Advancing Minnesota Families

Using the Implementation of Family First Prevention Services Act to Build a System of Prevention

2019

Association of Minnesota Counties

MACSSA
Minnesota Association of County Social Service Administrators

The Association of Minnesota Counties and Minnesota Association of County Social Services Administrators see the new federal Family First Prevention Services Act (FFPSA) and its focus on preventing out-of-home placement of children as an opportunity to re-examine Minnesota's child welfare system. In recent years, Minnesota has put greater emphasis on intensive child protection interventions. Increased substance use disorder in particular has pushed foster care entries up, and placement durations have increased.

Minnesota needs a new child welfare approach that supports families before children enter out-of-home care, and stabilizes families to promote child safety. The policy work required for FFPSA implementation can facilitate the convening of our child welfare system to move Minnesota in a better direction. Our organizations believe attention to some key aspects of this transformation must begin now, notably:

- Immediate assembly of a governance structure that includes a range of state agencies as well as county and tribal administrators of the child welfare system to guide the changes ahead,
- The gathering of perspectives and experiences of communities of color disproportionally affected by the current system and of parents who have had direct involvement,
- Development of a practice model based on consumer experiences, best practice research, and the expertise of multiple departments and levels of government,
- Integration of work from multiple child- and family-serving agencies, particularly in service delivery at the point of intake for services and service planning, and in service infrastructure regarding how data is collected, shared, and reported out,
- State funding commitments that replace lost federal revenue and maintain commitments to child protection services that will always be necessary at some level,
- Investment to create a sustainable array of prevention services statewide with the intent to reinvest savings garnered from preventing costly child protection services back toward the root causes that destabilize families, and
- Prompt action to establish required elements for Qualified Residential Treatment Programs (QRTP), with assistance to current congregate settings to meet QRTP standards so this portion of Minnesota's continuum of care is not lost.

Counties are committed to using the opportunity of FFPSA to improve family wellbeing in Minnesota, and are eager for this work to begin.

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Introduction

In February of 2018, the Bipartisan Budget Act of 2018 became law. This Act included within it the Family First Prevention Services Act (FFPSA). FFPSA is a significant shift in the use of Title IV-E funds from supporting stability and permanency in foster care to new uses for supporting services to prevent out-of-home placement. These prevention services must have a strong research foundation, and fall into the categories of mental health services, services for substance use disorder treatment or prevention, and in-home parenting skills training. FFPSA also intends to reduce use of congregate settings in favor of family foster care homes when placement is needed. Implementation of FFPSA in Minnesota invites an examination of our child welfare system, and offers an opportunity to orient toward prevention of maltreatment of children and greater stability for families.

The Association of Minnesota Counties (AMC) and the Minnesota Association of County Social Services Administrators (MACSSA) anticipate the positive potential of the Family First Prevention Services Act (FFPSA) as a means to examine and improve Minnesota practices regarding child welfare, promoting the long-term health of families. The framing of FFPSA from the federal level has been to promote child wellbeing and to support families in order to avoid out-of-home placement. AMC and MACSSA echo those sentiments, and hope to leverage FFPSA toward the broader goals of moving Minnesota's child welfare work away from a recent focus on intensive child protection intervention and toward one of delivering the best services to support child safety, family stability, and life-long health for families and their children. AMC and MACSSA have established principles that detail the counties' priorities in the implementation of FFPSA. (See Appendix B) In order to realize those principles, AMC and MACSSA promote the following steps, detailed in this paper:

- Assemble a governance structure with a range of state agencies and especially county and tribal administrators of the child welfare system to guide planning and implementation,
- Gather perspectives and experiences of communities of color disproportionally affected by the current system and of parents who have had direct system involvement to guide practices,
- Develop a practice model based on family and community experiences, best practice research, and the expertise of multiple departments and levels of government,
- Merge work from multiple child- and family-serving agencies in intake for services, service planning, and data infrastructure, in a manner that promotes administrative simplification and easy navigation for families,
- Secure state funding to replace lost federal revenue and sustain child protection services without cost shifts to counties,
- Invest in a sustainable array of prevention services statewide, including rural and underserved communities,
- Reinvest any savings from prevention to address the root causes that destabilize families, and
- Establish required elements for Qualified Residential Treatment Programs (QRTP) and assist settings to meet standards in order to retain this portion of Minnesota's continuum of care.

Counties are key informants on the needs of families and communities, and are best suited to navigate the operational challenges of capacity, cultural relevance, and adequate resourcing based on direct experience. As such, counties are vital partners in implementing an effective prevention focus for Minnesota's child welfare system. AMC and MACSSA recognize that FFPSA in and of itself

will not transform our system, but strongly believe that a thoughtful approach to implementation will make FFPSA a strategic part of the hope for a system that provides the right services to support families before a crisis occurs.

A Change in Approach

Attention to service improvement in Minnesota counties has incorporated some policy and practice approaches that transcend traditional department structures in an attempt to serve families holistically. There are county partners in Minnesota's 2-Generation Policy Network with state agencies, a tribe, and local organizations, in the work supporting parents and their children across the social determinants of health, work that is echoed in whole family work across counties. Much work has been done at the county level to pursue comprehensive needs assessments for the full family when a family comes to the county for services, and to seek ways of delivering services in an integrated manner that facilitates better access to services and coordinates service needs more seamlessly for families across the traditional service departments. These efforts have promoted the development of learning communities within and across counties, as the collaborative and relationship-based work that must occur in these practice approaches benefit from a continuous learning environment.

All these approaches provide a ready environment for the implementation of the prevention focus intended by FFPSA. This ready environment is augmented by counties' close proximity to family and community needs, and knowledge of service capacity. Counties are uniquely situated to see how prevention services would work operationally, and have experience with the challenges and possibilities in funding these systems. Similarly, counties see firsthand how cultural influences can lead to different outcomes from interventions, and witness the importance of cultural considerations for successful family support. All of these elements make counties critical partners in the implementation of FFPSA. Realizing the intent of a new focus on prevention services requires a new partnership at the local, state, and federal level, one that counties believe must be approached intentionally in order to create the most effective alliance for prevention work.

Whole Family Orientation

In addition to an effective alliance for operational implementation, a shared perspective on child welfare policy is needed if the resulting system is to focus on averting out-of-home placement, preventing maltreatment, and stabilizing families for their long-term health. It will call for a different way of thinking about and conducting child protection. This new approach would provide a screening process that screens for family service needs, not just for whether the statutory criteria is met to intervene in a family's life. Minnesota's prevalence of neglect (See Appendix C) is an opportunity to deliver appropriate services in response to a child protection report, including facilitation of substance use assessment and treatment—especially to settings that are culturally appropriate—rather than turning to a child protection investigation with law enforcement. A consideration of comprehensive family needs at the point of intake could have the effect of diverting families from child protection interventions per se, instead providing the means and timeframe for services that could address concerns without the need for court involvement or foster placement.

While there will always be situations that require intensive intervention, this response could be tailored to those circumstances instead of being a primary approach.

Coordinated Multisystem Service Delivery

Supporting a system that looks first to prevention services for families rather than assessing whether children need to be removed for safety also will require improved cross-system connections. Minnesota's current service structure segregates the key service types that are emerging for FFPSA across multiple divisions and even departments of state agencies, separation that is often mirrored at the local level. At a broad level, the categories of prevention services—substance use disorder prevention and treatment, mental health services, and in-home parenting skill-based services—have oversight from the Alcohol and Drug Abuse Division, Adult Mental Health Division, Children's Mental Health Division, and Child Safety and Permanency Division in the Minnesota Department of Human Services, as well as the Child and Family Health Division in the Minnesota Department of Health. Further, the small list of specific services that have been identified to date by the Administration on Children, Youth, and Families at the U.S. Department of Health and Human Services as meeting the required research standards under FFPSA are commonly delivered locally in Minnesota not only through mental health, substance abuse, and child welfare areas of social services, but also through home visiting in public health, in contracted community agencies, and in juvenile justice and adult corrections. Consistent with this scattering of service access, families with service needs regularly utilize multiple service systems simultaneously. Implementation of FFPSA in Minnesota provides an opportunity to improve this process for families, as successful implementation will require attention to cross-system service planning, data exchange, communication, and funding strategies.

With that as the foundation for implementation of FFPSA in Minnesota, the following elements should guide the implementation process.

Steps toward a New System

Create cross-agency governance

Given that FFPSA addresses the child welfare system, the temptation would be to vest the Child Safety and Permanency Division with implementation responsibilities, but this misses the scope and opportunities of FFPSA. Minnesota should instead devise a systemic implementation perspective that engages leadership in substance use and mental health along with child welfare, incorporating other service areas in light of the cross-system nature of delivering prevention services. Leadership at the state, county, and tribal levels must be engaged in leading implementation to ensure that implementation can be achieved more evenly statewide. AMC and MACSSA believe the Children's Cabinet has relevant experience in this area: its members include Commissioners of Education, Human Services, and Health to have the needed cross-system perspective, and hold roles within their agencies to be able to promote effective implementation. There is tremendous value in convening across agencies and systems, and the Children's Cabinet has a history of strategic thinking that has sought broadly to improve the social determinants for health for children and families. County and

tribal representation must be added to the Children's Cabinet in order for this work to advance a more complete operational perspective informed by local realities.

AMC and MACSSA recommend immediate assembly of a governance structure including a range of state agencies and both county and tribal administrators of the child welfare system.

Solicit guidance from lived experiences

Minnesota's current system has been inadequate for supporting marginalized communities, and has been especially insufficient in serving African American families and families from tribal nations. Sauer Family Foundation in particular has completed recent engagement within these communities to inform the child welfare system on service delivery, but Minnesota needs more input from people who have experienced the system as the implementation of FFPSA moves forward in Minnesota. Family panels and Minnesota's ICWA Advisory Council must be invited into the discussion about a more effective system of supporting families to promote child safety, including defining a meaningful, ongoing role for them as part of the system. The state must fund and promote a human-centered design process with cultural communities and parents who have received child welfare services, including as related to parental substance use and parental mental health. Their experiences will be vital to both prevention service planning and to practice model design.

AMC and MACSSA recommend that experiences of communities of color and parents who have had direct involvement in the current system be systematically gathered to inform the system design.

Develop a prevention-focused practice model

FFPSA, viewed most narrowly, will expand use of research-supported prevention services that improve the wellbeing and safety of children. AMC and MACSSA advocate that Minnesota uses the opportunity of FFPSA implementation to go beyond building up some prevention services to develop a practice model for Minnesota that proactively addresses family wellbeing. As noted above, the design process must be informed by communities of color, cultural communities, and parents who have experienced the system, and must move forward with active involvement of tribes, counties, and the state, including the range of service areas that have impact on families' social determinants of health, drawing on best practice research. Minnesota's current child welfare system is designed to be reactive, engaging families only when there is indication that maltreatment has already occurred: Minnesota needs a better approach guided by the wisdom of families about what could have prevented their circumstances, and what type of assistance would have made a difference for them.

In the design of a practice model, attention has to be given to some key elements. Minnesota's state plan will require determining the target population to be served by prevention services, and a definition of imminent risk of out-of-home placement for IV-E eligibility will be reached. By having counties and tribes that administer the services engaged in the implementation, consideration of local needs for those definitions and the local system of care can be incorporated in the practice model. Similarly, in an approach that engages the multiple agencies and systems that have a role in prevention service delivery, there is a mechanism for shared vision and shared leadership in a new

practice model. This would include expectations for achieving smooth service access for families across systems, for routine communication and coordination, for systematic outcome measurement, and for shared commitment to outcomes that go beyond maltreatment and placement measures to use social determinants of health as areas to mark progress. Most importantly, Minnesota must embrace a new approach to child welfare that values children's families as the best setting for their success and directs resources and professional development toward the strengthening of families rather than promoting intensive intervention by child protection in families' lives.

Counties are well-equipped and committed to this transformation in service perspective. While county efforts need to be balanced by proceeding with the state as a partner and system supervisor, Minnesota has always been most innovative when counties plan and pilot ahead of statewide efforts, working with the state in developing local ideas and vision. Development of a new practice model is no different than past initiatives and reforms: AMC and MACSSA are well aware of counties that are able and ready to pilot new approaches that can shape Minnesota's path toward a better way to serve families.

AMC and MACSSA recommend a practice model be developed based on consumer experiences, best practice research, and the expertise of multiple departments and levels of government.

Improve system integration

An approach to serving families across the social determinants of health will involve what are now separate program areas. There is the potential for interventions to be delivered in multiple areas of the public sector to take advantage of expertise and capacity, as well as the possibility of children at imminent risk of placement being identified in programs beyond just the child welfare system, especially in public health, education, juvenile justice, adult mental health, and substance use disorder treatment. As such, there is a need to look at changing or sharing infrastructure in support of a coordinated service delivery approach. This might include several aspects of how work is currently administered, but AMC and MACSSA see a few aspects as vital to be integrated.

A more comprehensive intake

The current child protection system accepts reports of concerns regarding a family and determines whether or not the circumstances, if true, would constitute maltreatment under Minnesota Statute. An approach of preventing harm and supporting families is likely to require a different type of intake that allows a family to be directed to the right service for the need, not just to a child protection assessment or Parent Support Outreach referral. This would likely mean an intake process that can identify what services a family currently is using to facilitate the ability to activate the most appropriate sector for a response. To access IV-E prevention reimbursement, a child must be a IV-E candidate and the family must have a case plan addressing the identified need prior to the service: this points to a process that focuses on a risk and needs assessment led by the family's voice to establish the right support, including inquiries across the social determinants of health in order to capture the root causes of instability in the family and risk for children.

Collective impact metrics

The data sharing that enables a comprehensive intake process also could facilitate the type of communication needed to streamline services across multiple systems, and to track family outcomes that are more meaningful than single program outcomes. While child maltreatment, maltreatment recurrence, and out-of-home placement rates reported by race and age are important community indicators, so too are rates of homelessness for accompanied or unaccompanied minors, rates of Adverse Childhood Experiences like parental incarceration or witnessing domestic violence, percentage of preschoolers receiving a preschool screening by age four, percentage of students reading at grade level in third grade, and measures of high school graduation, employment, and poverty. A shift toward monitoring child wellbeing in this way will better inform the success of prevention efforts.

Shared data infrastructure

Data systems used in serving families in Minnesota must be enhanced with an eye to service integration and administrative simplification. Counties strive to be data-driven in service delivery in order to understand program impact, adapt, and improve experiences. To do so, counties and tribes need better access to the data inputted into the data systems, being able to push and pull information to improve services. Dashboards that represent the type of shared metrics that show the health of a community, including measures from Minnesota Department of Education, the community correction systems, public health nursing, and social services will allow local government to set local priorities. In addition to ready availability of this aggregate information, restrictions in data sharing need to be re-examined, especially with schools, juvenile justice, public health, child welfare, and social services to allow for service coordination. The shared elements should be structured in a manner that allows families to access the same information on their own, so that the systems function transparently in their coordination efforts. Ultimately, counties and tribes need the means to consider the whole family in order to put focus on their priority needs if root causes of instability and health barriers are to be addressed.

AMC and MACSSA recommend integration of child- and family-serving agency work, especially at intake for services, service planning and in data infrastructure regarding how data is collected, shared, and reported.

Invest in system redesign

Creating new services requires resources, independent of the resources needed to design and realize a new approach to serving families. Minnesota's current system relies on county levy for the largest portion of child welfare funding, a practice that produces variability around the state in the local means to serve families. Consistent services available statewide will require investment at the state level to address this system weakness. This must involve Minnesota's health plans as well, seeking streamlined use of all funding streams in addressing family needs. AMC and MACSSA see several components of FFPSA implementation that need adequate funding to succeed.

Sustainable service array statewide

Minnesota will be required in the state's plan to identify specific services for which IV-E reimbursement will be sought. It is critical that a service array is selected that is broad in the type of needs that are addressed by the interventions, and that are appropriate across the full spectrum of child ages. It is also important not to select all possible services for inclusion and forfeit the opportunity to have scale that would allow for efficient provider training, sufficient capacity, and robust learning communities specific to the intervention. Minnesota must be thoughtful and intentional about building the provider community and learning community support to ensure statewide access to high quality services: AMC and MACSSA see service identification as an important task of the governance group at the Children's Cabinet, informed by the Results First work at Minnesota Management and Budget. Once selected, establishing these services will not occur relying upon the reimbursement of half of the service cost through IV-E. Health plans will have an important role, but additional state investment will be needed to achieve statewide access to the service array. Developing and maintaining an adequate capacity of service providers will only occur with continuous, predictable investment, an investment that should be anticipated and budgeted as part of FFPSA implementation.

Culturally specific services present a unique challenge in FFPSA. The research standards required of services under FFPSA are a barrier to most culturally-specific services, as the large-scale research underpinning required by FFPSA for service approval are seldom conducted on culturally-specific services. In light of Minnesota's disproportionality rates, having state and health plan funding as the priority for culturally-specific services likely will create more reliable capacity and access to these needed services rather than looking to FFPSA as the funding stream to reimburse half of the service costs.

Continued commitment to child protection

No matter what FFPSA implementation brings, our child protection system must keep children safe. It is important to recognize that there will still be families and children served in the child protection system, a system that in Minnesota is widely recognized as being inadequately funded. Current information system practices of Structured Decision Making and documenting risk across multiple domains must continue to be supported, just as any transition to a Child Welfare Information Sytem must be resourced. Child protection services, like all public sector services, need significant streamlining of documentation and administrative requirements as a means to improve capacity for direct services with families and children. Yet even if achieved, these efficiencies likely would not make up for the current insufficient investments in the child protection system.

AMC and MACSSA anticipate that over time, Minnesota will experience positive outcomes from increased prevention efforts by seeing a reduction in child maltreatment and child out-of-home placement. The temptation in that circumstance could be to reallocate funding for child protection to other areas of the budget. Taking steps that would continue inadequate funding for child protection still deprives some Minnesota children and families of the service resources that they depend on as they seek to reunify through the child protection court process. Financial commitments to the child protection system must persist for the existing needs of families in child protection.

Replacing lost federal revenue

FFPSA is a reallocation of federal funds, and did not include any new funding. As such, it anticipates a reduction in existing IV-E reimbursement to states to off-set prevention services costs. Reimbursement of a portion of the costs of congregate care setting such as group homes and shelters for eligible children will be limited significantly with FFPSA implementation. The restrictions on reimbursement of these settings are effective when the state opts in for reimbursement of prevention services costs, or by October 1, 2021, whichever comes first. For some counties, this loss of partial reimbursement of congregate placement costs for IV-E eligible children is a substantial financial blow. While the hope might be to place emphasis in service delivery on prevention and early intervention, this type of revenue loss could require counties to prioritize local resources to intensive services for children and families in-risk, rather than having the means to dedicate funds to other parts of the service continuum. Given the current reliance of the child welfare system on county funding, AMC and MACSSA know that it is critical to the functioning of the child welfare system for this lost federal revenue to be replaced.

Funding directed to root causes

FFPSA will open different funding opportunities to focus on prevention, and it is clearly the recommendation and intent of AMC and MACSSA that Minnesota places greater financial emphasis on providing families support before circumstances get worse, imperiling child safety. The redirection of IV-E reimbursement to prevention services could be an element of "growing the pie" in Minnesota: when IV-E reimbursement is accessed for prevention services, Minnesota should seek to redirect any savings toward unaddressed needs. The barriers to health and stability in Minnesota families that require greater financial attention include health disparities, housing instability, racial inequities, substance use disorder, and public program fiscal cliffs, all of which transcend specific programs and hold families and communities back when unaddressed.

AMC and MACSSA recommend that state funding commitments are secured to replace lost federal revenue, to maintain core child protection services, and to invest in a sustainable array of prevention services statewide, with any prevention-created savings being rededicated to support greater family stability in the areas social determinants of health.

Support Qualified Residential Treatment Programs

There is the potential for some congregate settings still to be reimbursed following FFPSA implementation if they meet new federal Qualified Residential Treatment Program (QRTP) requirements. These requirements have quality improvements in staffing and program elements for treatment programs, requirements that will come with additional costs for programs. There is already an effort underway to survey corporate foster homes regarding the potential to become qualified, and to determine with existing treatment programs whether they plan to comply with the new standards. Preliminary results of Minnesota's children's mental health intensive needs study underscore the limited access to residential treatment for children with the most significant treatment needs, yet there is the potential that this reimbursement loss will further compound access and funding difficulties. (Minnesota's residential treatment system for children is currently under financial pressure due to a reclassification of the programs as Institutions for Mental Disease,

eliminating Medical Assistance reimbursement, at the same time as the hoped-for transition to Psychiatric Residential Treatment Facilities for these programs has yet to fully materialize.) Loss of IV-E revenue for these placements without replacement of this revenue would shift costs to counties, forcing counties to focus resources on funding deep-end needs instead of prevention or early intervention.

There are benefits to investment in Minnesota's residential treatment programs, beyond avoiding the cost shift to counties that would impact service capacity overall. The current system commonly places children in treatment programs that are outside their communities, sometimes even outside of Minnesota. Travel can be beyond the means of the child's family, and family involvement both as sought now and as would be more rigorously required under FFPSA can be difficult to achieve at a distance. A state investment in Minnesota's residential treatment programs for children's mental health could support compliance with requirements to become Qualified Residential Treatment Programs, and the resulting family involvement and post-discharge service requirements for QRTP may even create needed local and community-based services. A state commitment to residential treatment programs is needed in a range of areas, including but not limited to:

- Establishing the process for newly-required independent evaluators to assess the appropriateness of the placement within thirty days, per FFPSA requirements,
- Aiding in capacity for earlier and thus a higher volume of court access, per FFPSA court oversight mandates,
- Providing financial assistance for the upgrades in staff and programming under the Act,
- Replacing lost IV-E revenue to counties and tribes, and
- Convening and educating court and other partners to stand up the system to uphold the new requirements for children's mental health treatment programs.

AMC and MACSSA recommend prompt establishment of QRTP compliance elements, with support for current congregate settings to meet standards and remain viable in the continuum of care.

Begin intentional communication and outreach

Just as convening and educating is needed regarding the new qualified residential treatment program status, communication is needed overall with service providers, with other child- and family-serving agencies, across the public sectors, with cultural communities, and more. A plan for communication to all stakeholders is needed in both FFPSA requirements and a new view of serving families to support and stabilize them for improved child wellbeing.

AMC and MACSSA recommend a comprehensive communication effort on FFPSA.

Require timely action

Minnesota, its counties, and tribes must move as expeditiously as possible on these matters. Together we must delineate our path forward so that we can all lead this transformation and have clear positions from which to respond to guidance from the federal government on FFPSA in the future. States may implement at any point from October 1, 2019 to October 1, 2021: Minnesota has indicated that we will not begin October 1, 2019, but we should not default to waiting until the end

and miss the chance to motivate necessary improvements sooner. At this point, optimal timing may come in moving promptly to establish the required elements for Qualified Residential Treatment Program reimbursement in order to reduce some IV-E revenue loss, and then identifying the scope of prevention services for Minnesota's plan based on the scope of needs and full continuum of child ages as the Administration on Children, Youth, and Families at the U.S. Department of Health and Human Services releases approved options. Minnesota should implement FFPSA as quickly as is feasible once these two components are in place.

AMC and MACSSA hope that convening the governance structure described above will happen as soon as possible, preferably not later than the third quarter of 2019. Minnesota has an urgent need to focus now on addiction, and bringing substance use disorder services into the planning process at the earliest phase could facilitate better integration with substance use disorder reform already underway. There is much work to be achieved in collecting the perspectives of families, communities, and partners to guide the multisystem governance group at the Children's Cabinet in designing a new practice model, yet it is vital work. The result could be real support for family wellbeing that provides lifelong benefits that transcend just reducing child maltreatment and out-of-home placement.

AMC and MACSSA recommend that action on implementation and a new prevention focus to improve family wellbeing begin now.

Appendices

Appendix A: Family First Prevention Services Act (FFPSA), National Conference of State Legislatures, May 15, 2018

Appendix B: County Principles on the Implementation of Family First Prevention Services Act, Association of Minnesota Counties and Minnesota Association of County Social Services Administrators, February 2019

Appendix C: Elements of Maltreatment in Minnesota

On Feb. 9, President Donald Trump signed the Bipartisan Budget Act of 2018 (H.R. 1892) to keep the government funded for six more weeks and pave the way for a long-term budget deal that will extend to the end of the fiscal year. Included in the act is the Family First Prevention Services Act, which has the potential to dramatically change child welfare systems across the country.

One of the major areas this legislation seeks to change is the way Title IV-E funds can be spent by states. Title IV-E funds previously could be used only to help with the costs of foster care maintenance for eligible children; administrative expenses to manage the program; and training for staff, foster parents, and certain private agency staff; adoption assistance; and kinship guardianship assistance.

Now states, territories, and tribes with an approved Title IV-E plan have the option to use these funds for prevention services that would allow "candidates for foster care" to stay with their parents or relatives. States will be reimbursed for prevention services for up to 12 months. A written, trauma-informed prevention plan must be created, and services will need to be evidence-based. The U.S. Department of Health and Human Services (HHS) expects to release guidance on service eligibility before Oct. 1, 2018.

The Family First Prevention Services Act also seeks to curtail the use of congregate or group care for children and instead places a new emphasis on family foster homes. With limited exceptions, the federal government will not reimburse states for children placed in group care settings for more than two weeks. Approved settings, known as qualified residential treatment programs, must use a trauma-informed treatment model and employ registered or licensed nursing staff and other licensed clinical staff. The child must be formally assessed within 30 days of placement to determine if his or her needs can be met by family members, in a family foster home or another approved setting.

Certain institutions are exempt from the two-week limitation, but even they are generally limited to 12-month placements. Additionally, to be eligible for federal reimbursement, the act generally limits the number of children allowed in a foster home to six. Although the new programs are optional state officials will need to review their policies and develop state plans that are in line with the latest federal guidelines.

TITLE VII—Family First Prevention Services Act | Subtitle A—Investing in Prevention and Supporting Families

SEC. 50702. PURPOSE:
"The purpose of this subtitle is to enable States to use Federal funds available under parts B and E of title IV of the Social Security Act to provide enhanced support to children and families and prevent foster care placements through the provision of mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator services."

PART I—Prevention Activities Under Title IV–E

States Have the Option to Use Title IV-E to Prevent Children's Entry into Foster Care

- Allows the use of Title IV-E funds for the following services to prevent the placement of children and youth into the foster care system.
  - In-home parent skill-based programs.
  - Mental health services and substance abuse prevention and treatment services.

- Title IV-E funds can only be used in this capacity for 12 months for children who are "candidates for foster care" and for pregnant or parenting foster youth. The act further clarifies that children and youth under the guardianship of a kin caregiver are also eligible for these funds.
- Eligible services must meet certain requirements:
  - The service must be described as part of a state's plan.
  - There must be a manual outlining the components of the service.
  - The service must show a clear benefit.
  - The service must meet one of the following three thresholds:
    - **Promising Practice:** Created from an independently reviewed study that uses a control group and shows statistically significant results.
    - **Supported Practice:** Uses a random-controlled trial or rigorous quasi-experimental design. Must have sustained success for at least six months after the end of treatment.
    - **Well-supported treatment:** Shows success beyond a year after treatment.
- The secretary of the Department of Health and Human Services will be responsible for creating a clearinghouse of approved services by October 2018. These services will most likely be similar to those identified through the California Evidence-Based Clearinghouse on Child Welfare
- The secretary may waive the evaluation requirement for a practice if they find the practice to be effective.
- States that choose to use Title IV-E funds must demonstrate maintenance of effort of state foster care prevention spending at the same level as their 2014 spending.
- States with fewer than 200,000 children for the year 2014 may opt to base their maintenance of effort on their expenditures for 2014, 2015 or 2016.
- This section also extends the matching rate from the federal government for prevention services to 2026. The Federal Medical Assistance Percentage will be applied beginning in 2027.

PART II—Enhanced Support Under Title IV–B

Improving the Interstate Placement of Children and Extending Substance Abuse Partnership Grants

- Funding authority is provided to support states in establishing an electronic interstate processing system for the placement of children into foster care, guardianship or adoption. It also creates a $5 million grant fund to improve interstate placement of children.
- FFPSA extends regional partnership grants for five years and allows the grants to be used on a statewide basis and for organizations that are not state agencies.

PART III—Miscellaneous

Model Licensing Standards for Kinship Care Homes and Preventing Child Maltreatment Deaths

- States must demonstrate that they are in line with newly established national model licensing standards for relative foster family homes.

Tracking and Preventing Child Maltreatment Deaths

- States must create a plan and fully document the steps taken to track and prevent child maltreatment deaths in their state.

PART IV—Ensuring the Necessity Of A Placement That Is Not In A Foster Family Home

Focus on Family Foster Care: Major Reforms to Congregate, Residential and Group Care

- Federal law defines a reimbursement-eligible family foster home as having six or fewer children, and a reimbursement-eligible child care institution as having 25 or fewer youth.
- This section places a limit of two weeks on federal payments for placements that are not foster homes or qualified residential treatment programs. This rule takes effect Oct. 1, 2019.
- An exception to this rule is made under the following circumstances:
  - Juvenile justice system (states may not incarcerate more juveniles under this provision).
  - Prenatal, postpartum or parenting support for teen moms.
  - A supervised setting for children 18 or older.
  - High-quality residential activities for youth that have been victims of trafficking or are at risk of it.
- States may delay the implementation of this part of the legislation for two years, but if they choose to do so they will delay funding for prevention services for the same length of time.
- For a setting to be designated as a qualified residential treatment program, it must meet the following qualifications:
  - Licensed by at least one of the following:
    - The Commission on Accreditation of Rehabilitation Facilities.
    - Joint Commission on Accreditation of Healthcare Organizations.
    - Council on Accreditation.
  - Utilizes a trauma-informed treatment model that includes service of clinical needs.
  - Must be staffed by a registered or licensed nursing staff.
    - Provide care within the scope of their practice as defined by state law.
    - Are on-site according to the treatment model.
    - Are available 24 hours a day and seven days a week.
  - Be inclusive of family members in the treatment process if possible, and documents the extent of their involvement.

- Offer at least six months of support after discharge.

- Within 30 days of a youth being placed in a qualified residential treatment program, an age-appropriate and evidence-based review must be performed to determine if a qualified residential treatment program is the best fit for them.

- The court must approve or disapprove the placement within 60 days and continue to demonstrate at each status review that the placement is beneficial to the youth. The state must also show that progress is being made in preparing a child to be placed with a family, in a foster family home or with an adoptive parent.

- After 12 consecutive months or 18 nonconsecutive months, the state must submit to the secretary of health and human services approval for continued placement from the head of the state child welfare agency

- States must develop a plan to prevent the enactment or advancement of policies or practices that would result in an increase in the population of youth in a state's juvenile justice system. States are also required to train judges and court staff on child welfare policies, including limitations on use of funding for children placed outside of a foster care family.

- By 2020 the Department of Health and Human Services will perform an assessment of best practices

- Starting Oct. 1, 2018, states are required to conduct criminal history and child abuse and neglect registry checks on any adults working in a childcare institution.

PART V—Continuing Support For Child And Family Services

Recruiting and Keeping Foster Families: Increased Financial Support through 2022

- A one-time, $8 million competitive grant will be made available through 2022 to support the recruitment and retention of high-quality foster families.

Extending John H. Chaffee Foster Care Independence Programs to Age 23

- States may use John H. Chafee Foster Care Independence Program funds for youth up to 23 years of age who have aged out of foster care if that state has extended federal Title IV-E funds to children up to age 23 They may also extend education and training vouchers up to age 26, but for no more than five years total.

PART VIII—Ensuring States Reinvest Savings Resulting From Increase In Adoption Assistance

- The Fostering Connections to Success and Increasing Adoptions Act, signed in 2008, set the income test for federal adoption assistance payments to gradually expire by 2019. Teens were to be the first group to be exempt from the income test and this exemption would gradually extend to newborns.

- With the FFPSA this process is halted at 2-year-olds until 2024. The federal Government Accountability Office is tasked with conducting a study to determine how states are using the money they saved from the exemptions. The income test for federal adoption assistance payments will end in October 2024.

NATIONAL CONFERENCE OF STATE LEGISLATURES, May 15, 2018. http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx

County Principles on the Implementation of Family First Prevention Services Act

Transformative: The way forward must promote transformation of current approaches for families and children to emphasize support before harm occurs, amplifying safety in a culturally relevant manner, equitably and consistently statewide.

Reduce disparities: Access, services, policies, and procedures must be equitable and just, culturally-appropriate and culturally-relevant, and reduce disproportionate impact on communities of color.

Preventative: It is vital to include in Minnesota's plan a full continuum of prevention services for supporting families. Child maltreatment is the result of the interaction of a number of individual, family, and environmental factors, thus prevention of maltreatment needs a comprehensive approach across sectors (e.g., public health, government, education, social services, and justice). Preventing maltreatment and out-of-home placement is a priority for the system changes.

Investment: Transforming systems requires financial viability across the continuum of care, sustaining a sufficient and predictable level of funding and effort through the transition and beyond. The State of Minnesota must commit to this investment, providing adequate and predictable investment in all regions, to all cultural communities, statewide.

Shared infrastructure: The connection between public service departments—education, public health, human services, corrections—must be strengthened to help ensure common practices are applied to fund services, implement shared data systems, and support families, youth, and children. Services should be aligned with outcomes and intended to prevent child maltreatment, avoiding child protection involvement. Data systems must allow seamless movement of individual family service plans across systems so that families can access support without being limited by the department where concerns first arose.

Governance: State, counties, and tribes need to be strong partners to lead in a transformation of the system.

Stakeholder role: Reimagining and building a system must include families, youth, cultural communities, and elected officials. Local realities must be integrated into system development.

Partnership: Decisions affecting planning and service delivery need to be made by engaging with a cross section of stakeholders, including non-government partners and cultural communities in both planning and delivering services.

Family-focused: A successful system must deliver interventions that families regard as being beneficial in addressing the needs of the family, youth, and children.

Statewide access: Families and children throughout the state must have equal access to services that are close to their families and communities.

Professional development: Expansion of a well-trained diverse workforce is necessary to deliver quality services statewide and prepared to deliver services across systems. This must include attention to creating learning communities for serving families with complex needs, as well as systems to ensure model fidelity for research-supported services.

Outcome-driven: Wherever possible, the system structure must be directed toward proven approaches that promote positive outcomes for families, youth, and children rather than prescriptive policies. Child wellbeing must take precedence over system compliance.

Elements of Maltreatment in Minnesota

The Minnesota Department of Human Services provided the following descriptions of child protection services in *Minnesota's Child Maltreatment Report, 2017*:

- There were 39,606 alleged victims involved in at least one completed assessment or investigation following a screened in child maltreatment report.
- Since 2008, there has been about a 75 percent increase in completed assessments/ investigations; the increase in workload has greatly exceeded increases in funding for child welfare agencies.
- American Indian children were about five times more likely to be involved in completed maltreatment assessments/investigations than white children, while children who identify with two or more races and African-American children were both approximately three times more likely to be involved.
- Minnesota continues to struggle with opportunity gaps for families of color and American Indian families. The disproportionality seen in child protection cases is further evidence of a gap in services and opportunities for these families and children.
- Children age 8 and younger represented the majority involved in completed maltreatment assessments/investigations (59.7 percent) in 2017.
- Alleged victims with allegations of neglect constituted the largest group of children by far, with approximately 62.2 percent of all children in 2017.
- Prenatal exposure to alcohol or substances is one form of neglect. In 2017, 1,672 children were prenatally exposed to alcohol or illegal substances. This represents a 26 percent increase since 2016, and a 121 percent increase since 2013.
- Maltreatment allegations of chronic and severe use of a controlled substance/alcohol have also seen a similar large increase. There were 2,681 children with this allegation identified in 2013, increasing to 6,321 alleged victims in 2017. (p. 5-6)

These statistics affirm the experiences of counties: that child protection volume has increased significantly and beyond the resources allocated for child protection intervention, that the children involved in child protection are young and disproportionally children of color or from tribal nations, and that neglect—especially related to parental substance use—is a dominant portion of child protection work in Minnesota counties and tribes.

Minnesota's Child Maltreatment Report notes the state's poor performance for children of color, which is not a new phenomenon in Minnesota. Disproportionality is also stark when looking at out of home placement. A Racial Disproportionality Index examines children's rate of representation in the foster care system compared to their rate of representation in the general population by racial group, with an index of 1.0 being no disproportionality, less than 1.0 being underrepresentation and greater than 1.0 being overrepresentation. Minnesota's 2010 Racial Disproportionality Index for African American/Black children was 4.4; the 2013 Racial Disproportionality Index was 2.1; the 2014 Index was 1.8; the 2015 Index was 1.9. For American Indians children in placement, the state's Racial Disproportionality Index in 2010 was 8.1; the 2013 Racial Disproportionality Index was 14.8; the 2014 Index was 17; the 2015 Index was 13.1. In all years reported, Minnesota's Racial Disproportionality Index for children from tribal nations was the worst in the United States, comparing to a U.S. rate of 2.7 for fiscal year 2015. (National Council of Juvenile and Family Court Judges Juvenile Law Program, 2015-2017.)

While no single element accounts for child maltreatment, much is known about conditions that place children at greater risk for maltreatment, and about conditions that help to protect children from maltreatment. Conditions that have been associated with increased risk of maltreatment are often parent characteristics— parental mental illness or substance abuse, parental history of maltreatment, young parent age, single parenthood, high stress—or family characteristics like low household income, many dependent children, intimate partner violence, social isolation, and parent-child conflict. The community environment itself also creates increased risk when there is prevalent community violence, high poverty, low employment, and housing instability in the family's neighborhood. As these risks might imply, strong family and social support, stable housing, access to supportive services, and parental employment can all assist in mitigating risk. (Centers for Disease Control and Prevention, 2015)

The conditions influencing child maltreatment risk point to the importance of the social determinants of health. Social determinants of health are conditions in people's lives and environments that serve as drivers of health inequities across the lifespan. (World Health Organization Commission on Social Determinants of Health, 2008). The key factors in social determinants of health for families include environmental health, safety, food and nutrition, employment and income stability, health and wellbeing, housing stability, transportation, and education. When these are secure for a family, the benefits extend beyond their children's early years, and can be determinant of health for children into adulthood. When left unaddressed, however, they create or exacerbate poor health outcomes in a manner that costs the community and impacts communities of color and people in poverty at higher rates than the general population. Counties' work attending to the social determinants of health supports both the immediate needs of children and families, but also the long range health of the community. In Minnesota, counties have the lead role in delivery of services in these domains, responding to the local realities with preventive services that can produce long-term benefits for the community. FFPSA has the potential to support some of these efforts at the local level.

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