TEXAS
Department of Family
and Protective Services

Family First Prevention Services Act Texas Prevention Plan

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Introduction

The Texas Department of Family and Protective Services' (DFPS) mission is to build on strengths of families and communities to keep children and vulnerable adults safe, so they thrive. The mission promises safe children and adults, strong families and communities, and a stronger Texas.

In furtherance of its mission and vision for Texas families, DFPS is electing to implement the Title IV-E prevention program as authorized by the Family First Prevention Services Act (FFPSA). As instructed in ACF-ACYF-CB-PI-24-10, the following is Texas' five-year prevention plan for Federal Fiscal Year (FFY) 2025 through FFY 2030. The FFPSA Division leads Texas' implementation of FFPSA focused on providing evidence-based services to families with children at imminent risk of entering foster care. The division provides technical assistance and support to internal and external stakeholders to ensure successful implementation of FFPSA. This plan provides details for the Texas Family First (TFF) Pilot Program, which focuses on strengthening parents' capacity to safely care for their children and reduce the need for foster care.

Texas Family First (TFF) Pilot Program

The 87th Texas Legislature enacted House Bill 3041 (HB 3041), codified as Texas Family Code Chapter 262, Subchapter F, which required DFPS to establish a family preservation services pilot program: the TFF Pilot Program. This program aims to prevent children from entering foster care by providing time-limited, court-ordered family preservation services (see Texas Family Code §262.402). DFPS refers families of a child who is a candidate for foster care to services, allowing children to remain home instead of entering foster care. A child is determined to be a candidate for foster care based upon criteria in HB 3041:

> *"Child who is a candidate for foster care" means a child who is at imminent risk of being removed from the child's home and placed into the conservatorship of the department because of a continuing danger to the child's physical health or safety caused by an act or failure to act of a person entitled to possession of the child but for whom a court of competent jurisdiction has issued an order allowing the child to remain safely in the child's home or in a kinship placement with the provision of family preservation services.*

TFF Pilot Program Collaboration

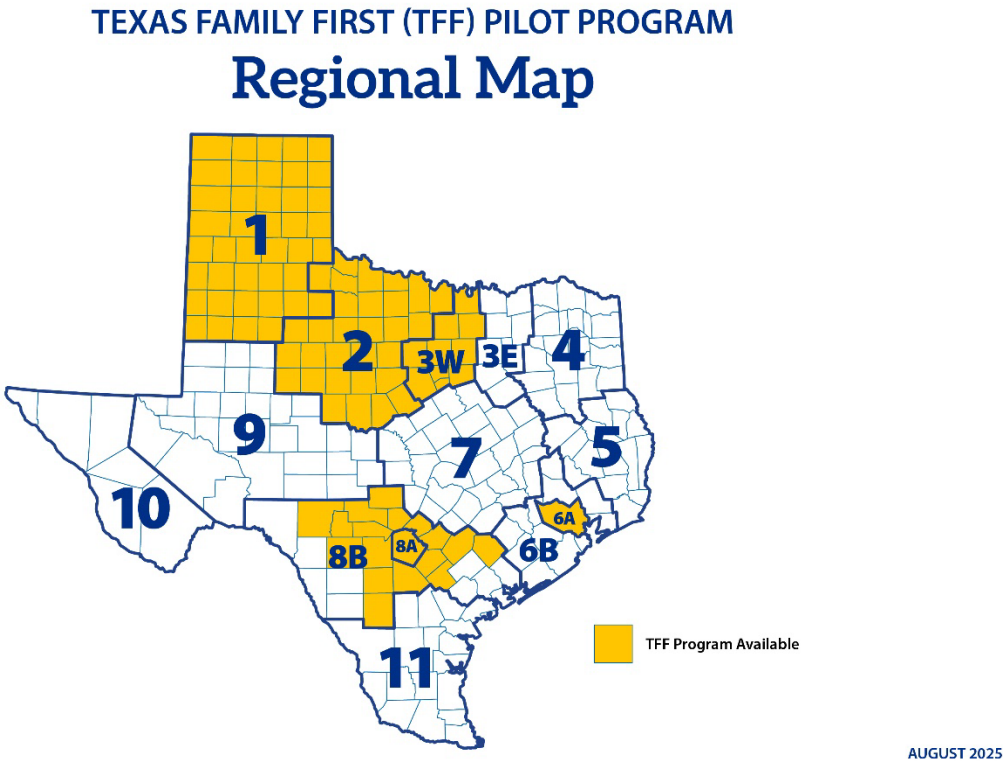
In the summer of 2022, collaborative planning took place between DFPS and TFF providers[1] to prepare for the implementation of FFPSA services. With Family First Transition Act[2] funds,

[1] Region 1 TFF Provider Saint Francis Ministries, Region 2 TFF Provider 2INgage, Region 3W TFF Provider Our Community Our Kids (OCOK), and Region 8B TFF Provider Belong.

[2]To support implementation of FFPSA and further its goals, Congress passed the Family First Transition Act (Transition Act or FFTA) as part of P.L. 116-94 (Subchapter F, §602) signed into law on December 20, 2019. Among other provisions, the Transition Act authorized $500,000,000 for FFPSA Transition Grants. Texas received grant funding to expend by the end of FY2025.

DFPS began implementing TFF in four DFPS regions — Region 1, Region 2, Region 3W, and Region 8B. Services have been available in these four regions since October 2022. Initially, TFF was available in 51 counties across the four pilot sites. To increase referrals, TFF providers expanded their services to a total of 98 counties. DFPS further expanded TFF to Region 6A in October 2024[3] and Region 8A in March 2025[4]. The 100 counties where TFF is available are depicted in Image 1 below.

Image 1: TFF Regional Map



TFF providers were required to propose evidence-based programs (EBPs) rated well-supported, supported, or promising by the FFPSA Title IV-E Prevention Services Clearinghouse (Clearinghouse) for mental health, substance use, or in-home parenting skill-based service types. TFF providers were encouraged to implement services for families with children ages zero to 17 to ensure any family referred to the pilot met the age eligibility requirements of the EBP. TFF providers selected EBPs based on the needs of their communities to provide family preservation support and prevent placing children in foster care.

[3] Region 6A TFF Provider The Harris Center.
[4] Region 8A TFF Provider The Center for Health Care Services.

The Supreme Court of Texas Children's Commission[5] (Children's Commission) assisted DFPS and TFF providers in engaging judges in pilot areas. DFPS trained DFPS employees with direct roles in TFF such as Child Protective Investigations (CPI), Family-Based Safety Services (FBSS), and DFPS attorneys. DFPS established dedicated positions responsible for the oversight and support of TFF implementation and for serving as a resource for TFF providers. Further, DFPS oversees TFF participant data collection and communicates program progress to stakeholders.

In June 2022, DFPS established a TFF Pilot Implementation Steering Committee to discuss activities pertaining to implementation. The committee met bi-weekly for the first five months of implementation and currently meets monthly to discuss the progress of the pilot. Leadership from divisions across DFPS participate in the steering committee, including Purchased Client Services, CPI, Child Protective Services (CPS), Office of Finance, Office of Strategic Operations, Office of Data and Systems Improvement (ODSI), Office of General Counsel, and the Community-Based Care Operations Division. As an external stakeholder directly involved in the pilot, the Children's Commission also participates in the steering committee.

The University of Texas Medical Branch (UTMB) is completing an external evaluation of TFF as required by Texas Family Code §262.417 to evaluate the effectiveness of TFF. DFPS and UTMB staff meet bi-weekly to discuss program progress, data collection, etc.

[5] The Texas Supreme Court established the Permanent Judicial Commission for Children, Youth, and Families (Children's Commission) in 2007 with the overall goal of improving the child welfare system by increasing public awareness of challenges facing children and families involved in the child welfare system and bringing attention to this important issue through judicial leadership, reforming judicial practice, and informing policy affecting child welfare.

Section 1. Services Description and Oversight

A. Services

TFF providers offer evidence-based services and programs to children and parents or kinship caregivers when a court has determined the child is at risk of entering foster care without TFF interventions. FBSS caseworkers monitor child safety using initial assessments and reassessments throughout the life of the TFF case and connect the family with services in addition to the EBPs that TFF providers offer.

Mental Health and Substance Abuse Prevention and Treatment Services and In-Home Parent Skill-Based Programs

TFF providers offer-approved, evidence-based mental health and substance abuse prevention and treatment services and in-home parent skill-based programs to a child and/or to the child's parent or kinship caregiver for up to six months, subject to a six-month extension if statutory criteria are met, (see Texas Family Code §262.413), beginning on the date the child was identified as a child who is a candidate for foster care in a prevention plan.

B. Outcomes

TFF providers selected and DFPS approved EBPs based on the needs of their communities to provide family preservation support to prevent placing children in foster care, keeping them safe with family. See Attachment V, Program Manuals by Family First Evidence-Based Program, for the book, manual or other document for each EBP to be implemented. In selecting program models from the Clearinghouse, the TFF providers considered several factors to ensure the services would meet the needs of families, such as:

- Availability of services for families with children aged zero–17 years old.
- Service gaps in the community.
- Reasonable ramp-up and service completion timeframes.
- Community relevance.
- Flexibility of the EBP.
- Alignment with TFF goals.
- Family systems approach.
- Strengths-based focus.
- Integration with existing systems and resources.
- Preventing recurrence of DFPS involvement.
- Recognizing and supporting the need for change.
- Self-efficacy.
- Interventions that recognize readiness and preparedness for change.

The EBPs selected for Texas' five-year Title IV-E Prevention Plan are listed in the tables below.

Table 1: Interventions Rated Well-Supported by the Clearinghouse

Service	Functional Family Therapy (FFT)
Service Description	A short-term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11–18-year-old youth who have been referred for behavioral or emotional problems.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FFT, Texas expects to see the following outcomes for children and families receiving this service: • Improved behavioral and emotional functioning. • Decreased substance use. • Decreased delinquent behavior. • Positive change around verbal aggression. • Positive change in family conflict.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and Continuous Quality Improvement (CQI) will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Youth 11–18 years old referred for behavioral or emotional problems and their families.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery
How Evaluated (Well-Designed and Rigorous Process)	DFPS is requesting a waiver for evaluation of FFT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2 below for

	supporting documentation that the effectiveness of the practice is compelling.

Service	Motivational Interviewing (MI)
Service Description	MI aims to identify ambivalence for change and increase motivation by helping clients progress through five stages of change by encouraging clients to consider their personal goals and how their current behaviors may compete with attainment of those goals.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Substance Use Programs and Services
Outcomes Expected to Improve	Consistent with the outcome identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for Motivational Interviewing, Texas expects to see decreased adult substance misuse.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	A range of target populations and problem areas.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DFPS is requesting a waiver for evaluation of MI, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II-a, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2 below for supporting documentation that the effectiveness of the practice is compelling.

Service	Multisystemic Therapy (MST)

Service Description	MST is an intensive treatment for troubled youth delivered in multiple settings. The program is delivered for an average of three to five months, and services are available 24/7. The program aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health and Substance Use Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for MST, Texas expects to see the following outcomes for children and families receiving this service: • Positive change in number of out-of-home placements. • Improved child behavioral and emotional functioning. • Decreased child substance misuse. • Decreased child delinquent behavior. • Improved positive parenting practices. • Improved parent/caregiver mental or emotional health. • Improved family functioning.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Youth 12–17 years old and their families.

Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DFPS is requesting a waiver for evaluation of MST, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II-b, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2 below for supporting documentation that the effectiveness of the practice is compelling.

Service	Parents as Teachers (PAT)
Service Description	A home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PAT, Texas expects to see the following outcomes for children and families receiving this service: • Positive impact on child safety through fewer child maltreatment and neglect reports. • Improved child social functioning, such as self-help and social development skills. • Improved child cognitive functions and abilities. • Improved family functioning.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in

	coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	New and expectant parents, starting prenatally, and continuing until the child reaches kindergarten. Title IV-E claiming will begin no earlier than the child's date of birth and after a candidacy determination has been completed.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DFPS is requesting a waiver for evaluation of PAT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II-c, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2 below for supporting documentation that the effectiveness of the practice is compelling.

Service	Parent-Child Interaction Therapy (PCIT)
Service Description	Parents are coached by a trained therapist in behavior management and relationship skills. PCIT aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship.
Level of Evidence	Well-Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT,

	Texas expects to see the following outcomes for children and families receiving this service: • Improved child behavioral and emotional functioning. • Improved parenting practices. • Improved parent/caregiver mental or emotional health.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Families with children ages 2–7 years old who experience emotional and behavioral problems that are frequent and intense.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	DFPS is requesting a waiver for evaluation of PCIT, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II-d, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice, and Section 2 below for supporting documentation that the effectiveness of the practice is compelling.

Table 2: Interventions Rated Supported by the Clearinghouse

Service	Family Centered Treatment (FCT)
Service Description	A home-based trauma treatment designed for families who are at risk of dissolution or in need of reunification. It is also designed to serve youth

	who move between the child welfare, behavioral health, and juvenile justice systems.
Level of Evidence	Supported (by the Title IV-E Prevention Services Clearinghouse)
Service Category	In-Home Parent Skills-Based Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for FCT, Texas expects to see the following outcomes for children and families receiving this service: • Decreased out-of-home placements. • Reduced post-traumatic stress symptoms. • Reduced emotional and conduct problems.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Designed to support families with youth who are at risk for out-of-home placements, have trauma exposure, have histories of delinquent behavior, or are working toward reunification. It is also designed to support youth who move between the child welfare, behavioral health, and juvenile justice systems.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.

How Evaluated (Well-Designed and Rigorous Process)	As required for services that are rated as supported, a well-designed and rigorous evaluation of FCT will be conducted.

Table 3: Interventions Rated Promising by the Clearinghouse

Service	Intensive Care Coordination Using High Fidelity Wraparound (HFW)
Service Description	HFW uses an individualized, team-based, collaborative process to provide a coordinated set of services and support.
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for HFW, Texas expects to see the following outcome for children and families receiving this service: Positive change in child behavior and emotion functioning.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Children and youth (birth to 21 years old) with complex emotional, behavioral, or mental health needs, and their families.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.

How Evaluated (Well-Designed and Rigorous Process)	As required for services that are rated as promising, a well-designed and rigorous evaluation of HFW will be conducted.

Service	Trauma- Focused Cognitive Behavioral Therapy (TF-CBT)
Service Description	TF-CBT is a program for children and adolescents who have symptoms associated with trauma exposure. The intervention also supports caregivers in overcoming their personal distress, implementing effective parenting skills, and fostering positive interactions with their child/adolescent.
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for TF-CBT, Texas expects to see the following outcomes for children and families receiving this service: • Reduced post-traumatic stress symptoms for caregivers. • Reduced depression for caregivers.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	TF-CBT serves children and adolescents who have experienced trauma. This program targets children/adolescents who have post-traumatic stress disorder symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained.

Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	As required for services that are rated as promising, a well-designed and rigorous evaluation of TF-CBT will be conducted.

Service	Trust-Based Relational Intervention (TBRI)-Caregiver Training
Service Description	TBRI is an intervention for caregivers of children who have faced abuse, neglect, and/or other trauma. It aims to provide parents and caregivers with the tools to meet the needs of these children.
Level of Evidence	Promising (by the Title IV-E Prevention Services Clearinghouse)
Service Category	Mental Health Programs and Services
Outcomes Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for TBRI, Texas expects to see the following outcomes for children and families receiving this service: • Positive impact on child behavior. • Positive impact on child emotional functioning and hyperactivity.
Plan to Monitor for Fidelity and to Use Outcome Data and Information Learned in Monitoring to Improve Practice	The overall design for fidelity monitoring and CQI will be a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with principles of the RE-AIM framework. TFF sites implementing FFPSA interventions will engage in

	coordinated data collection and collaborative meetings with DFPS and the evaluation team. DFPS will collect quantitative data from sites, and the evaluation team will collect qualitative data. Data integration will be conducted by the evaluation team for reporting and quality improvement.
Target Population	Parents and/or caregivers of children 0–17 years old who have experienced adversity, early harm, toxic stress, and/or trauma.
Assurance for Trauma-Informed Service Delivery	See Attachment III, State Assurance of Trauma-Informed Service Delivery.
How Evaluated (Well-Designed and Rigorous Process)	As required for services that are rated as promising, a well-designed and rigorous evaluation of TBRI will be conducted.

Section 2. Evaluation Strategy and Waiver Request

DFPS is committed to continuous quality improvement (CQI) and well-designed and rigorous evaluation activities. This commitment is essential to an investment in evidence-based programs (EBPs) under the FFPSA. DFPS contracted with The Center for Violence Prevention (CVP) at the University of Texas Health Science Center at Houston (UT Health) to develop a five-year evaluation plan to ensure the EBPs implemented and maintained by the Texas Family First (TFF) Program are effective in reducing child maltreatment. DFPS expects to contract with an experienced external evaluator (contracted evaluator) to implement the proposed plan.

CQI activities will be performed under the direction of DFPS's Office of Data and Systems Improvement (ODSI)[6]. Evaluation activities will be under the oversight of DFPS and conducted by the contracted evaluator experienced in program evaluation. CQI and evaluation activities will work in tandem to assess fidelity to program models, evaluate program effectiveness, assess outcomes for children and families, and inform overall program and system improvements.

A. Evaluation Strategy

DFPS is implementing EBPs rated well-supported, supported, and promising by the Clearinghouse. DFPS, through the contracted evaluator, will develop full evaluation designs for EBPs rated promising and supported. For well-supported EBPs approved by the Title IV-E Prevention Services Clearinghouse (Clearinghouse), a request to waive evaluation requirements

[6] The Office of Data & Systems Improvement, is a division within DFPS tasked with ensuring effective coordination, communication, and consistency throughout the agency around data reporting and how data is used to understand and improve performance and outcomes.

is included (See Attachments II-II-d) with documentation of compelling evidence of the program's effectiveness and verification that CQI requirements will be met.

A well-designed, rigorous evaluation plan will be developed for each program or service approved in Texas' Title IV-E Prevention Plan for which no evaluation waiver has been granted. The Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures, Version 1.0 and Version 2.0, and the Evaluation Plan Development Tip Sheet provided by the Children's Bureau will be usedto guide development of each evaluation plan.

B. Request for Waiver of Well-Designed, Rigorous Evaluation of Services and Programs for a Well-Supported Practice

1. Overall Continuous Quality Improvement (CQI) Strategy

Texas seeks a waiver of evaluation for the five well-supported EBPs being implemented in the state (Functional Family Therapy; Motivational Interviewing; Multisystemic Therapy; Parents as Teachers; and Parent-Child Interaction Therapy). The overall design for the fidelity monitoring and CQI is a collaborative, mixed-methods approach focused on implementation, reach, fidelity, completion, and outcomes, aligned with RE-AIM principles (Reach, Effectiveness, Adoption, Implementation and Maintenance). TFF sites implementing FFPSA interventions will engage in coordinated data collection and collaborative meetings with DFPS and the evaluation team of the contracted evaluator and contribute fidelity data per contract requirements. DFPS will collect quantitative data from sites via a data collection application being built for the providers that will integrate with the DFPS case management system, IMPACT (Information Management Protecting Adults and Children in Texas)[7]. The contracted evaluator will collect qualitative data. Data integration will be conducted by the contracted evaluator for reporting and quality improvement.

Coordination and Communications

DFPS and the contracted evaluator will coordinate CQI activities with sites participating in TFF. DFPS will be the point-of-contact for agency sites for data collection and fidelity documentation. All TFF sites participating in FFPSA programming will be required to attest or provide verification monthly that providers implementing FFPSA services are appropriately trained, and provide verification as requested. DFPS and the contracted evaluator will meet monthly to discuss CQI data and meet quarterly with sites to review data.

CQI Data

Provider-level data collection

Implementation and reach data will be collected from participating TFF sites and supplemented by DFPS. The collected data points include referrals, demographics of families served, intervention use, dosage of intervention, completion rates, and other interventions used.

[7] IMPACT is the primary system of record for case management used by DFPS programs to record case information about the children and adults the agency protects.

Model/purveyor-developed fidelity tools will be used, per model specifications. Should the model not detail a fidelity approach, the contracted evaluator/DFPS will work with model experts to develop an approach. The contracted evaluator and DFPS will also request verification and proof that the model is provided by trained staff.

DFPS-level data collection

DFPS will collect safety and permanency assessments of outcomes for children/families receiving well-supported model services using IMPACT data, including: 1) Subsequent substantiated case; 2) Subsequent removal; and 3) Length of services.

Contracted evaluator-led data collection

As part of the implementation assessment and the CQI approach, the contracted evaluator will conduct interviews and focus groups with providers at TFF sites to understand indicators of fidelity; program implementation and adoption at the agency; perceived program impact; and any barriers to program use or documentation. The interviews will be confidential, voluntary, and conducted by the contracted evaluator team. Providers and supervisors (n=24) implementing TFF services will be interviewed. Additionally, to center lived experience, adult clients engaged with FFPSA interventions at TFF sites (n=10, per site, per year) will be interviewed to understand programmatic impacts, experiences, and barriers. These client interviews will also be confidential, voluntary, and conducted by the contracted evaluator team.

CQI Data Analysis

Provider implementation and fidelity data will be analyzed using descriptive and bivariate statistical methods. IMPACT data will be analyzed using descriptive, bivariate, and multivariate statistical methods. Qualitative data will be analyzed using thematic analysis (Braun & Clarke, 2021).

CQI Reporting

TFF sites will be asked to contribute fidelity and implementation data at least monthly to DFPS. DFPS will share such data via a data use agreement (DUA) with the contracted evaluator. Data will be reviewed quarterly by the contracted evaluator and DFPS. There will be a yearly and a final fidelity report.

2. Interventions for Waiver and Compelling Evidence of Effectiveness of the Practice

Intervention One: Functional Family Therapy

Functional Family Therapy, LLC (FFT) is rated well-supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Sept 2022) and involves certification, training and monitoring through FFT (FFT LLC, 2022). This intervention will be used in Texas. FFT is a short-term, strength-based, manualized family therapy intervention for youth and families addressing risk and protective factors in five phases: engagement, motivation, relational assessment, behavior change, and generalization. The intervention ranges between 8 to 30 one-hour sessions, depending on the challenges faced by families, averaging

12–14 sessions and typically lasting between 3–6 months. The target population for this intervention is youth aged 11–18 years old (and their families), who are systems-involved (child protection or juvenile justice), have histories of violence or substance misuse, and/or are deemed at risk (CEBC, Jul 2023; FFT LLC, 2022).

The Title IV-E Prevention Services Clearinghouse found FFT effective in positively impacting the outcomes of child well-being and adult well-being (Title IV-E Prevention Services Clearinghouse, Sept 2022). The child well-being outcome involved statistically significant positive change to child behavioral and emotional functioning (Celinska et al, 2013; Slesnick et al, 2009), a reduction in substance use (Slesnick et al, 2009), and a reduction in delinquent behavior (Celinska et al, 2018). The adult well-being outcome involved statistically significant positive change around verbal aggression (Slesnick et al, 2009) and positive change in family conflict (Slesnick et al, 2009).

To assess program reach, implementation, fidelity, and outcomes for the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS IMPACT data. Reach data, including the number of referrals, participation, dosage, and completion, will be collected by agencies and reported to the state. Typically, FFT fidelity measures are guided by the FFT purveyor and include gathering information from multiple perspectives, including family members, therapists, and clinical supervisors, using measurement tools and checklists. The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. These include supervised reviews, progress monitoring, supervision calls, and checklists aligned with intervention provider partnership with FFT. State data from IMPACT will be used to assess outcomes (e.g., subsequent cases, removals, and length of services). Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Intervention Two: Motivational Interviewing

Motivational Interviewing (MI) is rated well-supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Dec 2020a). While there is no formal certification process for MI, there is an international network of trainers (MINT, 2021). Motivational interviewing centers and promotes behavior change and addresses people's ambivalence to change problematic behaviors such as substance misuse (CEBC, Jul 2024; Title IV-E Prevention Services Clearinghouse, Dec 2020a). This intervention guides people through five stages of change typically during one-to-three sessions lasting 30 to 50 minutes each (Title IV-E Prevention Services Clearinghouse, 2020a). The target population for this intervention is broad and has been used extensively with both adults and youth.

The Title IV-E Prevention Services Clearinghouse documented eight studies showing MI effective in positively impacting adult well-being through decreases in adult substance misuse

(Carey et al, 2006; Field et al, 2014; Freyer-Adam et al, 2008; Gentilello et al, 1999; Marlatt et al, 1998; Rendall-Mkosi et al, 2013; Saitz et al, 2014; Stein et al, 2009). In more recent studies, there have been mixed results on MI, with positive impacts being short-term and little focus on measuring fidelity of the intervention (Frost et al, 2018; Hall et al, 2020). A recent study (Feldstein Ewing, et al, 2022), which was focused on primarily Hispanic youth receiving MI, documented increased motivation to change alcohol and cannabis use and increased self-efficacy for changing alcohol and cannabis use than the comparison group. MI is often successfully paired with other interventions (Hall et al, 2020).

To assess program reach, implementation, fidelity, and outcomes (such as subsequent cases, removals, and length of services) for the CQI approach in Texas, the contracted evaluator will use fidelity metrics, qualitative interviews, and DFPS IMPACT data. Reach data, including number of referrals, participation, dosage, and completion, will be collected by the state and reported back to the CQI team. Unlike other programs included in the waiver, MI does not have a traditional purveyor established fidelity approach. Fidelity measures for MI typically include being trained by MINT trainers (MINT, 2021) and following a manual, which documents a treatment integrity coding process that involves the recording and review of MI sessions for key components of the intervention using the Motivational Interviewing Treatment Integrity (MITI) assessment tool (Moyers et al, 2014). To assess MI fidelity in Texas, DFPS and the contracted evaluator team will solicit training documentation for providers, have TFF sites report on MI-specific assessment tools (e.g. MITI), report on peer reviews, and conduct, as needed, periodic case reviews. State data from IMPACT will be used to assess outcomes (e.g., subsequent cases, removals, and length of services). Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Intervention Three: Multisystemic Therapy

Multisystemic Therapy® (MST®) is rated well-supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Dec 2020b) and involves certification, training and monitoring through MST Services® (MST Services®, 2021). MST will be used in Texas. Key features of MST include intensive therapeutic treatment for youth and families that address behavior change of risk factors in community-based settings. It aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use and is delivered for an average of three to five months, with services available 24/7 (CEBC, Mar 2024; MST Services, 2021). The target population for this intervention is youth 12–17 years old and their families.

MST has been found to be effective by the Title IV-E Prevention Services Clearinghouse based on outcomes from eight studies, which found MST effective in positively impacting child permanency, child well-being, and adult well-being (Title IV-E Prevention Services Clearinghouse, Dec 2020b). The child permanency outcome involved a positive change in the number of out-of-home placements (Vidal, 2017). The child well-being outcome involved

positive changes to child behavioral and emotional functioning (such as conduct disorder, oppositional defiant disorder, and impulsivity), substance misuse, and delinquent behavior (Asscher et al, 2013; Asscher et al, 2014; Deković et al, 2012; Fonagy et al, 2018; Henggeler et al, 1993; Henggeler et al, 1997; Manders et al, 2013; Ogden et al, 2004; Ogden et al, 2006). The adult well-being outcomes involved positive parenting practices, parent/caregiver mental or emotional health, and family functioning (Asscher et al, 2013; Deković et al, 2012; Fonagy et al, 2018).

To assess program reach, implementation, fidelity, and outcomes (such as subsequent cases, removals, and length of services) for the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS IMPACT data. Reach data, including number of referrals, participation, dosage, and completion, will be collected by the state and reported back to the CQI team. Fidelity measures for MST typically include supervision consultations with an expert, booster training, ongoing support for organizations using MST, and intensive fidelity monitoring through MST Services and the use of the MST Adherence scale (CEBC- Multisystemic Therapy, Mar 2024; MST Services, 2021). At Texas TFF sites, the approach includes adherence monitoring with expert trainers and supervisors and work sample (e.g., session) review. The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. State data from IMPACT will be used to assess outcomes (e.g., subsequent cases, removals, and length of services). Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Intervention Four: Parents as Teachers

Parents as Teachers™ (PAT) is rated well-supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Dec 2020c) and involves structured certification, training, and monitoring through the PAT national center and its organizational affiliates (Parents as Teachers™, 2024). PAT will be used in Texas and is a home visitation parent education program for new or expecting parents focused on positive child development and child maltreatment prevention (CEBC- Parents as Teachers™, Dec 2024; Title IV-E Prevention Services Clearinghouse – Parents as Teachers™, Dec 2020c). PAT features in-home or virtual personalized visits, group connections, resource networks, and child and caregiver screening, with full-time staff having caseloads of 20 families for once to twice per month visits for 12 to 24 months (CEBC, Dec 2024; Parents as Teachers™, 2024). The target population for this intervention is parents and caregivers who are expecting a child or who have a child who has not begun kindergarten (0–5 years old).

PAT has previously been found to be effective in positively impacting child safety, child well-being, and adult well-being based on outcomes from four studies (Title IV-E Prevention Services Clearinghouse, Dec 2020c). Chaiyachati et al (2018) found PAT to positively impact child safety through fewer child maltreatment and neglect reports. Child well-being outcomes

of PAT were positive shifts in children's social functioning with increases in self-help and social development skills (Wagner, 1999a; Wagner, 1999b) and in cognitive functions and abilities in expressive language and cognitive development (Neuhauser, 2018; Wagner, 1999a; Wagner, 1999b). Wagner et al (1999a, 1999b) found, when measuring adult well-being outcomes, that family functioning was improved.

To assess program reach, implementation, fidelity, and outcomes (such as subsequent cases, removals, and length of services) for the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS IMPACT data. Reach data, including number of referrals, participation, dosage, and completion, will be collected by the state and reported back to the CQI team. Fidelity measures for PAT typically include structured training through the PAT National Center, designation of each organization implementing as a PAT affiliate, participation in PAT quality endorsement improvement process (QEIP) to be completed every five years, and use of the Data Keeper's Visit Tracker online data system (Data Keeper Technologies, 2024). Fidelity typically occurs at the individual home visit level and at the organizational visit. The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. This approach will include monitoring from the national PAT office in the Affiliate Performance Report (APR). State data from IMPACT will be used to assess outcomes (e.g., subsequent cases, removals, and length of services). Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Intervention Five: Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is rated well-supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Dec 2020d), involves structured certification, training, and monitoring through PCIT International (PCIT International, 2023), and will be used in Texas. PCIT is a therapeutic play-based intervention that focuses on strengthening parent-child interactions and relationships and involves parent coaching by a therapist to teach behavior management. Completion is based on a parent/caregiver's mastery of skills and shifts in child behavior, not on a set timeframe, and typically last about 14 weeks of weekly one-hour sessions. The target population for this intervention is children aged 2–7 years old who have behavioral and parent-child relationship problems and their parents/caregivers (CEBC, Oct 2023; Title IV-E Prevention Services Clearinghouse, Dec 2020d).

The Title IV-E Prevention Services Clearinghouse found PCIT effective in positively impacting the outcomes of both child well-being and adult well-being. The child well-being outcomes involved positive changes to children's behavioral and emotional functioning, such as a reduction of intensity, externalizing and internalizing problems, hyperactivity, and aggression (Bagner et al, 2007; Bagner et al, 2010; Bjørseth et al, 2016; Leung et al, 2015; Leung et al, 2017; Matos et al, 2009; Schuhmann et al, 1998; Thomas et al, 2011). The adult well-being outcomes

involved positive changes to parenting practices and parent/caregiver mental or emotional health (Bagner et al, 2007; Bagner et al, 2010; Bjørseth et al, 2016; Leung et al, 2015; Leung et al, 2017; Matos et al, 2009; Schuhmann et al, 1998; Thomas et al, 2011).

To assess program reach, implementation, fidelity, and effectiveness (such as subsequent cases, removals, and length of services) for the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS IMPACT data. Reach data, including number of referrals, participation, dosage, and completion, will be collected by the state and reported back to the CQI team. Fidelity measures for PCIT typically include structured training and certification of therapists who must be re-certified every two years (CEBC, Oct 2023; PCIT International, 2023). Few studies have been done on the fidelity of the PCIT intervention, but some suggest that fidelity should occur in terms of dosage, adherence, quality, and participant responsiveness (Lieberman-Betz et al, 2015; O'Toole et al, 2024). The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. This approach includes live coding, session review, consultation calls, and certification maintenance. State data from IMPACT will be used to assess outcomes (e.g., subsequent cases, removals, and length of services). Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

C. Promising and Supported Programs Evaluation Approach

Overall Approach

Four programs used in Texas's TFF program — Family Centered Treatment (FCT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), High Fidelity Wraparound (HFW), and Trust-Based Relational Intervention (TBRI)) — are determined to be promising or supported by the Title IV-E Prevention Services Clearinghouse, thus meriting evaluation to be included in Texas' FFPSA Prevention Plan. The overall design approach is a quasi-experimental, longitudinal, mixed-methods process and outcome evaluation design using principals of the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework. Reach assesses the number and representativeness of who is engaged in the interventions, as well as assessing who is not participating (Glasgow et al., 2019). The contracted evaluator and DFPS team will use IMPACT and TFF site data to assess reach for each intervention and the TFF program in general. Effectiveness looks at the intervention impact, which for this study is understanding treatment (intervention), permanency, and safety impacts. This will be assessed in the outcome evaluation outlined below. Adoption will be assessed at the TFF site level and refers to the setting and staff implementing the intervention. This will be assessed qualitatively and through data collected by DFPS from the TFF sites that indicates the number of providers engaged in service provisions of the individual services, and statewide adoption of these interventions beyond the current scope. Implementation will be assessed through fidelity metrics collected from participating TFF sites and client-level use of intervention skills as noted in interviews and surveys collected for the evaluation by the contracted evaluator. Programmatic adaptations and

costs will be assessed. Finally, the design will examine the maintenance of services both at the client level (is impact sustained over a 12-month period?) in the outcome evaluation and the organizational level (are the services imbedded in the programs enrolled in TFF?) both qualitatively through interviews with adult clients and providers implementing the services, and quantitively via primary data collection from the contracted evaluator team and IMPACT data. Evaluation research questions include:

Process evaluation for all programs (FCT, HFW, TF-CBT, and TBRI):

- *Process RQ 1: What is the reach of the intervention(s)?*
- *Process RQ2: What is the extent of fidelity to intervention(s) among 1) TFF sites and providers and 2) program participants?*
- *Process RQ3: What are the barriers and facilitators to site adoption and implementation of the interventions?*
- *Process RQ4: What is the maintenance of the program at the TFF site level?*

Outcome (effectiveness) evaluation research questions for all programs (FCT, HFW, TF-CBT, and TBRI):

- *Outcome RQ 1: Does the intervention reduce the likelihood of a subsequent substantiated case?*
- *Outcome RQ 2: Does the intervention reduce the likelihood of the child being removed from the home?*
- *Outcome RQ 3: Does the intervention decrease the average length of time spent in services?*
- *Outcome RQ 4: Does the intervention improve adult wellness?*
- *Outcome RQ5: Are these changes sustained over the short (post-treatment), mid (6 months), and long (12 months) term?*

Interventions and Process Evaluation Approach

Similar to the fidelity monitoring process above for waiver programs, the contracted evaluator will conduct a process evaluation monitoring reach, adoption, and fidelity.

Evaluated Intervention One: Family Centered Treatment

Family Centered Treatment® (FCT) is rated supported by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Jun 2022) and involves certification, training and monitoring through Family Centered Treatment Foundation® in partnership with the National Child Traumatic Stress Network (Family Centered Treatment 2024). FCT will be used in Texas and is a home-based trauma treatment designed for families who are at risk of dissolution or in need of reunification that involves two multiple-hour sessions per week, on call support available 24/7/365 with an average length of treatment of six months (CEBC, Nov 2024; Family Centered Treatment 2024; Title IV-E Prevention Services Clearinghouse, Jun 2022). FCT has a target population of families with youth, 0–17 years old, who are at risk for out-of-home placements in the child welfare, behavioral health, and/or juvenile justice systems (CEBC, Nov 2024; Title IV-E Prevention Services Clearinghouse, Jun

2022). The Title IV-E Prevention Services Clearinghouse has documented one study showing FCT effective in positively impacting child permanency through decreased out-of-home placements (Sullivan & Bennear, 2021; Title IV-E Prevention Services Clearinghouse, Jun 2022).

To assess intervention reach and implementation as part of the process evaluation and the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS data. Data collected and reported back to the CQI team will include numbers of referrals, participation, dosage, and completion. Implementation and fidelity measures for FCT typically include minimum standards and credentials that are state-specific for practitioners, supervisors and agencies, online training modules and assessments of practitioners' core skills, re-certification every two years, and demonstration that staff are adhering to fidelity, which is measured through adherence measures, data collection, a case review instrument, and observation prior to providing services (CEBC, Nov 2024; Family Centered Treatment 2024; Title IV-E Prevention Services Clearinghouse, Jun 2022). The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. This includes monthly (at a minimum) check ins, certification, and session observations. Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Evaluated Intervention Two: High Fidelity Wraparound

Intensive Care Coordination Using High Fidelity Wraparound (HFW) is rated promising by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Jan 2022) and involves certification, training, and monitoring from the National Wraparound Initiative and the National Wraparound Implementation Center (NWI, 2024; NWIC, n.d.). HFW will be used in Texas and involves coordinated team-based services and support focused on phase-based intensive collaboration with families to address their needs (CEBC, Feb 2024; NWI, 2024; NWIC, n.d.). HFW involves intensive sessions with the team at first and then moving toward once a month, typically for around 14 months. The target population for this intervention is families and children ages 0–21 years old with severe emotional, behavioral, or mental health challenges who are at risk of out-of-home placements and involved in multiple systems such as child welfare, mental health, and juvenile justice (CEBC, Feb 2024). The Title IV-E Prevention Services Clearinghouse has documented HFW as a promising intervention with two studies showing a positive impact — one on child permanency through least restrictive placements (Cohen et al, 2004) and another on child well-being through positive change in children's behavioral and emotional functioning (Mears, 2009).

To assess intervention reach and implementation as part of the process evaluation and the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS data. Data collected and reported back to the CQI team will include numbers of referrals, participation, dosage, and completion. HFW has two national centers that provide trainings, protocols, assessment tools, and implementation guides to

agencies using HFW services as well as coaching feedback (Bruns et al, 2015; CEBC, Feb 2024; Miles et al, 2011). The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. In Texas, this fidelity assessment process will include discharge review forms, work sample reviews, and adherence measures to the model conducted in supervision. Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Evaluated Intervention Three: TF-CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children and adolescents who have experienced trauma. This program targets children and adolescents who have post-traumatic stress disorder symptoms, dysfunctional feelings or thoughts, or behavioral problems. Caregivers are included in treatment as long as they did not perpetrate the trauma and child safety is maintained. TF-CBT is 12–24 sessions in duration and consists of three phases: 1) skill building and stabilization, 2) constructing the trauma narrative, and 3) integration/consolidation. The elements of TF-CBT are best illustrated through the acronym PRACTICE: **P**sychoeducation; **R**elaxation; **A**ffect regulation; **C**ognitive Coping; **T**rauma narrative; **I**n-vivo exposures (if indicated); **C**onjoint parent-child session; and **E**nhancing safety and future growth. Although TF-CBT draws from several theoretical models, (family systems, cognitive, and behavioral), cognitive behavioral principles and exposure techniques are foundational to its delivery and for its facilitation of clinical change. Cultural modifications to TF-CBT have been tested and documented with the support of the intervention developers, to include modifications for children of Latino descent. Enhancements to the model have been identified and described for American Indian and Alaska Native children. (see Deblinger et al, 2003 for review of all listed adaptations). Additionally, TF-CBT has been deployed effectively in foster care and residential treatment settings. The effectiveness of TF-CBT has been documented through over 25 years of research, to include 43 scientific investigations examining its efficacy, 22 of which are rigorous randomized control trials. It is regarded as the most well-established evidence-based treatment for reducing symptoms of post-traumatic stress in children and youth. The details of several of these studies have been compiled and described through an evidence assessment conducted by de Arrellano et al. (2014). According to their review and analysis, TF-CBT effectively reduces post-traumatic stress symptoms, depression, behavior problems, and sexual acting out behaviors, and increased parenting practices. Caregiver post-traumatic stress and depression symptoms have also been found to decrease from pre- to post- TF-CBT completion. The Title IV-E Prevention Services Clearinghouse has documented TF-CBT as a promising intervention with at least one study indicating favorable effects on a target outcome (Title IV-E Prevention Services Clearinghouse, Dec 2020). Fidelity is measured using a TF-CBT fidelity measure checklist (Deblinger et al, (2008).

To assess program reach and implementation as part of the process evaluation and the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS data. Data collected and reported back to the CQI team will include numbers of referrals, participation, dosage, and completion. Fidelity for TF-CBT is typically measured by session-level fidelity assessed through clinician self-report using the Brief Practice Fidelity Checklist (BPFC), a tool developed by TF-CBT developers. The contracted evaluator will use purveyor developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. This includes session checklists, supervision, consultation and training calls, and client progress monitoring. Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Evaluated Intervention Four: TBRI-Caregiver Training

Trust-Based Relational Intervention® (TBRI)-Caregiver Training is rated promising by the Title IV-E Prevention Services Clearinghouse (Title IV-E Prevention Services Clearinghouse, Dec 2020) and will be used in Texas. TBRI provides training to parents and caregivers around attachment, connection, and meeting children's physical needs through four 6-hour training courses, which can be done once a week or for one week (CEBC, Oct 2024). Practitioners providing the training must go through an intensive two-phased training provided by The Karyn Purvis Institute of Child Development involving nine 3–4-hour online coursework sessions completed within 10 weeks, a 1–2-hour interview, and 40 hours of in-person training focused on implementation (CEBC, Oct 2024). The target population for TBRI is parents and/or caregivers of children aged 0–17 years old who have experienced trauma, harm, and/or intensive stress (Title IV-E Prevention Services Clearinghouse, Dec 2020).

The Title IV-E Prevention Services Clearinghouse has documented TBRI as a promising intervention with one study showing a positive impact to child well-being by positively impacting children's behavioral and emotional functioning and hyperactivity (Purvis, 2015). To assess intervention reach and implementation as part of the process evaluation and the CQI approach in Texas, the contracted evaluator will use purveyor-approved fidelity metrics, qualitative interviews, and DFPS data. Data collected and reported back to the CQI team will include numbers of referrals, participation, dosage, and completion. Fidelity for TBRI is typically measured through practitioners completing intensive training, implementation manuals, and workbooks (CEBC, Oct 2024; The Karyn Purvis Institute of Child Development (2024). The contracted evaluator will use purveyor-developed methods to assess fidelity as employed by the TFF sites and adapted as needed by the contracted evaluator and DFPS. In Texas, this includes certification, observation and supervision, and client feedback. Interviews with a sample of adults (n=10 per site) and providers (n=24 statewide) will be conducted by the contracted evaluator to further assess model fidelity.

Outcome Evaluation Approach

Promising and supported interventions (FCT, HFW, TF-CBT, and TBRI) will undergo outcome evaluation with comparison from a matched sample for outcomes related to child safety, permanency, and treatment outcomes (e.g., family (child/adult) wellness). Because it is not feasible to randomize participants into the treatment condition, the contracted evaluator will use a quasi-experimental approach and employ propensity score matching to draw a control group. The propensity score matched to those receiving intervention services will be based on demographic, family structure, and TFF eligibility (see below). The contracted evaluator will partner with DFPS to finalize the comparative approach for the evaluated interventions (FCT, HFW, TF-CBT, and TBRI) in year one (implementation year). The units of analysis will be the household or the child, depending on data availability, and final comparative approach. Treatment as usual will be defined as a comparable approach (e.g., TF-CBT would be compared to a clinical treatment). The contracted evaluator will match the intervention and control groups on the following:

- TFF Eligible
    - Meets at least one of the following criteria: 1) CPI investigation with a danger indicator with a safety plan; 2) no danger indicator and a risk level of high or very high risk on Risk Assessment; 3) Family-Based Safety Services involvement with a new circumstance resulting in a possible removal; or 4) CPI conducts a new removal, the investigation stage remains open, and the judge orders TFF at the 14-day adversary hearing after finding the child can remain safely in the home.
- Demographics by unit of analysis (date of birth, family structure, race/ethnicity, gender, income).
- Are of the target age and population for the intervention condition (FCT, HFW, TF-CBT, TBRI).
- History of prior DFPS engagement.
- Geography (County).

Further, cases *may* be excluded from the control condition if they are receiving multiple TFF interventions. In year one, the contracted evaluator and DFPS will model the approach using partial year-to-date data to test the comparative approach and assess any areas of missing data that must be addressed. To test treatment outcomes, the contracted evaluator will use a census approach and include 300 people in the treatment group and compare to an equal number in the matched sample. Should the treatment group exceed 300, the contracted evaluator will draw a random sample to evaluate.

To assess treatment outcomes, data will be collected using both IMPACT data and additional data collected via survey by the contracted evaluator team with adults enrolled in the treatment condition and a matched sample in the control group to assess intervention efficacy. Data collected by the contracted evaluator will be collected at baseline, post treatment, six months,

and 12 months post treatment for both intervention and comparison group via survey administered to adult caretakers. The contracted evaluator will work with DFPS to collaboratively finalize a set of eligibility criteria that match the prescribed definition of "a child who is a candidate for foster care" that can be aggregated and extracted from the existing IMPACT database to create a flag to indicate eligibility status. Among those participants flagged as eligible, the contracted evaluator will work with DFPS to define a set of variables from the IMPACT database to create a flag that identifies individuals who were referred to TFF. Among those participants flagged for referral, the contracted evaluator will work in collaboration with DFPS to define a set of criteria based on existing IMPACT data elements and agency-level data to identify and classify exposure to what type of TFF intervention, duration of exposure, and dosage of exposure. Data collection will occur online via survey. Participants will receive an incentive for each survey completed.

The fidelity assessment approach for the process evaluation will mirror the approach used for well-supported programs (see section above), using implementation and purveyor fidelity data. Additionally, qualitative methods will be used to assess fidelity and intervention impact. Providers will be interviewed (n=24) to assess fidelity, implementation, and perceived intervention outcomes. A subset of adult service participants (n=24, per intervention) will be interviewed at baseline, post treatment, six months, and 12 months to assess intervention fidelity, perception of impact, barrier to intervention impact, and adaptation.

Measures

Baseline, post-intervention, and 6- and 12-month follow-ups will be collected on all study participants (treatment and control). Each survey will be brief (less than 20 minutes) and conducted in English or Spanish. Should participants request, the survey can be administered by the study team via phone or zoom. Along with the study outcome measures listed below, the contracted evaluator will assess for established additional secondary outcomes (e.g., caregiver social support and caregiver mental health) and variable of interest to treatment (e.g., housing security and economic stability). Caregiver wellness will be evaluated through administration of the Patient Health Questionnaire – 8 (PHQ-8) (Kroenke et al., 2009) and the Generalized Anxiety Disorder -7 (GAD-7) (Spitzer et al., 2006) scales, respectively, and the Parenting Stress Scale (PSS; Berry & Jones, 1995) to examine change in caregiver stress over time. The PSS is an 18-item self-report scale that detects changes in the stress level of parents who have accessed targeted support, such as family support, parenting courses, and one-to-one parenting support. Adults will be administered surveys with measures designed for adults to report on child wellness.

Family Centered Treatment (FCT). Known improvements from completing FCT include fewer youth in residential treatment, reduction in length of time in residential placement, and reduction in length of average stay in community detention (Sullivan et al., 2012). Youth may also show reductions in problem behaviors through completion of FCT, a home-based therapy model that systematically addresses child and family trauma histories. As such, the primary

outcomes for FCT will be child wellness as indexed by the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997) and the Child and Adolescent Trauma Screen (CATS) Sacher et al, 2017). The SDQ is 25 items, with items loading on 1 of 5 subscales (i.e., emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior). Responses to items on the SDQ can be summed to calculate total and subscale scores. Based on FCT treatment targets, the team expects reductions in post-traumatic stress symptoms measured on the Child and Adolescent Trauma Screen (CATS; Sacher et al, 2017) and emotional and conduct problems on the SDQ (Goodman, 1997) at treatment completion and their maintenance throughout follow-up time points. The contracted evaluator will also analyze data for gains in positive behaviors through increases on the prosocial behavior subscale of the SDQ.

High Fidelity Wraparound (HFW). Based on review, few evaluations of HFW on caregiver and child wellness have been conducted. Extant empirical investigations indicate small but statistically insignificant improvements in caregiver stress. Significant improvements in children's emotional problems from pre- to post-treatment have been detected (Connell et al., 2024). To evaluate improvements in child wellness, caregivers will also complete Strength and Difficulties Questionnaire (SDQ; Goodman, 1997). Based on HFW treatment targets, we expect reductions in emotional and behavioral problems on the SDQ (Goodman, 1997) at treatment completion and their maintenance throughout follow-up time points.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Known impacts of TF-CBT on child mental health include reductions in post-traumatic stress symptoms and depression, and for caregivers, reductions in anxious and depressive symptoms. The CATS (Sachser et al., 2017) caregiver report will be administered to evaluate the child's trauma exposure, post-traumatic stress symptom level, and function impairment in relation to trauma. Child depressive symptoms will be evaluated using the Mood & Feelings Questionnaire, Short Form (MFQ-SF), parent version. The MFQ-SF, parent version, is a 13-item questionnaire designed to detect symptoms of depression in children and youth ages 6–18 years old.

Trust-Based Relational Intervention (TBRI). Caregivers completing TBRI have reported significant reductions in their child's trauma symptoms and behavioral problems (Purvis et al., 2015; Razuri et al., 2016). To evaluate improvements in child wellness, caregivers will report on their child's trauma symptoms and their emotional and behavioral functioning. The caregiver will complete a measure on the child's trauma exposures and any post-traumatic stress symptoms related to the trauma (the Child and Adolescent Trauma Screen, CATS; Sacher et al, 2017). The caregiver will also complete the Strength and Difficulties Questionnaire (SDQ; Goodman, 1997). The SDQ is 25 items, with items loading on 1 of 5 subscales (i.e., emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior). Responses to items on the SDQ can be summed to calculate total and subscale scores. Based on treatment targets, the contracted evaluator expects reductions in post-traumatic stress symptoms measured on the CATS (Sacher et al., 2017) and emotional and

conduct problems on the SDQ (Goodman, 1997) at treatment completion and their maintenance throughout follow-up time points.

Data Matching and Quantitative Analysis Approach

The primary goal of the outcome evaluation will be to test the short- (six months) and long-term (12 months) effectiveness of each intervention (FCT, HFW, TF-CBT, and TBRI) as measured by child safety and permanency and treatment outcomes. To accomplish this, for each intervention the contracted evaluator will identify a control group that meets the same inclusion criteria that are consistent with those eligible for services (e.g., age, presenting needs/reason for treatment). The contracted evaluator anticipates a large group of potential control participants that meet each set of selection criteria. From this pool, the contracted evaluator will use a 1-1 match to draw a control condition for each of the four interventions. Outcomes of child safety and permanency and treatment outcomes will be compared between treatment and control conditions for both the immediate (post-treatment), short-term (six months), and long-term (12 months) assessments. To ensure equivalence between treatment conditions, participant characteristics such as demographics, family structure, and risk profiles will be compared between groups for each point in time. Based on the size of the pool available for propensity score matching, the contracted evaluator anticipates the profiles of each group to its corresponding control to be closely aligned. Bivariate tests of treatment group differences will be used to assess intervention effectiveness at each point in time, where type I error rates will be set at 0.05. In the event that propensity score matching does not adequately control for differences in sample characteristics, regression modeling will be used to test for intervention effects through the inclusion of any identified potential confounding characteristics that are shown to be both related to the outcome under consideration and differentially distributed between treatment and control condition. An attrition analysis will be conducted to understand and quantify any differences in lost to follow up rates by treatment condition.

Sample Size and Power. The primary research questions to be evaluated are the immediate, short-term, and long-term effectiveness of the interventions (FCT, HFW, TF-CBT, TBRI) in reducing child maltreatment as measured by child safety, permanency, and treatment outcomes that produce increased well-being. To calculate power, we presumed that the normality assumption is satisfied. Two-tailed tests were used in all calculations, with the Type I error rate set at 0.05 and power at 80 percent. The minimum detectible differences (MDD) between the intervention condition and control condition were estimated based across a range of anticipated sample sizes from 100 to 350 individuals in the intervention group and a propensity score matched sample of equal size from the control condition. The MDD, or smallest difference between treatment conditions that can be observed with the given power, were estimated across a broad range of prevalence values from 5 percent to 40 percent to represent a complete range of potential values for each of the study outcomes. The contracted evaluator recommends a sample size of 300 per group (TAU and intervention) (600 total) to ensure the ability to detect small-to-modest differences between study conditions across a broad prevalence range for the

primary outcomes at each follow-up point. The TFF program served 220 families in 20 months (10/2022-05/2024). Harris County is expected to serve 100 families a year, and Bexar County is expected to serve 150 families a year. This yields a potential pool of study participants of 382 annually. We expect to recruit the sample for each intervention over the course of three years (years 2–4), giving adequate numbers from which to draw out sample.

Qualitative Data Analysis

Qualitative data sources for this project will include staff and adult client interview transcripts and memos/notes from data collection. Interview recordings will be transcribed verbatim by a professional transcription company, and identifying information will be redacted. Thematic analysis will be used to analyze qualitative data (Braun & Clarke, 2006; Braun & Clarke, 2021; Guest et al., 2012). Thematic analysis steps include data familiarization; coding; generating initial themes; developing and reviewing themes; refining, defining, and naming themes; and writing results (Braun & Clarke, 2006; 2021). Verbatim transcripts, along with memos, will be analyzed for themes or patterned meaning (Braun & Clarke, 2006). Data will be initially reviewed for familiarization by three research team members. From this review, a codebook of initial themes will be developed from the dataset and then later refined, through initial coding to confirm the codebook with the dataset. Data will then be coded by two members of the team, with the third member available to resolve discrepancies, using secure analysis software with regular meetings to discuss analysis. After initial coding, the team will conduct a second phase of analysis to define and refine relationships and subsequent themes. Additional analytic rigor will be introduced through feedback on thematic trends with DFPS staff and by assessing thematic saturation (Guest, et al., 2020; Huberman & Miles, 1994). The final coded dataset will be organized by themes, complete with a codebook with inclusion, exclusion, and example data.

Cost Analysis of FFPSA Interventions

A cost analysis will be conducted for all FFPSA interventions at TFF sites, assessing costs for each evaluated program per child receiving services and per child with a favorable short- and longer-term outcome. To accomplish this, the contracted evaluator team will identify and classify a standardized list of key cost components across programs in the implementation assessment phase in year one. With input from agency partners, the contracted evaluator will use this information to develop a data collection protocol and tool for each program to record cost data associated with each program under evaluation. Contents of each category will be clearly defined and collected from all programs in the same manner. We will then combine and analyze this data to produce a cost analysis for each intervention detailing overall costs and cost per child served. The contracted evaluator will then link the cost data with the outcome data for each program to provide a cost estimate for each favorable outcome observed. All details will be documented and provided so that results from the evaluated programs can be compared by the state to internal cost estimates for treatment as usual and foster care.

Section 3. Monitoring Child Safety

The Family-Based Safety Services (FBSS) program is child-safety centered and family-focused. While Texas Family First (TFF) providers deliver evidence-based programs (EBPs) to the family, the FBSS caseworkers focus on child safety through initial assessments and reassessments throughout the life of a case. The FBSS caseworkers connect the family with additional services that TFF providers do not provide through TFF. DFPS provides all FBSS caseworkers with foundational training upon being hired and ongoing training via a certification track. There is a continuous focus on building knowledge from the Child Protective Services Practice Model. This training teaches all FBSS caseworkers how to thoroughly assess each family's needs using the Family Strengths and Needs Assessment (Family Assessment) and develop the initial Family Plan of Service (Family Plan). The initial Family Plan outlines the appropriate resources and services that will be provided to the family, including EBPs offered through TFF. Parents and caregivers must participate in the development of the Family Plan and complete services outlined to build protective capacities and mitigate child safety concerns. Family Plan evaluations are completed according to the following timeframes as provided in DFPS policy 12540:

- Within six months after completing the initial Family Plan.
- Within six months after completing a previous Family Plan Evaluation.
- Within 21 days after the supervisor approves a Risk Reassessment that has a higher risk level than the previous Risk Assessment or Risk Reassessment.
- When a new child is born.

FBSS caseworkers are also trained to complete Safety Assessments, Safety Reassessments, Risk Assessments, and Risk Reassessments. These tools along with continuous face-to-face visits (announced or unannounced) with the family, ongoing communication between the FBSS caseworker and the family's support system, professional service providers, and collateral contacts allow the FBSS caseworker to fully assess the family's progress and closely monitor the parents' or caregivers' behavioral changes. The FBSS caseworker may also collect supporting documents such as medical records, school attendance records, police records, therapy notes, and photographs, to further support their decision-making when completing assessments, along with support and guidance from their FBSS supervisor. The role of the FBSS supervisor is detailed in DFPS policy 12130. The FBSS supervisor provides ongoing case guidance and monitoring by holding at least 10 monthly conferences per year with each caseworker.

Per DFPS policy 12610, the purpose of the Safety Assessment tool is to:

- Assess whether any child is likely in immediate danger of serious harm or maltreatment, which requires a safety intervention.
- Determine what safety interventions should be initiated or maintained to provide appropriate protection.

The FBSS caseworker completes a Safety Assessment in any of the following situations:

- When circumstances suggest that the child's safety may be jeopardized.
- When changing safety interventions on an existing safety plan.
- Before closing an FBSS case with at least one child in the home.
- When considering changing parental contacts with a child from supervised to unsupervised.
- Before returning a child from a parental child safety placement (PCSP).
- When closing the case when the child is living in a PCSP, the Safety Assessment tool is completed on the parent's home to determine if danger indicators continue to exist in the parent's home.

DFPS policy 12620 requires ongoing monitoring of safety and risk throughout the entirety of an FBSS case for all children. FBSS caseworkers are required to immediately reassess safety in the home if, at any point during the case, the FBSS caseworker develops concern for the child's safety due to a change in the family's circumstances, composition, or willingness to work with DFPS, concerns for conditions of the home, or other reasons.

DFPS policy 12240 requires FBSS caseworkers to make regular face-to-face contact with each child receiving services, the child's parents or kin caregivers, non-offending or noncustodial parents who are not part of the household where the allegations occurred, and PCSP caregivers. The FBSS caseworker is required to make at least one face-to-face contact per month with each parent or caregiver. These contacts are both announced and unannounced. In all FBSS cases, the FBSS caseworker uses the risk level of the most recent Risk Assessment or Risk Reassessment tool to determine the minimum number of face-to-face contacts with the child and parent or caregiver monthly. FBSS cases with a low risk rating require at least one face-to-face visit per month with the child and parent or caregiver. FBSS cases with a rating of moderate risk level require at least two face-to-face visits per month with the child and the parent or caregiver. FBSS cases with a high or very high risk rating require at least two face-to-face visits per month with the child and three face-to-face visits per month with the parent or caregiver.

DFPS developed a Risk Reassessment Procedure and Reference Manual to ensure staff use the tool appropriately. DFPS policy 12450 provides that Risk Reassessments are to be completed 90 days after the completion of the initial Family Plan and every 90 days after. A caseworker can also reassess for risk any time there are new circumstances or information that may affect risk. If the risk reassessment results in a higher risk rating than before, the FBSS caseworker must complete a new Family Assessment along with a Family Plan Evaluation within 21 days after the Risk Reassessment is approved in IMPACT (Information Management Protecting Adults and Children in Texas) by the FBSS supervisor.

The FBSS caseworker also completes a monthly evaluation of progress in each open FBSS case per DFPS policy 12420. The FBSS caseworker is required to make reasonable efforts to contact the service providers working with the family to determine their progress. Contacts with

collaterals such as family, friends, and other professionals who may be mandated reporters such as teachers, doctors, and TFF providers are used to gather information related to child safety.

Section 4. Consultation and Coordination

A. Consultation with other State Agencies

The Department of Family and Protective Services (DFPS), through its Office of Behavioral Health Strategy (OBHS), consults with other state agencies and public and private agencies with experience in administering child and family services to foster access to a full continuum of services for children. Leadership from the Texas Health and Human Services Commission (HHSC) and DFPS meet monthly to guide the collaborative work in improving behavioral health outcomes for children and youth involved with the Texas child welfare system.

The Behavioral Health Advisory Committee (BHAC) serves as the primary advisory voice to HHSC for issues related to mental health and substance use for Texans of all ages. The Children and Youth Behavioral Health Subcommittee to the BHAC provides recommendations on children and youth behavioral health topics and serves as the advisory body for the Texas System of Care[8]. The Texas System of Care is a framework for assuring access to a community-based, family-centered, strength-focused, and culturally relevant service delivery system designed to meet the needs of children, youth, and young adults with mental health challenges and their families. DFPS is a member agency of the Children and Youth Behavioral Health subcommittee alongside other child-serving state agencies, people with lived experience, community representatives, and advocacy organizations.

The Texas Department of State Health Services (DSHS), HHSC, and DFPS hold a coordinated meeting, the Interagency Maternal/Child Health Coordination Meeting, to identify ways to improve the health and well-being of mothers and children.

The Statewide Behavioral Health Coordinating Council[9] through its consultation efforts guided the development of the State Children's Behavioral Health Strategic Plan submitted to the Texas Legislature on December 21, 2024[10]. A subcommittee of the council was formed to complete the plan and included child-serving state agencies, including DFPS, community providers, people with lived experience, pediatric providers, and university partners. The plan incorporates

[8] Texas System of Care.

[9] During its Regular Session, 2015, the 84th Texas Legislature, established the Statewide Behavioral Health Coordinating Council (SBHCC) to ensure a strategic statewide approach to behavioral health services by coordinating behavioral health services across state agencies. The SBHCC is comprised of representatives of state agencies or institutions of higher education that receive state general revenue for behavioral health services.

[10] Report on the Children's Behavioral Health Strategic Plan - 2024.

recommendations relating to the full continuum of care needed to support the behavioral health of Texas children and their families.

The Partners for Children and Families Committee (PCFC) is an advisory committee established in 2024 to advise DFPS on improving and strengthening Texas' child protection system, including its new Texas foster care model, Community-Based Care (CBC). CBC allows local communities to meet the unique and individual needs of children and their families by tapping into the strengths and resources of each community. Most Child Protective Services (CPS) duties will transition to local service networks, each operated by a Single Source Continuum Contractor (SSCC). The SSCC is responsible for finding foster homes or other living arrangements for children in state care and providing a full range of services, including case management. CBC currently serves about one-half of the children who are in state custody due to child abuse or neglect. The purpose of the PCFC is to explore, study, and recommend innovative practices to DFPS that affect the Texas child protection system. The PCFC membership includes providers and provider associations, youth formerly in foster care, members of the judiciary and legal system, child welfare advocacy groups, foster parents and kinship families, and other child welfare stakeholders. One of the six PCFC subcommittees is the Services and Supports Subcommittee, which focuses on behavioral health, family support services, and aging/older youth.

DFPS was appointed to serve on the Executive Committee of the Texas Child Mental Health Care Consortium (TCMHCC). The TCMHCC was created by the 86th Texas Legislature to leverage the expertise and capacity of health-related institutions of higher education to address urgent mental health challenges and improve access to the mental health care system for children and adolescents. TCMHCC provides a forum for coordination among participating organizations and assures that DFPS is aware of how foster youth can access TCMHCC services.

B. Coordination of State Plans in Effect Under Subparts 1 and 2 of Part B

Texas' Title IV-B-funded traditional preventive services will be provided in conjunction with TFF evidence-based preventive services. Title IV-B Subpart 1, Child Welfare Services funds are used for services such as adoption readiness studies, counseling, and administrative costs (i.e., direct delivery staff). Title IV-B Subpart 2, Promoting Safe and Stable Families funds cover costs the state will expend on delivery of family preservation and community-based family support, as well as planning and service coordination. Examples of these services are listed below:

- Family Preservation Services.
- Family Support Services.
- Evaluation and treatment services.
- Substance abuse assessments and treatment (individual, family, and group counseling).

FBSS will consult with the TFF provider to discuss all needed services identified to determine which services are provided within the evidence-based services modality and which services need to be provided through FBSS. The caseworker communicates at least monthly with the TFF provider to ensure the family is receiving the identified services.

For more information on the overall collaboration efforts for DFPS, along with coordination of services under the Title IV-B plan, please see the sections on Collaboration and Coordination in Texas's 2020-2024 Child and Family Services Plan (CFSP[11]) and 2024 Annual Progress and Services Report (APSR)[12] (available upon request).

Section 5. Child Welfare Workforce Support

A. Services Provided by Qualified Agency and Provider Staff

Child Protective Investigations (CPI)

CPI is the division that identifies families who are eligible for TFF and is the first division to discuss TFF evidence-based programs with the family. To ensure CPI staff are qualified to provide services or programs, including referrals to TFF, DFPS requires all staff to receive training to investigate reports of abuse and neglect. DFPS staff undergo a comprehensive 14-week training program before they can investigate or supervise any case. Prior to case assignability, staff complete required assessments and testing to ensure competency in the required investigative tasks. During CPI Policy and Competency Testing, staff are observed and assessed while demonstrating investigation tasks and completion of policy-based knowledge assessments. The following are the Investigation Task - Demonstration Testing and policy assessments completed before staff can work with families13:

Investigation Task - Demonstration Testing

- Review and Assess the Family History.
- Contact the Reporter.
- Child/Youth Interview.
- Interview the Parent.
- Identify all Relevant Collaterals.
- Complete a Safety and Risk Assessment.
- Disposition a Case.

Policy Assessments

- Substance Use.
- Investigation Process.
- Interviewing Children.

[11] Title IV-B Child and Family Services Plan Requirements, see pages 7-19.
[12] 2024 Annual Progress and Services Report - Title IV-B, see Section II pages 9-26.
[13] *Texas Family Code §261.3016*, *§261.310*, *§264.2041.*

- Examining Children.
- Interviewing Adults.
- Safety and Risk.
- Dispositions.
- Special Circumstances.
- Human Trafficking.
- Referring a Case to FBSS.
- Emergency Assistance (EA) Eligibility.
- Danger to a Child.
- Family Initiated PCSP.
- Placements.
- Alternatives to Removal.
- Removals.
- Reports of Abuse and Neglect.

DFPS recognizes that additional and ongoing training is needed for CPI staff to identify families who are prevention foster care candidates and would benefit from evidence-based programs (EBPs) offered in Texas Family First (TFF). After CPI staff successfully complete the 14-week comprehensive training and required testing, CPI staff are required to complete the TFF training before they refer a family to TFF. DFPS collaborates with TFF providers to train DFPS staff, judges, and attorneys on the EBPs available in their region. The training provides information on EBPs, how to discuss the models with children and parents, how to refer a family to the EBP, and the credentialing and fidelity monitoring requirements of each model. Additionally, ongoing technical assistance is provided to DFPS staff and TFF providers through ongoing meetings in which cases are reviewed to ensure all parties are meeting TFF. Through this process, DFPS staff receive continuous training on the EBPs.

FBSS

Newly hired Family-Based Safety Services (FBSS) caseworkers are required to complete three months of foundational training, which includes trauma-informed training. Learning and Development Academy trainers cover Trauma 101, a curriculum developed by The National Child Traumatic Stress Network, as an introduction on the diverse types of traumas, neurobiology of trauma, the effects of trauma, and how trauma can affect developmental stages of a child. Additional trauma-informed trainings required for all FBSS and CPI staff include:

- Building Resilience in the Face of Trauma: Focuses on the impact of primary and secondary trauma as well as compassion fatigue as it relates to Child Protective Services (CPS) staff. This training was designed to provide tools and strategies for dealing with the stress of protecting vulnerable children and their families. Staff are informed of the impacts of trauma, the global perspective on trauma, resiliency, and the principles of connecting, empowering, and correcting.

- Trauma-Informed Care Refresher: Discusses trauma and traumatic stress among children, families, caregivers, and professionals involved in the child welfare system. The training also discusses the impact of trauma and how caseworkers respond with compassion and ensure the best safety, permanency, and well-being outcomes for children in the child welfare system.

TFF Providers

The TFF providers are responsible for training and verifying their staff and clinicians adhere to fidelity for each model. TFF providers coordinate and collaborate with DFPS, attorneys, and the courts to support positive outcomes for families. TFF providers hire, train, and supervise staff who provide the EBPs to families. TFF providers submit monthly progress reports to DFPS for each family enrolled in TFF.

EBPs are implemented with fidelity including the appropriate:

- Service provisions and timeframes.
- Program standards for frequency and intensity services.
- Caseloads.
- Data tracking.
- Reporting and record keeping.
- Monitoring activities.
- Staffing and qualification requirements.

B. Developing Prevention Plans and Conducting Risk Assessments

FBSS caseworkers receive training on developing child-specific prevention plans, or what DFPS refers to as the Family Plan of Service (Family Plan). The Family Plan outlines the services and EBPs parents and caregivers must complete to build protective capacities and mitigate identified child safety concerns. Family Plans remain in effect for 180 days and evaluations are completed:

- Six months after completing the initial plan.
- Within six months after completing a previous Family Plan Evaluation.
- Within 21 days after the supervisor approves a Risk Reassessment that has a higher risk level than the previous Risk Assessment or Risk Reassessment.

FBSS caseworkers also complete safety and risk assessments to monitor and oversee the safety of each child receiving services. DFPS has developed a Risk Reassessment Procedure and Reference Manual for staff to ensure this tool is used appropriately. If the Risk Reassessment results in a higher risk rating than before, the FBSS caseworker must complete a new Family Assessment along with a Family Plan within 21 days after the Risk Reassessment is approved in IMPACT by the FBSS supervisor.

Section 6. Child Welfare Workforce Training

DFPS ensures all Family-Based Safety Services (FBSS) staff are fully trained in the Child Protective Services Practice Model. DFPS's approach is always:

- **Safety Organized:** We arrange every aspect of our practice around child safety, focusing on what must happen and who must be involved in the everyday life of the child or youth to address danger.
- **Child Centered:** We help children and youth to understand why we are involved with their families and ensure they have a voice in saying what should change.
- **Family Focused:** We engage caregivers and families in partnerships to help them develop a new understanding of their children's needs and to support them to take protective actions that address danger.

FBSS caseworkers are required to complete foundational training in the family preservation stage of service. This in-depth training also includes mastering practice competencies and the proper use of Safety and Risk Assessment tools in IMPACT. DFPS's practice competencies allow the FBSS caseworkers to develop in their roles by learning and mastering:

- **Engaging:** Developing a trust-based relationship with the family and their safety networks to drive positive changes in the family. Engaging families that we serve involves a combination of skills — the ability to intervene to protect children while developing a helping relationship with caregivers. FBSS caseworkers use solution-focused strategies to ensure successful engagement by children, parents, and their safety networks.
- **Assessing:** Assessment of safety, permanency, and well-being is based on balanced, unbiased, and factually supported information gathered throughout the FBSS case. The FBSS caseworker continuously seeks new information and revises Safety and Risk Assessments and Family Assessments accordingly.
- **Teaming:** Assembling a safety network to team with the child(ren) and the family to help achieve safety, permanency, and well-being. Constructive relationships between people are critical to effective child protection work.
- **Planning:** Planning involves setting goals, developing strategies, and prioritizing tasks and schedules to meet goals. These goals and tasks are outlined in the Family Plan, which is created jointly with the family.
- **Intervening:** The intervention is the least intrusive required for child safety, when possible. The goal is to mobilize caregivers and safety networks to act quickly, knowing that each intervention has an impact on the long-term outcome for the child.
- **Evaluating:** Plans are routinely evaluated to ensure the family's needs are met. Plans are adjusted as needed, while keeping child safety the priority.

Additionally, DFPS and Texas Family First (TFF) providers conduct joint trainings for staff, so they are well-informed on all eligibility requirements, evidence-based programs (EBPs), the TFF referral process, and ongoing safety and risk assessments during the FBSS case. The FBSS caseworkers link the family to the TFF providers and continue their case management duties, such as assessing safety and risk in the family, noting behavioral changes caregivers are making to mitigate danger concerns, attending any court hearings regarding TFF, and reexamining the prevention plan, as necessary.

Section 7. Prevention Caseloads

DFPS Caseload Management

DFPS has set target caseload sizes for both Child Protective Investigations (CPI) investigators and Family-Based Safety Services (FBSS) caseworkers. CPI investigators have an average caseload goal of 13 cases while FBSS caseworkers' average caseload goal is 10 cases. To provide children and families with first-rate service and to support CPI and FBSS caseworker retention, DFPS has set a manageable caseload transition for newly hired investigators and FBSS caseworkers.

After caseworkers complete their foundational training, investigators and FBSS caseworkers are assigned one-third of an average caseload for the first 30 days; this number varies between three and four cases. After 60 days, the cap is increased monthly by one-third until the caseworker reaches a full caseload. The gradual increase in assigned cases allows for newly hired caseworkers to grow and develop competency skills learned during their 12-week foundational training period.

Caseworkers are provided with continuous ongoing support by their leadership to ensure policies and practice procedures are followed, aid in meeting timeframes, and provide effective case management services to families. Leadership support includes daily and weekly check-ins, additional case reviews, and ongoing monthly training for the first six months of employment. Supervisors manage the workers' caseloads in a multitude of ways, providing case direction to investigators and FBSS caseworkers via initial and periodic case consultations. These consultations allow caseworkers and supervisors to monitor case progression and determine safety when cases are eligible for closure. DFPS has developed policies geared toward caseload management in accordance with laws and statutes that direct DFPS to close the CPI and FBSS cases in a timely manner.

DFPS recognizes the correlation between caseload size and effective case management services and that manageable caseloads allow staff to work more effectively with each family and connect families with needed prevention services to keep families together. [14]DFPS data shows a

[14] Legislative Budget Board (LBB) Performance Metrics

downward trend of average daily caseload sizes, showing methods to help maintain caseload goals have improved.

Table 4: Average Daily Caseloads

Fiscal Year	Investigations Average Daily Caseload	FBSS Average Daily Caseload
2020	12.6	11.0
2021	15.1	8.8
2022	17.1	4.8
2023	13.8	7.1
2024	9.6	9.9
2025	8.4	8.8

Texas Family First (TFF) Provider Caseload Management

TFF providers follow evidence-based program (EBP) guidelines for maximum caseload sizes, but some staff may have fewer cases to ensure quality and fidelity requirements of the EBPs are maintained. TFF providers conduct regular reviews to monitor caseloads for alignment with program expectations and staffing levels. This includes tracking outcomes to determine if the caseload size is appropriate for achieving the desired service impact. When assigning cases, TFF providers consider many factors including, but not limited to, the following: the family's level of risk, current caseloads, data collection responsibilities, tenure of staff, staff's area of expertise, the location of cases, and number of family members within the household. This tailored approach aims to balance staff workloads and optimize service delivery. The TFF providers implement the following programs:

- **High Fidelity Wraparound (HFW)**: Designed to accommodate no more than 12 cases.
- **Functional Family Therapy (FFT):** Allows caseloads up to 10.
- **Parents as Teachers (PAT):** Caseloads are managed by maximum visits per month for parent educators rather than a set caseload size. Typically, full-time parent educators complete no more than 40 visits monthly. For a parent educator who sees families twice monthly, this translates to a caseload of 18.
- **Family Centered Treatment (FCT):** Suggests a caseload size of four to six families per practitioner. Supervisors oversee the caseloads, ensuring that staff adhere to the therapeutic model's fidelity.
- **Parent Child Interaction Therapy (PCIT):** Caseloads are managed by a maximum number of sessions per month rather than a set caseload size. The average length of

treatment is 14-16 weeks, with services most frequently delivered once per week (60-minute weekly sessions). Most families complete the program content in 12 to 20 one-hour sessions.

- **Trauma Focused- Cognitive Behavioral Therapy (TF-CBT):** Caseloads are managed by a maximum number of sessions per month rather than a set caseload size. TF-CBT effectively improves a range of trauma-related outcomes in eight to 25 weekly sessions with the child/adolescent and caregiver for approximately one hour, though this can vary.
- **Trust-Based Relational Intervention (TBRI) Caregiver Training:** Caseloads are managed by a maximum number of sessions per month rather than a set caseload size. TBRI is typically delivered in four to five in-person group sessions per week that last up to 60 minutes each for two to five weeks. The length of time is sometimes extended to eight to 10 weeks if a family can only commit to one to two sessions per week.
- **Motivational Interviewing (MI):** MI is typically delivered over one to three sessions (two to three sessions are preferred) with each session lasting about 30 to 50 minutes. Sessions are often used prior to or in conjunction with other therapies or programs.
- **Multisystemic Therapy (MST)**: Therapists work intensively with four to six families at a time. The typical length of treatment time is three to five months with services provided in the community, school, and home.

Section 8. Assurance on Prevention Program Reporting

DFPS provides an assurance in Attachment I that it will report to the Secretary of the U.S. Department of Health and Human Services required information and data with respect to the provision of services and programs included in Texas' Title IV-E Prevention Plan. This will include data necessary to determine performance measures for the state and compliance. Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019.

Section 9. Child and Family Eligibility for the Title IV-E Prevention Program

For purposes of Texas' prevention plan, a child is determined to be a foster care candidate if they meet eligibility for Texas Family First (TFF) as defined in Texas Family Code §262.401. The definition is as follows:

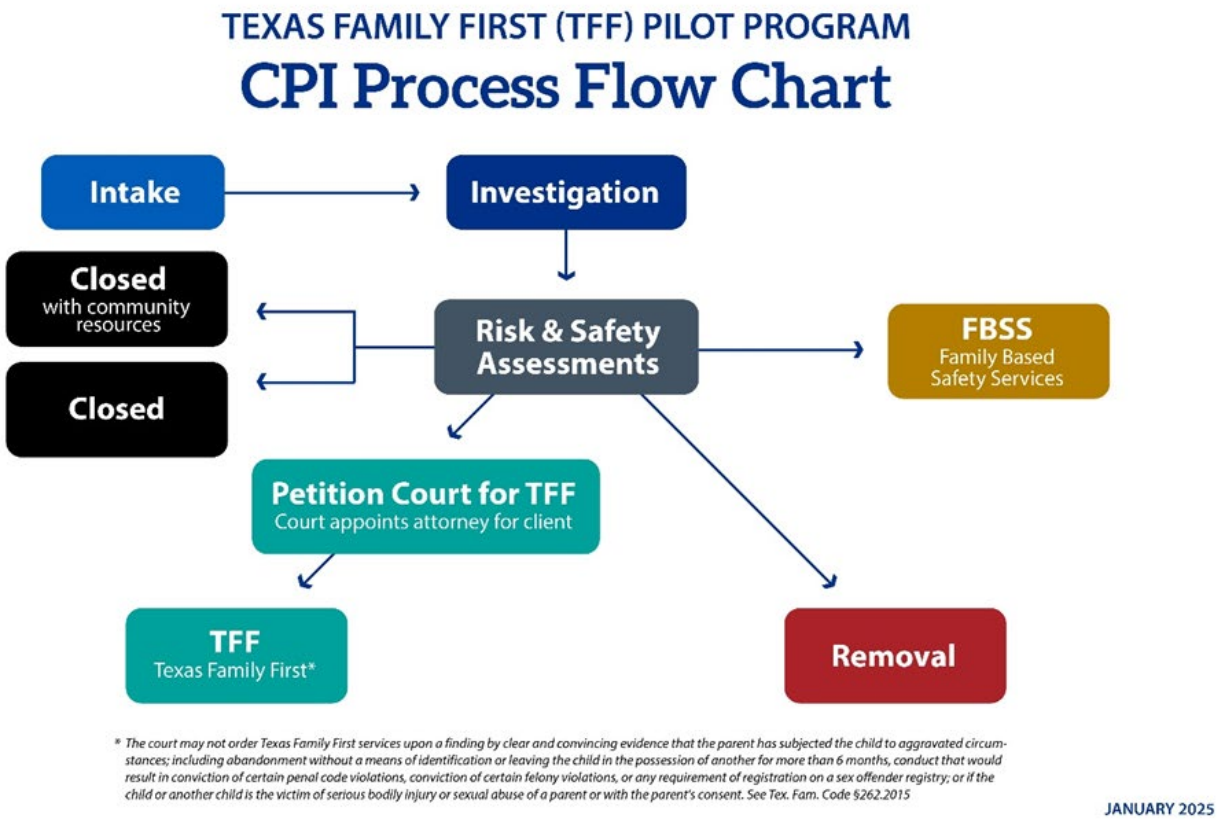
"A child who is a candidate for foster care means a child who is at imminent risk of being removed from the child's home and placed into the conservatorship of the department because of a continuing danger to the child's physical health or safety caused by an act or failure to act of a person entitled to possession of the child but for whom a court of competent jurisdiction has issued an order allowing the child to remain safely in the child's home or in a kinship placement with the provision of family preservation services."

A child is determined by Child Protective Investigations (CPI) staff to be a candidate for TFF if they meet any of the following criteria:

- Child Protection Investigation with a danger indicator with any risk level and a supervision safety plan in place, keeping the child safely in the home with a parent or legal guardian.
- Child Protection Investigation with no danger indicator (no safety plan) with a risk level of High or Very High on the Risk Assessment.
- A family is currently involved with Family-Based Safety Services (FBSS) and a new circumstance occurs leading to a possible removal, but a safety plan is implemented to address dangers. FBSS may make a referral to TFF.
- CPI conducts a new removal, the investigation stage remains open, and the judge orders TFF at the 14-day adversary hearing after finding the child can remain safely in the home.

Once CPI identifies TFF criteria has been met, CPI meets with DFPS regional leadership and legal counsel about the case. If it is determined the family meets TFF eligibility criteria, CPI files an affidavit using the TFF Court-Ordered Services Petition and affidavit format. DFPS staff discuss the referral with the TFF provider to identify the evidence-based program (EBP) most appropriate for the family. TFF provides an option for cases where a child can be kept safely at home with court oversight and evidence-based services. See Image 2 below.

Image 2: CPI Process Flow Chart for TFF

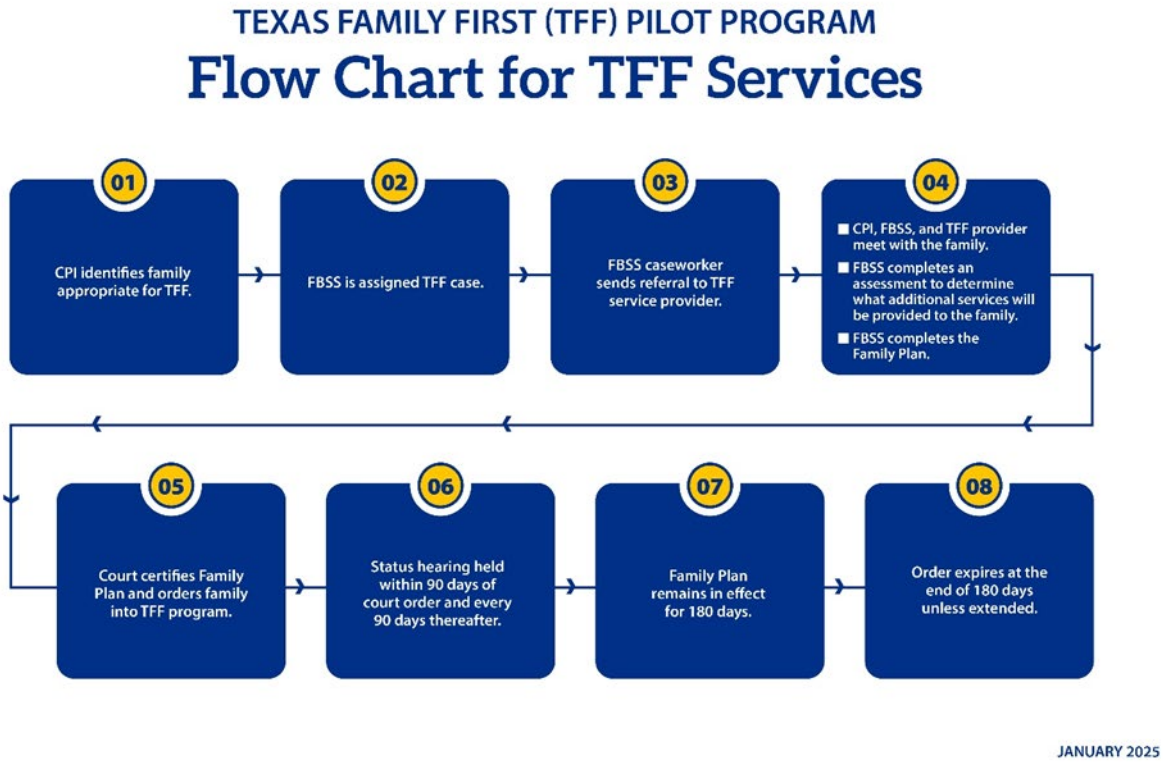


When a hearing is set, all parties ensure services meet the family's needs, and legal representation for the family is provided. During the court hearing, outcomes could include:

- The family is ordered into TFF.
- The family is ordered to participate in FBSS, but TFF services are not court-ordered.
- A removal is ordered.
- The case is ordered to be closed.

The FBSS caseworker collaborates with the TFF provider and family to develop a Family Plan, comprised of EBPs provided by the TFF provider and any additional family preservation services coordinated through FBSS. The Family Plan is then presented to the judge at a court hearing. If the judge agrees that TFF services are appropriate, the family will begin their TFF services. A detailed depiction of the process from the time of court petition for TFF is in Image 3 below.

Image 3: Flow Chart for TFF Services



Conclusion

This Prevention Plan outlines Texas's approach to supporting families through evidence-based services and community partnerships to keep children safely at home whenever possible. The state remains committed to implementing FFPSA as a strategy for strengthening families and improving outcomes for children.

Appendices

Appendix A: Attachments

Attachment I: State Title IV-E Prevention Program Reporting Assurance

Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice-Functional Family Therapy

- **Attachment II-a**: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice-Motivational Interviewing
- **Attachment II-b**: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice-Multisystemic Therapy
- **Attachment II-c**: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice-Parents as Teachers
- **Attachment II-d**: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice -Parent-Child Interaction Therapy

Attachment III: State Assurance of Trauma-Informed Service Delivery

Attachment IV: State Annual Maintenance of Effort (MOE) Report

Attachment V: Program Manuals by Family First Evidence-Based Program

Appendix B: Long Descriptions for Figures

Image 1 TFF Regional Map

The map identifies Texas counties and DFPS regions participating in the Texas Family First (TFF) program. Service areas include:

DFPS Region 1: All counties within Region 1 are included in the TFF service area.

DFPS Region 2: All counties within Region 2 are included in the TFF service area.

DFPS Region 3W: Cooke, Denton, Erath, Hood, Johnson, Palo Pinto, Parker, Somervell, Tarrant, and Wise counties.

DFPS Region 6A: Harris County.

DFPS Region 8A: Bexar County.

DFPS Region 8B: Atascosa, Bandera, Comal, Edwards, Frio, Gillespie, Gonzales, Guadalupe, Karnes, Kendall, Kerr, La Salle, Lavaca, Medina, Real, Uvalde, Wilson, and Zavala counties.

The map highlights these counties and regions as locations where Texas Family First services are available. Regions 1, 2, 3W, 6A, and 8A are highlighted in their entirety, while Region 8B include specific participating counties. The visual is intended to illustrate the geographic distribution of Texas Family First service availability across the state.

Image 2: CPI Process Flow Chart for TFF

The Child Protective Investigations (CPI) process begins with intake and investigation, followed by a risk and safety assessment. Once CPI determines that Texas Family First (TFF) eligibility criteria are met, CPI staff consult with DFPS regional leadership and legal counsel. If the family is eligible, CPI files a TFF court-ordered services petition and affidavit. DFPS staff coordinate with the TFF provider to identify the evidence-based program that best meets the family's needs.

TFF provides an alternative to child removal by allowing children to remain safely in the home with court oversight and evidence-based services. During the court process, legal representation is provided to the family and the court reviews the recommended services and family circumstances.

Following assessment and court review, several outcomes are possible:

- The case is closed.
- The case is closed with community resources provided to the family.
- The family is referred to Family-Based Safety Services (FBSS).
- The court orders the family into Texas Family First (TFF).
- The court orders child removal.

For families participating in TFF, the FBSS caseworker collaborates with the TFF provider and family to develop a Family Plan consisting of evidence-based programs and additional family preservation services. The Family Plan is presented to the court for approval. If the judge determines that TFF services are appropriate, the family begins TFF services under court oversight.

Image 3: Flow Chart for TFF Services

The flowchart depicts a linear process from identification through court oversight and program completion. The Texas Family First (TFF) Pilot Program service process consists of eight sequential steps.

Step 1: Child Protective Investigations (CPI) identifies a family appropriate for TFF services.

Step 2: Family-Based Safety Services (FBSS) is assigned the TFF case.

Step 3: The FBSS caseworker sends a referral to a TFF service provider.

Step 4: CPI, FBSS, and the TFF provider meet with the family; FBSS completes an assessment to determine needed services and develops the Family Plan.

Step 5: The court certifies the Family Plan and orders the family into the TFF program.

Step 6: A status hearing is held within 90 days of the court order and every 90 days thereafter.

Step 7: The Family Plan remains in effect for 180 days.

Step 8: The court order expires at the end of 180 days unless extended.