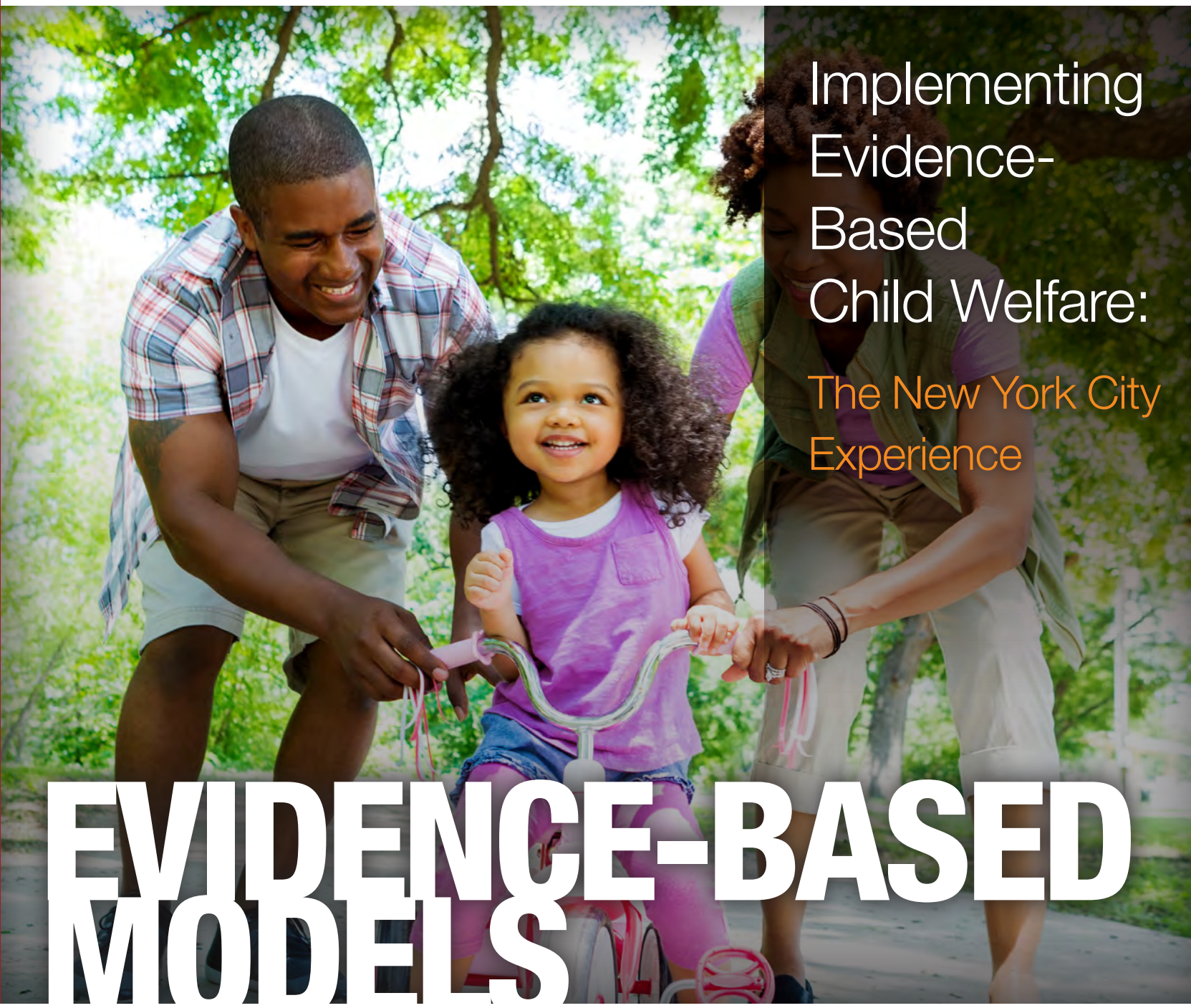
SAFECHILDRENSTRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDRENSTRONG
FAMILIESSUPPORTIVECOMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVE
COMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDREN
STRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVE
COMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDREN
STRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVE
SAFECHILDRENSTRONGFAMILIESSUPPORTIVECOMMUNITIESSAFECHILDRENSTRONGFAMILIES
SUPPORTIVECOMMUNITIESSAFECHILDRENSTRONGFAMILIESSUPPORTIVECOMMUNITIES



Implementing Evidence-Based Child Welfare:

The New York City Experience

EVIDENCE-BASED MODELS

nirn National Implementation Research Network

casey family programs

TABLE OF CONTENTS

EVIDENCE-BASED MODELS

ACKNOWLEDGMENTS

The authors wish to give special thanks to the following contributor: **Deborah Rubien** (New York City Administration for Children's Services).

The authors would like to acknowledge the following for their contributions and support to the development of this report:

Andrew White, New York City Administration for Children's Services

Jacqueline Martin, New York City Administration for Children's Services

Jaime Madden, New York City Administration for Children's Services

Kerri Smith, New York City Administration for Children's Services

Melissa Baker, Casey Family Programs

Zeinab Chahine, Casey Family Programs

JooYeun Chang, Casey Family Programs

Peter Pecora, Casey Family Programs

The authors would like to acknowledge former Commissioners **Gladys Carrion** and **Ronald E. Richter** for their vision and leadership in the initiation and implementation of evidence-based models for preventive services in New York City, and current Commissioner **David A. Hansell** for his leadership and support of evidence-based innovations in child welfare services.

This report was written and prepared by **Fernando Clara** (Casey Family Programs), **Kamalii Yeh García** (Casey Family Programs), and **Allison Metz** (National Implementation Research Network).

EVIDENCE-BASED MODELS

Executive summary

In 2011 the New York City Administration for Children's Services (ACS), in partnership with Casey Family Programs, started on a bold new course of introducing 11 evidence-based and evidence-informed practice models into its continuum of preventive services. This initiative is the largest and most diverse continuum of evidence-based and evidence-informed preventive programs in any child welfare jurisdiction in the country.

By 2015 almost 5,000 families were served annually through an evidence-based model (EBM), representing one in every four families served by the ACS preventive system. The work that ACS embarked on is pioneering in scope for the field of child welfare. The field benefits today by learning how to successfully integrate evidence-based models into daily practice, and it benefits in the future by learning from the outcomes of ACS's preventive service continuum.

Implementation of evidence-based models

In New York City, preventive services are purchased primarily using city and state child welfare funds. ACS contracts with nonprofit providers to deliver the evidence-based models. The providers are required to not only deliver the intervention itself, but to also address the full range of case management issues. These include monitoring child safety, assisting with entitlements, providing housing and educational supports, and making other necessary service referrals.

The goals of the preventive services EBM initiative are to improve outcomes by:

- Improving family functioning and child well-being.
- Reducing repeat maltreatment.
- Preventing placement in foster care.

ACS also decided early in the process to utilize implementation science as a framework for the initiative. As a result, the National Implementation Research Network (NIRN) became an integral part of the preventive services EBM initiative, with support from Casey Family Programs. ACS built the capacity of its own staff, as well as the staff of the provider agencies, to actively utilize an implementation science framework.

Lessons learned

STRENGTHS OF THE EBM IMPLEMENTATION PROCESS

- **Communication and collaboration.** The partnership between ACS, the EBM developers, and providers was critical to the initiative's success. Establishing multiple feedback loops with all partners was the primary mechanism that contributed to the positive relationship.

- **Leadership and commitment.** All partners have maintained commitment to the initiative, despite the implementation process being more challenging and longer than most had anticipated.
- **Use of implementation science.** The partnership with NIRN and use of implementation science provided a valuable framework and helped all partners to tend to aspects of the work that they might not have thought about otherwise.
- **Improvement in quality and variety of services.** While long-term outcome data are still needed, ACS and its partners feel that the addition of such a diverse array of EBMs has been beneficial in serving a range of families, as well as serving more families.

CHALLENGES OF THE EBM IMPLEMENTATION PROCESS

- **Staff turnover at provider agencies.** A high turnover rate for staff at the provider agencies has been attributed to higher salaries offered in other fields as well as the intensive work requirements of EBMs.
- **Training costs.** Funding the ongoing costs of training is an issue for some provider organizations. For some EBMs with multiple providers, agencies formed a partnership to share training resources.
- **Referrals.** ACS made targeted changes to its system to improve the process of referring a family to an EBM, but referrals continue to be a challenge. In large part, this appears to be due to the sheer size of the ACS system and the number of models introduced.
- **Policy-practice alignment.** Aligning ACS policies with the specific EBM practices and approaches has been an ongoing focus of implementation. One of the key alignment challenges has been how to determine the degree to which fidelity to the model by each provider agency aligns with the child welfare outcomes they achieve.

ASPECTS TO ATTEND TO EARLY IN THE IMPLEMENTATION PROCESS

- **Plan for sustainability.** While sustainability is embedded throughout the implementation science framework, it is still a difficult aspect for an agency to attend to at the same time that it is attempting to develop and implement a particular program.
- **Consider the "best fit" of EBM.** ACS dedicated considerable effort to determine which EBMs should be included in the preventive services continuum, but it did not always know what questions to ask. This was particularly true when it came to anticipating the specific challenges of bringing an EBM from another arena, such as juvenile justice, into a child welfare setting.
- **Time and commitment.** ACS providers indicated that they were not prepared for the amount of time and effort that was needed to get them to where they are today, but thanks to the consistent, open communication among all partners, commitment remains strong years later.

Preliminary outcomes and impact on families

While outcome data are still limited, some preliminary results indicate that preventive EBMs are having a positive impact. For instance, due to the EBMs' shorter length of service, more families are now being served annually per paid contracted slot.

In comparing high-risk families served by EBMs to high-risk families served by ACS traditional models, preliminary data show that:

- Achievement of case goals for closed cases in high-risk program models has been higher for families being served through EBMs.
- Collaboration between the ACS Division of Child Protection and its contracted providers has increased for high-risk families served by EBMs.
- There has been a decrease in the number of indicated investigations for families receiving high-risk family services.

ACS at a glance

ACS is responsible for administering child protection, child welfare, juvenile justice, and early childhood care and education services in New York City, through a network of more than 75 contract agencies and approximately 7,000 employees. ACS child protection staff investigate more than 61,000 reports of alleged child maltreatment each year. More than 20,000 families each year participate in preventive services provided by 59 ACS-funded contracted agencies.

Moving forward

While evidence-based practice is widely used in other fields and is gaining momentum in child welfare, there is still much that is not known about "what works" in child welfare. As the federal Children's Bureau highlights, "The lack of available evidence about specific child welfare practices and programs is one barrier to widespread implementation of evidence-based practice."[1] The work of ACS contributes tremendously to the field of evidence-based practice by finally being able to answer the question of "what works." It brings evidence-based practice and implementation science firmly into child welfare. Finally, the ACS initiative provides valuable insight and learning about the factors that contribute to successful implementation of evidence-based interventions in a large public jurisdiction.

Introduction

New York City's Administration for Children's Services (ACS), in partnership with and support from Casey Family Programs, set a bold goal for itself in 2011: To incorporate a range of evidence-based models (EBMs) into its continuum of preventive family support services to meet the widely varied and complex needs of the city's families. In 2015, ACS served almost 5,000 families by providing them with 11 evidence-based and evidence-informed preventive models of practice, ranging from families with children at low risk of entering foster care to those with very high levels of need.

ACS now operates the largest and most diverse continuum of evidence-based and evidence-informed preventive programs in any child welfare jurisdiction in the country. This report describes why ACS decided to implement this wide array of EBMs, what it took to do so successfully and with fidelity, and what impact these EBMs have had on families as well as practice.

Context

Title IV-E waivers are one way in which the field has attempted to build evidence and knowledge regarding effective child welfare practices; although waiver applicants were not required to use EBMs in their waiver demonstrations, priority was given to projects that would "use the waiver as a vehicle to test or implement … evidence-based or evidence-informed intervention approaches that will produce positive well-being outcomes for children, youth and their families."[2] The ACS initiative has been implemented alongside a Title IV-E waiver but is funded with state and city dollars. Its work is a significant contribution to the field's understanding of EBMs. Not only can outcomes from ACS's EBM preventive service continuum help inform "what works" to prevent entries into child welfare, but the field can also learn about how to successfully integrate EBMs into the daily practice of child welfare through ACS's implementation process, its successes and challenges, and lessons learned.

Why evidence-based models

General preventive services have been a cornerstone of ACS for more than 35 years, ever since ACS began building a community-based prevention system in 1978. Over the years, the prevention continuum has expanded to include programs targeted toward caregivers with substance abuse and mental health concerns, as well as a handful of specialized preventive programs. (Specialized preventive programs focus on populations with special needs, such as medically fragile children, developmentally delayed children, sexually exploited children, and hearing-impaired families.) As a result of these and other improvements, ACS has seen a dramatic decline in the number of children in foster care, from a high of 40,000 children in care in 1996 to 9,563 children in care in March 2016.

A decade ago, ACS piloted the use of EBMs on a small scale in several of its programs, such as Intensive Preventive and After Care for Adolescents, the Juvenile Justice Initiative, and the Family Assessment Program, which were geared toward keeping teens out of foster care and away from deeper involvement with the criminal justice system. Positive outcomes from these pilots, including the steady decrease in foster care placements, provided the impetus for ACS to incorporate EBMs into its larger preventive services continuum. (See Appendix A for a timeline of ACS's EBM implementation.)

ACS is also unique in its goal to incorporate EBMs as part of the preventive service continuum rather than as a specialized addition to the system. In many other jurisdictions where evidence-based preventive services are in use, they are purchased as stand-alone therapies or behavioral health interventions, often using Medicaid funding or commercial insurance, with concrete case management and overall decision-making remaining in the hands of a public agency caseworker. In New York City, these services are purchased primarily using city and state child welfare funds, and practitioners of EBMs (who are contracted providers) are required to not only deliver the intervention itself but to also address the full range of case management issues. These include monitoring child safety, assisting with entitlements, providing housing and educational supports, and making other service referrals.

Casey Family Programs

Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families across America.

Since its founding in 1966, Casey Family Programs has invested more than $2.3 billion to support improvements in programs, services, and public policies that benefit children and families in the child welfare system.

Implementation of evidence-based models

The goals of the preventive services EBM initiative are to improve outcomes by:

- Improving family functioning and child well-being.
- Reducing repeat maltreatment.
- Preventing placement in foster care.

In particular, ACS wants to help parents safely care for their children in their own communities. With this in mind, ACS has focused on implementing EBMs that provide services in the family home, rather than at an agency. For those models that were not originally designed to be home-based, ACS asked that the providers agree to provide their services in the home of the family.

ACS also decided early in the process to utilize implementation science as a framework for the initiative. As a result, the National Implementation Research Network (NIRN) became an integral part of the preventive services EBM initiative with support from Casey Family Programs. According to NIRN, the formula for success[3] involves defining what needs to be done (effective interventions), how to establish what needs to be done in practice and who will do the work to accomplish positive outcomes in typical human service settings (effective implementation), and

where effective interventions and effective implementation will thrive (enabling contexts). In other words, to achieve positive, sustainable outcomes for children and families, interventions must be research-based and matched to the needs of children and families, implemented in a deliberate and adaptive manner, and supported by a hospitable environment and intentional learning processes. Practitioners, supervisors, leaders, and systems need time to successfully implement evidence-based models. Research shows that purposeful and effective implementation of evidence-based models occurs in discernable stages, with common elements present throughout each stage.[4-7] A core principle of NIRN is that implementation is a developmental process that occurs in stages,[4,7] which include exploration, installation, initial implementation, and full implementation.[8] Implementation may not always move linearly through such phases,[6,7,9,10] and the stages are often messy, overlapping, and iterative. Often, strategies and practices may advance to the next stage, then have to revisit a previous stage based on implementation needs. There also may be instances in which one may be actively involved in more than one stage. Below we describe the purpose and activities for each stage of implementation in the scaling up of evidence-based models in New York City's child welfare system.

FORMULA FOR SUCCESS

Exploration stage

SELECTION OF EBMS

The purpose of the exploration stage is to examine the needs of children and families, identify potential models to meet these needs, examine the fit and feasibility of implementing potential models, and attain buy-in from key stakeholders. ACS began the exploration stage by determining which EBMs would be most appropriate for their target population and outcome goals, beginning with those EBMs that were already in use in ACS's pilot programs. Officials also consulted with contracted providers, as some were already using EBMs in their agencies. In addition, ACS completed a national scan of EBMs, including a review of the evidence base and each model's fit and feasibility with child welfare. Since most EBMs are not designed for child welfare, but rather for behavioral health or juvenile justice settings, ACS assessed each model's potential for aligning with child welfare and the preventive system's desired outcomes.

ACS chose 11 models of practice: Seven are evidence-based, one is evidence-informed, and three are considered promising practices. Although four of these models are not yet "evidence-based," the term "EBMs" is used in this report to refer to all 11 models of practice. (See Appendix B for a summary of each model.)

EVIDENCE-BASED MODELS

Implementing such a diverse array of EBMs simultaneously was a significant undertaking, but ACS sought to establish a menu of services that could address a variety of family needs, including those of:

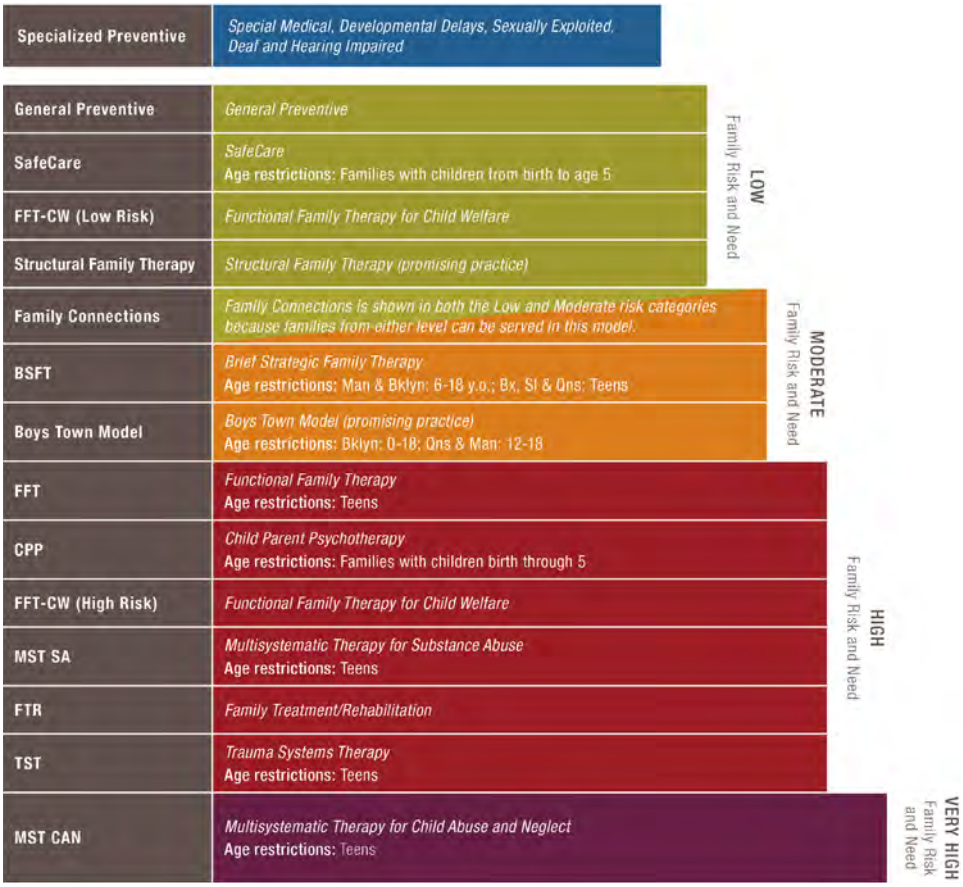
- Families with young children.
- Families with teens.
- Families that have had recent indicated/substantiated cases of physical abuse or neglect.

ACS also wanted to have different types of interventions available, such as:

- Trauma-informed models.
- Behavior-focused models.
- Family therapy models.

These models are categorized within the ACS preventive services continuum by level of risk and service need:

ACS PREVENTIVE SERVICES CONTINUUM



USE OF IMPLEMENTATION SCIENCE BEST PRACTICES

Implementation team development

Another key aspect of the exploration stage is to build an accountable structure to shepherd new practices and interventions through all the stages of implementation. ACS formed a core implementation team to support the exploration activities, including assessing system and family needs, conducting the fit and feasibility assessment, and developing communication protocols. The core implementation team has remained active through all stages of implementation, although it has changed in size, composition, and activity level depending upon the need of the agency. For example, a more complex teaming structure that included additional stakeholders and more diverse perspectives was added and refined throughout later stages.

Structured and efficient feedback loops

As part of ACS's partnership with the provider community, ACS sponsored open houses to introduce the models themselves as well as implementation science to its funded provider agencies. The developers of the EBMs — that is, the organizations that created and in most cases own the rights to each model — were included in this process, to give providers the opportunity to better understand each EBM and to explore its fit with their agency.

Fit and feasibility assessment

During the exploration stage, NIRN conducted a "listening tour" with ACS staff and providers to gather their perspectives regarding the strengths and challenges of implementing EBMs within the ACS system. Specific areas assessed included (1) the extent to which selected EBMs would meet the needs of children and families; (2) the capacity of ACS and providers to implement the EBMs effectively; (3) the resources needed to support and sustain EBM implementation; (4) the alignment of EBMs with other ACS initiatives and programs; (5) the extent to which selected EBMs were well defined and ready to be implemented in child welfare; and (6) the evidence that the EBMs could achieve the desired child welfare outcomes.

The implementation team used findings from the listening tour to support communication and build readiness with ACS staff and providers and to inform the next phase of implementation, the installation stage.

Installation stage

PROCUREMENT OF EBMS

The purpose of the installation stage is to secure and develop the support structures and tools needed to put the EBMs in place (i.e., communication protocols, financial and human resources, and even internal enthusiasm for the initiative). This stage relies on feedback loops between those at the practice level and those in leadership to streamline communication and gather feedback about challenges as they arise.

Once the EBMs were identified, ACS began its procurement process through two avenues. One was an Expression of Interest (EOI) request to existing preventive service providers, which gave providers the option to modify their prevention program to provide one or more EBMs. The EOI required that the conversion be cost-neutral. To make this feasible for providers, who would have to account for the higher cost of implementing an EBM, ACS reduced the number of contracted slots and increased the cost-per-slot value. ACS anticipated that, since all of the EBMs have a shorter length of service than previous preventive services, the overall number of families served each year would still be equal to or greater than the current number.

ACS issued a second procurement through the traditional Request for Proposal (RFP) process, as new funds became available for specialized prevention programs for teens and for families with intensive needs. Through both of these procurement efforts, providers could choose from a list of designated EBMs or they could propose an evidence-based home-based family therapy, a multitrack family therapy for child welfare, or a promising practice of their choice. In all, 23 providers were awarded EBM contracts.

The National Implementation Research Network

The mission of the National Implementation Research Network is to contribute to the best practices and science of implementation, organization change, and system reinvention to improve outcomes across the spectrum of human services.

USE OF IMPLEMENTATION SCIENCE BEST PRACTICES

Governance and accountability

As the effort proceeded, ACS put in place a multi-team structure to support and align all aspects of implementation. Three implementation task teams were created, with the following purposes.

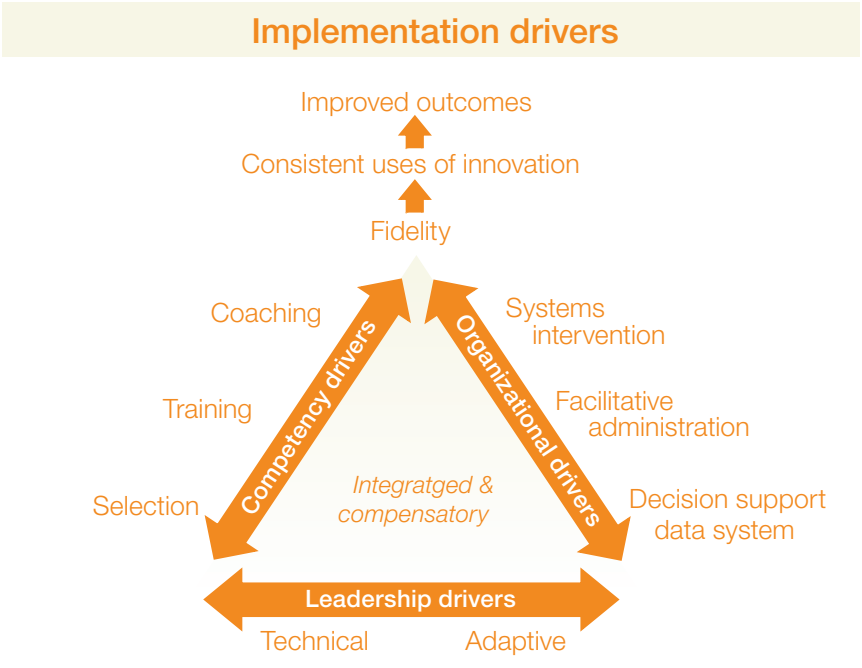
- ACS capacity-building:
  - Identify strategies for building internal capacity of ACS.
  - Develop internal communication strategies.

- Policy and practice alignment:
  - Assess current ACS and provider agencies' policies.
  - Develop long-term strategies to promote alignment between EBM practices and fidelity measurement.
- Evaluation and monitoring:
  - Develop model-specific practice and performance standards.
  - Eliminate duplicative documentation requirements.
  - Align current child welfare data reporting requirements and EBM requirements.

Task team members included ACS staff from various work units, and the Policy and Practice Alignment team included providers as well. Teams met regularly for six months until the EBMs were launched, and they played a key role in getting stakeholders involved and building internal capacity, as well as developing accountability and governance structures for the initiative.

Infrastructure assessment

During the installation stage, NIRN conducted an Implementation Drivers Analysis with the developers of the EBMs. Implementation drivers are the building blocks of the infrastructure needed to support practice, organizational, and systems change for effective implementation of EBMs, according to the principles of implementation science.[7,11]



To understand the extent to which the EBM developers would support the provider agencies to achieve and maintain high-fidelity implementation of the EBM programs, NIRN collected data on each model's competency and organizational drivers. Research included document reviews as well as semi-structured telephone interviews with the developers. The resulting analysis identified the level of support that ACS and the provider agencies could expect from each model developer on each of the key implementation drivers, such as training, coaching, decision-support data systems, and so on. NIRN then developed learning opportunities for the provider agencies to fill in the gaps and to augment their understanding of implementation science and of the challenges they faced in establishing their new programs.

The Drivers Analysis, using the implementation drivers, helped ACS staff understand what each developer offered in terms of their work with providers. The Drivers Analysis also provided recommendations to ACS regarding steps that ACS could take to strengthen and sustain implementation of EBMs in their preventive service continuum.

Structured and efficient feedback loops

Strong communication and the establishment of efficient feedback loops were another hallmark of the installation stage and included a number of key strategies, including:

- ACS set up an Implementation Institute for staff to learn about implementation science.
- EBM developers presented to ACS staff to teach them about the EBMs.
- NIRN and ACS created learning modules based on the findings of the Drivers Analysis.
- ACS assigned program development (PD) managers to each EBM so that providers and developers would have a consistent point of contact at ACS. PD managers also facilitated:
  - Biweekly calls between the providers and model developers, which continued for two years.
  - Monthly in-person provider meetings for each EBM, which are still ongoing, though some meetings are now bimonthly.
  - Monthly calls with the developer of each EBM, which are still ongoing.

Initial and full implementation stages

Initial implementation began in June 2013 when the EOI contracts began, followed by the RFP contracts in the fall of 2013. While these were key milestones, the implementation process required ongoing strategies to promote continuous improvement. As programs began to serve families, ACS gathered data to monitor implementation progress and began to work with providers to develop improvement strategies based on the data.

Although there have been several changes in administration within ACS since the inception of the EBMs, each administration has deepened the agency's dedication to evidence-based approaches in preventive services by increasing the size of some of the program models, exploring new and sustainable methods for tracking program fidelity and reporting outcomes, and encouraging

support and enthusiasm for the approach across the child welfare sector and among elected officials. All of these efforts have always been with the goal of fully implementing EBMs within ACS's preventive system.

Full implementation will be achieved only when the EBMs are stabilized and when ACS and provider agencies see that the consistent use of EBMs results in improved child and family outcomes. Three years after start-up, this work is still under way. ACS is now conducting activities related to full implementation such as "highly functioning improvement cycles." (Improvement cycles are bi-directional forms of communication between policy and practice that are facilitated by the teams.) In these improvement cycles, information is routinely collected on how EBMs are being delivered, and policymakers learn about and develop additional supports to sustain the EBMs.

Full implementation is often defined as the point where more than 50 percent of practitioners are implementing the EBMs with fidelity, proven through data collection. ACS has the added challenge of ensuring that fidelity is achieved alongside child welfare outcomes, most notably child safety. It typically takes two to four years to get to full implementation of any new practice. ACS, the providers, and the developers have learned that successful and sustainable implementation takes time and commitment.

Successful and sustainable implementation takes time as well as commitment.

USE OF IMPLEMENTATION SCIENCE BEST PRACTICES

Structured and efficient feedback loops

The ACS Division of Child Protection is the front door for preventive services for most families. During or following the completion of an investigation of suspected abuse or neglect, child protection staff often make referrals to preventive agencies, including those providing EBMs. These frontline workers have to understand the various models and have a grasp on which families are most appropriate for which services.

ACS had to provide training to ACS staff regarding the new EBMs available in the preventive services continuum, both to the child protective workers and to the preventive services liaisons who help coordinate their referrals. In addition, ACS expanded the feedback loops established during the installation phase to include broader internal stakeholder representation, ensuring more targeted communication paths.

Ongoing use of data to drive implementation support

In the summer of 2014, NIRN conducted a follow-up listening tour to better understand how the child welfare system had changed to support EBM implementation, to identify current strengths and challenges related to EBM implementation, to gain clarity on roles and functions of key stakeholder groups, and to identify next steps. The interviews confirmed that practitioners believed the EBMs were meeting the needs of families, strong implementation processes were in place, and there were clear paths of communication and collaboration. The interviews also illuminated challenges involved with using EBMs in the child welfare context, difficulties in the referral process, and the need to broaden internal ACS capacity for sustainability, monitoring, and evaluation. ACS used the findings from the listening tour to prioritize next steps in the following areas.

Capacity-building

ACS set out to develop additional tools to improve staff capacity, such as additional learning opportunities and a permanent educational and training infrastructure for the use of evidence in child welfare. Training to support the preventive services continuum is also being incorporated into the ACS Workforce Institute, so that all child protective staff and other relevant staff know what services are available, how to refer families to the service that best meets a family's needs, and how EBMs can support healthy child development.

In addition, ACS created tools to support the referral process. The ServiceConnect Instrument (SCI) is an online structured decision-making tool that recommends a service level (low, moderate, high, very high) for a family. In conjunction with a child protective worker's knowledge about the family, a completed SCI provides a list of EBMs that meet the family's needs and are available near where the family lives. This tool is currently undergoing improvements but has been an innovative part of the EBM implementation process.

ACS also developed a desk guide reference booklet with one-page summaries of each preventive services model, so that frontline workers across the child welfare system have ready access to basic information about the various programs, who they are meant to serve, and where they are available. These guides are used by child protective staff, family court attorneys, providers, and advocates throughout the system.

Tools and mechanisms developed by ACS to support EBM implementation

- Structured feedback loops
- Data infrastructure
- Training infrastructure for ACS staff
- Implementation science learning modules
- Implementation Drivers Analysis
- Structured decision-making tool
- *ACS Preventive Service Models: Desk Guide*
- Listening tours
- Preventive service logic models for each EBM
- *Fidelity of Preventive Services Desk Guide*
- Task teams with internal and external stakeholders
- Cross-divisional leadership team for sustainability

Policy-practice alignment

Through the various feedback loops and the listening tour, ACS identified misalignment between its preventive service standards and fidelity criteria for the EBMs. For example, the use of family team conferencing throughout the ACS child welfare continuum was not always reflected in the practice of the EBMs, and case contact requirements did not fully reflect the phased work of some EBMs. The complexities of service standards and fidelity criteria across so many EBMs added to the challenge of aligning ACS policies with EBM practices. Through mutual collaboration, model developers made adjustments in their EBM requirements, and ACS revised its Preventive Standards and Indicators, with a goal toward aligning policy and practice — work that continues today.

ACS developed preventive services logic models for each EBM, to illustrate how each EBM aligns with the core child welfare objectives of ACS's preventive services system. The logic models describe the theory of change and core components of each EBM, along with ways in which the EBM addresses essential child welfare issues and processes, such as child safety, case management, supervision, and child well-being. (Appendix C contains an example of one of the many logic models ACS developed for their programs.) The logic models have proven valuable in increasing stakeholder buy-in by providing constituents with easy-to-understand information about how each EBM fits in the child welfare system and aligns with its desired outcomes, helping to counter misinformation.

Monitoring and evaluation

ACS and its provider agencies found that they needed to align ACS reporting and documentation requirements with the documentation requirements of each EBM. ACS has made adjustments to its performance evaluation tool, the Preventive Scorecard, to align expectations with fidelity to the EBMs. ACS also developed a *Fidelity of Preventive Services Desk Guide* to support staff in interpreting the different EBM fidelity reports, monitoring program implementation, and communicating with developers and service providers.

In the beginning phases of implementation, the providers were monitored by ACS's Program Development unit, which provided an individual and personal approach to monitoring, along with technical assistance. New ACS initiatives typically spend one to two years with this unit. As part of the transition from implementation to continued sustainability, ACS began to transfer responsibility for monitoring the EBMs from Program Development staff to its Agency Program Assistance (APA) unit, which has responsibility for ongoing performance monitoring and collaborative quality improvement. At that time, EBM providers also started to be included in the ACS practice evaluation system, ACS Provider Agency Measurements System (PAMS), which reviews a sample of cases and scores each program's performance. This is combined with process and outcomes data to produce the annual Preventive Scorecard for each provider.

Beyond monitoring for fidelity, ACS also began to establish the data infrastructure for fairly evaluating child welfare outcomes in the EBMs and across its preventive programs more generally. Even with program fidelity and the achievement of model-specific milestones, ACS recognized that child welfare outcomes might not be achieved, since the EBMs were not all designed with child

welfare outcomes in mind. Likewise, providers also wanted to evaluate the impact of EBMs on their own practice and outcomes. And ACS noted the importance of adjusting its evaluations by the level of need of the families that each program serves.

Roles and stakeholders

Given the groundbreaking work that ACS, providers, and developers were undertaking by incorporating such an array of EBMs into the preventive services continuum, roles were initially somewhat unclear. As the partnership developed and transitioned through the stages of implementation, clarity improved for staff who had the most direct responsibility for the initiative, such as ACS's program development managers and the provider program staff. Inside ACS, leadership recognized the necessity of deepening the involvement across ACS program divisions to increase buy-in and sustain the initiative. In addition, ACS set out to increase engagement of external stakeholders such as schools, hospitals, the court system, and community partners.

In a study funded by the William T. Grant Foundation, NIRN found that collaboration and mutual consultation among ACS, providers, and developers increased over time, and that improvement in collaboration resulted from increasing the intensity of stakeholder interactions. The study identified that a variety of methods for collaboration were in use, including structured meeting processes and co-creation processes and products to support and sustain implementation (e.g., fidelity desk guide, logic models).

The findings demonstrate that relationships are valuable not only at the beginning (e.g., during the decision to uptake research evidence) but through every step of implementation. The trusting relationships that have developed among key stakeholders (e.g., ACS, model developers, and providers) throughout the decision-making processes were important to the uptake of research evidence in New York City's child welfare system and remain important for its sustainability over time.

Sustainability

An eye toward sustainability should be embedded throughout each implementation stage, and as such, implementation science does not specifically identify sustainability as a final stage of implementation. During the full implementation stage, ACS highlighted implementation activities that were explicitly designed to support sustainability. One pivotal example is ACS's Sustaining and Integrating Preventive EBMs (SIPE) team, a cross-divisional leadership group. ACS leadership created the SIPE team with the following purposes:

1. To expand the commitment and leadership of evidence-based preventive services across ACS divisions.
2. To provide an accountable structure to support and sustain current evidence-based and promising models in preventive services.
3. To continue to address systems barriers to sustainable implementation of these models.

As such, the key areas of focus for the SIPE team mirror many of the areas of implementation focus discussed above: formal communication strategies, data analysis and continuous quality improvement, program monitoring and technical assistance, and policy-practice alignment.

The SIPE team has been meeting biweekly since March 2015 and utilizes three key strategies to accomplish its goals:

1. Increasing members' knowledge base by bringing in providers and developers to present cases.
2. Solving problems by identifying challenges and bringing everyone necessary to the table to develop solutions.
3. Utilizing targeted and short-term workgroups to develop tools or propose improvements to the current system, such as creating a Frequently Asked Questions document.

What does it look like in practice?

Five years after its genesis, ACS's preventive services continuum is strikingly different from what it looked like in 2011. In addition to understanding the work of the exploration, installation, and implementation stages, it is important to reflect on what it took to get to this point, as well as what the impact has been on the child welfare system and on families.

Having supported this effort from inception, Casey Family Programs conducted individual and small group interviews with select ACS staff, providers, developers, and families to gain a better understanding of what the EBM case flow process looks like today, how the system has changed, and what can be learned from preliminary outcome data as well as anecdotal evidence regarding families' experiences with preventive EBMs.*

EBM case flow process

In New York City, ACS's child protective specialists investigate reports of suspected child maltreatment called in to the state child abuse and neglect hotline. If an investigator determines that preventive services are appropriate for a family, he or she completes the SCI tool to help determine which type of program best fits the family's needs and level of risk.

*Note: Interviewees were not selected randomly and do not reflect a representative sample of staff, providers, developers, or families; however, attempts were made to select interviewees that would reflect, to the degree possible, the wide scope of partners involved in the EBM implementation process.

After completing the SCI tool, the investigator sends a referral to an ACS preventive services liaison. Referrals for preventive services can also come from other sources, such as schools, physicians, or community programs, but approximately 80 percent come from child protective investigators. It is the responsibility of the liaison to refer the family's case to a provider agency.

Providers have the discretion to accept or refuse referrals, based on the provider's determination of whether their program is appropriate for the family's needs. Once a provider has accepted a family, the case and responsibility for case management transfers to the provider. Families are eligible for preventive services if they are determined to be under stress and their child is at risk for out-of-home placement; the outcome of the child protective investigation (e.g., indicated or not indicated) is not a factor in service eligibility. (The one exception is MST-CAN, which requires an indicated finding, or the likelihood of an indicated finding, for a family to be eligible for the service.)

Major changes to support EBM implementation

Interviewees noted several significant changes to ACS's system as a result of the EBM implementation process, several of which echo the priority focus areas discussed above. These changes include:

- A higher level of knowledge and internal ACS expertise regarding the EBMs, as well as increased buy-in across ACS divisions.
- Strong collaboration and communication, particularly through the use of the feedback loops and the partnership between ACS, provider agencies, and model developers.
- A higher level of alignment between ACS's preventive policies and EBM practices, including documentation requirements.
- Modifications to Preventive Scorecard, ACS's performance evaluation tool, leading to increased alignment between ACS's standards and EBM fidelity measures.
- Modifications to the preventive services referral process, including development of the ServiceConnect Instrument.
- Increased understanding and application of implementation science.

Preliminary outcomes and impact on families

New York City now serves an increasing number of families through evidence-based prevention models. Prior to 2013, less than 4 percent of families were served using EBMs. Since 2013, more than 25 percent of families, numbering about 5,000, are now being served through preventive EBMs.

While outcome data are still limited, some preliminary outcomes indicate that preventive EBMs are having a positive impact:

- ACS's capacity to serve families has increased. Due to the shorter length of service of the EBMs, the ratio of families seen annually per paid slot increased from an average of 0.95 to 1.2 families per year.

EVIDENCE-BASED MODELS

- Achievement of goals for closed cases in high-risk program models has been higher for EBMs. From January 2016 through June 2016, EBMs serving high-risk families reported an average of 82.6 percent of cases closed with goals achieved, compared to 77.6 percent for Family Treatment and Rehabilitation (FT/R) cases, which also serve high-risk families.
- Collaboration between ACS's Division of Child Protection (DCP) and ACS's contracted providers has increased. Between January 2016 and June 2016, 78.6 percent of EBMs serving high-risk families had a joint transition meeting with DCP and preventive providers, compared to a meeting occurring only 68.6 percent of the time with DCP and FT/R cases.
- There has been a decrease in the number of indicated investigations for families receiving services. From October 2015 through December 2015, only 8.8 percent of low-risk families being served by EBMs had an indicated investigation while in services, compared to 10.4 percent of families being served by General Preventive programs. For high-risk families being served by EBMs, only 9.5 percent of families had an indicated investigation while in preventive services, compared to 21.5 percent of families being served by FT/R programs.
- There has been a decrease in the number of indicated investigations within six months of finishing preventive services. From October 2015 through December 2015, only 1.5 percent of high-risk families being served by EBMs had an indicated investigation within six months of completing preventive services, compared to 1.9 percent of families in FT/R programs.

Interviews with parents who were participating in three different EBMs at three different agencies also provided some anecdotal evidence that these EBMs are positively impacting families.[†] All the parents stated that they felt very supported by their EBM practitioner, that they have a voice in their service plan, and that they were able to state specific ways that they have seen concrete, positive changes in their families' lives.

> My son and I are getting along now ... that is the greatest experience.
>
> **- PARENT**

[†]Note: These families were not randomly selected and do not reflect a representative sample of families served by the EBM preventive service continuum.

For example, one parent shared that she has recommended her EBM to others, and two of the parents stated that they would be happy to continue in their EBMs indefinitely, because of how helpful they have been to their families. The parents particularly appreciated that services are delivered in their home and that practitioners engage and work with the whole family unit, not just the parent.

Lessons learned

Across interviews, several themes emerged regarding both the strengths and challenges of the EBM implementation process, as well as what interviewees might do differently if they were to embark upon this process again. Many of these themes reflected the priority focus areas and major systems changes previously discussed, indicating that while progress has been made, there is still room for improvement. This is consistent with the philosophy that implementation is rarely "completed;" rather, it becomes an ongoing process of continuous quality improvement.

Strengths of the EBM implementation process

COMMUNICATION AND COLLABORATION

Universally, the ACS staff, providers, and developers interviewed identified the collaboration between the three partners as a cornerstone to the success of the EBM implementation process. While participants acknowledged that the conversations were difficult at times, the shared commitment to success and to working together allowed for honest conversations.

> ACS's leadership has to be commended for their courage in pushing EBMs forward, and ACS as a system has to be commended for continuing on this path, regardless of the obstacles they've faced.
>
> - EBM DEVELOPER

Two key factors in the success of the collaboration were the feedback loops created by ACS, which provided regular forums for communication, and the role of the program development manager, who served as a consistent point of contact for developers and providers. Standing agendas for meetings among developers, ACS, and providers also helped to ensure that challenges were identified and that meetings did not focus solely on troubleshooting, but on accomplishments as well.

LEADERSHIP AND COMMITMENT

Interviewees also praised the leadership of ACS for its commitment to implementing EBMs in the preventive services continuum, both before and after the change in administrations.

They also highlighted the commitment of the developers as well as many of the provider agencies. The EBM implementation process has been more challenging than most had anticipated, yet all of the partners have remained committed to its success.

USE OF IMPLEMENTATION SCIENCE

Interviewees noted the value of the partnership with NIRN to apply implementation science principles and best practices. Many felt that implementation science provided a useful framework and helped them tend to aspects of the work that they might not have thought about otherwise. For example, the Drivers Analysis of infrastructure supports available for each EBM provided important information for action planning among the various partners.

BENEFITS TO FAMILIES AND PROVIDER STAFF

While outcome data are still needed, interviewees felt that the addition of such a diverse array of EBMs was beneficial in serving a range of families, as well as serving more families than could be served under the other longstanding models of preventive services.

Interviewees also appreciated the professional development opportunity that EBMs afforded to provider agency staff, both the direct practitioners as well as supervisors. Providers indicated that utilizing an EBM improved staff clinical skills and also provided more structure for practitioners than the general preventive service model.

> If I could, I'd continue even after my case was closed.
>
> **- PARENT**

Challenges of the EBM implementation process

PROVIDER AGENCY STAFF TURNOVER

ACS staff, providers, and developers all identified turnover as one of the biggest challenges to the EBM implementation process — specifically, turnover of EBM practitioners at the provider agencies. Some initial turnover was expected by providers, as not all staff met the requirements for EBMs (some models require a master's degree), so some staff moved to different program areas, while others chose to leave their agencies altogether. Even beyond the initial "staffing up" phase, turnover has continued to be an ongoing challenge for some organizations, and its impact has been felt greatly given the intense training and ongoing consultation required of each employee needed to provide the model with fidelity. Turnover is attributed in part to the higher salaries offered by other sectors (e.g., education), in addition to the intense nature of providing an EBM that requires frequent in-home interventions, some evening hours, and the careful attention to the child welfare role a case manager provides alongside the clinical requirements of the EBM.

TRAINING AND FUNDING

Related to the turnover challenge, interviewees noted training to be a significant challenge as well, in particular the costs associated with training on an ongoing basis due to higher-than-expected turnover. Training and developer costs were initially factored into the revised rates by ACS, but the unexpected challenges such as high turnover and increased training and consultation needs have led to higher-than-expected costs. Both initial and ongoing training for the EBMs is primarily provided by the developers or their designees, which creates a significant cost burden for providers. Some agencies providing the same EBM have formed a partnership to share their training resources, so that their staff can be trained together, thereby reducing some of the training costs. However, funding the ongoing costs of training continues to be an issue for some provider organizations.

REFERRALS

As discussed earlier, ACS made targeted changes to its system to improve the process of referring a family to an EBM. While interviewees acknowledged and appreciated the improvements that have been made, there was also consensus that referrals continue to be a major challenge. In large part, this appears to be due to the sheer size of the ACS system, as it can be difficult to ensure that all protective service units are receiving the same information. Interviewees felt that centralized office staff, and program development managers in particular, have a good understanding of the preventive service continuum but that this knowledge has not spread uniformly to the borough staff and child protective investigators.

Since investigators are responsible for originating referrals, this has led to underutilization of some EBMs as well as inappropriate referrals. The SCI tool has been helpful, but both ACS and providers acknowledge that it needs to be improved; specific steps toward improving the tool are currently under way. In addition, providers and ACS have begun a more assertive effort to educate ACS field office investigative units about the EBMs available in their communities.

COMMUNICATION ACROSS ACS AND EXTERNALLY

Many interviewees attributed the challenges surrounding the referral process to the larger challenge of effectively communicating across an organization as large as ACS. Similarly, it has also been a challenge to effectively engage external stakeholders regarding ACS's EBM preventive services continuum in a jurisdiction as large as New York City. As noted earlier, both of these issues were identified during implementation, and progress has been made to improve buy-in across ACS, as this continues to be a key area of focus for the SIPE team.

> We all worked together on quality assurance and learning from one another.
>
> - EBM DEVELOPER

POLICY-PRACTICE ALIGNMENT AND FIDELITY

Aligning ACS policies with the EBM practices has been a key focus of implementation, and many interviewees report that this continues to be a challenge. Some interviewees felt that when this initiative began, developers did not have a clear understanding of child welfare in general and the ACS system in particular, while providers and ACS did not anticipate the ways in which some of the EBMs would create more work (e.g., documentation, dual role of practitioners) not only for provider staff, but for CPS ACS staff as well. Therefore, mutual education and negotiation have been needed throughout implementation to successfully integrate the EBMs into child welfare preventive practice, and this work is ongoing.

One of the key alignment challenges has been how to monitor model fidelity, program standards, and results so that ACS can determine (1) whether each EBM is achieving the service provision improvements it is designed to achieve and (2) what impact EBMs are having on child welfare outcomes. The complexity of integrating fidelity data into ongoing monitoring and improvement processes for public child welfare agencies cannot be underestimated. Fidelity assessments look quite different from model to model, including the fidelity metrics. This lack of "common currency" across EBMs leaves many child welfare agencies in the difficult position of figuring out how their data systems can accommodate the different indicators and scoring rubrics used across models. Many interviewees felt that these challenges should have been discussed in more detail with developers

from the outset of the initiative. Establishing this common currency has now become one of the key priorities of the initiative within ACS, to sustain fidelity in the child welfare context going forward.

Aspects to attend to early in the implementation process

PLAN FOR SUSTAINABILITY FROM THE BEGINNING

While sustainability is embedded throughout the implementation science framework, it is still a difficult aspect for an agency to attend to at the same time that it is attempting to develop and implement a particular program. With regard to New York City's EBM implementation project, this meant that while the agency was focused on supporting providers to incorporate and implement EBMs into their service array, there were some missed opportunities regarding sustainability. For example, in hindsight, it would have been helpful to (1) communicate about the EBM preventive services initiative more often across ACS and throughout boroughs outside of the central office and (2) have integrated the EBM project into ACS's preventive services infrastructure earlier in the process to track child welfare outcomes and fidelity to the models. However, this was the first time any child welfare jurisdiction had attempted to implement EBMs on such a large scale. There were no comparable efforts to draw from at that time, but the field now has the benefit of learning from ACS's experience.

CONSIDER THE "BEST FIT" OF EBMS

As described above, ACS dedicated considerable effort to determine which EBMs should be included in the preventive services continuum. Nonetheless, interviewees indicated that more deliberation and preparation in the exploration stage could have benefited the overall implementation process. For example, each EBM provided varying levels of support to providers, as identified by the Drivers Analysis, but the "best fit" between developers and providers was not assessed early enough in the process.

Further, since providers were allowed to choose which EBM they wanted to implement, EBMs were not distributed throughout the boroughs by need or geographic distribution. As a result, ACS is now working to determine if the right models are in the right places, and in the right amount.

UNDERSTAND THAT SUCCESSFUL IMPLEMENTATION TAKES TIME AND COMMITMENT

Thanks to the consistent communication among all partners, participants in the EBM preventive services initiative understood that it would take time to successfully implement the EBMs. Yet interviewees expressed that they still were not prepared for the amount of time and effort that was needed to get them to where they are today. Regardless, all of the interviewees felt that their time and efforts were well spent.

Some interviewees indicated that it was necessary to have one point of contact for the initiative, rather than having it assigned as a special project to various individuals for communication reasons. Others also indicated that having additional resources (both time and money) in the beginning might have been helpful in building capacity earlier on, thereby mitigating some of the later challenges.

What's next?

ACS has firmly and successfully established EBMs in its preventive services continuum, and as the agency looks to the future, it seeks to more fully demonstrate the value in their investment. As ACS, provider agencies, and developers continue working together to resolve the challenges that remain, their priority is to assess the short-term and long-term effectiveness and outcomes of each EBM in relation to the city's child welfare outcomes. In particular, demonstrating the effectiveness of a diverse preventive service array in reducing child maltreatment and entries into care would be a significant contribution to the field of child welfare.

While evidence-based practice is widely used in other fields and is gaining momentum in child welfare, there is still much that is not known about "what works" in child welfare. The work that ACS embarked on is pioneering in scope, in its systematic use of implementation science, and in ongoing sustainability efforts. It is a significant contribution to the field's understanding and use of EBMs. Not only will the field of child welfare benefit in the future by learning from the outcomes of ACS's EBM preventive service continuum, in terms of what works to prevent entries into child welfare, but the field will also benefit today by learning how to successfully integrate EBMs into the daily practice of child welfare through ACS's implementation process.

References

1. Child Welfare Information Gateway. (n.d.). Evidence-based practice in child welfare. Retrieved from https://www.childwelfare.gov/topics/management/practice-improvement/evidence/ebp/
2. National Conference of State Legislatures. (2016). FAQs related to Title IV-E waivers. Retrieved from http://www.ncsl.org/research/human-services/faqs-related-to-title-iv-e-waivers.aspx
3. National Implementation Research Network. (n.d.). Implementation defined. Retrieved from http://nirn.fpg.unc.edu/learn-implementation/implementation-defined
4. Metz, A., Naoom, S. F., Halle, T., & Bartley, L. (2015). *An integrated stage-based framework for implementation of early childhood programs and systems* (OPRE Research Brief 2015-48). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
5. Meyers, D. C., Durlak, J. A., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology*, 50(3), 462–480.
6. Aarons, G. A., Hurlburt, M., & Horowitz, S. M. (2011). Advancing a conceptual model for evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*, 38, 4–23.
7. Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, National Implementation Research Network.
8. National Implementation Research Network (n.d.). Implementation stages. Retrieved from http://nirn.fpg.unc.edu/learn-implementation/implementation-stages
9. Bertram, R., Blase, K., Shern, D., Shea, P., & Fixsen, D. (2011). *Policy research brief: Implementation opportunities and challenges for prevention and promotion initiatives*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD).
10. Mendel, P., Meredith, L. S., Schoembaum, M., Sherbourne, C. D., & Wells, K. B. (2008). Interventions in organizational and community context: A framework for building evidence on dissemination and implementation in health services research. *Administration and Policy in Mental Health and Mental Health Services Research*, 35, 21–37.
11. Metz, A., & Bartley, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. *Zero to Three Journal*, 34 (4), 11–18.

EVIDENCE-BASED MODELS

SAFECHILDREN**STRONG**FAMILIES**SUPPORTIVE**COMMUNITIES**SAFE**CHILDREN**STRONG**FAMILIES
SUPPORTIVECOMMUNITIES**SAFE**CHILDREN**STRONG**FAMILIES**SUPPORTIVE**COMMUNITIES**SAFE**
CHILDREN**STRONG**FAMILIES**SUPPORTIVE**COMMUNITIES**SAFE**CHILDREN**STRONG**FAMILIES

Appendix A. Phases of implementation

ACS PREVENTIVE EVIDENCE-BASED MODEL

EXPLORATION STAGE

The purpose of the exploration stage is to examine the needs of children and families, identify potential models to meet these needs, examine the fit and feasibility of implementing potential models, and attain buy-in from key stakeholders.

INSTALLATION STAGE

The purpose of the installation stage is to secure and develop the support structures and tools needed to put the EBMs in place (i.e., communication protocols, financial and human resources, and internal enthusiasm for the initiative).

INITIAL IMPLEMENTATION

Initial implementation began in June 2013 when the EOI contracts began, followed by the RFP contracts in the fall of 2013. While these were key milestones, the implementation process required ongoing strategies to promote continuous improvement.

FULL IMPLEMENTATION

Full implementation will be achieved only when the EBMs are stabilized and ACS and provider agencies see the consistent use of EBMs resulting in improved child and family outcomes. Three years after start-up, this work is still under way.

SUSTAINABILITY

An eye toward sustainability should be embedded in each implementation stage, as implementation science does not specifically identify sustainability as a final stage. During full implementation, ACS highlighted activities that were explicitly designed to support sustainability.

APPENDIX A.

Pre-implementation milestones

ACS PREVENTIVE EVIDENCE-BASED MODEL

2006

ACS begins using the Evidence-Based Model (EBM) in its Intensive Preventive and After Care Program serving adolescents, initially called IPAP.

2007

Juvenile Justice Initiative (JJI) is launched. The Alternatives to Placement program uses FFT, MST, MST-Psych, and MDFT. New York Foundling, a private nonprofit that has numerous contracts with ACS, starts Blue Sky, which is an integration of FFT, MST, and TFCO (formerly known as MTFC).

2010

Family Assistance Program (FAP) is launched. A PINS diversion program, FAP was developed as a model similar to JJI. It also uses FFT, MST, and TFCO.

FIRST PHASE:
EXPLORATION

Exploration

ACS PREVENTIVE EVIDENCE-BASED MODEL

2011

ACS brings more EBMs into its preventive services continuum. It decides to use models in use by FAP, JJI, and some NYC nonprofit child welfare providers, making additions to the original list based on the needs of the NYC child welfare population, in addition to documented child welfare outcomes of other models.

A focus on ensuring that models meet needs and are a good fit with the system contributes to sustainability.

2012

January: ACS sponsors a full-day open house to introduce EBMs and implementation science. BSFT, FFT, MST, MTFC-KEEP, and SafeCare models are presented. The model developers conduct the presentations and facilitate discussions. Dr. Allison Metz provides an introduction to implementation science.

APPENDIX A.

March: Listening Tour 1 is facilitated by Dr. Metz. Listening sessions are held with ACS (foster care, FAP/JJI, APA, Preventive Services), providers, and developers.

NEXT PHASE:
INSTALLATION

April: ACS sponsors a half-day open house to introduce Family Connections and CPP, presented by their respective model developers. Dr. Metz presents on implementation readiness.

February: ACS hires an associate commissioner for evidence-based practice and a senior adviser for evidence-based program development.

Leadership commitment and allocation of resources contribute to sustainability.

Installation

ACS PREVENTIVE EVIDENCE-BASED MODEL

2012

April: Three task teams are launched: Policy & Practice Alignment, Capacity-Building Within ACS, and Evaluation & Monitoring. The teams include ACS staff from various units. Providers are part of the Policy & Practice Alignment task team. The task teams meet for six months, until September 2012.

Implementation teams provide an accountable structure to support stage-matched implementation activities. Data show that conducting stage-appropriate work contributes to reaching full implementation and sustainability.

May: Specialized Teen Prevention Request for Proposal (RFP) issued to provide funds to add new preventive service slots targeted to teens. Providers choose from a list of EBMs offered by ACS or propose another EBM or promising practice.

June: Expression of Interest (EOI) issued for existing general prevention and FT/R programs to convert their existing program slots to an EBM they select from an ACS list or a promising practice of their choice.

APPENDIX A.

October: Intensive Family Prevention RFP issued, focusing on FFT and FFT-CW models, in addition to a promising practice that the provider chooses. Dr. Metz facilitates an Implementation Institute for ACS staff.

November–December: ACS brings in developers of seven models to give a full-day presentation on their model to ACS staff. About 65 staff attend each day. The MTFC, MST, FFT-CW, Family Connections, BSFT, and CPP models are presented.

Identifying infrastructure supports and gaps early on ensures that gaps are filled, leading to a greater likelihood of sustainability.

December: Dr. Metz conducts a Drivers Analysis and issues a report describing the support each EBM developer provides for each implementation driver.

Installation

ACS PREVENTIVE EVIDENCE-BASED MODEL

2013

February–March:
EOI awards announced.

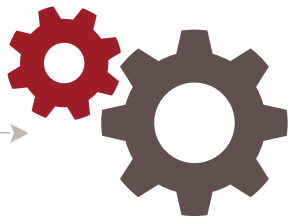
April: Specialized Teen and Intensive Prevention awards announced. Monthly calls with the developer of every EBM begin, as do monthly model meetings for all providers implementing that model. Calls and meetings continue for more than three years.

Feedback loops support sustainability.

APPENDIX A.

April–June: Learning Modules 1, 2, 3, and 4 developed by Dr. Metz, based on the needs identified in the Drivers Analysis.

NEXT PHASE:
INITIAL IMPLEMENTATION



May–August: Monitoring tools are developed for each evidence-based, evidence-informed, and promising practice model. The tools are based on the three primary implementation drivers and are used by program development staff on biweekly calls with each of the 23 provider agencies. Biweekly calls continue through April 2015.

Feedback loops support sustainability

Initial implementation

ACS PREVENTIVE EVIDENCE-BASED MODEL

2013

June: EOI contracts begin. First edition of *ACS Preventive Service Models: Desk Guide* is released. Training for PPRS liaisons is offered, providing an overview of evidence-based practice and instructions on using a corresponding structured decision-making tool, the ServiceConnect Instrument (SCI).

June-July: Senior adviser provides "train the trainer" sessions to James Satterwhite Academy (JSA) trainers. In turn, JSA provides training to more than 2,000 CPS workers via long-distance learning.

APPENDIX A.

NEXT PHASE:
FULL IMPLEMENTATION

September: Learning Module 5 is introduced.

July: ACS revises the referral process for preventive services and completes development of SCI to support this process. In-person training for DCP CPS, CPSS II, and CPMs is conducted, providing an overview of evidence-based practice and instructions for using the SCI tool.

September–October: Specialized Teen and Intensive Prevention contracts begin.

Creating new systems-level processes and protocols to support the evidence-based models increases likelihood of sustainability.

Full implementation

ACS PREVENTIVE EVIDENCE-BASED MODEL

2013

October: Dr. Metz provides technical assistance to the ACS Program Development unit.

2014

March–April: Learning Event 1, Action Planning to Improve the Implementation Drivers, and Learning Event 2, Tools of the Implementation, are conducted.

APPENDIX A.

Continued feedback loops contribute to sustainability.

July–September: Listening Tour 2 is conducted. The tour includes listening sessions with ACS (Protective Services, Preventive Services, Policy/ Planning, and Measurement), providers, and developers.

August: *Fidelity Desk Guide* is finalized.

Considerations for fidelity data integration contribute to sustainability.

September: First draft of *Sustainability Action Plan*, based on results of Listening Tour 2, is developed. First revised edition of *ACS Preventive Service Models: Desk Guide* is produced.

October: Program Development and APA begin discussions of transition of EBMs from PD unit to APA. Dr. Metz facilitates some of the meetings.

NEXT PHASE:
SUSTAINABILITY

Sustainability

ACS PREVENTIVE EVIDENCE-BASED MODEL

APPENDIX A.

February: Third revised edition of *ACS Preventive Service Models: Desk Guide* is produced.

March: Quarterly Developer Forum is launched, providing a forum for ACS to update all developers about ACS activities.

June: Large printing of *ACS Preventive Service Models: Desk Guide* is completed; 10,000 copies are distributed.

July: Some EBM providers reduce meetings to bimonthly schedule. All developer calls continue on a monthly basis.

Continued feedback loops contribute to sustainability.

Appendix B. Program overviews

Boys Town In-Home Family Services – IHFS (promising practice)

For moderate-risk families. The Boys Town model, called In-Home Family Services (IHFS), teaches parenting and life skills to families that have a moderate level of need and are in or near crisis. Quick engagement of families is a key component of the model. Case planners are called family consultants and deliver services in families' homes, meeting with families at least two hours per week. The model focuses on building the parents' knowledge and practice of parenting skills and addressing families' concrete needs.

Website: www.boystown.org

Brief Strategic Family Therapy® – BSFT® (evidence-based)

For moderate-risk families. The BSFT model is a brief family intervention for children and youth with serious behavior problems and/or drug use. The BSFT intervention works well for families with poor behavior management and problematic relationships. The intervention identifies patterns of family interaction and improves them to restore effective parental leadership and involvement with the youth. BSFT also seeks to reduce drug use and delinquency in youth. BSFT therapists meet weekly with families and work with all family members.

Website: www.bsft.org

Child–Parent Psychotherapy (CPP) (evidence-based)

For high-risk families. CPP is an intervention model for children aged 0 to 5 years who have experienced at least one traumatic event or are experiencing mental health, attachment, or behavioral problems. CPP examines how the child's and/or caregivers' trauma histories affect the parent-child relationship and the child's development. CPP supports and strengthens the caregiver-child relationship as a way to restore the child's sense of safety and attachment and to improve the child's functioning. Cultural, socioeconomic, and immigration-related stressors are addressed. Treatment focuses on safety and stabilization and incorporates case management.

Website: http://childtrauma.ucsf.edu

Family Connections (evidence-based)

For low- and moderate-risk families. Family Connections is designed to prevent child maltreatment. Case planners emphasize engaging with families to create an alliance that respects cultural differences. Standardized tools are used to identify risks associated with child neglect or maltreatment, and a comprehensive family assessment is completed. Tailored outcome-driven service

plans with SMART goals are developed with each family. Interventions include in-home counseling and advocacy on behalf of families with community-based services. Emergency and concrete service needs are addressed, and families are seen weekly in their homes for at least one hour.

Website: http://www.family.umaryland.edu/fcb-home/

Functional Family Therapy (FFT) (evidence-based)

For high-risk families. FFT is a family therapy intervention for the treatment of violent, criminal, behavioral, school, and conduct problems with youth and their families. Both intra-familial and extra-familial factors are addressed. An FFT belief is that the motivation of a family is to a great extent the responsibility of the therapist, not just the family. The intervention is home-based. The frequency of contacts between the therapist and the family depends on the stage of treatment, with more frequent contacts in the beginning of the intervention.

Website: www.fftinc.com

Functional Family Therapy – Child Welfare (FFT–CW) (evidence-informed)

For low- and high-risk families. FFT–CW is an adaptation of Functional Family Therapy developed in New York City and integrates a developmental focus for children birth to 18 years old. FFT–CW has low-risk and high-risk tracks. Families in the low-risk track meet with an interventionist who provides case management and counseling. Families in the high-risk track meet with a therapist and receive traditional therapeutic FFT services, focusing on familial relationships and risk factors. For both low- and high-risk tracks, sessions take place in the home.

Website: www.fftinc.com

Multisystemic Therapy for Child Abuse and Neglect® (MST-CAN) (evidence-based)

For very high-risk families. MST-CAN is an adaptation of Multisystemic Therapy (MST) and was developed to treat families with teens that have come to the attention of CPS due to high risk and safety issues. MST-CAN is reserved only for very high-risk cases. MST-CAN therapists complete a functional assessment of the family and safety plans. Therapists provide treatment in the home, including parent training, safety planning, substance abuse treatment, PTSD treatment for youth and adults, anger management, marital therapy, and family therapy. There are limited outside referrals. Therapists have very small caseloads to allow for intensive involvement with a family.

Website: www.mstservices.com

Multisystemic Therapy® for Substance Abuse (MST-SA) (evidence-based)

For high-risk families. MST–SA is an adaptation of Multisystemic Therapy (MST) and was developed for families with teens who are engaging in substance-use or other challenging or delinquent behavior. MST–SA is also targeted for families with high levels of conflict. MST–SA aims to improve families' capacity to work effectively with all systems involved with the adolescent to encourage more

responsible behavior. MST–SA therapists have small caseloads to allow for intensive involvement with the family. Treatment takes place in the home and includes family therapy, parenting skills, substance abuse treatment, cognitive behavioral therapy, and behavioral management planning. There are limited outside referrals.

Website: www.mstservices.com

SafeCare® (evidence-based)

For low-risk families. SafeCare is a structured home-based parent training program for families with children birth to five years old. The program includes three training modules focused on home safety, child health, and parent-child/infant interaction. Parents learn to improve home safety, recognize and respond to symptoms of children's illnesses and injuries, and interact in a positive manner with children. SafeCare providers are called home visitors, and they train parents by first explaining and modeling the skills, then having the parent practice and provide immediate feedback. SafeCare takes place in families' homes, typically on a weekly basis.

Website: http://safecare.publichealth.gsu.edu/

Structural Family Therapy (SFT) (promising practice)

For low-risk families. SFT is a family therapy intervention that focuses on structural change within a family, based on work pioneered by Dr. Salvador Minuchin. Social workers use in-session activities to help family members experiment with new ways of interacting. Sessions are weekly and are home- and office-based. Case management is also provided.

Website: http://minuchincenter.org/

Trauma Systems Therapy (TST) (promising practice)

For high-risk families. TST is a trauma-informed clinical intervention for families with adolescents who have been exposed to traumatic events and are experiencing emotional and behavioral problems as a result. TST focuses on the interaction between the child's difficulties regulating his/her emotions and the deficits within the child's social environment (home, school, and neighborhood). Trauma-informed psychotherapy and casework strategies are used in TST. Families are engaged as allies in the treatment.

Website: http://www.cebc4cw.org/program/trauma-systems-therapy-tst/detailed

BRIEF STRATEGIC FAMILY THERAPY

MODEL APPROACH: Short term family treatment model developed for prevention and treatment of 6-17 year olds with behavior problems and drug use. BSFT uses a structured, problem-focused, directive, and practical approach.

MODEL ACTIVITIES: BSFT identifies patterns of family interaction, and works to restore parental leadership and involvement with the youth. All family members participate.

UNDERLYING LOGIC: Family is the most influential context for youth and therefore is the focus of intervention. Transforming how the family functions will improve youth's presenting problems.

PREVENTIVE STANDARDS	INFORM	MODEL ACTIVITIES	THAT ARE LINKED TO SIGNS OF	MEASUREABLE PROGESS
✓ Addressing reasons for indication and/or referral ✓ Monitoring of all children in home ✓ Ongoing Safety & Risk Assessment ✓ Domestic Violence Assessment		**SAFETY AND RISK** In addition to ACS requirements to assess and monitor child safety and risk (at intake and on an ongoing basis), BSFT does the following: • BSFT is designed to reduce or eliminate serious behavior problems, family conflict and/or drug use for children and/or youth • BSFT uses Youth Self-Report, a Behavior Problem Checklist, Urinalysis Drug Screen and Urinalysis Self- Report to assess behavior changes • BSFT intervention strengthens parental functioning, specifically parental leadership, nurturance, and protection which are related to abuse and neglect • BSFT uses standard ACS practice for responding to safety and risk issues such as SCR reports and ERCs		Youth and parent behavior change is continually monitored and improved through ongoing assessments which reduces risk occurrences
✓ Core preventive services to address parent and child well-being (e.g. education, childcare, DV, mental health, education, parent child interaction, health)		**WELL-BEING** • BSFT addresses family issues that are closely related to well-being: connections between family members, family conflict and improving relationships with extended family • Promotes communication among family members		Improved youth behavior; improved family relationships and functioning
✓ Completion of FASP assessments ✓ Family Team Conferences ✓ Provide referrals to ancillary services		**CASE MANAGEMENT** • BSFT addresses case management in the context of the therapeutic goals • Some BSFT programs self-fund a case manager or program assistant to assist with case management needs • Family Team Sessions replace Family Team Conferences; ACS joins as an observer		Families are matched with services that attend to their needs effectively
✓ Weekly individual supervision ✓ Multidisciplinary team can substitute as an individual ✓ Supervision includes professional development ✓ Monthly review of every case by supervisor		**CONSULTATION AND/OR COACHING** In addition to ACS minimum requirements of weekly supervision and monthly case review, • All sessions with families are video recorded and selected clips are viewed by BSFT Model specialists • Agency is licensed by BSFT based on therapists' competency and fidelity to the model. After licensing, videos are viewed quarterly by BSFT • All case records are reviewed according to GP standards. BSFT Model Managers consult with teams weekly. After an in-house clinical supervisor is identified, BSFT consults monthly with the supervisor. Cases with safety and risk concerns are prioritized • Therapists conduct weekly Peer Review of cases		Youth and parent behavior change is continually monitored and improved through ongoing assessments which reduces risk occurrences
✓ Services terminated in a planned and structured manner after case review, assessment of need, and Program Director approval		**SUCCESSFUL COMPLETION** In addition to ACS requirements of a case review, needs assessment and administrative approval, • Decision to close case is based upon therapist and supervisor review of the case, a review of a video clip, assessment of positive family restructuring, and assessment of safety and risk		Family goals are achieved and demonstrated on video related to safety, risk and well-being

AND **OUTCOMES**

Increased safety, well-being and stability of children and families

Reduction in out-of-home placement and repeat maltreatment

Presenting issues at time of referral and other case management issues addressed effectively

Prevent, reduce and/or treat youth behavior problems

Improved family functioning

NYC Administration for Children's Services

casey family programs

May 2015

APPENDIX C

Response from Administration for Children's Services

Since the authors completed their research and wrote this report, New York City's Administration for Children's Services (ACS) has progressed on a number of projects related to the challenges and lessons that were described.

Among these is a concerted effort to build the capacity of the nonprofit organizations that ACS funds to provide these services. As the authors explained, a high staff turnover rate has been especially challenging for the evidence-based models (EBMs) because of increasing competition for social workers and other human services professionals in New York City, and the sometimes high workloads of our preventive practice. For the fiscal year that started July 1, 2017, ACS received new funding to revise its preventive providers' budgets for a number of purposes, including coverage for time spent in training; new conferencing staff; cost-of-living increases for staff; and general capacity-building to support staff and supervisors. In addition, the ACS Workforce Institute provides foundational courses in supervision practice that are designed to ensure that frontline staff receive strong, supportive coaching from their supervisors, which can help reduce turnover.

ACS has also instituted a requirement that all preventive staff participate in six days of training each year, and is creating a 12-day onboarding training program for new hires at the provider agencies. Practitioners at the EBMs will take part, and may substitute their model-specific trainings for some of the required coursework at the ACS Workforce Institute.

As the authors noted, ACS made targeted changes to its referral system to improve the process of connecting a family to an EBM, but referrals have continued to be a challenge largely because of the sheer size of the ACS system. ACS is taking steps toward improving the referral process and the technology that supports it, and has invested in educating frontline investigative staff about the EBMs that are available in the communities where they work.

Another substantial change is in the area of monitoring and oversight. The ACS Provider Scorecard now incorporates an adjustment in its evaluations based on the level of need of the families that each program serves. This allows both the provider and ACS to assess their outcomes in comparison to other providers and models working with similar families. ACS is also developing new methods to align practice, policy and fidelity. These are major steps toward a much larger goal: as ACS prepares for the next round of new procurements with its preventive providers, slated for 2020, it has begun an evaluation of its preventive programs to more fully assess each model's effectiveness with families and children in a variety of situations.

ADDENDUM

ACS is grateful to Casey Family Programs, the National Implementation Research Network and to all of the city's preventive partners for helping us to assess the challenges, lessons and rewards of our efforts to install research-based services in our preventive family support system. As we move forward toward making preventive services more widely available, we are committed to fully understanding the long-term impact of this strategic shift. Most of all, ACS and its providers are learning from parents, children and kin about their experiences in preventive services, as well as from the staff who work directly with families about the importance of these programs. There is still a great deal to learn — and a great deal to share — as we move forward with this work.

Casey Family Programs

Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families across America. Founded in 1966, we work in all 50 states, the District of Columbia and two territories and with more than a dozen tribal nations to influence long-lasting improvements to the safety and success of children, families and the communities where they live.

P 800.228.3559
P 206.282.7300
F 206.282.3555

casey.org | contactus@casey.org

Revised August 2017