Healthy Families is a voluntary model, which isn't necessarily the case with families receiving services under Family

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First; and 2) Healthy Families targets children up to age 5, and many of our families have older children. We included families that receive the Healthy Families model across our state in our (Family First prevention plan) — this widened our definition of candidacy to hopefully get some federal support for delivering the model, which we've been doing for a long time. We also offer [Parents as Teachers](#).

How have you changed your contracting with providers?

It was clear that fee-for-service was not resulting in good outcomes for our families. At the time, we had different reimbursement rates for different levels of need and, in my opinion, this led to perverse arguments about different family challenges. When we reimbursed by the hour, the provider was not incentivized to focus on the outcome for that family. Instead, the provider was incentivized to spend more time with the family. Fee-for-service disincentivized engagement and outreach: for example, providers wouldn't want to keep going to a house where no one answered the door to try to engage that family, as they may not get paid for the time. So they would cancel that referral and move on to other families that were home and would open the door. In this scenario, the family that needed the most help — the family that didn't come to the door — ends up receiving the least amount of services.

So we went back to the drawing board and asked: What makes sense for families, and how do we shift away from a fee-for-service strategy? What can providers deliver and what should services look like? We decided to contract with providers using one per-diem rate, statewide. The best proposals from providers earned contracts, and the best providers get referrals. We refer based on outcomes instead of the amount of time a provider spends with a family. With per-diem reimbursement, our providers can do better work. They can vary their intensity, spending more or less time, depending on what the family needs. We are committed to giving the professionals the flexibility to determine what intervention to use to keep the family together. Sometimes this means the per diem is used to meet concrete supports for the family, if not doing so would result in removal of the child. Providers may

teach families how to access resources and apply for TANF and other entitlements, or help the family get caught up on rent. All of this is possible with our per-diem model.

We should be supporting families based on what each particular family needs. If families are experiencing multiple crises and really struggling, we might need to spend a lot of time with them to help them get stabilized. But once they get stabilized, we should begin backing off. As we proceed with our involvement with families, our goal should be to spend less time with them because they're demonstrating that they are able to take care of their own challenges and the intervention we provided was effective.

How have you prepared providers for this new contracting approach?

It's important for us to talk openly with providers and show providers how the per-diem model is in everyone's best interests. With a daily rate, providers can predict income more easily and will feel more secure in the long term. Most importantly, when we tie the outcome of their services to their contract, as opposed to how many hours they spend, they will keep knocking on that door when a family is not responding as they are incentivized to keep trying, think creatively about how to engage a family, and help families heal.

Do you have sufficient capacity to meet the anticipated demand under Family First?

Yes, we do have the capacity in all of our 92 counties to deliver evidence-based models as well as concrete supports to families when needed to prevent removals. Indiana Family Preservation Services has 96 providers under contract across the state, and every county has at least four different providers, with our larger counties having as many as 42 different providers. The per-diem funding model has helped ensure adequate capacity, even in our rural areas.

What have been the results of evidence-based practices so far?

As of November 2021, we've served over 5,000 families and 11,000 children since launching Family

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Preservation Services in June 2020. Consistent with what research says about the effects of foster care on children, Indiana DCS has been working hard to reduce the number of children in foster care since Director Stigdon arrived at the agency in January 2018. Since that time, the number of youth in out-of-home placement has dropped by more than 35% and by almost 2,000 kids since Family Preservation Services launched. We've invested in families, and we are seeing outcomes.

We are currently conducting [evaluations of our Family Preservation Services program](#), including the provision of concrete supports and [Trauma-Focused Cognitive Behavioral Therapy](#). It all boils down to this: **How do we serve diverse families, and how do we make sure providers make good clinical decisions and are incentivized to deliver what families need?**

To learn more, visit [Questions from the field](#) at [Casey.org](#).

- 1 Adapted from an interview with David Reed on February 15, 2019, and email correspondence on November 5, 2021. Content also informed by comments from David Reed during Family First Learning Collaborative meetings hosted by Casey Family Programs between January and June 2021.
- 2 Family First was enacted as part of the Bipartisan Budget Act of 2018 (P.L. 115-123). To read the Act, see: <https://www.congress.gov/bill/115th-congress/house-bill/1892/text?q=%7B%22search%22%3A%5B%22hr1892%22%5D%7D&r=1>
- 3 As of publication, Indiana had submitted its Family First prevention plan and was waiting for approval.

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