TITLE IV-E PREVENTION SERVICES PLAN

Virginia Department of Social Services

Table of CONTENTS

FAMILY FIRST PREVENTION PLAN

INTRODUCTION

Virginia operates a state-supervised/county-administered social services system. The Virginia Department of Social Services (VDSS) provides oversight and guidance to the local departments of social services (LDSS) that provide services throughout the Commonwealth. Prevention services are provided across the continuum and include primary, secondary, and tertiary activities. The passing of the Family First Act in conjunction with the 2020-2024 Child and Family Service Plan (CFSP) provides the strategic direction and fiscal resources necessary for VDSS to enhance all prevention services with a specific emphasis on expanding our tertiary prevention efforts to prevent foster care entry. Through Family First, VDSS has begun and continues to increase the use of our In-Home Services program to ensure that all LDSS have the resources needed to provide prevention services for children and families to reduce the likelihood of foster care entry.

In Virginia's locally administered child welfare system, Virginia's LDSS have the flexibility to design services to meet a wide range of needs based on individual children, youth and family circumstances, local demographics, and available resources. LDSS are expected to coordinate services with local private agencies and community organizations, and the Office of Children's Services (OCS). The Family First Prevention Services Act (Family First) enables the use of federal funds under parts B and E of Title IV of the Social Security Act. These funds provide enhanced support to children and families and prevent foster care placements through the provision of mental health prevention and treatment services, substance use disorder prevention and treatment services, in-home, skill-based parenting programs; and Kinship Navigator services. Family First is the first major modernization and overhaul of Title IV-E and IV-B funds in nearly three decades, and represents a significant milestone in ongoing efforts to transform the child welfare system.

In June 2018, VDSS began preparing to implement Family First by launching a multi-system community-based approach through the Three Branch model which was designed by the National Governors Association, National Conference of State Legislatures, and Casey Family Programs' Three Branch Institute. This approach is collaborative and team-based, with membership from multiple state and community-based agencies that respond to the needs of children and families, thus expanding the responsibility of child welfare to all agencies that serve children and families. The Three Branch model leverages multisystem group leadership to enact interconnected and coordinated legislative, financial, and policy changes in a unified way to collectively and efficiently make improvements to the child welfare system. Virginia has been a participant in three previous Three Branch Institutes and has seen significant success in improving the child welfare system through this approach.

To support Family First, the Three Branch team is led by a leadership team consisting of two individuals from each branch of the government (judicial, executive, and legislative). The leadership team worked with approximately 110 Three Branch team members who made recommendations to inform the implementation of Family First in Virginia (See Appendix A for a list of specific Family First stakeholders.) The Three Branch team coordinated with other child welfare advisory groups including programmatic

advisory groups (Prevention, Child Protective Services, and Foster Care), the Virginia League of Social Services Executives (VLSSE) and the Child Welfare Advisory Committee (CWAC).

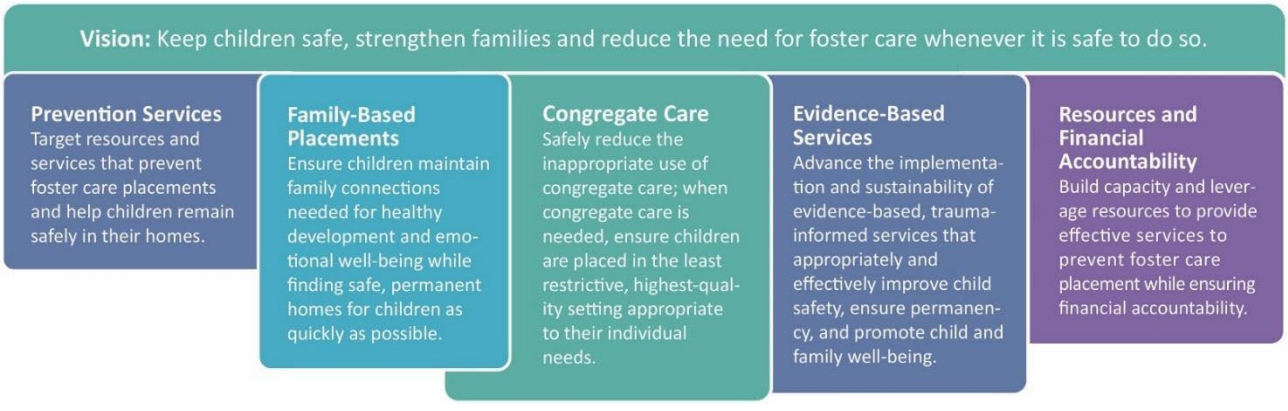
Using implementation science principles as a guiding framework, the Three Branch team convened four workgroups to plan Family First related activities: Prevention, Evidenced-Based Services, Finance, and Appropriate Foster Care Placements. Each workgroup developed a vision, work plan, communication plan, and strategy for implementation/operation, as well as identifying data-sharing needs, system/IT needs, and legislative needs.

The primary goals for each workgroup were as follows:

- Prevention Services Workgroups: Target resources and services that prevent foster care placements and help children remain safely in their homes (Prevention Strategy 1).
- Appropriate Foster Care Placements Workgroup: Ensure children maintain family connections needed for healthy development and emotional well-being while finding safe, permanent homes for children as quickly as possible. Safely reduce the inappropriate use of non-family based placements; when a non-family based placement is needed, ensure children are placed in the least restrictive, highest-quality setting appropriate to their individual needs (Permanency Strategy 1, 3, and 5).
- Evidence-Based Services Workgroup: Advance the implementation and sustainability of evidence-based, trauma-informed services that appropriately and effectively improve child safety, ensure permanency, and promote child and family well-being (Prevention Strategy 2).
- Finance Workgroup: Build capacity and leverage resources to provide effective services to prevent foster care placement while ensuring financial accountability (Prevention Strategy 3).

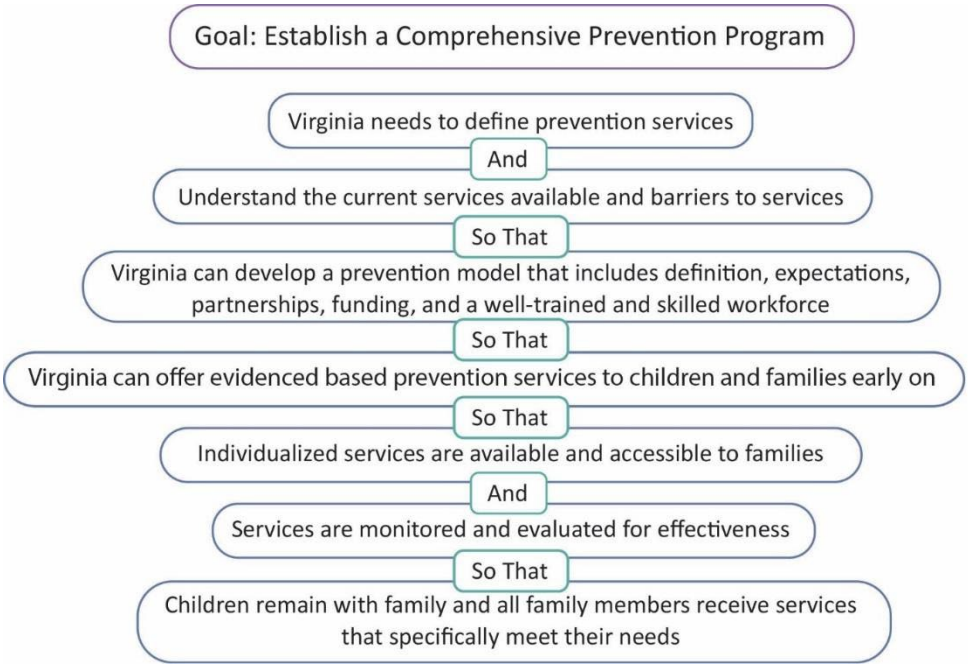
VDSS' goals for the Three Branch model included:

- Use data to improve decision-making and ensure services provided are informed by outcomes;
- Promote reliable, accurate, transparent and timely two-way communication among stakeholders throughout the implementation of Family First;
- Acknowledge that true transformation will take time, and implementation will continually be monitored and updated to meet emerging needs; and,
- Collaborate and partner with systems across the state as the key to successful implementation of Family First.



Through the CFSP Strategic plan, VDSS is focusing on enhancing the In-Home Services program guided by the Family First legislation. The Prevention Services and Child Protective Services programs play an integral role in targeting resources and services that prevent foster care placements and help children remain safely in their homes or with relatives when possible (CFSP Prevention Strategies).

Prevention Theory of Change

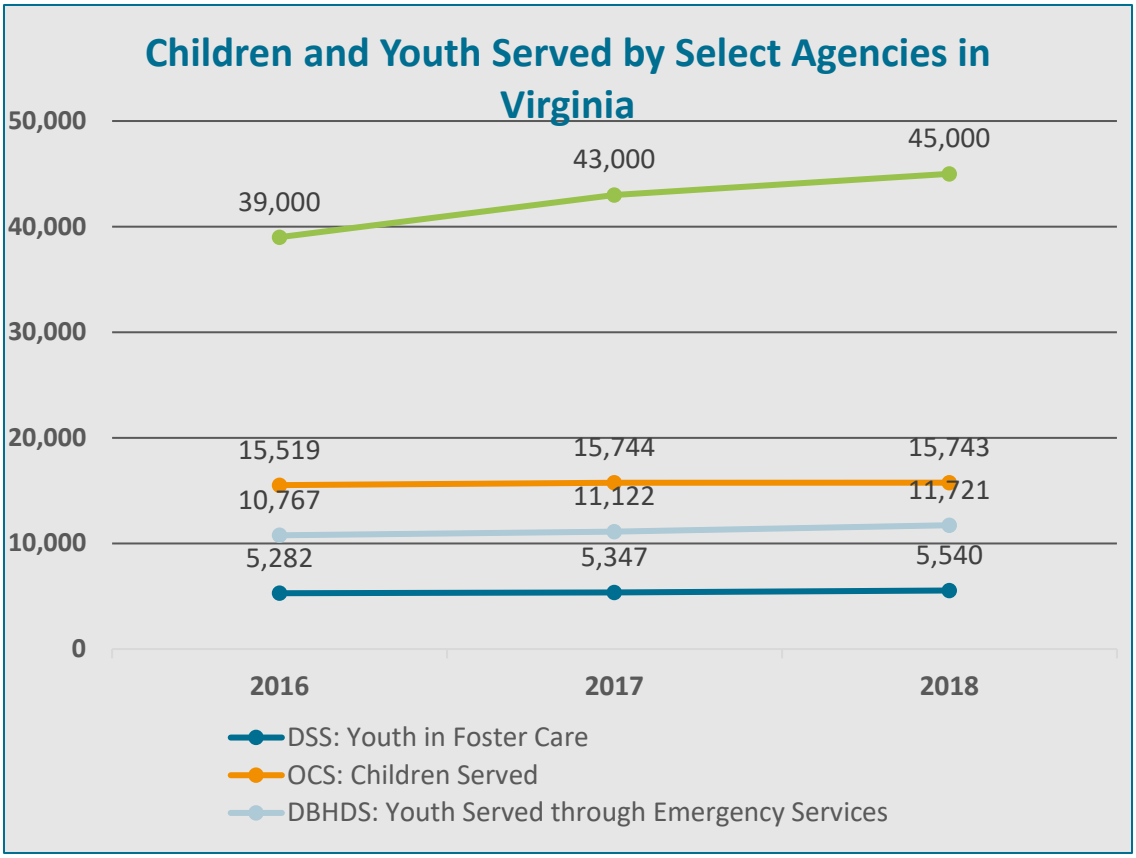


CONSULTATION AND COORDINATION

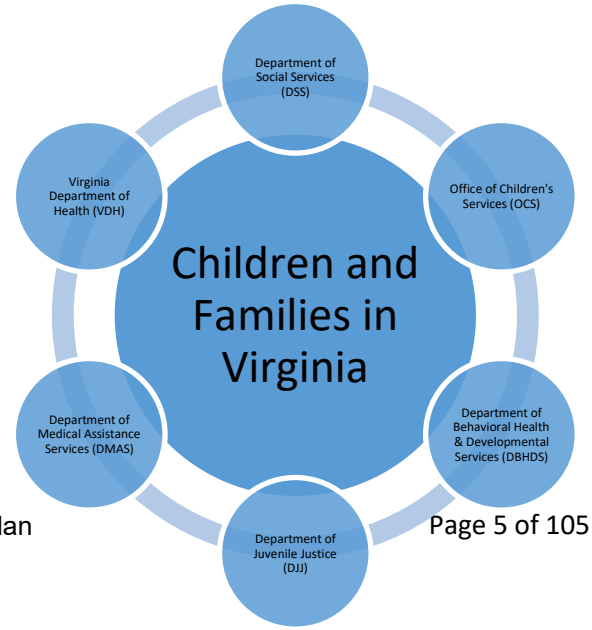
As described in detail above, VDSS utilized the Three Branch model in order to plan for and begin implementation of Family First. This model ensures a collaborative and coordinated approach to implementation with other state agencies, including the Department of Behavioral Health and Developmental Services (DBHDS), Department of Medical Assistance Services (DMAS), Department of Juvenile Justice (DJJ), Virginia Department of Health (VDH), Office of Children's Services (OCS), and the Court Improvement Program (CIP), as well as public and private agencies providing and/or advocating for child and family services in Virginia (Appendix B) (Prevention Strategy 1.1, 3.1, 3.2, and 3.3). VDSS acknowledges that, without the close partnership of other agencies, Virginia will not be able to offer a full continuum of care for children, parents, and caregivers who receive prevention services and are served by multiple state agencies.

The shift to a prevention-based system requires significant system transformation. This is needed, because despite the hard work and dedication of state agencies and significant progress in some areas, a number of key indicators of child and family well-being in Virginia are not significantly improving. Child and family-serving agencies in Virginia individually serve up to 45,000 children in a given year, but are not seeing evidence of sustained improved progress. We believe that Family First provides a new opportunity to transform our work and improve outcomes.

- The number of youth in foster care for VDSS remained relatively flat over a recent three year period (2016-2018) at approximately 5500 children in the foster care system at any given time.
- The number of children served by OCS has remained relatively flat over the same three years.
- The number of youth served through DBHDS emergency services increased over the ~~last~~ three years, and Commonwealth Center for Children and Adolescents (CCCA) inpatient admissions increased 32% from 2017 to 2018.
- The number of children receiving at least one community mental health rehabilitation service (CMHRS) increased over the three years.



Six child and family-serving agencies (DBHDS, DMAS, VDSS, OCS, VDH, and DJJ) across two secretariats are united in a common vision to provide holistic support to the children and families of Virginia. This unity is important, as we often serve the same children and families and/or children and families with similar needs. Our mission statements demonstrate our unique capabilities to provide critical services and reflect a common vision of supporting the physical,



mental and behavioral health, safety, well-being, and success of all children and families in Virginia.

Our Unique Capabilities	Our Common Vision
❖ Promote recovery, self-determination, and wellness ❖ Provide a system of high quality and cost-effective health care services ❖ Help people triumph over poverty, abuse and neglect ❖ Create a collaborative system of services and funding ❖ Prepare court-involved youth for success	❖ Wellness in all aspects of life ❖ Health and well-being of all people in Virginia ❖ Strong futures for people, families, and communities ❖ Child-centered, family-focused and community-based system of services ❖ Successful citizens

The six agencies share a set of values that guide our work as teams within agencies, as partners with other organizations and the community, and as a vital support network for children and families.

- Prevention Focused: We promote services that keep children safe, strengthen families and support long-term well-being, reducing the likelihood that children and families will need to access more costly crisis or intensive services.
- Evidence Based: We invest in programs and services that are proven to work, improving child safety and promoting child and family well-being through tested strategies with measurable outcomes.
- Trauma Informed: We take into account past trauma when serving children and families, providing programs and services that appropriately and holistically address the needs of children and families while striving to reduce additional trauma.
- Efficient: We strive to avoid unnecessary cost and duplication of effort, creating an efficient system that minimizes the difficulty of accessing and reduces delay in receiving services for children and families.

In efforts to ensure ongoing and continual improvements are made to our child welfare system, in partnership with these six agencies, regular consultation and coordination in the day-to-day business of serving children and families will continue.

VDSS is working closely with DBHDS and DMAS on the Children's Behavioral Health Enhancement, which will promote a robust array of outpatient services, integrated behavioral health services in primary care and schools, and intensive community-based and clinic-based supports shifting from a crisis-oriented approach towards prevention and early intervention. While Medicaid is the largest payer of behavioral health services for children in Virginia, VDSS' coordination with this Enhancement is integral to success in ensuring children, regardless of funding source, have access to high-quality, evidence-based, and trauma-informed services.

VDSS is also working closely with DJJ which previously implemented evidence-based programming for youth served by the juvenile justice system. DJJ has systematically stood up Functional Family Therapy (FFT) and Multisystemic Therapy (MST) throughout the Commonwealth to serve youth. DJJ has been an asset to VDSS throughout the implementation process, sharing lessons learned and resources which made the implementation successful. LDSS is able to use DJJ providers of FFT and MST for children who are candidates of foster care by purchasing services from DJJ's existing contracts.

In addition to DBHDS and DMAS, the OCS is the primary funding source of services for children, parents, and caregivers who are involved in the child welfare system. OCS is a collaborative partner who also served on the Three Branch leadership team and is advancing policies that support the implementation of Family First, as well as a broad continuum of care to meet the holistic needs of children and families. OCS will be critical to ensuring children and families receiving title IV-E funded services also receive supports that may not be funded with title IV-E funding (transportation, homemaker services, etc.)

Additionally, VDSS is aligning with the Children's Cabinet and the Governor's Trauma-Informed Care Working Group around their work on trauma-informed care in Virginia. Virginia Executive Order 11 requires a coordinated effort across state agencies, an in partnership with external stakeholders and local communities, to foster systems that provide a consistent, trauma-informed response to children with adverse childhood experiences and to build the resiliency of individuals and communities. The 2018 Appropriation Act included the language "develop strategies to build trauma-informed systems of care." The Governor's Trauma-Informed Care Workgroup was created and established a trauma-informed framework based on the Substance Abuse and Mental Health Services Administration (SAMSHA) trauma-informed care to include the four R's:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and,
- Seeks to actively resist re-traumatization.

As VDSS continues to work on the implementation and sustainability of Family First, we ~~will~~ continue to follow the Governor's Trauma-Informed Care Workgroup and recommendations for trauma-informed work to ensure consistent delivery across all child-serving agencies in Virginia.

Implementing Family First in Virginia enhances the current public child welfare system, which is administered through 120 LDSS and funded primarily through title IV-B and IV-E funding. LDSS provide services that protect and promote the welfare of children through the provision of child protective services, foster care and adoption services across the Commonwealth. VDSS' Child Protective Services and Prevention guidance manuals provide clear guidance to LDSS in the provision of services to children and families to include:

- Prevent further future abuse and neglect to the child;
- Assure child safety; and,
- Maintain the child in their family.

Title IV-E Prevention Services are integrated seamlessly into our public child welfare system, ensuring that children and their families are provided a full array of services to meet their individual needs. Children and families eligible for title IV-E Prevention Services will also be eligible for existing funding streams such as OCS (state and local funding), Promoting Safe and Stable Families (PSSF), and other funding sources. This ensures that children and families have a wide array of funding and services to meet their unique needs.

Child Welfare Workforce Support

VDSS took a transformational case practice approach in implementing Family First in conjunction with our root cause analysis during our Child and Family Services Review (CFSR) and our Practice Improvement Program (PIP) efforts. To support Family First, VDSS aligned our existing CPS Ongoing and Prevention Practices, to launch the In-Home Services Framework.

Much of existing CPS practice, guidance, and training focused on intake, investigations, and family assessments. CFSR findings demonstrate that in-home cases are performing at 75% for item 2 and 44% for item 3. About 85% of high and very high cases are opened, which is expected because Virginia requires staff to open these cases. Of the open cases, data reflects that documented visits with children and family members are achieved at around 50%; the family strengths and needs assessment (FSNA) tool is completed about 75% of the time; and service plans are completed about 87% of the time. It is a positive finding that tools are utilized and safety plans are developed and documented; yet, the data suggests that service plans are created without family involvement and information from the FSNA tool.

To support providing services identified by using the FSNA tool, it is important for services to be easily available. In the feedback and town hall events, themes of inconsistent approval of services and lack of safety services within regions and between LDSS emerged. The majority of services are funded through OCS through the Children's Services Act (CSA). Each LDSS has a CSA Community Policy and Management Team (CPMT) and services are approved by a Family Assessment Planning Team (FAPT), which is made up of LDSS, CSA, providers, parents, and foster parents. Because each LDSS has a different local CSA dollar match and approval depends on the individual FAPT teams, it is difficult for services to be consistently available and consistently approved in a locally administered, state-supervised system. Strategy 2.3.3 and 3.1 address the lack of services, approval of services, and inconsistency of services.

There also was not a strong foundation for In-Home case practice. This has led to inconsistency in practice, assessments, visits, and documentation. VDSS offered only one training on In-Home case practice and assumed that other foster care training courses could supplement in-home training. In-Home work with children at high or very high risk requires a skill set that focuses on family engagement

and establishing a relationship, identifying individualized needs, creating and monitoring case plans and progress with families, while continually assessing safety and risk. Attention to In-Home case practice at both the supervisor level and worker level is needed to create consistency in practice. This practice focus can occur through using the Structured Decision Making (SDM) tools to create individualized case plans; establishing frequent visits with the family to focus on quality contacts in order to empower family members to participate in case planning; and supporting case decision-making through consistent use of SDM tools.

Through our CFSR town hall events, we learned that workers utilized supervision to make decisions when considering a removal, creating safety plans, seeking funding, clarifying guidance, considering personal safety, helping think outside of the box, and identifying services. Staff also use team staffing sessions to assist with decision-making. Although supervisors are engaged at specific decision points, survey results indicate that about 50% of the time workers receive formal supervision every other week. About 50% receive supervision once a month. Additionally, most of the time supervisory sessions fail to include coaching and utilizing practice profiles. One limitation identified was supervisors carrying caseloads and making decisions on cases on behalf of workers. This is consistent with the feedback that challenges our workforce experiences, at both the direct worker and supervisor level and potentially, has a negative impact on overall performance with the CFSR outcomes.

In our transformational approach to address what was learned from the Round 3 CFSR and the town hall events, and to maximize the new federal funding stream for prevention services, VDSS brought together a workgroup of over 100 staff from LDSS to align our In-Home Services practice. The In-Home Services framework provides a consistent set of practice (aligning the CPS Ongoing and Prevention Work) while also meeting the requirements of Family First in order to easily fund prevention services. The goal of In-Home practice is to work with children in their own home or with relatives to address identified safety and risk concerns; to reduce the reoccurrence of child maltreatment; and to prevent out-of-home care or placement into foster care. The In-Home services alignment offers a framework that includes:

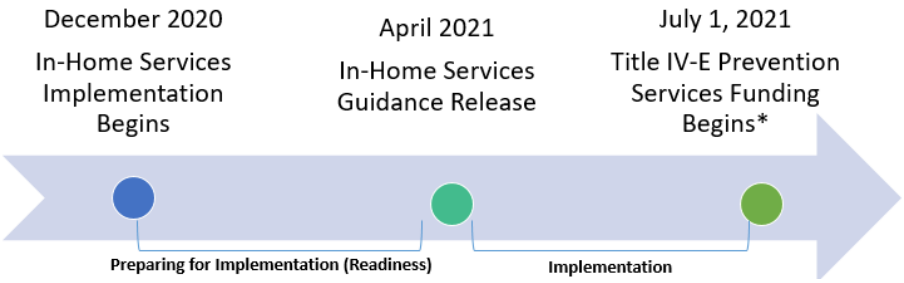
- Safety Scenarios
- Visits with the Family
- Assessment
- Service Planning
- Re-assessment
- Case Closure

In-Home Services practice ensures that when children temporarily or permanently reside with relatives or fictive kin, services are provided to ensure safety and permanency of that placement. Historically, the provision of services to children and youth residing temporarily or permanently with relatives has varied by locality; part of the alignment included making uniform policy and practices to support relative placement when needed.

The In-Home Services framework includes three safety scenarios and the practice requirements needed to support families based on their unique needs.

- Child or youth residing with parent(s) or relative/kin caregivers(s)
- Child or youth temporarily residing with relative/kin caregiver(s) and will return to the parent(s) or caretaker/guardian(s) within six months
- Child or youth permanently residing with relative/kin caregiver(s)

Regardless of where the child may be temporarily or permanently residing, the framework ensures regular assessment, and provision and monitoring of services to ensure safety of the child. In-Home services provide an opportunity to partner with families to assess strengths, needs, protective factors and what services may be needed to ensure the safety of the child and prevent out of home placement. As part of the new In-Home Services guidance there is a "Suite of Tools" which includes Structured Decision Making (SDM) safety and risk assessments, the completion of the CANS, and assessment of Candidacy to guide service planning. Consistent contact with the family and collaterals is required, including child and family team meetings to be held every 90 days and Family Partnership Meetings to be held at all critical decision points.



In preparation for the shift in practice, VDSS launched a multi-pronged strategy of training, communication and support. During the readiness phase of implementation, VDSS developed and offered the 2021 Child Welfare Best Practices Webinar Series for In-Home Services Supervisors and staff; provided practice, support and technical webinars; and, provided consistent bimonthly communication through our Division newsletter. Upon the In-Home Services guidance release in April 2021, VDSS will provide transmittal training on the new guidance and begin offering additional technical webinars to promote the use of evidence-based programming, use of title IV-E prevention services funding and the alignment of other funding sources for prevention services.

VDSS required Family Services Specialists and supervisors to complete (if they had not already done so) prerequisite courses to include: CWSE1006: Reasonable Candidacy, CWSE1510: Structured Decision Making, CWS5307: Assessing Safety, Risk, and Protective Capacities in Child Welfare; and Virginia Child and Adolescent Needs and Strengths (CANS) Assessment training and certification; and CWS1071: Family-Centered Case Planning. These prerequisites are already required courses for Family Services staff. In addition, the 2021 Child Welfare Best Practices Webinar Series for In-Home Services launched in January 2021, including the courses listed below:

- **In-Home: What Do You Need to Know?** In-Home is an alignment of CPS Ongoing and Prevention Services that prioritizes family preservation through meaningful partnerships with families and their support systems to ensure child safety, permanency, and well-being. In particular, In-Home structures all case practices around three child safety scenarios: a child living in his or her own home; a child living temporarily with a relative (kin); or a child living long-term with a relative (kin) with regular visitation with parents. This introductory webinar

commences an instructional series that provides an overview of how In-Home services focuses on specific, integrated strategies directed towards teaming engagement efforts, collective, streamlined assessment decision-making, behavior-based safety goals, and needs-driven service provision.

- **In-Home: Collective Assessment and Planning** In-Home prioritizes engaging families and their support systems to jointly identify safety and risk concerns while preserving family structure. This webinar details a collective assessment and planning framework used to elicit and analyze all the key information known about a child and family at any given time into domains of: risks, safety, strengths, and needs. Specifically, a discussion is held around how to undertake a balanced and collective assessment approach in partnership with the family and their support system in critically thinking about what happened, is happening, and what needs to happen to enhance the child's ongoing safety, permanency, and well-being prior to service plan development as it pertains to each of the three In-Home child safety scenarios.
- **In-Home: Assessment-Driven Service Delivery** In-Home prioritizes providing families with easily accessible, individualized services to reduce the recurrence of child maltreatment and out of home placement. This webinar details how to prioritize an array of needs-driven evidence-based, trauma informed services through a collaborative effort of assessing and planning with the family and their support systems in initially identifying and continually prioritizing and revising service delivery through the ongoing identification of achieved needs and/or newly identified needs as it pertains to the three In-Home child safety scenarios.
- **In-Home: Behavior-Based Safety Goal Attainment** In-Home prioritizes increasing protective factors to reduce the risk of future harm or maltreatment so that children can live safely with their families or with relatives (kin) in the children's own community. This webinar focuses upon specific, concrete strategies and actions used to effectively identify parental behavior changes and their impact upon the safety, permanency, and well-being of a child. Specifically, the webinar outlines ways to identify when an In-Home case is ready for closure based upon behavior-based safety goal attainment, rather than mere service completion or compliance. Examples of best case practices are presented and structured around each of the three In-Home child safety scenarios.
- **In-Home: Engaging Children and Youth in Assessment and Planning** In-Home prioritizes engaging families and their support systems to jointly identify safety and risk concerns; meaning children and young people are not exempt. This webinar explains the importance of utilizing the Three Houses Tool to help escort the voice of children and young people more fully into the information gathering processes, collaborative assessments, and service plans by providing a visual way of exploring what is happening in their lives, in relation to danger, safety factors, and hopes for the future. In addition, the Three Houses Tool helps parents and their support systems identify their strengths, hopes, vulnerabilities, and identifies ways to help enhance safety. Examples of best case practices are presented and structured around each of the three In-Home child safety scenarios.
- **In-Home: Engaging Fathers in Assessment and Planning** In-Home prioritizes engaging families and their support systems to jointly identify safety and risk concerns; meaning, fathers are not exempt. This includes fathers who are living with their children, but would like to be more engaged with them, and fathers who are not living with their children full-time, or are incarcerated. This webinar details effective ways to engage fathers, addresses the implicit

biases family services specialists may possess as a result of their own relationships with father figures, and most importantly, lists ways to immediately implement effective father engagement strategies. Examples of best case practices are presented and structured around each of the three In-Home child safety scenarios.

- **In-Home: Engaging Relatives (Fictive Kin) for Assessment and Planning** Relatives are the preferred resource for children who must be removed from when they cannot live safely with their parents because it maintains the children's connections with their families in their own communities. This webinar details how to best support kinship care efforts and collaboratively address needs through service identification and delivery as it pertains to all individuals involved in the three In-Home child safety scenarios.

The Webinar Series advances learning on key skills required to demonstrate optimal practice for all Family Services Specialists and supervisors delivering In-Home Services. These instructional webinars focus on child welfare best practices to improve outcomes for children, youth, and families in our communities. In addition, a "Practice Place" interview session will feature a subject matter expert from the field who will share their own obstacles, triumphs, and advice regarding the highlighted webinar topic. Each of the webinar sessions lasts 90 minutes and includes essential job aids and resource materials to enhance practice. In addition, all of the webinars will be recorded for online viewing later date.

Additionally, new uniform training requirements have been established for all In-Home services workers and supervisors and is described on pages 18-20 in Child Welfare Workforce Training. These training opportunities will be accomplished in both instructor-led classroom and online courses. In conjunction with our alignment of In-Home Services, Virginia's General Assembly allocated approximately $13 million to add over 140 local positions to deliver In-Home services across the LDSS beginning in State Fiscal Year 2022. All new staff hired after July 1, 2021 will continue to complete the required trainings for In-Home Services workers.

In Virginia, local agencies make referrals to community-based providers who are skilled in providing evidence-based services for children and families. The local agency child welfare workforce utilizes a multidisciplinary approach, the Family Assessment and Planning Team (FAPT), to identify services that are needed for children and their families. For title IV-E Prevention Services, LDSS will manage contracts with service providers for programs identified in Virginia's approved federal title IV-E Prevention Services Plan. VDSS provides a template for these contracts to ensure service providers maintain the appropriate education, licenses, training, and fidelity to deliver services. Additionally, as referenced below on pages 26-31, VDSS will do this through regular monitoring and a CQI cycle to ensure children and families are receiving the highest quality of services.

As described in detail in the Monitoring Child Safety section of this plan (pages 15-17), Family Services Specialists will develop individualized prevention plans through the development of a service plan within 30 days of the identification of a candidate for foster care. Family Services Specialists will continuously monitor the plan as well as conduct regular safety and risk (re)assessments for children receiving In-Home services. Family Services Specialists will partner with community-based providers who deliver the prevention services in monitoring the service plan and assessing risk.

VDSS provides an array of ongoing and technical support to LDSS through our CQI process in order to monitor the outcomes that are expected with this alignment. VDSS regional Practice Consultants assist LDSS in building capacity around efficient, accountable service provision. They provide programmatic supervision, consultation, and support to LDSS related to the delivery of In-Home services and analyze practice to ensure it meets VDSS guidance standards. The support and coaching consists of policy, procedure and casework review. Practice Consultants provides LDSS with ongoing support to enhance competencies and skills to meet the diverse needs of children and families throughout the Commonwealth.

ASSESSMENT AND ELIGIBILITY OF CHILDREN AND FAMILIES

VDSS intends to serve all three "candidate for foster care" target populations, as defined within the Family First law. A "candidate for foster care" includes:

- A child identified in an In-Home Services service plan as being at imminent risk of entering foster care, but who can remain safely in the child's home or in a kinship placement as long as services or programs identified in Virginia's approved federal title IV-E Prevention Services Plan that are necessary to prevent the entry of the child into foster care are provided.
- A child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.
- A child in foster care who is a pregnant or parenting.

For each of the three target populations, Virginia considers "Imminent risk" as meaning a child and family's circumstances demand that a defined case plan is put into place within 30 days; that the plan must identify interventions, services, and/or supports; and, absent these interventions, services, and/or supports, foster care placement is the planned arrangement for the child.

The first target population, children being served through an In-Home Services case, are generally families who are known to the child welfare system through a referral to the local agency via the child abuse and neglect hotline or other referral process. A child may also be identified by a community partner, service provider, or through referral from the court. In SFY 2020, VDSS served 20,378 children in CPS ongoing (In-Home Services) and prevention cases. These children received ongoing, in-home services to prevent removal from the home. Over half (52%) of CPS ongoing and prevention cases received a referral for mental health, substance abuse, or parent skill-based training – all services eligible for reimbursement under Family First.

The second target population is youth who have been adopted and are at risk of an adoption disruption/dissolution. In SFY 2020, 88 youth were identified as experiencing an adoption disruption, which put them at risk for entering foster care. This number includes children adopted internationally, domestic, in and out of state.

The third target population is pregnant or parenting youth who are in foster care. At this time, VDSS does not track pregnant and/or parenting foster youth in our child welfare case management system. In

a representative sample from the National Youth in Transition Database (NYTD) for Virginia, 9% of 19 year olds and 30% of 21 year olds surveyed reported that they had a child in the past two years.[1]

Multiple sections of the Code of Virginia provide statutory authority for the delivery of In-Home Services to reduce risk of additional maltreatment and/or entry into foster care.

- § 63.2-319 provides a statutory requirement for each local board to provide services which are directed toward "…Preventing or remedying, or assisting in the solution of problems that may result in the neglect, exploitation or delinquency of children and Preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving these problems and preventing the breakup of the family where preventing the removal of a child is desirable and possible."
- §§ 63.2-1505 and 63.2-1506 provide statutory authority "to provide or arrange for services to families at the conclusion of a family assessment or an investigation. "
- § 63.2-1501 defines "Prevention" as "the efforts that (i) promote health and competence in people and (ii) create, promote and strengthen environments that nurture people in their development."
- § 63.2-905 provides the statutory authority to provide foster care services which includes a child who has been identified as needing services to prevent the need for foster care placements. "Foster care services are the provision of a full range of casework, treatment and community services, including but not limited to independent living services, for a planned period of time to a child who is abused or neglected as defined in § 63.2-100 or in need of services as defined in § 16.1-228 and his family when the child (i) has been identified as needing services to prevent or eliminate the need for foster care placement, (ii) has been placed through an agreement between the local board or the public agency designated by the community policy and management team and the parents or guardians where legal custody remains with the parents or guardians, or (iii) has been committed or entrusted to a local board or licensed child placing agency. Foster care services also include the provision and restoration of independent living services to a person who is over the age of 18 years but who has not yet reached the age of 21 years, in accordance with § 63.2-905.1."

Additionally, 22 VAC 40-705-150 A provides the following direction: "At the completion of a family assessment or investigation, the local department shall consult with the family to provide or arrange for necessary protective and rehabilitative services to be provided to the child and his family to the extent funding is available pursuant to § 63.2-1505 or 63.2-1506 of the Code of Virginia."

LDSS will identify children and their parents or kin caregivers to determine their eligibility for title IV-E Prevention Services through multiple strategies:

- At the conclusion of a CPS family assessment or investigation where services are identified that will reduce the risk for future abuse or neglect or entry into foster care,

[1] National Youth in Transition Database https://datacenter.kidscount.org/data/tables/10217-youth-transitioning-out-of-foster-care-had-a-child-in-the-past-two-years?loc=48&loct=2#detailed/2/48/false/1698,1697/6259,6260,6261,6262/19768,19769

- At the conclusion of a CPS family assessment or investigation when there is a “high” or “very high risk” of future abuse or neglect without intervention (CPS Policy 4.5.15.1 and 4.6.25.1, Prevention and In-Home Services Policy 2.3.2)
- Parent or caregiver self-referrals (Prevention and In-Home Services Policy 2.3.2) or
- Referrals to the LDSS from courts, schools, or other community-based organizations because of a specific concern that has or may impact the family’s daily functioning (Prevention and In-Home Services Policy 2.3.2)

After the identification of a child, and their parents or kin caregivers as referenced above, the CANS must be completed on a child in the home to assess the family’s strengths and needs and identify contributing factors and underlying conditions that may influence child maltreatment and risk for entry into foster care. The CANS is a structured assessment instrument developed by John S. Lyons, Ph.D. with the University of Chicago (Chapin Hall) to assist in the planning and management of services to children and adolescents and their families. The CANS provides numerical ratings of various items, organized in a set of dimensions, or domains. These ratings are indicators of the presence and urgency/prominence of specific needs and strengths. Current certification on the CANS is required for all raters who administer the assessment. Certification must be renewed annually. Domains assessed through the CANS include life functioning, child strengths/resiliency, child behavioral/emotional needs, child risk factors, child and family functioning modules and parent/guardian strengths and needs. LDSS identify which needs can be addressed through the provision of title IV-E Prevention Services (described below) and which services can be addressed through other funding streams such as PSSF, local and state funding streams. The CANS, along with a safety assessment, risk (re)assessment, and child and family team meeting are conducted every 90 days to regularly assess child and family needs.

MONITORING CHILD SAFETY

The Prevention Services and Child Protective Services (CPS) programs provide guidance for LDSS to support In-Home Services casework. When a candidate for foster care has been identified, the worker must open a child welfare case in the child welfare information system. With the information documented in the CANS, the safety assessment, risk (re)assessment, and child and family team meeting, a service plan must be developed within 30 days identifying the child as a candidate for foster care, identifying the foster care prevention strategy and the list of services or programs provided to or on behalf of the child (Prevention and In-Home Services Guidance 2.5).

Monitoring child safety involves multiple strategies. Primarily, monitoring child safety is through contact with the child and family. The frequency of contacts with the child and family should be determined from the safety, risk and CANS assessments, and at a minimum should occur once a month in the home. Monitoring child safety is also assessed through contacts with collaterals. The Family Services Specialist maintains a focus on child safety at all points of the case including reassessing child safety and risk, developing plans to control threats to child safety and ensuring safety plan participants understand and fulfill their roles. The Family Services Specialist documents efforts to monitor child safety by ensuring the case record in the child welfare information system is accurate and current, that all decisions and the

basis for those decisions are well documented, and maintains copies of all court documents and other vital reports in the hard case file or in the child information system.

The process of assessing child safety is ongoing throughout the life of the case (Prevention and In-Home Services Guidance 2.5). Safety is assessed, both initially and ongoing, through the Structured Decision Making Safety Assessment Tool. The following circumstances must be documented on a new Safety Assessment Tool within three (3) business days:

- A change in family circumstances such that one (1) or more safety factors previously present are no longer present;
- A change in information known about the family in that one (1) or more safety factors not present before are present now;
- A change in ability of safety interventions to mitigate safety factors and require changes to the safety plan; or
- A case is recommended for closure.

When safety is reassessed, the safety plan (if applicable) and service plan should be reviewed and revised accordingly. A family partnership meeting may be considered if safety concerns escalate and at all critical decision points.

The service plan must be re-evaluated every 90 days or sooner if safety, risk, or family circumstances change (Prevention and In-Home Services Guidance 2.8). The purpose of the service plan review is to:

- Document all services to prevent further child maltreatment, out-of-home care, or placement into foster care;
- Assess and manage child safety;
- Assess objectives to ensure they are helping attain goals;
- Assess family progress toward establishing and maintaining a safe environment;
- Keep all parties involved with the case plan informed and focused on common goals;
- Review performance and appropriateness of services and service providers;
- Determine the need to revise the case plan;
- Determine whether case closure is appropriate; and,
- Consider issues related to permanency and well-being as applicable.

In conjunction with the service plan review, the Structured Decision Making Safety Assessment and Risk Reassessment Tool must be utilized to assess the risk of future maltreatment. The Risk Reassessment Tool informs whether the future likelihood of maltreatment has been reduced, increased or remained the same following the provision of services or changing circumstances within the family. Reassessing risk in an In-Home Services case measures the progress of the family towards meeting the goals and objectives of the service plan. Reassessing risk guides decisions about case closure. The risk reassessment must be completed every 90 days until the case is closed (Prevention and In-Home Services 2.5).

If it is determined that a child's risk of entering foster care remains high despite the provision of programs and services, the Family Services Specialists and Supervisor will examine the reason(s) the risk remains high. The examination will include a review of the results of the Structured Decision Making Risk

Reassessment Tool, the results of the CANS, the service plan, and feedback from the family and collateral contacts. As long as the child can remain safely in the home, the Family Services Specialists may need to reassess the services in place and modify the service plan to include different services and/or providers. In addition, the Family Services Specialists will collaborate with the family and community supports to continue to build upon and create protective factors which serve to mitigate the risk to the child.

CHILD WELFARE WORKFORCE TRAINING

As referenced throughout the CFSP strategic plan, VDSS intends to enhance our entire child welfare workforce training program (CFSP Workforce Strategy 3). Additional information related to VDSS's training program can be found in the 2020-2024 Training Plan Attachment. Specifically related to the alignment of In-Home Services and the implementation of Family First, VDSS hired a curriculum developer to work closely with the prevention services team to enhance our existing training curriculum for child welfare workers to ensure that staff:

- Are qualified to identify and make referrals for trauma-informed and evidence-based services;
- Can develop appropriate child- and family-specific In-Home Services service plans;
- Can conduct risk assessments; and,
- Assess children and their families' needs.

The required training for Family Services Specialists is tracked through the VDSS Learning Management System (COVLC). COVLC tracks a worker's required training timeframes based on the worker's and supervisor's job functions. COVLC generates emails to both the worker and the supervisor regarding the required trainings to be completed by a designated time. All overdue training requirements are sent to the worker's supervisor, or in the case of the supervisor to the LDSS Director. The Family Services Training Manager maintains a dashboard regarding these required trainings.

Through the implementation of In-Home Services, we identified a series of training courses for child welfare workers who will deliver these services (CFSP Prevention Strategies 1.3 and 1.4) (Prevention and In-Home Services Guidance 1.20.4).

First three (3) weeks training requirements

The following online courses are required to be completed within the first three (3) weeks of employment.

- CWSE1002: Exploring Child Welfare.
- CWSE5692: Recognizing and Reporting Child Abuse and Neglect – Mandated Reporter Training.
- CWSE1510: Structured Decision Making in Virginia.
- Children's Services Act (CSA) for New LDSS Employees (Five (5) modules numbered CSA011 – CSA015).

First three (3) months training requirements

The following instructor-led or online courses are required to be completed no later than within the first three (3) months of employment.

- CWS1000 In-Home Services New Worker Guidance Training with OASIS – 2 days.
- CWS4020 Engaging Families and Building Trust-Based Relationships.
- CWS5307 Assessing Safety, Risk, and Protective Capacities in Child Welfare – 2 days.
- CWS2010 In-Home Services Skills – 2 days.
- CWS4080 Kinship Care in Virginia – 2 days.
- CSA CANS Certification.
- CWSE4060 Family Search and Engagement.
- CWSE5501 Substance Abuse.
- CWSE1006 Reasonable Candidacy.
- CWSE2090 Injury Identification in Child Welfare.
- CWSE4000 Identifying Sex Trafficking in Child Welfare.
- CWS5011 Case Documentation – 1 day.
- CWS1061 Family Centered Assessment in Child Welfare – 2 days.
- CWS1071 Family Centered Case Planning – 2 days.
- CWSE7000 Family First in Virginia – e-Learning series.
    - Module 1: Overview of Family First.
    - Module 2: Opening an In-Home Services Case: First 30 Days.
    - Module 3: Service Planning for In-Home Services.
    - Module 4: Monitoring the Delivery of In-Home Services.
    - Module 5: Goal Achievement and Case Closure or Case Transfer for In-Home Services.

First six (6) months training requirements

The following online and instructor-led courses are required to be completed no later than within the first six (6) months of employment.

- CWS1305 The Helping Interview: Engaging Adults for Assessment and Problem-Solving – 2 days.
- CWS5305 Advanced Interviewing: Motivating Families for Change – 2 days.
- CWSE4015 Trauma-Informed Child Welfare Practice.
- CWS4015 Trauma-Informed Child Welfare Practice – 2 days
- DVS1001 Understanding Domestic Violence – 2 days.
- DVS1031 Domestic Violence and Its Impact on Children – 1 day.

First 12 months training requirements

The following instructor-led courses are required to be completed no later than within the first 12 months of employment.

- CWS1021 The Effects of Abuse and Neglect on Child and Adolescent Development – 2 days.
- CWS1305 The Helping Interview: Engaging Adults for Assessment and Problem-Solving – 2 days.
- CWS5305 Advanced Interviewing: Motivating Families for Change – 2 days.
- CWS3071 Concurrent Permanency Planning – 1 Day.
- CWSE6010 Working with Families of Substance Exposed Infants (two modules).

- FSWEB1027 Swift and Savvy Actions to Improve Safety Outcomes.

First 24 months training requirements

The following instructor-led courses are required to be completed no later than within the first 12 months of employment.

- CWSE4050 Psychotropic Medications in the Child Welfare System.
- CWSE5000 Preventing Premature Case Closure in In-Home Services.
- CWSE5010 Advocating for Child and Adolescent Mental Health Services.
- CWSE2020 On-Call for Non-CPS Workers (On-call workers only).
- CWS2020: On-Call for Non-CPS Workers – 1 day (On-call workers only).

PREVENTION/IN-HOME SERVICES CASELOADS

VDSS plans to follow recommended caseload guidelines from the National Child Welfare Workforce Institute (NCWWI) of no more than 17 In-Home cases[2]. In order to meet this target caseload over time, VDSS has secured funding for 148 new In-Home positions for LDSS SFY2022, and will continue to advocate for additional In-Home positions over the next several years. As we build up the In-Home positions (to include repurposing current foster home positions as caseloads reduce), we will be able to better meet the target In-Home caseload average. VDSS will pull In-Home Services caseloads annually and for those LDSS who appear to exceed the NCWWI load standards, VDSS will provide technical assistance to develop a plan to address exceeding the caseload.

SERVICE DESCRIPTION AND OVERSIGHT

In order to inform our initial service selection, implementation, and evaluation process, we reviewed three years of data to identify key circumstances driving foster care entries.

Parental drug use was the most common circumstance driving removals across all three years (31.4% - 39.4%) followed by child behavior problems (18.4% - 15.5%), physical abuse (13.7% - 15.0%), parent unable to cope (7.4% - 6.4%), and child drug abuse (3.1% - 2.7%) (See Table 1). Similar patterns were evident across all three years.

Table 1 shows the prevalence of key circumstances leading to removals over the last three SFYs (2018-2020):

Table 1: Key Circumstances Leading to Removal

	Parental Drug Abuse	Child Behavior Problem	Physical Abuse	Parent Unable to Cope	Child Drug Abuse
SFY2018	31.4%	18.4%	13.7%	7.4%	3.1%
SFY2019	30.7%	18.0%	13.9%	7.1%	2.5%
SFY2020	39.4%	15.5%	15.0%	6.4%	2.7%

[2] https://ncwwi.org/index.php/resourcemenu/resource-library/workload/1510-effective-workload-management/file

We further examined SFY2020 data to identify needs that could benefit from Family First evidence-based services. Of the 1,643 cases involving entry into care during SFY2020, 30% (498) received prior In-Home and Prevention Services and had mental health, substance use and/or parent skill-based needs.

- 16% of total cases involving a removal had a need for substance use services.
- 25% of total cases involving a removal had a need for mental health services.
- 13% of total cases involving a removal had a need for in-home parent skill based training.

For SFY 2020 In-Home and Prevention Services cases not involving a removal similar service needs were present. Of the 10,017 In-Home Services and Prevention cases, 52% (5,250) had service needs identified to mental health, substance use and/or parent skill-based training.

- 23% identified a need for substance use services.
- 43% identified a need for mental health services.
- 18% identified a need for in-home parent skill based training.

To inform the selection of Family First services, the Evidence-Based Services workgroup designed a stakeholder survey and distributed it in 2018. The survey was designed to gather stakeholder perceptions regarding evidence-based practices (EBPs), current gaps in Virginia child welfare service offerings, availability of specific EBPs across the Commonwealth, and additional insights and comments regarding the implementation of evidence-based services.

A total of 657 child welfare stakeholders participated in the survey. Of these, 16.6% of respondents were clinicians (*n* = 109), 34.6% were brokers (*n* = 227) (those who refer for services), and 48.9% were senior leaders (*n* = 321). Most participants had their master's (60.9%) or bachelor's (29.4%) degrees. Employment settings included public child welfare (28.4%), child/family mental health (12.7%), educational settings (8.9%), juvenile justice (6.4%), and others. Respondents reported an average of 15.5 years in child welfare (range: 1-27 years). Across Virginia, 22.5% (*n*=139) of respondents were located in the northern region, 23.8% (*n*=147) in the central region, 20.4% (*n*=126) in the eastern region, 22.0% (*n*=136) in the Piedmont region, 8.6% (*n*=53) in the western region, and 2.6% (*n*=17) working statewide or across two or more regions.

All stakeholders (clinicians, brokers, and senior leaders) were asked to respond to a core set of questions regarding attitudes and perceptions toward EBPs, EBPs offered by their agency, perceived gaps in services in child welfare-related services in their community, and additional comments and insights regarding Family First. Each survey also had one supplemental area of inquiry: clinicians offered more detailed information about aspects of their perceptions and attitudes toward EBPs, brokers were asked to provide specific information regarding the availability and accessibility of Family First-related services in their community, and senior leaders were asked to describe their familiarity with 30 (10 adult, 20 child/family) specific EBPs considered "well-supported" by the California Clearinghouse of Evidence-Based Practices in Child Welfare (at the time of survey design, 9/2018). For all qualitative items (gaps, additional comments), a codebook was created to collate all responses. Then responses were coded by two coders (research assistants) to create quantitative indicators for each identified code. In this report,

results are provided across respondents, and a regional perspective based on VDSS' five regions is provided when appropriate.

A total of 75 individuals described at least one parenting-related need and gap. A total of 110 parenting-related needs and gaps were provided by respondents. Nearly a quarter—24.7%—of respondents who provided a response described something in the area of parenting, and 23.6% of the total gaps described involved parenting. Most described a specific need or gap within parenting, and these are detailed in the subsequent table. As can be seen, almost half of parenting-related gaps identified related to tangible supports for caregivers. Fifty-one respondents described gaps related to substance use. A total of 62 gaps were described. This represents 16.8% of respondents and 13.3% of all gaps described. Many respondents described more specifically caregiver or youth substance use service needs and gaps. Sixty-eight individuals described a gap or need related to mental or behavioral health, with a total of 83 gaps described. This represents 22.4% of respondents and 16.9% of all gaps described. Many respondents described more specific areas of mental/behavioral health. These gaps, particularly in parenting and substance use treatment support the need to enhance EBS offering in these areas in the Commonwealth.

All respondents were asked to list programs and treatments provided by their agencies that they believed were evidence-based, or that they thought were working well and were unsure whether they were considered evidence-based. Across respondents, more than 200 programs, treatments, and models were listed. Regarding the programs currently supported under Family First, the following results were obtained:

Table 2: EBP Stakeholder Survey 2018

EBP Name	**Number of Senior Leaders**	**Never Heard of It**	**Heard of It Only**	**We Don't Offer It, But It's Available In Our Community**	**We Have Some Training In This Or Use It Rarely**	**This Is Regularly Used At Our Agency**
Multisystemic Therapy	96	15 (15.6%)	20 (20.8%)	31 (32.3%)	9 (9.4%)	21 (21.9%)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**	96	1 (1.0%)	8 (8.3%)	13 (13.5%)	14 (14.6%)	60 (62.5%)
Healthy Families America**	95	41 (4%)	20 (21.1%)	20 (21.1%)	6 (6.3%)	8 (8.4%)

Nurse-Family Partnership**	95	64 (67.4%)	17 (17.9%)	10 (10.5%)	3 (3.2%)	1 (1.1%)
Parent-Child Interaction Therapy	92	31 (33.7%)	31 (33.7%)	10 (10.9%)	13 (14.1%)	7 (7.6%)

***While these services were identified as evidence-based programs currently being delivered in Virginia, VDSS determined that these programs would not be included in the first phase of Family First implementation and eligible for title IV-E reimbursement.*

In addition to the evidence-based services previously referenced, VDSS offers Kinship Navigator services throughout the Commonwealth (Prevention Strategy 1.5). VDSS received a grant from the Children's Bureau for $379,246 for use from October 1, 2018-September 30, 2021. With the grant, VDSS developed six regionally located Kinship Navigator programs involving 40 localities (33% of the state) and partnered with 2-1-1 VIRGINIA to provide a dedicated, toll-free number specifically for kinship families to receive 24-hour information and referral services across the state. Our programs are diversified and were created to meet the needs of their particular communities; however, all of the programs provide information, referral, outreach, and advocacy. Many of our programs use creative strategies, such as strategically placed electronic kiosks, to assist families with applying for benefits. Programs engage school systems and the faith-based community to reach kinship families and form regional public-private consortiums, including kinship caregivers and youth, to assess the needs of kinship families in their communities. VDSS is providing technical assistance to each program on a quarterly basis by hosting conference calls that allow programs to communicate with one another and problem solve, as well as talk on an ad hoc basis in between conference calls.

Since the program began in 2018, 861 youth and 790 kinship caregivers have received services. For children and youth, the programs have served 69% ages 0-12 and 22% ages 13-17. Caregivers served a range in age from 18-60+, with 23% in the 60+ range. Grandparents and aunts represent the majority of caregivers, at 52% and 16% respectively. Kinship families received information and referral services, including information about local, state, and federal benefits, mental health services, medical services, and advocacy, including face-to-face assistance in applying for benefits. Kinship families also received services through the provision of outreach, training and/or supportive activities, including case management, support groups, and social support activities (697 individuals).

All local departments of social services provide benefit and support services to families. The following local departments and surrounding localities offer Kinship Navigator programs:

- Arlington Department of Social Services (Partnering with Alexandria, Fairfax, Prince William, and Loudoun Departments of Social Services);
- Bedford Department of Social Services (Partnering with Amherst, Appomattox, Campbell, Lynchburg, and Nelson Departments of Social Services);

- Dickenson Department of Social Services (Partnering with Buchanan, Russell, Tazewell, Lee, Wise, Scott, and Norton Departments of Social Services);
- James City County Department of Social Services (Partnering with Williamsburg and York-Poquoson Department of Social Services);
- Virginia Department of Human Services (partnering with Chesapeake, Portsmouth, Suffolk, and Norfolk Departments of Social Services); and,
- Smyth Department of Social Services (partnering with Wythe, Bland, Bristol, Carroll, Galax, Giles, Grayson, Montgomery, Pulaski, Radford and Washington Departments of Social Services)

Our Kinship Navigator programs continue to strive to problem-solve challenges that arise in providing Kinship Navigator services. Challenges our programs have identified include those noted below.

- Regionally located programs require a considerable amount of travel. In our rural areas, this could mean traveling several hours to visit a family.
- Engaging school systems has been challenging, as many of our school systems only recognize kinship families when they have formal legal arrangements.
- Lack of financial assistance and appropriate housing options are major barriers to kinship families in general.

Health and Human Services-Approved Prevention Services

With the prevalence of mental health, substance use, and parent skill-based training for families in Virginia, VDSS implemented Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Parent-Child Interactive Therapy (PCIT). Over 50% of families receiving In-Home services had service needs identified to mental health, substance use and/or parent skill-based training. Additionally, parental drug use was the most common circumstance driving removals followed by child behavior problems, physical abuse, parent unable to cope, and child drug abuse which could all be served through the selected evidence based services. A description of each program with the identified target population is included within the following sections of each service. All three are rated as well-supported on the Title IV-E Prevention Services Clearinghouse. Through examination of our data and information collected in our provider survey, these three services are available throughout Virginia and will meet the needs of our families currently being served through In-Home Services and Prevention.

VDSS partnered with the Center for Evidence-based Partnerships in Virginia (CEP-Va), which is a partnership between agencies of the Commonwealth and Virginia higher education institutions to support the implementation, capacity building, fidelity monitoring, evaluation and sustainability of evidence-based programs. The Governance Committee for CEP-Va includes DBHDS, DMAS, DJJ, DSS, OCS, and VDH. VDSS will utilize title IV-E funding for CEP-Va to conduct fidelity monitoring of providers and provide quarterly fidelity monitoring reports for VDSS to utilize in the child welfare CQI process. As a part of their capacity building work, CEP-Va completed an initial Needs Assessment and Gaps Analysis (NAGA) for VDSS. The NAGA report included ten recommendations. Of those, three have been identified as priorities: 1) implementation of additional EBPs; 2) supplement the services arrays of CSBs where the foster care entry rate is high; and 3) strengthen LDSS engagement with families through frontline personnel training in Motivational Interviewing. In review of the well-supported EBPs in the Clearinghouse, VDSS intends to implement Brief Strategic Family Therapy (BSFT), Homebuilders, Family

Check-Up, and Motivational Interviewing (MI). VDSS also plans to implement High Fidelity Wraparound (HFW), recently listed in the Clearinghouse as promising as HFW is already well established and available throughout the Commonwealth. A description of each of these programs and their targeted populations are included within the following sections of each service.

Improving Outcomes for Children and Families

By providing Title IV-E Prevention Services and Kinship Navigator Services, VDSS expects to address the needs of families as demonstrated through the targeted outcomes goals data above, as well as stakeholder identified gaps in service delivery. As part of our CQI approach, we will seek to understand the reach of the proposed services, to monitor the fidelity of the proposed services, and to assess if the service-specific and overall desired outcomes are being achieved for families and our larger child welfare system. We expect to answer the following questions resulting in the following short and long term outcomes. Our 2020-2024 Child and Services Plan (CFSP) strategic plan and annually reported in Annual Progress and Services Report (APSR) aligns In-Home practice goals and outcomes measured via the CFSP and CFSR outcomes, this current plan has been aligned with the Virginia CFSP.

Reach: *Are children/families being identified, referred and receiving evidenced-based services/programs? Is our prevention service array expanding? Are there regional variations in EBP referrals, service receipt, and service completion?*

- Annual number of children and/or caregivers who meet the Family First candidate requirements being identified for EBS
- Annual number of children/families who are identified as high/very risk with an open In-Home service case.
- Annual number of children and/or caregivers who are referred for evidence based services through Family First funding.
- Annual number of children/and or caregivers who have completed service plans and assessments (including CANS)
- Annual number of children and/or caregivers who are receive evidence based services through Family First funding.
- Annual number of children and/or caregivers who completed the evidence based services through Family First funding.
- Identification and annual increase of evidence-based service providers providing services in the Title IV-E Prevention Services Clearinghouse.
    - Expand the use of current Kinship Navigator programs

Short-term outcomes: *Are children/families experiencing improved child and family well-being outcomes? Are children/Families having input on their service planning?*

- Children/families that *receive* an EBP service experience better mental health, parenting outcomes, increased youth and family participation in service planning, and increased parental coping skills as prescribed by each EBP (FFT, MST, PCIT, BSFT, HB, FCU, MI, HFW).
- Children/families that *receive* an EBP service will experience an increase in youth coping skills~~,~~ and a reduction in the prevalence of youth delinquent behaviors as prescribed by each EBP (FFT, MST, BSFT, FCU).
- Children/families that *receive* an EBP service will experience a reduction in the prevalence of substance use and violence as prescribed by each EBP (FFT, MST, BSFT, MI)

- Children/families that *receive* an EBP service will experience improvement in economic and housing stability and a reduction in the prevalence of child abuse and neglect (HB, MI, HFW)

Long-term outcomes: Are children safely remaining in their homes; thus reducing foster care

- Children/families who receive FFT, MST, or PCIT have a reduction in maltreatment as measured by:
    - Decrease in the annual number of children re-referred for suspected child maltreatment
        - Within 12 months of the child-specific prevention plan start date
        - Within 24 months of the child-specific prevention plan start date
- Children/families who receive FFT, MST, or PCIT have a reduction in foster care entries as measured by:
    - Decrease in the annual number of children entering foster care
        - Within 12 months of the child-specific prevention plan start date
        - Within 24 months of the child-specific prevention plan start date

Implementation Services and Fidelity Monitoring

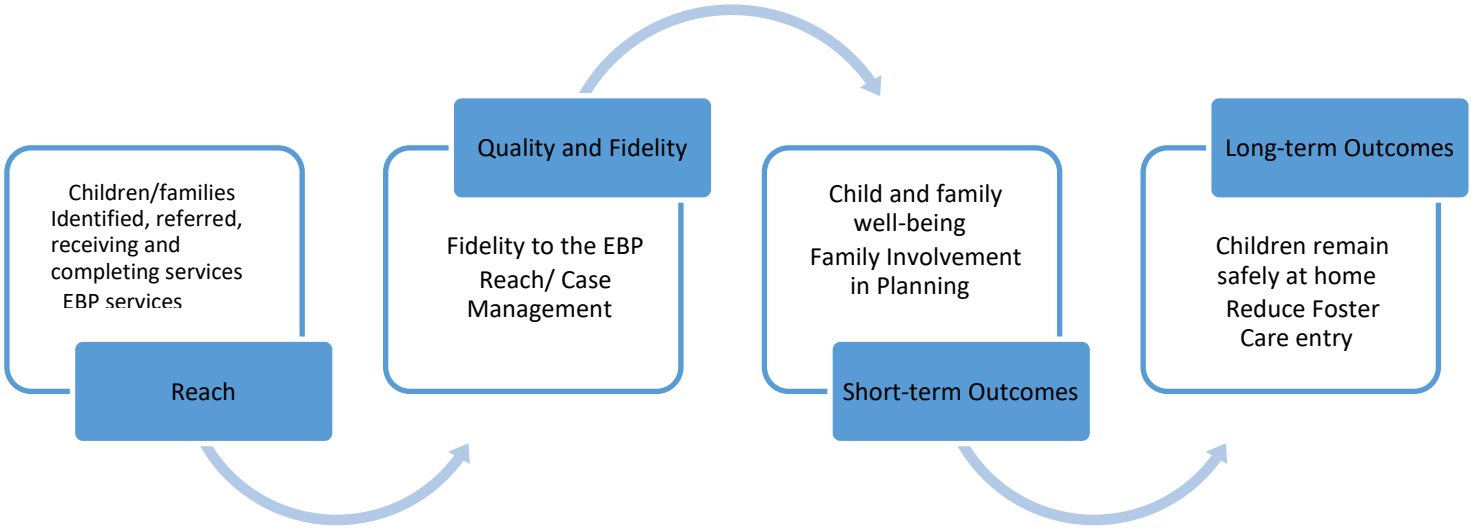
As a state-supervised and locally-administered child welfare system, each locality is responsible for the service provision in their community depending on various funding streams. Family First presents an opportunity to utilize federal funds to more equitably provide services across the Commonwealth through matching federal funds rather than being dependent on each locality's resources. LDSS provide the approved title IV-E Prevention Services, approved in Virginia's plan, through their current local contract process. VDSS provides a contract template for LDSS to ensure providers meet the standards of the evidence-based programs and provide necessary information needed for fidelity monitoring. We will use the information to assess fidelity and understand whether evidenced-based services are being delivered as prescribed.

As evidenced in the table on pages 21-22 while the programs are available in Virginia, they may not be readily available to every locality in the first phase of Family First implementation; however, this does not preclude an agency from utilizing the service. In preparation for the first round of implementation of Family First, through the Three Branch team, VDSS requested and ultimately received $851,000 from the Virginia General Assembly to support providers in enhancing their evidence-based service delivery, specifically for services listed in the Title IV-E Prevention Services Clearinghouse. VDSS utilized this funding to offer statewide training for providers, in order to enhance service delivery throughout the state (Prevention Strategy 2). Virginia offered training opportunities, at no cost to providers, for five Multisystemic Therapy (MST) Teams, five Functional Family Therapy (FFT) Teams and 16 Parent-Child Interaction Therapy (PCIT) clinicians to increase availability across the Commonwealth. Provider selection for these services occurred through an application process in collaboration with MST Services, FFT Site Certification Training Services, and The Center for Child and Family Health (CCFH) respective to their program expertise. In a second round of trainings, VDSS will offer training opportunities for providers in Brief Strategic Family Therapy (BSFT), Homebuilders, and Family Check-Up, as well as to supplement MST, FFT, and PCIT teams. Providers will be chosen through an application process facilitated by CEP-Va, with VDSS personnel participating on the review committee. In addition, VDSS will incorporate Motivational Interviewing (MI) training into Family Services Specialists and Supervisor

trainings. High Fidelity Wraparound (HFW) is already well established in Virginia so VDSS does not anticipate a need to offer widespread training to promote the availability of this service. VDSS plans to continue to utilize this state funding with IV-E matching funds to enhance availability of evidence-based services throughout the Commonwealth. Further descriptions of training efforts for each EBP are described within the following sections of each service.

Continuous Quality Improvement

VDSS is committed to performance monitoring and outcomes to ensure the best service delivery system for clients of the child welfare system. Ensuring positive outcomes is a process that includes ensuring that children and families are reaching services, monitoring the fidelity of the EBP model, achieving short-term child and family well-being outcomes and assessing overall achievement of long-term outcomes for the entire system (as illustrated in the graphic below).



The overarching CQI program integrates three tiers of review, assessment and intervention, including high level CQI accomplished in regional CQI meetings; secondary CQI dedicated to fidelity specifically regarding the evidence based service accompanying Virginia's implementation of Family First; and, tertiary CQI involving deep dives into local agency data, root cause analysis processes involving state, regional and local staff. The first level wraps in all of our outcomes, looking at regional trends in terms of strengths and gaps. The Family First-specific fidelity piece of CQI involves our Center research partners contracted, EBS providers in communities, and our child welfare data. CEP-Va will conduct fidelity monitoring of the selected EBT's (MST, FFT and PCIT) as described on pages 30-31 and aligning with national purveyor standards. Providers in communities who are enacting the selected EBPs will adhere to the fidelity of their chosen model and agree (through local contracts) to perform their own fidelity

monitoring and adherence to the model as prescribed by the model. They will also provide information about their performance and practices to CEP-Va in order to understand if services are improving the expected child and family well-being outcomes. DFS regularly reviews regional and local child welfare data from the child welfare information system to include correlated safety, well-being and permanency outcomes as identified in the Child and Family Services Review (CFSR). VDSS, in collaboration with CEP-Va research partners will review the fidelity monitoring and the child welfare outcomes, integrating quantitative and qualitative data, as well as through anecdotal evidence from local agency and provider partners into the larger assessment/CQI process within this targeted echelon. Thirdly, our CQI process allows for regional data to be drilled down to local levels, identifying specific agency strengths, risks, trends in performance, potential for peer-to-peer resource and learning collaborative sharing opportunities based on strengths, or problems with agency-wide or individual-level performance.

Within the secondary CQI level process, all identified EBS will be wrapped into the fidelity and assessment and monitoring processes, to involve providers, stakeholders, VCU researchers and Center for EBP Excellence representation. Additionally, Strategic Consultants will facilitate the connection of these elements with the greater CQI processes, through soliciting input from Practice Consultants, the IV-E Review team (QAA), community providers of these services, and local department In-Home workers. To maintain fidelity to our commitment to assimilating voices of lived experience, parent representation could be included representationally (via written reports or feedback) or in person as relevant to hear from the service recipients' perspective. VCU researchers and designees will work in tandem with VDSS Strategic Consultants and Practice Consultants to understand how the quantitative and qualitative information gained through performance of their contract deliverables for fidelity monitoring can be complemented or supplemented by anecdotal information that practice consultants, LDSS In-Home workers, EBS providers and service recipients share. While VCU researchers will facilitate this second level of CQI dedicated to fidelity monitoring and implementation of the three, and perhaps later, additional, EBS, all aforementioned partners and stakeholders will take an active role in moving this process forward. Further detail is provided in the subsequent section, Evaluation Waiver Request.

As noted in the VDSS 2020-2024 CFSP:

> *"Virginia recognizes that a robust CQI system is vital to improve services and supports for children and families, ensure effective use of resources, and achieve targets and desired outcomes. An effective system integrates the quantitative and qualitative measures toward an integrated system that thoroughly captures data processes to properly inform policy and service provision at all levels. This is inclusive of building out a comprehensive data plan allowing examination of the many data sources, while also identifying opportunities to incorporate the different qualitative and qualitative aspects of the case review system. Our approach is both data-driven and practice-informed."*[3]

[3]2 Virginia Department of Social Services 2020-2024 Child and Family Services Plan (CFSP), https://www.dss.virginia.gov/family/cfs_plan.cgi

Within the context of the aforementioned second tier of CQI which would be dedicated to fidelity to our EBS and contain the future ability to assess additional EBS as those opportunities arise, VDSS plans to utilize similar methodology of CQI models currently used in other child welfare programming and monitoring (VDSS CFSP Items 20, 21 and 25 Case Review and QAA System) to complement the addition of these evidence based services in Virginia. VDSS intends to utilize title IV-E administrative funds to support the CQI and fidelity monitoring components through the delivery of title IV-E prevention services. VDSS' approach to fidelity monitoring of FFT, MST, PCIT, BSFT, Homebuilders, Family Check-up, Motivational Interviewing, and HFW is guided by the following questions:

- Do the referred children/families meet the eligibility requirements for each specific EBP model?
- Are the EBP services delivered as prescribed by each specific EBP model and guiding manual/curriculum (e.g. fidelity to the model)?
- How many EBP service sessions took place and is this consistent with the EBP model?

The VDSS fidelity-monitoring plan has been updated with support from CEP-Va. VDSS will overlay a multi-component fidelity model with each EBP model purveyor's requirements as outlined below. This will ensure that fidelity to each EBP model takes into account the following domains: (a) training status, (b) provider EBP experience, (c) adherence, (d) competence, and (e) overall fidelity. Individualized descriptions of fidelity monitoring for each EBP is included within the following sections of each service.

VDSS has contracted with CEP-VA to provide ongoing fidelity monitoring for all current and new EBP's. CEP-Va is to provide data analysis, reporting, and presentation to VDSS and relevant stakeholders of fidelity of the providers funded through title IV-E prevention services funding, as well as outcome data. CEP-Va is responsible for acquiring data for these reports, as described in the fidelity monitoring section of each EBP. CEP-Va is to make recommendations for improving fidelity monitoring and/or outcomes based on their data analysis and expertise in fidelity and outcomes of EBPs. VDSS will incorporate these reports into the larger CQI process. Recommendations from CEP-Va will be considered in the development and evolution of practices that improve outcomes.

VDSS received evaluation waivers for Functional Family Therapy (FFT), Multisystemic Therapy (MST) and Parent-Child Interaction Therapy (PCIT) which are each rated as "well supported" in the title IV-E prevention services clearinghouse. VDSS intends to request evaluation waivers for BSFT, Homebuilders, Family Check-Up, and Motivational Interviewing. (See Attachment II for the *State Request for Waiver of Evaluation Requirement for a Well-Supported Practice).*

VDSS assures that each Health and Human Services-approved Title IV-E Prevention Service provided as outlined in this state plan meets the trauma informed service delivery as outlined in section 471(e)(4)(B) of the Act. (See Attachment III). VDSS will monitor this through the provider's annual review.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a well-established, well-supported, community-based evidence-based intervention for troubled youth (ages 12-18). FFT addresses risk and protective factors for youth with behavioral or emotional stressors, by working within the context of the family.

Service	Functional Family Therapy
Service Category	Mental Health Prevention or Treatment Services
Rating	Well-Supported
Target Population	FFT is intended for 11 to 18 year old youth who have been referred for behavioral or emotional problems by juvenile justice, mental health, school, or child welfare systems. Family discord is also a target factor for this program.
Program Documentation	Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). Functional Family Therapy for adolescent behavioral problems. American Psychological Association.
Targeted Outcomes	● Child well-being: Behavioral and emotional functioning ● Child well-being: Substance use ● Child well-being: Delinquent behavior ● Adult well-being: Family functioning
Targeted Outcomes Goals	● Reduce youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use) ● Improve prosocial behaviors (i.e., school attendance) ● Improve family and individual skills
Data Collection and Transfer	● FFT providers will submit fidelity and outcome data to the FFT purveyor data base ● CEP-Va will work directly with the FFT purveyor and the providers to retrieve and analyze the data to support FFT fidelity and outcome monitoring ● FFT providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS partnered with FFT Site Certification Training Services to provide implementation support and technical assistance for new Functional Family Therapy (FFT) programs. Functional Family Therapy provided support through a three-phase process. During the first phase, FFT Site Certification Training Services provided clinical training to providers. In the second phase, FFT Site Certification Training Services provides supervision training to support greater self-sufficiency in the delivery of FFT while maintaining and enhancing site adherence and competence in the FFT model. In the third phase, FFT Site Certification Training Services will assure ongoing fidelity, support issues of staff development, interagency linking, and program expansion. FFT Site Certification Training Services will review the database for site/therapist adherence, service delivery trends, and client outcomes as well as providing a one day on-site training for continuing education in FFT.

Fidelity Monitoring

Functional Family Therapy LLC, the proprietor of the FFT model, provides internal fidelity controls for all FFT teams. FFT conducts the following fidelity monitoring processes:

- Global Therapist Ratings every four months which examines the therapists' delivery of the FFT model;
- TriYearly Performance Evaluation conducted every four months which examines the FFT teams' performance with FFT National Standards along with outcomes; and,
- Functional Family Therapy LLC, utilizes a Quality Improvement Plan utilized by Functional Family Therapy LLC as needed with the TriYearly Performance Evaluation Plans, providing a mechanism to monitor progress and address priorities for the upcoming review period.
- Additionally, VDSS will:
    - Require providers to report and adhere to their continuous quality improvement (CQI) process and fidelity monitoring process. An analysis will be performed on uniformed provider reports on systematic outcomes. These tools will assist in monitoring whether the outcomes are achieved. From these reviews the results are provided to practice consultants for practice improvement, and provides data in key performance areas to inform performance management.
    - Regularly monitor providers through adherence to performance measures (both established by the Family First Evaluation Team but also by each provider).
    - Continuously work as a team (which may include evaluation specialists, researchers, fidelity-monitoring specialists, and data visualization specialists) to maintain regular contact and receive required reporting content from contracted providers.
    - Conduct an annual review of each contracted service provider to review their practice, guidelines and training.

VDSS will conduct the review by utilizing data reported quarterly by each contracted service provider and examining and analyzing our outcomes to see if there is a reduction in children entering the foster care system. If outcomes are not being met (by the program and/or in accordance with VDSS' outcomes), VDSS will meet with the service provider to conduct a root cause analysis to determine why outcomes are not being met. VDSS will develop a program improvement plan in consultation with the service provider to improve outcomes. Reviews will be performed to ensure compliance in accordance with sub-recipient monitoring requirements.

Evaluation Waiver Request Basis

FFT has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child well-being: Behavioral and emotional functioning, substance use, and delinquent behavior; and,
- Adult well-being: Family functioning

Through the Title IV-E Prevention Services' Clearinghouse review, of the 22 studies identified for review, nine studies demonstrated favorable effects on the target outcomes. A total of six of those studies rated as moderate or high and none of the studies identified a risk of harm.

In conjunction with the review of the evidence of effectiveness of FFT stated above, VDSS also reviewed the following articles.

An outcome evaluation of Functional Family Therapy for court-involved youth[4] examined the effects of two measures of the effectiveness of FFT under Family Court Supervision. Within this study, family functioning also improved with the family-based treatment model of FFT. The Strengths and Needs Assessment (SNA) scores of participants demonstrated statistically significant improvements in life domain functioning, child strengths, caregiver strengths, child behavioral/emotional needs and child risk behaviors after completed treatment demonstrating that FFT improves family functioning resilience. In this particular study, FFT also impacted the recidivism of court-involved youth, while treating the youth in the context of their family.

In a study reviewing the effects of FFT and if it was more effective in mandating a youth and family's attendance versus non-mandating attendance indicates that the consistent predictor of positive change was connected to the number of attended sessions. Celinska's article, *Effectiveness of Functional Family Therapy for Mandated versus Non-Mandated Youth*[5], indicate the fidelity of the FFT model which requires FFT therapists to not advance to the next phase of the model until they assess that the family is engaged and motivated. While VDSS In-Home Services are based upon the foundation of family engagement, it is expected that not all families may enthusiastically want to participate in identified services. This study suggests that despite the enthusiasm of a family, the fidelity of the model engages the family through each of the phases.

FFT addresses youth's needs along with their parents, presenting a family-based treatment. This method of treatment provides for a family-based and comprehensive model of treatment that promotes stronger family connections which helps children remain with their parents in their communities. During SFY 2020, approximately 33% percent of children actively involved in an In-Home case fell within the age range to receive FFT services. Data on the age of children upon entry into foster care indicate that over one-third of children entering each year were within the age range to receive FFT services at the time of entry: 39% in SFY2018, and 37% in SFY2019 and SFY2020. Data on circumstances present during removal also indicate that children entering foster care in Virginia may have benefitted from FFT services to prevent their entry into foster care. Child behavioral issues were present among 15% to 18% of removals for the last three state fiscal years. In SFY2020, children in FFT's service age range were also over-represented among removals where child behavior problems were present. While the percentage of removals involving parental inability to cope is relatively small overall (present among 3% of removals over the last three fiscal years), it was disproportionately more prevalent among children entering care at an age where they would have been eligible to receive FFT services (ages 11 and 13-16).

Reviewing the service needs identified for children and families who had In-Home involvement prior to the child's removal during SFY2020, two-thirds (67%) of cases indicated a need for counseling or therapy

[4] Celinska, Katarzyna, Sung, Hung-En, Kim, Chunrye, & Valdimarsdottir, Margret. (2019). An outcome evaluation of Functional Family Therapy for court-involved youth. *Journal of Family Therapy, 41*(2), 251-276.
[5] Celinska, K. (2015). Effectiveness of Functional Family Therapy for Mandated Versus Non-Mandated Youth. *Juvenile & Family Court Journal, 66*(4), 17-2

as a support. Parenting education was identified as a need in one-third of these cases (38%).Based on a review and analysis of the literature and data provided over the past three state fiscal years, youth and caregivers in Virginia should receive the same outcomes, based on the rigorous research and evaluation that has occurred regarding FFT.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is a well-established, well-supported, community-based evidence-based intervention for troubled youth (ages 12-17) in a variety of settings. MST promotes prosocial behavior and reduces mental health symptoms, out of home placement, and substance use, which are often found in Virginia's child welfare system.

Service	Multisystemic Therapy**
Service Category	Mental Health Prevention or Treatment Services, Substance Use Disorder Prevention or Treatment Services
Rating	Well-Supported
Target Population	This program provides services to youth between the ages of 12 and 17 and their families. Target populations include youth who are at risk for or are engaging in delinquent activity or substance misuse, experience mental health issues, and are at-risk for out-of-home placement.
Program Documentation	Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (2009). *Multisystemic Therapy for antisocial behavior in children and adolescents* (2nd ed.). Guilford Press.
Targeted Outcomes	● Child permanency ● Child well-being: Behavioral and emotional functioning ● Child well-being: Substance use ● Child well-being: Delinquent behavior ● Child well-being: Educational Achievement and Attainment ● Adult well-being: Positive parenting practices ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Family functioning
Targeted Outcomes Goals	● Child well-being: Behavioral and emotional functioning ● Child well-being: Substance use ● Child well-being: Delinquent behavior ● Child well-being: Educational Achievement and Attainment ● Adult well-being: Positive parenting practices ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Family functioning
Data Collection and Transfer	● MST providers will submit fidelity and outcome data to the MST purveyor data base ● CEP-Va will work directly with the MST purveyor and providers to retrieve and analyze the data to support MST fidelity and outcome monitoring ● MST providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS partnered with MST Services to provide additional implementation, sustainability and fidelity supports to new Multisystemic Therapy programs in Virginia. MST Services provided MST model implementation support, training and Quality Assurance oversight and support as outlined in their standard MST Program Support and Training Licensing Agreement, both to VDSS and to provider organizations. MST Services will support program development and start up services through the following activities.

- Conducting a needs assessment with each provider agency to discuss the need for MST and the feasibility of building a sustainable program.
- Conducting a critical issues review session to discuss the key elements of a successful MST program including Stakeholder relationships, defining target populations, developing referral processes, program finance, and program evaluation. Participants will gain information necessary to develop a comprehensive program description.
- Conducting a Readiness Review meeting to provide an overview of MST to the community, and to meet with key stakeholders to refine the final implementation plan.
- Providing staff recruitment assistance by providing sample advertisements, job descriptions, interview protocols and selection criteria.
- A 5-day Orientation Training for each new program start-up. The training provides the foundation for on-going implementation and program support and includes program managers, supervisors and therapists.

Once MST program operations have been initiated, MST Services will provide MST program support and training services tailored to the needs of the agency's program. MST Services will provide annual support and training services by:

- Weekly MST telephone consultation for the MST Clinical Team(s). This weekly telephone consultation will average one hour per MST Clinical Team per week for up to 45 weeks during the year,
- Unlimited consultation regarding the following: program quality assurance and improvement; organizational/systems consulting addressing issues related to the program's adherence to MST protocols or those that impact the quality of the MST program's outcomes; program development assistance related to program expansion,
- Up to four (4) Booster Training sessions in each year of operation, and
- All required training materials and manuals.

Fidelity Monitoring

MST Services LLC, the proprietor of the MST model, provides internal fidelity controls for all MST teams. There are several foundational requirements that are included in the MST licensing agreement that each provider/agency signs to become an MST provider and includes the following:

- Adherence to MST System. The MST system is to be used by all licensed organizations in a consistent manner and in accordance with the highest professional standards. Through the licensing agreement, providers agree to comply with all of the policies and procedures in the MST Manuals. The provider is required to periodically advise MST Services LLC, of any changes in

the nature of the population that is being served by the MST System, and of any policies that affect the frequency, intensity, or fidelity with which providers can deliver MST services.

- Providers shall ensure that all of the employees involved with the MST System are competent and fully trained in the use of MST.
- Providers are required to fully cooperate with MST Institute in assessing the providers' level of adherence to the MST System. The provider is required to provide the following data: Therapist Adherence Measure (TAM), and Supervisor Adherence Measure (SAM).
- The ability for MST Services LLC, to conduct audits, investigations and observations of audio recordings of family sessions, team supervision, or team consultant (consistent with the maintenance of client confidentiality).
- If MST Services LLC, determines that the provider is failing to use the MST System with an acceptable level of quality, MST Services LLC, will meet with the provider, assess the problem and work to implement remedial measures.

Evaluation Waiver Request Basis

MST has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child permanency: out of home placement;
- Child well-being: behavioral and emotional functioning, substance use, delinquent behavior; and,
- Adult well-being: positive parenting practices, parent/caregiver mental or emotional health, and family functioning.

Through the Title IV-E Prevention Services' Clearinghouse review, of the 28 studies identified for review, 23 studies demonstrated favorable effects on the target outcomes. A total of ten of those studies rated as moderate or high and only one study reviewed indicated a risk of harm.

In conjunction with the review of the evidence of effectiveness of MST stated above, VDSS also reviewed the following articles.

The article, *Multisystemic treatment of series juvenile offenders: long-term prevention of criminality and violence*[6], compared the long term effects of this therapy compared to individual therapy, adding to several previous studies on MST (Henggeler et al., 1992, 1993, Hennggeler et al., 1986, Scherer et al., 1993, Brunk, Henggeler, & Whelan, 1987, and Borduin, Henggeler, Blaske, & Stein, 1990). The article outlined that the results from the 176 juveniles confirmed that MST is more effective than individual therapy. More importantly the ongoing results of these same youth four years later still showed youth who received MST compared to individual therapy was more effective in preventing future criminal behavior which included violent offending. Particularly for family relations, this study showed that families reported increase in family relationships, and in their "cohesion and adaptability at

[6] Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, *63*(4), 569–578. https://doi-org.proxy.library.vcu.edu/10.1037/0022-006X.63.4.569

posttreatment"[3]. Families who received MST had favorable effects on perceived family relations, but also saw improvement at both the parent and youth levels. In this study, the efficacy of MST was not based on demographic characteristics.

With over twenty years of MST practice, recent studies are looking at the long term effects of MST. Johnides, Bordin, Wagner & Dopp published their findings in the *Effects of multisystemic therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial* (2017)[7]. This study looked at 276 caregivers of serious juvenile offenders and were originally randomized for either MST or individual therapy. This study focuses on the family-based treatment of MST and the proven outcomes not just for youth, but also for caregivers. Caregivers who have a history of criminal involvement or antisocial behaviors are a barrier to effective parenting and are a risk for youth to repeat the same behaviors. The study showed that there was a significant decrease in the number of criminal behavior, 94% fewer felonies and 70% fewer misdemeanors. Additionally, and potentially more in line with child welfare outcomes, this study also found that those who had received MST services had 50% fewer family-related civil matters. This study also notes the improved family functioning through self- and observational reports. Similar to other research, the efficacy of MST was not based on demographic characteristics.

MST addresses intrapersonal and systemic factors by focusing on individual needs and the family needs. This combination of treatment is a holistic treatment that we believe will help children remain in their homes with their parents.

During SFY 2020, approximately 28% percent of children actively involved in an In-Home case fell within the age range to receive MST services. Data on the age of children upon entry into foster care indicate that nearly one-third of children entering each year were within the age range to receive MST services at the time of entry: 35% in SFY2018, and 34% in SFY2019 and 32% in SFY2020. Data on circumstances present during removal also indicate that children entering foster care in Virginia may have benefitted from MST services to prevent their entry into foster care. Child behavioral issues were present among 15% to 18% of removals for the last three state fiscal years. In SFY2020, children in MST's service age range were also over-represented among removals where child behavior problems were present.

Substance abuse is a consistent and increasing issue in both referrals received and child entries into foster care. Between SFY2018 and SFY2020, the indication of substance abuse as an issue during referral intake has sustained at one-third of all validated referrals statewide. Among annual entries into foster care, the circumstance of parental drug abuse present has increased from 31% in SFY2018 to 39% in SFY2020. While the percentage of removals involving child drug abuse is relatively small overall (present among 3% of removals over the last three fiscal years), this circumstance was disproportionately more prevalent among children entering care at an age where they would have been eligible to receive MST services (ages 13 and 15-17).

[7] Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of multisystemic therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *85*(4), 323–334. https://doi-org.proxy.library.vcu.edu/10.1037/ccp0000199

Reviewing the service needs identified for children and families who had In-Home involvement prior to the child's removal during SFY2020, two-thirds (67%) of cases indicated a need for counseling or therapy as a support. Parenting education was identified as a need in one-third of these cases (38%). Substance and drug abuse treatment were selected as needed in 36% of these cases, and substance or drug abuse evaluation was indicated as needed among 27% of these cases. Based on a review and analysis of the literature, and data over the past three state fiscal years youth and caregivers in Virginia should receive the same outcomes, based on the rigorous research and evaluation that has occurred regarding MST.

The extensive literature of favorable effects along with the robust internal fidelity controls through the proprietor and VDSS' monitoring protocol described above supports the request to waive the evaluation requirement for MST.

Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT) is a well-established, well-supported, community-based evidence-based behavior parent training treatment program for young children (ages 2-7). PCIT promotes the quality of the parent-child relationship and addressing interaction patterns. PCIT includes training and education for parents and then allows parents to practice their newly learned skills with the support of a trained clinician.

Service	Parent-Child Interaction Therapy
Service Category	Mental Health Prevention or Treatment Services
Rating	Well-Supported
Target Population	PCIT is typically appropriate for families with children who are between 2 and 7 years old and experience emotional and behavioral problems that are frequent and intense.
Program Documentation	Eyberg, S., & Funderburk, B. (2011) *Parent-Child Interaction Therapy protocol: 2011.* PCIT International, Inc.
Targeted Outcomes	● Child well-being: Behavioral and emotional functioning ● Adult well-being: Positive parenting practices ● Adult well-being: Parent/caregiver mental or emotional health
Targeted Outcomes Goals	● Decrease externalizing child behavior problems (e.g., defiance, aggression) ● Increase child social skills and cooperation ● Improve the parent-child attachment relationship
Data Collection and Transfer	● PCIT providers will submit fidelity and outcome data to CEP-Va's data base ● CEP-Va will work directly with the PCIT clinicians to retrieve and analyze the data to support PCIT fidelity and outcome monitoring ● PCIT providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS partnered with the Center for Child and Family Health (CCFH) to offer PCIT/CARE training to support new Parent Child Interaction Therapy (PCIT) programs. CCFH provided two training sessions including all training materials, including treatment protocols, training manuals, training binders, a set of

required ECBI assessments, preparation and post-cohort reporting. CCFH staff coordinated and scheduled all consultation components and provided technological support (conference call lines, video upload services, and data collection tools) as required. CCFH supports PCIT treatment through weekly data submission, bi-weekly phone-based clinical consultation, and review of selected session video recordings. CCFH will provide updates on clinician achievement of skills mastery and case experience requirements on a monthly basis through the completion of twelve months of training, and a final report of the training course including participant evaluation of all in-person training events, participant evaluation of the clinical consultation process, and a clinician-level report showing achievement of all national certification requirements.

Fidelity Monitoring

PCIT is an assessment-driven treatment and requires data from Eyberg Child Behavioral Inventory (ECBI) and Dyadic Parent-Child Interaction Coding System (DPICS). The ECBI is a parent report of 36 items to assess a child's common behaviors that occur frequently for children with disruptive behavior disorders. The DPICS is a coding system that assesses the quality of the parent and child's interaction. DPICS is used to monitor progress of the parent's skills during treatment and allows for objectivity and well-validated measure of change in the child's treatment. These tools in conjunction with the PCIT International Protocol Treatment Integrity checklists provide accountability and integrity of the model.

Evaluation Waiver Request Basis

PCIT has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child Well-being: Behavioral and emotional functioning; and,
- Adult well-being: Positive parenting practices, Parent/caregiver mental or emotional health.

Through the Title IV-E Prevention Services' Clearinghouse review, of the 36 studies identified for review, 20 studies demonstrated favorable effects on the target outcomes. None of the studies reviewed indicated a risk of harm.

In conjunction with the review of the evidence of effectiveness of PCIT stated above, VDSS also reviewed the following articles.

Thomas and Zimmer-Gembeck reviewed the effectiveness of PCIT and correlations of child maltreatment. Their study, *Accumulating Evidence for Parent-Child Interaction Therapy in the Prevention of Child Maltreatment* unlike many other studies, relates directly to the population VDSS intends to serve, parents who are at risk of or have history of child maltreatment[8]. This study includes findings that demonstrate the reduction of child maltreatment when a caregiver received PCIT. Within 12 weeks of receiving PCIT services, the treatment group demonstrated a reduction in stress due to the child and their behaviors and increased positive parent-child interactions. The majority of participants were found to have clinically significant and reliable improvements in the outcome measures. Thomas and Zimmer-

[8] Thomas, T., & Zimmer-Gembeck, M. J., (2011). Accumulating Evidence for Parent-Child Interaction Therapy in the Prevention of Child Maltreatment. *Child Development, 82*(1), 177-192. https://srcd-onlinelibrary-wiley-com.proxy.library.vcu.edu/doi/pdfdirect/10.1111/j.1467-8624.2010.01548.x

Gembeck found that while improvements in parent-child interactions improved prior to the completion of PCIT, more improvements were found upon successful completion of the PCIT treatment model.

The article, *Effectiveness of Parent-Child Interaction Therapy (PCIT) in the Treatment of Young Children's Behavior Problems*[9] demonstrates the positive effects PCIT had on over 81 families with children between the ages of two and seven years old with a greater reduction in child behavior problems. Results from this study indicate that for children who received PCIT there were greater improvements than other treatment modalities. The improvements were shown at the 6-month mark, but improved even more after completion of the entire treatment program. The study found that parents receiving PCIT improved their parenting skills at a greater level than parents with other treatments and greater compared with the average effect of parenting training programs.

PCIT provides parent education and ongoing coaching to practice new skills learned. PCIT promotes consistent parent behaviors and actions focusing on positive reinforcement. By focusing on the strength of the parent-child relationship, we believe PCIT will help children remain in their homes with their parents.

During SFY 2020, approximately 38% percent of children actively involved in an In-Home case fell within the age range to receive PCIT services. Data on the age of children upon entry into foster care indicate that nearly one-third of children entering each year were within the age range to receive PCIT services at the time of entry: 27% in SFY2018, and 28% in SFY2019 and 29% in SFY2020. Data on circumstances present during removal also indicate that children entering foster care in Virginia may have benefitted from PCIT services to prevent their entry into foster care. Child behavioral issues were present among 15% to 18% of all removals for the last three state fiscal years. In SFY2020, children in PCIT's service age range were also over-represented among removals where physical abuse was present (ages 3, 4, 6 and 7). While the percentage of removals involving parental inability to cope is relatively small overall (present among 3% of removals over the last three fiscal years), it was disproportionately more prevalent among children entering care at an age where they would have been eligible to receive PCIT services (6 years of age).

Reviewing the service needs identified for children and families who had In-Home involvement prior to the child's removal during SFY2020, two-thirds (67%) of cases indicated a need for counseling or therapy as a support. Parenting education was identified as a need in one-third of these cases (38%). Medical or psychological services were cited as a need in 32% of these cases. Based on a review and analysis of the literature, youth and caregivers in Virginia should receive the same outcomes, based on the rigorous research and evaluation that has occurred regarding PCIT.

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT) is a well-established, well-supported, community-based evidence-based mental health and substance abuse intervention for youth ages 6017 intended to reduce

[9] Bjørseth, Åse, & Wichstrøm, Lars. (2016). Effectiveness of Parent-Child Interaction Therapy (PCIT) in the Treatment of Young Children's Behavior Problems. A Randomized Controlled Study. *PloS One, 11*(9), E0159845.

adolescent risk behavior. Through observation and diagnosis of relational interactions, BSFT aims to improve family interactions and thereby improving youth behavior.

Service	Brief Strategic Family Therapy
Service Category	Mental Health Prevention or Treatment Services, Substance Use Disorder Prevention or Treatment Services, In-Home Parent Skill-Based Services
Rating	Well-Supported
Target Population	BSFT is for families with children or adolescents (6-17 years) who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying, or truancy.
Program Documentation	Szapocznik, J., Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse.
Targeted Outcomes	● Child well-being: Behavioral and emotional functioning ● Child well-being: Substance use ● Child well-being: Delinquent behavior ● Adult well-being: Family Functioning
Targeted Outcomes Goals	● Improve family communication and functioning ● Improve child behavioral and emotional functioning ● Decrease child and/or adult substance use ● Reduce child delinquent behavior
Data Collection and Outcomes	● BSFT providers will submit fidelity and outcome data to the BSFT purveyor database ● CEP-Va will work directly with the BSFT purveyor and providers to retrieve and analyze the data to support BSFT fidelity and outcome monitoring ● BSFT providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS is partnering with the Brief Strategic Family Therapy Institute (BSFT Institute) to provide BSFT implementation, sustainability, and fidelity supports to new BSFT programs in Virginia through the BSFT Program. Providers creating BSFT teams will be provided introductory workshops, interactive workshops, and weekly supervision session as follows:

- Introductory Workshops - Offered to administrative, supervisory staff, case managers, stakeholders, and other interested parties whose presence will support the implementation of the model
- Interactive Workshops – three sessions of three-day interactive workshops conducted by a BSFT Model Manager, consisting of interactive lectures, taped demonstrations of family therapy sessions, and clinical case consultations
- Weekly Supervision Session – conducted via video conference with the BSFT Model Manger providing feedback to therapists on their digitally recorded family sessions

The BSFT Program training curriculum is comprehensively manualized and will be provided to organizations who agree and commit to training, supervision, and licensure. BSFT Program competence

occurs when a therapist has successfully demonstrated a level of competence to the principles as determined by an evaluation of their work by the BSFT program Competency Panel. A BSFT Program On-Site Supervisor will be selected and trained to ensure quality and adherence to the model on-site. Ongoing oversight will be provided through weekly supervision with the BSFT Program On-Site Supervisor and monthly consultation by a BSFT Program Trainer.

Fidelity Monitoring

The Brief Strategic Family Therapy® Institute, proprietor of the BSFT® model, provides internal fidelity controls for all BSFT® teams. BSFT provides the following:

- Training to competence – workshops plus supervision
- BSFT® Program Competence occurs when a therapist has successfully demonstrated a level of competence in the principles of the BSFT® Program as determined by an evaluation of their work by the BSFT® Program Competency Panel; is not guaranteed as a part of the training curriculum; and can only occur as a result of supervision by an approved BSFT® Program Trainer
- A BSFT® Program On-Site Supervisor will be selected and trained to ensure quality and adherence to the model on-site
- Once therapists achieve competence, weekly supervision is provided by the BSFT® Program On-Site Supervisor and monthly consultation by a BSFT® Program Trainer
- Therapists and/or agencies submit DVDs of their work for Adherence Ratings to the Brief Strategic Family Therapy® Institute

Furthermore, VDSS will utilize CEP-Va's multi-component fidelity model which includes the following domains: (a) training status, (b) provider EBP experience, (c) adherence, (d) competence, and (e) overall fidelity. In addition to the outcomes submitted by the provider to the purveyor and analyzed by CEP-Va as they pertain to the targeted outcomes of BSFT (see table above), VDSS will be looking for evidence that children and families receiving BSFT have a reduction in maltreatment and entries into foster care (within 12 and 24 months of the start of the prevention plan).

Evaluation Waiver Request Basis

BSFT has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child well-being: Out-of-home placement
- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Economic and housing stability

Through the Title IV-E Prevention Services Clearinghouse Review, of the 6 studies identified in search, 5 were eligible for review, 5 demonstrated favorable effects on the target outcomes ranging from high to low in efficacy of meeting intended outcomes. Some studies reviewed were rated lower due to inability to account for missing data and other methodological discrepancies. None of the studies reviewed indicated a risk of harm.

In conjunction with the review of effectiveness of BSFT stated above, we also identified additional relevant evidence considered in devising the proposed plan.

In a study measuring the effectiveness of BSFT in community treatment settings, BSFT was found to be significantly more effective than treatment as usual in terms of improved family functioning, as reported by parents. BSFT was also found to be more effective than treatment as usual in their ability to engage adolescents (Robbins, 2011), underscoring the uniqueness of BSFT in its focus on engagement. Indeed, improvement of engagement has been the focus of several studies on BSFT (Szapocznik et al., 2015).

Another study found that BSFT produced positive outcomes on parent substance use and the association between parent and adolescent substance use (Horigian et al., 2015). However, these findings would need to be confirmed in a randomized controlled trial.

A final research note is that whereas the majority of studies that measure the efficacy of BSFT have been conducted primarily with Latinx families, effectiveness research has suggested that the model may be equally applicable to several other racial/ethnic/cultural groups (Robbins et al., 2011).

- BSFT targets interpersonal dynamics and includes a personalized treatment plan designed to reduce symptoms youth may be experiencing. This approach may be effective in addressing relevant child welfare targets such as improving behavioral and emotional functioning, decreasing substance use and reducing delinquent behavior. BSFT's focus on relational dynamics and communication may be relevant to improved family communication and an increase in overall family functioning and a reduction of caregiver substance use. In February 2022, approximately 60% of all children being served in an In-Home services case fell within BSFT's service age range of 6-18, making this service highly applicable and filling a gap between PCIT for younger children and MST and FFT for older youth.

Homebuilders

Homebuilders is a well-established, well-supported, home- and community-based evidence-based intensive family preservation services treatment program for families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. Families are engaged as partners in assessment, goal setting, and treatment planning.

Service	Homebuilders
Service Category	Mental Health Prevention or Treatment Services, Substance Use Disorder Prevention or Treatment Services, In-Home Parent Skill-Based Services
Rating	Well-Supported
Target Population	Homebuilders is for families with children of all ages (0-18) at imminent risk of, or reunifying from, out-of-home placement
Program Documentation	Kinney, J., Haapala, D. A., & Booth, C. (1991). *Keeping families together: The HOMEBUILDERS model*. Taylor Francis.
Targeted Outcomes	● Child well-being: out-of-home placement ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Economic and housing stability
Targeted Outcomes Goals	● Reduce family conflict ● Reduce child behavior problems ● Improve child safety

	● Reduce child abuse and neglect
Data Collection and Outcomes	● Homebuilders providers will submit fidelity and outcome data to the Homebuilders purveyor database ● CEP-Va will work directly with the Homebuilders purveyor and providers to retrieve and analyze the data to support Homebuilders fidelity and outcome monitoring ● Homebuilders providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS will partner with the Institute for Family Development (IFD) to provide training, implementation, and fidelity support for Homebuilders. IFD has a comprehensive site development plan that incorporates administrative and clinical activities, ongoing quality enhancement activities, and training over three years. Training includes two weeks of training for therapists and three weeks of training for supervisors prior to program start-up, with continued training opportunities, weekly supervision, site visits, and clinical and program supports over the first three years.

Fidelity Monitoring

The Institute for Family Development, developer of the Homebuilders Program, utilizes the Homebuilders quality enhancement system, known as QUEST, to assure quality through the development and continual improvement of the knowledge and skills necessary to obtain model fidelity and service outcomes. QUEST activities focus on providing training and creating an internal management system of on-going evaluation and feedback. QUEST offers a three pronged process for assessing the performance of Homebuilders programs, and a methodology for continuous quality improvement - delineation of Homebuilders standards; measurement of and feedback regarding fidelity of service implementation; and development of quality enhancement plans, including training and consultation, which upgrade program capacities at all levels. QUEST Activities Include:

- Infrastructure development in the public agency/ funding agency;
- Assistance in hiring program staff;
- Workshop training for program managers, supervisors, and therapists;
- Clinical consultation and home visits with therapists and supervisors;
- Technical assistance for program managers, supervisors, and support staff;
- Review of case record documentation;
- Review of agency and individual performance on fidelity measures;
- Review of program outcomes.

Furthermore, VDSS will utilize CEP-Va's multi-component fidelity model which includes the following domains: (a) training status, (b) provider EBP experience, (c) adherence, (d) competence, and (e) overall fidelity. In addition to the outcomes submitted by the provider to the purveyor and analyzed by CEP-Va as they pertain to the targeted outcomes of Homebuilders (see table above), VDSS will be looking for evidence that children and families receiving Homebuilders have a reduction in maltreatment and entries into foster care (within 12 and 24 months of the start of the prevention plan).

Evaluation Waiver Request Basis

Homebuilders has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child well-being: Out-of-home placement
- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Economic and housing stability

Of the three studies identified as eligible for review by the Title IV-E Prevention Services' Clearinghouse review, all three demonstrated at least one favorable effect on at least one target outcome. However, one study (Kirk & Griffith, 2004) did receive a lower study quality rating because baseline equivalence of the intervention and comparison groups was necessary and not demonstrated.

In an early study, Walton (1993) found Homebuilders led to fewer out of home placements for children (measured by days in home at 0, 6, and 12 months after Homebuilders) as well as higher rates of family reunification at 0, 6, and 12 months. Additionally, in a follow up study, Walton (1998) found that two-thirds of the HB families were classified as "stabilized" at the time all public agency involvement was terminated, compared with approximately one-third of the control group.

Almost a decade later, Westat (2002) found a decrease in family use of the WIC program in the state of Kentucky for those participating in Homebuilders, although no effects were found for other indicators of economic and housing stability.

In sum, the Title IV-E Prevention Services' Clearinghouse review indicates that Homebuilders' largest effects have been found in the permanency domain, especially for fewer planned permanent exits. Smaller effect sizes were reported for other measures in the permanency domain. Notably, almost no significant effects were found for differences in the child safety and adult well-being domains.

Homebuilders targets family conflict, child behavior problems, and child safety, which are relevant to child welfare targets such as out-of-home placements and recidivism of abuse and neglect. Because Homebuilders targets families with children of all ages, it may be considered as an option for all candidates of foster care in In-Home services cases. In-Home services cases consist of families where the child(ren) is living at home or in an alternate living arrangement (temporary or permanent). As evidenced in the Walton (1993) study, Homebuilders will support families with in-home services cases where the child(ren) is living at home to maintain that so that out-of-home placement (foster care or alternate living arrangement) is not necessary. For families where the child(ren) is in an alternate living arrangement, Homebuilders may support reunification, as is often the primary goal. Virginia, like other states, serves many families with poverty-adjacent neglect. With an adult well-being target outcome of economic and housing stability, and evidence of at least some overall economic improvement (Westat, 2002), Homebuilders may be well suited for many of the families served through In-Home services cases.

Family Check-Up

Family Check-Up is a well-established, well-supported, home- and community-based evidence-based brief (3 phase) intervention for families with children (ages 2-17). FCU aims to improve a range of

emotional, behavioral, and academic outcomes for children, parenting skills, and family management practices.

Service	Family Check-Up
Service Category	Mental Health Prevention or Treatment Services, In-Home Parent Skill-Based Services
Rating	Well-Supported
Target Population	Family Check-Up is for families with children aged 2 through 17 addressing a range of family functioning and management practices, and child emotional, behavioral, and academic issues.
Program Documentation	Dishion, T. J., Gill, A. M., Shaw, D. S., Risso-Weaver, J., Veltman, M., Wilson, M. N., Mauricio, A. M., & Stormshak, B. (2019). *Family check-up in early childhood: An intervention manual* (2nd ed.) [Unpublished intervention manual]. Child and Family Center, University of Oregon.
Targeted Outcomes	● Child well-being: Behavioral and emotional functioning ● Child well-being: Cognitive functions and ability ● Child well-being: Educational achievement and attainment ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Positive parenting practices
Targeted Outcomes Goals	● Improve parenting skills ● Improve family management practices ● Improve child behavioral and emotional functioning ● Improve child academic success
Data Collection and Outcomes	● FCU providers will submit fidelity and outcome data to the FCU purveyor database ● CEP-Va will work directly with the FCU purveyor and providers to retrieve and analyze the data to support FCU fidelity and outcome monitoring ● FCU providers will submit monthly progress reports to LDSS/VDSS

Training & Implementation

VDSS is partnering with the University of Oregon to provide Family Check-Up implementation, sustainability, and fidelity supports to new Family Check-Up programs in Virginia. The Family Check-Up training provides an introduction to the theory underlying the development of the model and thorough instruction on how to implement the model. After participating in the training, providers will be able to:

- Describe and implement the Family Check-Up
- Conduct a strengths-based family assessment
- Apply assessment results to form a case conceptualization
- Identify motivational strategies used in the Family Check-Up

After completing the Family Check-Up training, providers will need to train a qualified in-house candidate as a Certified Trainer/Supervisor. Certification involves meeting with a Family Check-Up consultant who offers individualized consultation to support delivery of the intervention model with fidelity, as well as developing supervisory and training capabilities. Certification promotes skill development and supports delivery of the model across a provider agency with adherence and quality to

optimize benefits families receive from participating in the Family Check-Up. Implementing with fidelity can build families' trust in the intervention process, increase the family's sense of self-efficacy as well as their motivation to try new strategies and skills – all of which can also better ensure sustained funding for program implementation.

Fidelity Monitoring

The University of Oregon, proprietor of Family Check-Up, provides consultants and utilizes the COACH tool to monitor fidelity. The Family Check-Up certification process is designed to: enhance provider skills in delivering the model; share useful feedback with providers on how to develop their expertise and skills as a Family Check-Up provider in their particular context; increase providers' confidence in delivering the model, and promote their ability to implement the model with fidelity by offering them clinical, administrative, and technical support; and help providers promote continued engagement of the family. The first step in the certification process involves providers video recording and uploading their sessions (with family consent or mock sessions) to a HIPAA-compliant video platform or portal that can be accessed by a Family Check-Up consultant. The consultant uses COACH (the model's empirically based observational fidelity assessment tools) to review the videos with the provider and assess session fidelity. There are separate COACH tools for Family Check-Up and Everyday Parenting, but they each assess the same major domains. The acronym COACH stands for the first letter of each of the tools' five domains of fidelity: (1) Conceptually accurate and adherent, (2) Observant and responsive to family needs, (3) Active in structuring session, (4) Careful when teaching and providing feedback, and (5) Hope and motivation generating.

To become certified, providers must deliver two Family Check-Up sessions that consultants determine meet "fidelity criteria," as assessed using COACH, for each of the COACH domains. VDSS will require providers to recertify every two years.

Furthermore, VDSS will utilize CEP-Va's multi-component fidelity model which includes the following domains: (a) training status, (b) provider EBP experience, (c) adherence, (d) competence, and (e) overall fidelity. In addition to the outcomes submitted by the provider to the purveyor and analyzed by CEP-Va as they pertain to the targeted outcomes of Family Check-Up (see table above), VDSS will be looking for evidence that children and families receiving Family Check-up have a reduction in maltreatment and entries into foster care (within 12 and 24 months of the start of the prevention plan).

Evaluation Waiver Request Basis

Family Check-Up has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child well-being: Behavioral and emotional functioning
- Child well-being: Cognitive functions and ability
- Child well-being: Educational achievement and attainment
- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Positive parenting practices

Of the five (5) studies eligible for the Title IV-E Prevention Services Clearinghouse review, five demonstrated favorable effects on positive parenting practices. The studies reported significant improvements in maternal involvement, proactive parenting, parents' usage of positive reinforcement compared to the control, and a decrease in over-involved parenting. One study was rated low on effectiveness due to not demonstrating baseline equivalence of intervention and comparison group. None of the studies were identified as a risk of harm.

We also reviewed several other studies deemed relevant to our consideration of improving our prevention plan. In one study (Stormshak et al., 2020) that examined data from three RCTs, including data from 2,322 families over 14 years. Notable here was that in families who received FCU, the children showed steeper declines in children's depressive symptoms over the first 10 years compared to children in control groups. A second study by Hentges and colleagues (2020) found somewhat similar results, reporting that FCU plus Everyday Parenting (focused on parent management training includes positive behavior support, limit setting, and relationship building) provided during the brief follow-up intervention may indirectly decrease internalizing and externalizing problem behaviors in youth by increasing inhibitory control. These two studies suggest that although the program targets several key family functioning domains, the program also has effects on youth behaviors. In another study, Metcalfe and colleagues (2021) found that receipt of FCU was associated with more benefits for parents who experienced more contextual stress. This was particularly true in outcome domains such as monitoring/family routines (these improved) and negative parenting behaviors (these decreased). In short, families experiencing high levels of stress may be particularly good candidates for FCU.

Family Check-Up targets several family and youth dimensions that make it relevant to the service array in Virginia's Family First plan. The program targets youth behavioral health and academic outcomes. As well, the program directly targets parenting skills, emphasizing positive parenting. With a targeted age range of 2-17, Family Check-Up may be an option for up to 85% of all In-Home services cases.

Motivational Interviewing (MI)

Motivational Interviewing (MI) is a well-established, well-supported, style of approaching individuals of all ages to help them to meet their personal goals. A person trained in MI does this by guiding individuals to reflect on their current behaviors and reinforce motivation for change. MI can be delivered with other EBPs, clinical strategies, and interventions because MI strategies work to empower patients to be the drivers of their own change.

Service	Motivational Interviewing
Service Category	Substance Use Disorder Prevention or Treatment Services
Rating	Well-Supported
Target Population	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas
Program Documentation	Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.
Targeted Outcomes	● Child well-being: Child substance use ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Parent/caregiver substance use

	● Adult well-being: Parent/caregiver criminal behavior ● Adult well-being: Family functioning ● Adult well-being: Parent/caregiver physical health ● Adult well-being: Economic and housing stability
Targeted Outcomes Goals	● Reduce substance use ● Improve motivation for change ● Improve treatment participation and completion ● Reduce child abuse and neglect ● Reduce family violence
Data Collection and Outcomes	● LDSS will provide CEP-Va with recordings and/or other evidence as requested to complete the behavioral observation tool ● CEP-Va will work with VDSS and LDSS to collect data on MI delivery ● VDSS will collect data from OASIS on the clients receiving MI, as documented in their prevention plan

Training & Implementation

Motivational Interviewing (MI) is a therapeutic approach that differs from other models that target personal change because it requires a shift in how care is typically provided. MI requires a partnership that honors and respects the other's autonomy, and a practitioner who is continuously seeking to understand the patient's internal frame of reference. MI enhances patient engagement by creating an environment of trust and eliciting the patient's own motivations for change and personal goals. The spirit of MI can be combined with other treatment modalities, because its practice is less of a set of skills and more of a philosophy to care.

The Title IV-E Prevention Services Clearinghouse rated MI as a well-supported service that can be applied to a range of problem areas and, when combined with other services, is effective in motivating caregiver engagement and participation in services. MI was selected by Virginia because it is highly accessible and has demonstrated effectiveness in meeting the needs of caregivers who struggle with substance abuse and/or in recovery. MI can also be used in a variety of settings such as community agencies, clinical outpatient settings, healthcare facilities, and hospitals, adding to its flexibility. MI has been found to be effective when delivered by professionals outside of the mental health profession, such as nurses and behavioral technicians, and is agnostic to training background.

In contrast to the other EBPs in this plan, LDSS Family Services Specialists and supervisors will receive training in MI. Utilization of MI in all In-Home cases is a case management engagement strategy that will cross cut with substance use disorder, mental health, and parent skill building. MI, provided by the LDSS, will be included in the prevention services case plan that is developed within the first 30 days of the In-Home case and delivered throughout the life of the case. While utilization of MI may begin at first contact, claiming for IV-E will not begin until it has been included in the prevention services case plan. Research conducted on MI indicates its use would help facilitate a family's enrollment into treatment, as families are often lost in the time between caseworker referral and service intake. MI also has the potential to strengthen rapport between family service specialists and caregivers, which may in turn increase the quality of family partnership meetings that aim to support caregivers and their progress toward their own permanency goals (Carroll et al., 2001). MI has also demonstrated support for

enhancing the effectiveness of other EBPs when delivered in conjunction (Chaffin et al., 2009; Schaeffer et al., 2013; Silovsky et al., 2011; Webb et al., 2016).

The goal of MI is behavior change and family well-being. Utilizing MI within Virginia's In-Home Services has the potential to prevent children from entering out-of-home care by strengthening the relationship between the caregiver and caseworker in charge of guiding a family into services. Through increased engagement, we also anticipate better service matching to the needs of each child and family. Currently, staff have received training in MI through a virtual 6 hour training. Learning is best achieved when training is interactive and experiential, meaning when content is taught through modeling, roleplay, and immediate feedback. Care will be taken to develop and craft training to complement the content provided to caseworkers through the preexisting virtual learning module, building on caseworkers' foundation of MI knowledge.

University partners will provide assistance to VDSS to develop a standard MI training program that aligns with Virginia's current infrastructure and training course. This will include in-person and virtual workshop didactics interlaced with opportunities for practice and feedback. MI training will first be implemented in a selection of pilot sites. Feedback elicited from pilot site caseworkers will enhance the MI training protocol. This stage is crucial for sustainment, as all EBPs require adjustment to context while maintaining adherence to the essential elements of the practice. After pilot study, the protocol will be offered statewide and a series of promotional events will be held to generate interest from local departments. The individuals providing didactics in MI will be trainers that belong to the Motivational Interviewing Network of Trainers (MINT).

Fidelity Monitoring

Fidelity to MI will be measured through a behavioral observational tool developed and/or approved by CEP-Va. CEP-Va exhibits national expertise in behavioral coding as a methodology, particularly within the research area of therapeutic alliance (e.g., Southam-Gerow et al., 2020). Measurement of alliance differs from other observational protocols because it requires attention to the dynamic between the assigned helper and identified patient, and the success of any strategy is determined within the context of the dyad, or two individuals. This approach aligns with the collaborative spirit central to MI. The observational coding protocol will include the foundational strategies of the model, and competence of delivery will be assessed by scoring the patient's response, as recorded through video. In other words, MI is client-driven and client-determined; therefore, fidelity to the model should capture the extent to which a strategy achieved the response from the client that the helper intended.

Evaluation Waiver Request Basis

MI has an extensive research base and received a rating of well-supported on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child well-being: Child substance use
- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Parent/caregiver substance use
- Adult well-being: Parent/caregiver criminal behavior

- Adult well-being: Family functioning
- Adult well-being: Parent/caregiver physical health
- Adult well-being: Economic and housing stability

Through the Title IV-E Prevention Services Clearinghouse review, of the 75 studies identified for review, a total of 21 studies showed moderate or high effect size on parent/caregiver substance in particular use for alcohol consumption, including a reduction in numbers of drinks per week, percentage days of heavy drinking, and reduction in marijuana use. Nine studies were rated as low quality due to methodological problems. The Clearinghouse also reviewed 45 studies for risk of harm and identified two unfavorable outcomes, including percentage of any heavy episodic drinking in the past 12 months and opioid scores on Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST).

In conjunction with the review of the evidence of the effectiveness of MI stated above, VDSS also reviewed several other studies deemed relevant to our consideration of improving our prevention plan. One narrative review (Shah et al., 2019) and one systematic review (Hall et al., 2020) examined the usage of MI in child welfare. The systematic review found a positive impact for families in child welfare. In particular, Carroll et al. (2001) found when comparing substance use treatment uptake among parent's referred to child welfare for substance use evaluation, those who received MI-based evaluation were significantly more likely to attend subsequent treatment sessions than those receiving the standard evaluation. Parents who received MI-based evaluation completed treatment at higher rates (Carroll et al., 2001).

Both reviews found a positive impact for families in child welfare. For example, they found that when MI was combined with Parent Child Interaction Therapy (PCIT- another EBP in the Virginia prevention plan), results showcased MI combined with PCIT increased parent's levels of readiness to change and showed a decline in children's externalizing internalizing behavior (Webb et al., 2016). Another study by Chaffin and colleagues (2009) found positive effects of MI combined with PCIT. The study, conducted with 192 parents referred for parenting services through child welfare, found significantly improved retention compared to standard practice among individuals with low or moderate motivation for change related to harsh discipline practices and negative interaction patterns at baseline (Chaffin et al., 2009). The follow-up of this study conducted by Chaffin and colleagues (2011) found the MI combined with PCIT group significantly reduced recurrent maltreatment over media of 2.5 years after baseline.

Furthermore, when MI was combined with skills-based parenting programs, fewer domestic violence-related reports were reported to child welfare services (Silovsky et al., 2011). Another RCT conducted with 25 mother-child dyads receiving MI is combined with Multisystemic therapy (another EBP in our prevention plan), and 18 mother-dyads receiving usual care found mothers in the treatment group experienced positive treatment outcomes for alcohol and drug use, depression, psychological aggression, and nonviolent discipline. The study also found mothers in the treatment group were three times less likely to have another substantiated incident of maltreatment 24 months post-referral. Additionally, the study found children experienced a reduction in anxiety and spent significantly fewer days in out-of-home placements than the control group (Schaeffer et al., 2013).

MI targets several behavioral change domains, focusing on guiding clients through ambivalence to change and increasing motivation for change. As such, MI has positive effects on its own but will also promote engagement with other EBPs in the Virginia service array. Application of MI may be helpful in addressing caregiver substance use, guiding parents to connect with other services to reduce substance abuse. MI may also increase engagement in parenting oriented EBPs such as PCIT, FFT, or BSFT. Training all Family Services Specialists and Supervisors will improve family engagement which will lead to improved outcomes for children and families being served with an In-Home services case.

High Fidelity Wraparound (HFW)

High Fidelity Wraparound (HFW) is an established, promising, community-based evidence-based collaborative process for families with children and youth, birth to age 21. HFW employs an individualized, team-based, collaborative process to provide a coordinated set of services and supports. Typically HFW targets youth with complex emotional, behavioral, or mental health needs. A care coordinator convenes, facilitates, and coordinates efforts of the wraparound team and helps the family navigate planned services and supports.

Service	High Fidelity Wraparound
Service Category	Mental Health Prevention or Treatment Services
Rating	Promising
Target Population	Wraparound is typically targeted toward children and youth birth to age 21 with complex emotional, behavioral, or mental health needs, and their families.
Program Documentation	Bruns, E. J., & Walker, J. S. (Eds.) (2015). *The resource guide to Wraparound.* National Wraparound Initiative. Miles, P., Brown, N., & The National Wraparound Initiative Implementation Work Group. (2011). *The Wraparound implementation guide: A handbook for administrators and managers*. National Wraparound Initiative.
Targeted Outcomes	● Child safety: Child welfare reports ● Child permanency: Least restrictive placement ● Child permanency: Placement stability ● Child well-being: Behavioral and emotional functioning ● Child well-being: Social functioning ● Child well-being: Educational achievement and attainment ● Adult well-being: Parent/caregiver mental or emotional health ● Adult well-being: Family Functioning
Targeted Outcomes Goals	● Reduce child abuse and neglect ● Prevent out-of-home placement ● Improve child behavioral and emotional functioning ● Improve family access to resources and treatment
Data Collection and Outcomes	● Providers will submit WFI-EZ data directly to CEP-Va ● Providers will responsible for the pre-post test data and submitting it directly to CEP-Va ● VDSS will provide CEP-Va with long-term outcome data from OASIS on the recurrence of maltreatment and entries into foster care within 12 and 24 months of the prevention plan start date

Training & Implementation

In 2008 the Virginia General Assembly directed the State Executive Council to oversee the development and implementation of mandatory uniform guidelines for Intensive Care Coordination (ICC). ICC was developed in response to concerns regarding the number and length of stay of youth in residential placements. In the beginning of ICC implementation, improving successful transition and preventing a return to residential care set the foundation for the work of Intensive Care Coordinators. The goal was to serve youth in their homes and communities, using residential placement only when clinically necessary and then for as short a time as needed. The ICC approach recognized a need for smaller caseloads than traditional case management due to the higher intensity of the work. ICC also explicitly acknowledged the need to work in partnership with both youth and families in designing and implementing services to meet common goals. When first introduced, there was no preferred or specific model for the implementation and delivery of ICC services. From 2008-2013, the providers of Intensive Care Coordination were Community Services Boards, which are the public mental health agencies in Virginia.

In 2013, the State Executive Council adopted specific policy with regard to the delivery of ICC. In brief, this policy established minimum credentials and required that all ICC providers and supervisors be trained in a model known as High Fidelity Wraparound (HFW). HFW is a family-driven, strengths-based care coordination process that embodies the System of Care values and principles at the service level for children and families facing mental health challenges. The target population for ICC was expanded beyond youth already in placement to include those at high-risk of out of home placement, acknowledging that prevention of residential placement through intensive work with youth and families is a highly valued outcome. Additionally, the policy was revised to allow private providers as well as Community Service Boards to provide Intensive Care Coordination.

Between the years 2011-2020, federal System of Care Grants awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Virginia Department of Behavioral Health and Developmental Services further enhanced the expansion of the High Fidelity Wraparound process in Virginia. Through the System of Care grants, Virginia expanded the use of High Fidelity Wraparound to 42 localities. In addition, Family Support Partner services were required as part of the High Fidelity Wraparound process in the grant funded localities. The Family Support Partner is a paid position in Virginia that is designed to provide an intensive level of support for families of youth with mental health challenges. Family members in this role must have experience as a family member of a youth with complex emotional or behavioral health needs involved in multiple service systems. In High Fidelity Wraparound, Family Support Partners are formal members of the team, and are equal workforce partners. They work closely with the Intensive Care Coordinator (High Fidelity Wraparound Facilitator) to support positive outcomes for the family. VDSS will utilize its partnership with CEP-Va for continued capacity building for HFW on an as needed basis.

Evidence-based Review and Fidelity Monitoring & Evaluation Plan

Evidence-based Review. HFW has a research base and received a rating of promising on Title IV-E Prevention Services Clearinghouse in the following subdomains:

- Child safety: Child welfare reports
- Child permanency: Least restrictive placement
- Child permanency: Placement stability
- Child well-being: Behavioral and emotional functioning
- Child well-being: Social functioning
- Child well-being: Educational achievement and attainment
- Adult well-being: Parent/caregiver mental or emotional health
- Adult well-being: Family Functioning

The clearinghouse identified a study with a favorable effect for child permanency and a study with a favorable effect for child behavioral and emotional functioning. Additionally, a recent meta-analysis (Olsen et al., 2021) included 16 controlled studies of Wraparound. The largest effects were observed for residential outcomes, with a medium and statistically significant effect size that favored Wraparound youths compared to those receiving treatment as usual. Medium effect sizes were also observed for school functioning and mental health symptoms. A smaller, but still significant effect size was observed for mental health functioning and a non-significant effect was observed for juvenile justice related outcomes. The authors noted that larger effects were observed for samples with a higher percentage of youths of color and Wraparound conditions with higher fidelity.

The goal of HFW is to develop and implement a plan capable of maintaining youths with serious emotional disorders (SED) in their homes and communities, which is relevant to child welfare targets such as out-of-home placements. HFW's ability to serve families with children of all ages makes it an option for all In-Home services cases. Virginia, like many states, has seen a rise in children and youth with intensive needs unable to find placement in residential treatment facilities. Virginia's Safe and Sound Taskforce, a 2022 Governor's initiative, has been focusing on youth in foster care who fall within that category and have been spending nights in LDSS offices and other unapproved placements (such as emergency rooms and hotels) as they wait for a residential placement. Children and youth served through In-Home services cases who are on a trajectory for foster care and/or residential placement may avoid both if they receive HFW prior to out-of-home placement. Supporting families and youth by providing HFW during an In-Home services case will likely prevent entries into foster care and the need to place in residential treatment facilities.

Fidelity Monitoring and Evaluation Plan. VDSS will leverage its partnership with CEP-Va to both monitor fidelity and evaluate HFW. Fidelity monitoring is incorporated into the larger evaluation plan. There are two related evaluation components: (a) process evaluation (including fidelity monitoring) and (b) outcome evaluation. The process evaluation seeks to answer two research questions:

1. To what extent are families engaging in planned services and supports?
2. To what extend do HFW teams provide the service with fidelity?

The measures and data used to answer these questions include participation in meetings, activities, and services, team training/certification level, team experience, and fidelity scores from the Wraparound Fidelity Index Short Form (WFI-EZ). The outcome evaluation seeks to answer four research questions:

1. Do children who receive HFW have fewer future reports of child abuse or neglect within 6 and 12 months after HFW start and end compared to a matched group?
2. Do children who receive HFW show lower rates of out-of-home placements compared to a matched group?
3. Do children who receive HFW show statistically significant improvement in key well-being measures?
4. To what extend does team fidelity relate to family outcomes?

Data and measures to answer these questions will come from OASIS (Virginia's child welfare information system), the Virginia Child and Adolescent Needs and Strengths Assessment – DSS Enhanced (CANS-DSS), and the WFI-EZ. The full evaluation and fidelity monitoring plan, detailing the (a) research design, (b) measurement plan, (c) sampling plan (including power analysis), and (d) analytic plan is provided in Appendix B – *Evaluation Plan for High Fidelity Wraparound*.

ASSURANCE ON PREVENTION PROGRAM REPORTING

VDSS will report to the Secretary such information and data as the secretary requires with respect to the Title IV-E prevention program, including information and data necessary to determine the performance measures (See Attachment I).

APPENDIX A: FAMILY FIRST STAKEHOLDERS

**as of June 10, 2019*

Agency or Organization Name
ADORE Children and Family Services
Attorney General's Office
Charlottesville Department of Social Services
Chesterfield/Colonial Heights Department of Social Services
Children's Home Society
Commission on Youth
Court Improvement Program, Office of the Executive Secretary Supreme Court of Virginia
Culpeper Juvenile and Domestic Relations Court
Department of Juvenile Justice
Department of Medical Assistance Services
Depaul Community Resources
Depaul Community Resources
Early Impact VA
Economist with VLM and VACO
Elk Hill Farm
Fairfax Children's Services Act
Fairfax CSB Child, Youth, and Family Services
Fairfax Department of Human Services
Families Forward
Family and Children’s Trust Fund of Virginia
Family Focused Treatment Association
Family Preservation Services of Virginia
Fredericksburg Department of Social Services
Governor’s Office
Greater Richmond SCAN
Hanover Children's Services Act
Hanover Department of Social Services
HopeTree Family Services
House Health Welfare and Institutions Committee
James City County Department of Social Services
Judicial Advocate
Mt. Rogers Community Services Board
National Counseling Group
Newport News Department of Human Services
Norfolk Department of Human Services
Northumberland Department of Social Services
Office of Children's Services
Office of the Attorney General

Powhatan Department of Social Services
Prince William Department of Social Services
Quin Rivers, Inc.
Richmond Behavioral Health Authority
Senate Rehabilitation and Social Service Committee
Senator Mason's Office
Shenandoah Department of Social Services
Spotsylvania Department of Social Services
The Up Center
Troutman Sanders Strategies
United Methodist Family Services
University of Richmond
Virginia Association of Community Services Boards
Virginia Association of Community-Based Providers
Virginia Association of Counties
Virginia Association of Licensed Child-Placing Agencies
Virginia Coalition of Private Provider Associations
Virginia Coalition of Private Providers of Virginia
Virginia Commonwealth University
Virginia Department of Behavioral Health and Developmental Services
Virginia Department of Health
Virginia Department of Juvenile Justice
Virginia Department of Medical Assistance Services
Virginia Department of Planning and Budget
Virginia Department of Social Services
Virginia Division of Legislative Services
Virginia Home for Boys and Girls
Virginia House of Appropriations
Virginia League of Social Services Executives
Virginia Municipal League
Virginia Network of Private Providers
Virginia Poverty Law Center
Virginia Senate Finance Committee
Voices for Virginia’s Children
York-Poquoson Department of Social Services
Youth for Tomorrow

APPENDIX B: EVALUATION PLAN FOR HIGH FIDELITY WRAPAROUND

1. INTRODUCTION.

VDSS has partnered with the Center for Evidence-based Partnerships in Virginia (CEP-Va) for fidelity monitoring and evaluation work required as part of FFPSA. One of the programs in the Virginia plan, High Fidelity Wraparound (HFW), is listed as *Promising* in the Title IV-E Prevention Services Clearinghouse. As such, an evaluation plan is needed. CEP-Va will provide the evaluation, as detailed in the following appendix.

2. THE EVALUATION TEAM.

The evaluation team is drawn from the Center for Evidence-based Partnerships in Virginia (CEP-Va). CEP-Va is led by its director, Dr. Michael Southam-Gerow, a national expert in dissemination and implementation research and treatment fidelity research. Dr. Southam-Gerow (see "Curriculum Vitae for the Director of Evaluation" below) has extensive experience and numerous publications in the area of implementation of evidence-based programs, including large-scale implementation in California, Minnesota, and Virginia. He is also a leading expert on the topic of fidelity and outcome measurement, with numerous publications on the topic. He has also served as PI and co-I on several NIH grants related to fidelity measurement.

The CEP-Va team also has an associate director, Dr. Rafaella Sale, with extensive expertise in EBPs. CEP-Va also has a master's-level data director, Ashley Robinson, who has several years of industry experience in data management. The team also has a bachelor's-level training coordinator and a team of four graduate and two undergraduate researchers.

CEP-Va is located at Virginia Commonwealth University (VCU) in the Department of Psychology. VCU is a Carnegie R1 research institution, the highest rank for a university, meaning that VCU is among the most research-intensive universities in the United States. VCU also has the minority-serving institution designation, meaning that more than 50% of VCU's student body are from minority racial and ethnic groups. The Psychology department at VCU is among the strongest units on campus, with more than $13M federal grant dollars annually. The department has a faculty of nearly 50 PhD level psychologists and is home to four PhD programs, including a top-50 ranked clinical psychology Ph.D. program. The department has more than 125 PhD students and the undergraduate major numbers more than 1,700 students annually. As a result, CEP-Va is located in a rich and research-productive context.

CEP-Va has been collaborating with VDSS and other state agencies since 2019. CEP-Va is currently conducting fidelity monitoring and evaluation for all of VDSS' currently approved EBPs. They have also been engaged in VDSS' capacity-building efforts. CEP-Va has provided specific recommendations based on a needs assessment for targeted EBP training and has begun to coordinate those EBP training efforts. CEP-Va is also involved in EBP and implementation-related projects for other state agencies, including development of a registry of EBP practitioners and the development of a sustainment plan for High Fidelity Wraparound for the state.

3. THE INTERVENTION

High Fidelity Wraparound (HFW) is a community-based, team-based, strengths-focused, collaborative, and individualized process designed to provide a coordinated set of services and supports for families with children and youth, birth to age 21, with complex emotional, behavioral, or mental health needs. The approach has a rich and developing evidence base supporting its use (Olson et al., 2021).

HFW is a team-based approach. An HFW team is generally comprised of one or more facilitators (referred to by other states by other names, including care coordinators) along with peer and/or family support workers. Each team also has supervisor. Teams are agency-based and the certification process in Virginia is agency-based.

HFW is an individualized approach. HFW targets a diverse set of youth with complex emotional, behavioral, or mental health needs. The facilitator convenes, facilitates, and coordinates efforts of the wraparound team and helps the family navigate planned services and supports. Each family's experience with the service will be unique to their strengths and needs.

HFW is comprised of four phases. The basic flow of HFW occurs across four phases: (a) engagement, (b) planning, (c) implementation, and (d) transition. In the first phase, the focus is on engaging and stabilizing the family. The planning phase results in a plan of action for the family built collaboratively. In the implementation phase, the plan(s) identified are enacted, with the team supporting the efforts of the family. In the transition phase, the team and family prepare for a time with less formal supports coming from the agency.

HFW is centered on ten principles. The ten principles that guide teams in delivering HFW are found in Table 1.

Table 1. High Fidelity Wraparound (HFW) Principles

Family voice and choice: HFW process is family-driven and focused on their visions of a good future
Team-based: The HFW team includes the trained professionals and the family. Together, the team builds and implements the plan
Natural supports: HFW involves strengthening existing and potential community and family support systems
Collaboration: HFW emphasizes collaboration within the team as well as across involved local and state agencies
Community-based: HFW occurs in the family's community and the team develops awareness of that community
Culturally competent: Tailoring of services for culture, preferences, language, etc. is core to HFW
Individualized: The plan developed by the HFW team is individualized to the strengths and needs of each family
Strengths based: HFW emphasizes and leverages family strengths
Unconditional care: HFW teams make a commitment to each family, not a set discharge date.

Outcome based: HFW teams focus on fidelity to the model and working to achieve desired family outcomes

In HFW's theory of change, the ten principles drive key short- and long-term outcomes. When HFW teams work aligned with the ten principles, there are several anticipated short-term outcomes, including:

1. Follow through on the team's plan
2. Service and support appropriateness
3. Strength-based services and supports
4. Family satisfaction with and engagement in supports and services
5. Family-level improvements, including feelings of self-efficacy and success in moving toward stated goals.

Longer-term outcomes for HFW include:

1. Stable placements
2. Improved mental health outcomes for youth and other family members
3. Improved school or vocational functioning
4. Improved quality of life.

Virginia is supporting its own HFW training center. VDSS has partnered with other state agencies and CEP-Va to support the Virginia Wraparound Implementation Center (VWIC). The state agencies are providing financial support and CEP-Va has worked with VWIC to develop a professional development plan for all roles in an HFW team. With the support, VWIC will be able to train and coach more than 150 practitioners per year with a full-time team of two trainers, allowing the state to build capacity for delivering HFW rapidly. Furthermore, the plan provides for the development of regionally-based coaches, allowing VWIC to focus more on early development of teams, with regional coaches serving to maintain the teams' fidelity.

Table 2 provides a summary of key characteristics of HFW.

Table 2. Summary of HFW select characteristics

Service	High Fidelity Wraparound
Service Category	Mental Health Prevention or Treatment Services
Title IV-E Clearinghouse Rating	Promising
Target Population	Children and youth birth to age 21 with complex emotional, behavioral, or mental health needs, and their families.
Program Documentation	Bruns, E. J., & Walker, J. S. (Eds.) (2015). *The resource guide to Wraparound.* National Wraparound Initiative.

	Miles, P., Brown, N., & The National Wraparound Initiative Implementation Work Group. (2011). *The Wraparound implementation guide: A handbook for administrators and managers*. National Wraparound Initiative.

4. EVALUATION GOALS, RATIONALE, AND PLAN

There are two related evaluation components: (a) **process evaluation** (including fidelity monitoring) and (b) **outcome evaluation**. In the next section, details on each of these evaluation plans will be provided in turn, focusing on: (a) research design, (b) measurement plan, (c) sampling plan (including power analysis), and (d) analytic plan.

Part 1. Process Evaluation.

Table 3 presents a summary of the key research questions, research design elements, and other information for the Process Evaluation. Following the table, the process evaluation is described in detail.

Table 3. Process Evaluation: Summary of research questions, data sources, and methods

#	Research question	Process Category	Measures and data sources	Research Design	Analysis methods
1	To what extent are families engaging in planned services and supports?	Service engagement	1. % of scheduled HFW team meetings attended **Source**: CEP-Va data form 2. % of planned services and supports attended **Source**: CEP-Va data form 3. Family Satisfaction score **Source**: WFI-EZ*	Descriptive	Descriptive statistics (counts, percentages, mean scores), reported by HFW team and overall for the state
2	To what extent do HFW teams provide the service with fidelity?	Fidelity	1. Team training/ certification level **Source**: CEP-Va EBP registry 2. Months of experience **Source**: CEP-Va data form 3. Fidelity scores, including a global score and five (5) subscale scores **Source**: WFI-EZ	Descriptive	Descriptive statistics (counts, percentages, means) reported by HFW team and overall for the state

* WFI-EZ = Wraparound Fidelity Index Short Form (Bruns et al., 2012)

Details on the process evaluation.

Research design.

For both research questions, a descriptive research design will be used. A descriptive research design is appropriate for these questions as the goal is to document the frequency and extent of specific behaviors and activities, such as family engagement, satisfaction, training, consultation, and fidelity. CEP-Va (the technical assistance center) and VWIC (the training center) will coordinate data collection for the process evaluation.

Measurement plan.

In this section, the measurement plan for each of the three research questions is described.

Engagement measurement plan. Family engagement is a key element of the HFW theory of change. Three measures will be used to assess family engagement:

1. Family engagement in HFW team meetings
2. Family engagement in planned services and supports
3. Family satisfaction

For **family engagement in HFW team meetings**, the number of planned meetings in a quarter will serve as the denominator and the number of meetings attended will serve as the numerator. As an example, if Family A had 10 planned meetings in the quarter and attended seven of them, their *team meeting engagement* score would be 70%. Meeting attendance for each family will be documented by the HFW team facilitator in required documentation; the attendance data will be collected by CEP-Va on a data form as part of data sharing agreements with agencies with HFW teams.

For **family engagement in planned services and supports**, a similar approach will be used. Each quarter, the number of planned services and supports appointments will serve as the denominator and the number of planned services and supports appointments attended will serve as the numerator. Thus, for example, if Family A had 15 planned services and supports appointments in the quarter and attended 10 of them, their services engagement score would be 67%. Service and support engagement data will be documented by the HFW team facilitator on a data form and collected by CEP-Va on a data form as part of data sharing agreements with agencies with HFW teams.

Family satisfaction data will come from the Wraparound Fidelity Index Short Form (WFI-EZ; Bruns et al., 2012). Primarily used to gauge fidelity, the WFI-EZ includes a four-item Satisfaction scale that is scored from 0-100, with 100 meaning the highest level of satisfaction. The WFI-EZ will be administered by agencies with HFW teams and completed by families. The WFI-EZ has both electronic and paper versions. Data gathered at agencies will be collected by CEP-Va as part of data sharing agreements with agencies with HFW teams. More details on the WFI-EZ are found in the Fidelity section that follows.

Fidelity measurement plan. CEP-Va has constructed a multidimensional model of fidelity for HFW. The fidelity indicators monitored for HFW will include:

1. Training and certification status of HFW team members
2. Months of experience in the model
3. The Wraparound Fidelity Index Short Form (WFI-EZ).

Details on each indicator follow.

Training and certification level will be monitored by CEP-Va in partnership with VWIC. CEP-Va maintains a statewide registry of trained or in-training EBP practitioners. VWIC and CEP-Va will ensure that all trained or in-training HFW practitioners are included in the registry; their certification status will be verified and reported quarterly. Training and certification status will be scored as follows:

1. Training ongoing: 0
2. Training completed and certification ongoing: 1
3. Training and certification completed: 2

Similarly, the registry will be the source for capturing ***months of experience*** with HFW. Experience will be measured with the 0 point being the day prior to a first meeting with a first client.

Fidelity will also be gauged by the Wraparound Fidelity Index Short Form (WFI-EZ; Bruns et al., 2012). This tool includes 42 items with 5 scales and a global total score. The individual scale scores and the total score are all converted to a percentage score, ranging from 0-100, with 100 representing 100% fidelity. The five scales are:

1. Family and Strengths Driven
2. Needs Based
3. Natural/Community Supports Leveraged
4. Effective Teamwork
5. Outcomes-Based

Family members complete the WFI-EZ form, which is administered by the HFW team either electronically or on paper, depending on the preference of the HFW team. The WFI-EZ is based on several more extensive HFW fidelity tools (e.g., WFI-4; e.g., Bruns et al., 2014). These earlier tools have a solid evidence base of reliability and validity for their use in children's mental health service settings (e.g., Bartlett & Freeze, 2019; Bruns et al., 2014). The WFI-EZ itself has a growing psychometric evidence base, including evidence of its reliability and supportive factor analytic results (e.g., Bruns et al., 2012).

To ensure provider agency participation in WFI-EZ data collection, VDSS will leverage the ability of LDSS to make fidelity monitoring and other data collection a requirement of their contract. CEP-Va will coordinate the collection and aggregation of fidelity data. The WFI-EZ has a paper and an online version

and both will be used, depending on the provider and HFW team preference, in consultation with the training entity, VWIC, and the evaluator, CEP-Va. Fidelity data will also be used as a means to gauge the development and fitness of the HFW teams across the state, in concert with CEP-Va and VWIC.

Sampling plan.

The process evaluation will focus on families who receive HFW via FFPSA funding (hereafter, **FFPSA sample**). However, because HFW has broad applicability for families, VDSS (and Title IVE) will not be the only funder for the service nor will all families receiving HFW have VDSS involvement and not all would be eligible FFPSA cases.[10] As a result, CEP-Va will conduct an evaluation with a second, statewide, sample (hereafter, **statewide sample)**, and thus have outcome data on a broader population of families to inform other continuous quality improvement efforts for VDSS and its partners.

Using data from FY2022, 750 children received HFW across the state (i.e., the statewide sample). About 23% of these families were referred by LDSS (i.e., around 172 children) and about 50% of these would likely qualify as FFPSA cases. Thus, per quarter we anticipate about 25 cases for the FFPSA sample and about 188 cases for the statewide sample. Once HFW is officially in the FFPSA prevention plan, these numbers are likely to increase. Thus, these estimates provide a floor for expected cases.

Power analysis. A power analysis is not needed for the research questions in the process evaluation, as the engagement and fidelity research questions will not involve statistical testing.

Analytic plan

In this section, the analytic plan for each of the two research questions is described.

Engagement and fidelity analytic plans. For both the engagement and fidelity research questions, dashboards will be developed and employed. Tables 4 and 5 provide examples of the dashboards. After one year, CEP-Va will work with VDSS to establish benchmarks for each indicator leveraging either a national standard from the Wraparound Evaluation and Research Team (WERT, 2021) or a set of state-normed benchmarks. Once selected, dashboards will be updated to reflect each team's performance relative to the chosen benchmarks, with a green (meeting or exceeding benchmark), yellow (below the benchmark by 15%), and red (below the benchmark by 16% or worse) system employed to identify indicators to target in continuous quality improvement (CQI) efforts.

Table 4. Sample engagement dashboard.

Engagement indicator	Team A	Team B	Team C	Statewide
% of HFW team meetings attended by families	85		80	82.5
% of planned services and supports engaged by family	90		70	80
Family satisfaction score (0-100)	83		75	79

[10] Families who receive HFW via FFPSA can be identified in the data and distinguished from non-FFPSA cases based on their Family First candidacy status and use of a IV-E prevention plan.

Table 5. Sample fidelity dashboard.

Fidelity Indicator	Team A	Team B	Team C	Statewide
Training / Certification Level*	2	0	1	1
Months of experience providing HFW	12	0	3	5
WFI-EZ-Total **	85		60	72.5
WFI-EZ Family and Strengths Driven	77		70	73.5
WFI-EZ Needs Based	90		50	70
WFI-EZ Natural/Community Supports Leveraged	90		60	75
WFI-EZ Effective Teamwork	81		65	73
WFI-EZ Outcomes-Based	87		55	71

*For Training/Certification Level: 2=trained and certified; 1= trained-certification pending; 0=currently in training

** WFI-EZ scores range from 0 to 100, with 100 representing 100% fidelity.

Part 2. Outcome Evaluation.

Table 6 presents a summary of the key research questions, research design elements, and other information for the outcome evaluation. Following the table, the outcome evaluation is described in detail.

Table 6. Outcome Evaluation: Summary of research questions, data sources, and methods

#	Research question	Outcome Category	Measures and data sources	Research Design	Analysis methods
1	Do children who receive HFW have fewer future reports of child abuse or neglect within 6 and 12 months after HFW start and end compared to a matched group?	Safety	1. % of children with child abuse report at 6 months from **start** of HFW **Source**: OASIS [11] 2. % of children with child abuse report at 12 months from **start** of HFW **Source**: OASIS 3. % of children with child abuse report at 6	Quasi-Experimental with matched sample (i.e., comparison group)	Dashboard summary Two-sample z-test of proportions

[11] OASIS, or Online Automated Services Information System, is Virginia's SACWIS.

			months from **end** of HFW **Source**: OASIS 4. % of children with child abuse report at 12 months from **end** of HFW **Source**: OASIS		
2	Do children who receive HFW show lower rates of out of home placements compared to a matched group?	Permanency	1. % of children *without* an out of home placement within 12 months from **start** of HFW **Source**: OASIS 2. % of children *without* an out of home placement within 12 months from **end** of HFW **Source**: OASIS	Quasi-Experimental with matched sample (i.e., comparison group)	Dashboard summary Two-sample z-test of proportions
3	Do children who receive HFW show statistically significant improvement in key well-being measures?	Well-Being	1. Life domain functioning (CANS-DSS)* 2. Strengths (CANS-DSS) 3. Behavioral / emotional needs (CANS-DSS) 4. Risk behaviors (CANS-DSS) **Source**: OASIS 5. Caregiver strengths/ needs (CANS-DSS) **Source**: OASIS 6. Child Welfare: Caregiver strengths (CANS-DSS) **Source**: OASIS	Quasi-Experimental with matched sample (i.e., comparison group) and pre-post test design	Paired t-tests Matched sample t-tests
4	To what extent does team fidelity relate to family outcomes?	Fidelity/Outcome	1. WFI-EZ scores **Source**: CEP-Va data collection 2. All six CANS-DSS scale scores **Source**: Oasis	Correlational	Regression analysis with outcome (i.e., CANS-DSS scores) as the dependent variable and

					WFI-EZ global fidelity score as the predictor

** CANS-DSS = The Virginia Child Adolescent Needs and Strengths Assessment-DSS Enhanced (Lyons, 1999; Virginia OCS, 2016)*

***Details on the outcome evaluation**.*

Research design.

For the Safety and Permanency research questions (i.e., questions 1-3), a matched sample quasi-experimental research design will be used. For the Well-Being research question, a quasi-experimental, matched sample and a pre-post research design will be employed. For the Fidelity/Outcome research question, a correlational design will be used.

Details on the quasi-experimental, matched sample. For the matched sample, a comparison group will be identified by matching FFPSA cases from FY2022 (from Virginia's SACWIS, OASIS) who did not receive HFW to a sample treated with HFW. The match will be based on demographic and case severity characteristics (e.g., scores from the CANS-DSS) from both groups.

Details on the pre-post design. For families who receive HFW and are part of the pre-post design, CANS-DSS data collected at the start and at the end of HFW services (see details in the Measurement plan section) will be used to examine if HFW recipients experienced significant improvements in well-being.

Measurement plan.

In this section, the measurement plan for each of the four research questions is described.

Safety measurement plan. Safety outcomes will assess proximal and long-term outcomes, as measured with datapoints from OASIS as follows:

1. **Proximal**: Percentage of children with screened-in child/abuse neglect reports at 6 months since the **start** of HFW services
2. **Long-term**: Percentage of children with screened-in child/abuse neglect reports at 12 months since the **start** of HFW services
3. **Long-term**: Percentage of children with screened-in child/abuse neglect reports at 6 months since the **end** of HFW services
4. **Long-term**: Percentage of children with screened-in child/abuse neglect reports at 12 months since the **end** of HFW services

These indicators will be scored from 0 (i.e., no reports) to *n*, the total number of reports. For purposes of analysis, the variable will be collapsed to 0 (no reports) or 1 (one or more reports).

Permanency measurement plan. Permanency will be measured using datapoints from OASIS:

1. **Proximal**: Percentage of children who do NOT enter care within 12 months of HFW **start**.
2. **Long-term**: Percentage of children who do NOT enter care within 12 months of HFW **close**.

Entries into foster care will be scored with a 0 (i.e., no entries) to *n*, the total number of entries. For purposes of analysis, the variable will be collapsed to 0 (no entries) or 1 (one or more entries).

Well-being measurement plan. Well-being will be measured using four scale scores from the Virginia Child and Adolescent Needs and Strengths-DSS Enhanced (CANS-DSS; Lyons, 1999; VA OCS, 2016). A required standardized assessment, the CANS-DSS is completed within 30 calendar days of opening the case and updated every 90 days thereafter if the case is to remain open. The CANS-DSS is also completed when the case is closed. CANS are completed online using CANVaS software.

In VDSS, the CANS is collected on a per-family basis. In other words, if there is more than one child in the family connected to VDSS for services, the CANS is collected for one child only—the child for whom in-home services has been indicated. In these instances, there may be a small subset of families with more than one child who is identified as needing in-home services. As a result, and as discussed in the analytic section, the sample of eligible cases with CANS data will be somewhat smaller than eligible cases with other outcome data.

The CANS-DSS is a revised version of the CANS (Lyons, 1999) designed for use with families involved in DSS. The CANS-DSS includes 41-items that identify type and severity of clinical and psychosocial needs and resources. Each item is rated from 0 to 3, with 0 generally being absence of risk or presence of strength and higher ratings reflecting poorer functioning or lack of strength. Psychometric data support the use of the standard items in child welfare and children's mental health contexts . Studies suggest that the bachelor's level professionals administer the CANS-DSS with high reliability (e.g., Anderson et al., 2003; Brown et al., 2022). The CANS-DSS has several scales: (a) Life Functioning, (b) Child Strengths, (c) School, (d) Child Behavioral/ Emotional Needs, (e) Child Risk Behaviors, and (f) Parent/ Caregiver Strengths/ Needs. There are also several additional, optional modules, completed as needed, including Trauma, Developmental Needs, and Substance Use Needs. As well, there is a Child Welfare module that includes three subscales: (a) Caregiver Safety Concerns, (b) Caregiver Strengths, and (c) Caregiver Commitment to Reunification/ Permanency.

The following six scales used in the evaluation will be:

1. Life Domain Functioning (15 items)
2. Child Strengths (11 items)
3. Child Behavioral/Emotional Needs (10 items)
4. Child Risk Behaviors (11 items)
5. Caregiver Strengths/ Needs (19 items)
6. Child Welfare Module: Caregiver Strengths (3 items)

For the purposes of the evaluation, the initial CANS-DSS will be considered the pre-treatment datapoint (hereafter, T1). The CANS-DSS collected at the end of services will be considered the post-treatment

datapoint (hereafter, T2). All other CANS-DSS scores will be numbered from I1 (interim-1) to In (interim-n). Thus, each case will have a T1, T2, and zero (or higher) I (e.g., I1, I2) CANS-DSS scores.

Sampling plan.

As with the process evaluation, the outcome evaluation will focus on families who receive HFW via FFPSA funding (hereafter, **FFPSA sample**). Because HFW has broad applicability for families, VDSS (and Title IVE) will not be the only funder for the service nor will all families receiving HFW have VDSS involvement and not all would be eligible FFPSA cases. As a result, CEP-Va will conduct an evaluation with a second, statewide, sample (hereafter, **statewide sample),** and thus have outcome data on a broader population of families to inform other continuous quality improvement efforts for VDSS and its partners.

Using data from FY2022, 750 children received HFW across the state (i.e., the statewide sample). About 23% of these families were referred by LDSS (i.e., around 172 children) and about 50% of these would likely qualify as FFPSA cases. Thus, per quarter we anticipate about 25 cases for the FFPSA sample (i.e., 100/year) and about 188 cases for the statewide sample (i.e., about 750/year). Once HFW is approved as part of Virginia's FFPSA prevention plan, these numbers are likely to increase. Thus, these estimates provide a floor for expected cases.

***Power analysis*.** For the **Safety** and **Permanency** research questions, we will use two sample z-tests of proportions (detailed in the next section). We used local data on re-reporting of child/abuse neglect reports to estimate the expected rate for the matched sample. The sample needed to detect a 10% reduction in report rate to achieve a power of 0.80 using a p-value of 0.05 is 111 (using the G*Power program for calculation; Faul et al., 2007). Given the proposed sampling plan and projected enrollment rate (described earlier), the **FFPSA sample** will be sufficiently powered in 12-15 months whereas the **statewide sample** will be sufficiently powered in the first quarter.

For the **Well-being** research question, we will conduct independent (for the matched sample) and dependent (for the pre-post design) t-tests (detailed in the next section). To guide power analysis, effect size estimates were identified from controlled research on HFW. Past work has generated a variety of findings using a heterogeneous set of outcome variables (e.g., Colidiron, et al., 2017; Olson et al., 2021). As a result, there was not a clear effect size to anticipate. To be conservative, an effect size of 0.40 (Cohen's *d*) – i.e., a medium effect – was assumed. Given that assumption, to achieve a power of 0.80 using a p-value of 0.05, the sample needed for the independent samples t-test (matched group comparison) would be 78. For the dependent samples t-test (the pre-post research design), the needed sample is 41 (using the G*Power program for calculation).

Given the proposed sampling plan, a sufficiently powered sample will be available for the **FFPSA sample** within 9 to 12 months for the matched sample comparison and within 6 to 9 months for the pre-post comparison. Time to achieve adequate power for the FFPSA sample with CANS-DSS data may be somewhat longer, given the somewhat slower accumulation of that data because of the VDSS CANS-DSS data collection process described earlier (i.e., only one child per family receives a CANS-DSS measurement). A sufficiently powered sample for the **statewide sample** will be available for both the matched and pre-post comparison in the first quarter.

Analytic plan

In this section, the analytic plan for each of the four research questions is described.

Safety analytic plan. Two analytic approaches will be used for the Safety research questions. First, a dashboard will be developed to report data across teams and for all teams across the state. Second, two sample z-tests of proportions will be employed to compare the HFW treated sample to a matched group of youth from FY 2022. SPSS (Version 29) will be used to conduct the two sample z-tests of proportions. Separate tests will be conducted for the **FFPSA sample** and the **statewide sample.**

The statistical tests will be used once the sample size has reached the level needed for adequate power—i.e., within 12-15 months. However, the dashboard will provide data within the first quarter of the evaluation. An example of the dashboard can be found in Table 7.

Table 7. Sample Safety Indicators Dashboard.

Safety indicators	Team A	Team B	Team C	Statewide
% of children with abuse/ neglect reports within 6 months from **start** of HFW	15	NA	23	19
% of children with abuse/ neglect reports within 6 months from **end** of HFW	10	NA	18	14
% of children with abuse/ neglect reports within 12 months from **end** of HFW	8	NA	16	12

Permanency analytic plan. Two analytic approaches will be used for the Permanency research questions, similar to the approach used for the Safety analytic plan. First, a dashboard will be developed to report data across teams and for all teams across the state. Second, two sample z-tests of proportions will be employed to compare the HFW treated sample to a matched group of youth from FY 2022. SPSS (Version 29) will be used to conduct the two sample z-tests of proportions. Separate tests will be conducted for the **FFPSA sample** and the **statewide sample.**

The statistical tests will be used once the **FFPSA sample** size has reached the level needed for adequate power—i.e., within 12-15 months. However, the dashboard will provide data within the first quarter of the evaluation. An example of the dashboard can be found in Table 8.

Table 8. Sample Permanency Indicators Dashboard.

Permanency indicators	Team A	Team B	Team C	Statewide

% of cases *without* an out of home placement within 12 months from **start** of HFW	85	NA	78	81.5
% of cases *without* an out of home placement within 12 months from **end** of HFW	95	NA	82	88.5

Well-being analytic plan. Two analytic approaches will be used for the Well-being research questions. First, leveraging the pre-post design, four sets of dependent sample t-tests will be conducted, one test for each of the scales of the CANS-DSS, using the T1 (i.e., pre) and T2 (i.e., post) datapoints for each scale.

Second, leveraging the matched samples, four sets of independent samples t-tests will be conducted, one test for each of the scales of the CANS-DSS. SPSS (Version 29) will be used to conduct all tests. Separate tests will be conducted for the **FFPSA sample** and the **statewide sample.**

Statistical tests will be employed once the sample size has reached the level needed for adequate power—i.e., within 6-12 months for the **FFPSA sample** and within the first quarter for the **statewide sample**.

Fidelity-outcome analytic plan. To examine the link between family outcomes and fidelity, hierarchical regression analyses will be employed. CANS-DSS scores at discharge will be used as the dependent variable (i.e., the outcome). Statistical models will be run for each of the CANS-DSS scales (Life Domain Functioning, Strengths, Behavioral/Emotional Needs, and Risk Behaviors, Caregiver Strengths/ Needs, Child Welfare Module: Caregiver Strengths). The primary independent variable will be the global WFI-EZ score. Each model will include pre-treatment CANS-DSS scale scores in the first step. Demographic control variables (i.e., child age, child race, child gender) will also be included in the analysis. The Statistical Package for Social Sciences (SPSS) version 29 will be used to conduct these analyses. This analysis will be conducted every six months for both **FFPSA sample** and the **statewide sample**.

5. OTHER CONSIDERATIONS

Data collection, storage, and security

Data collection. CEP-Va has existing data-sharing agreements with VDSS and the Office of Children's Services, the source of most of the data needed for the evaluation. Fidelity data and some process data (engagement in services) will be collected in partnership with VWIC and a data-sharing agreement will be established for that purpose.

Data storage and security. All data will be stored on Virginia Commonwealth University's (VCU) encrypted network server. The encrypted files are only accessible to CEP-Va data staff via VCU's two-factor authentication login process. All CEP-Va staff are required to complete data security training. The training is renewed annually.

Research ethics. An advantage of working with CEP-Va is that any research that stems from the work in the evaluation plan will be reviewed by VCU's Institutional Review Board. In addition, all CEP-Va staff will complete the Collaborative Institutional Training Initiative (CITI Program) training, a national training in research ethics. The training is renewed annually.

Timeline

Table 9 includes an estimated timeline for the main activities of the evaluation plan.

Table 9. Timeline for Key Activities of the Evaluation Plan

	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2
Data collection begins	XX					
Matched sample ready	XX					
Engagement dashboard available		XX				
Fidelity dashboard available		XX				
Safety dashboard available		XX				
Permanency dashboard available		XX				
*Fidelity-outcome regression analysis (**statewide sample**)*		XX				
*Fidelity-outcome regression analysis (**FFPSA sample**)*					XX	
*Safety statistical tests (**statewide sample**)*		XX				

*Safety statistical tests (**FFPSA sample**)*						XX
*Permanency statistical tests (**statewide sample**)*		XX				
*Permanency statistical tests (**FFPSA sample**)*						XX
*Well-being statistical tests (pre-post; **statewide sample**)*		XX				
*Well-being statistical tests (pre-post; **FFPSA sample**)*				XX		
*Well-being statistical tests (matched sample; **statewide sample**)*		XX				
*Well-being statistical tests (matched sample; **FFPSA sample**)*					XX	

Limitations

Although the proposed evaluation plan has several strengths (e.g., leveraging partnership with university collaborators, gathering data across multiple domains, assessing proximal and long-term outcomes, strong and multi-dimension measurement of fidelity), some limitations exist. Primary among these is reliance on a relatively small number of assessment points to gauge outcome. Although a pre-post design represents a common and defensible approach, in some research trials, multiple during and post-treatment assessment points provide better evidence on the trajectory of a child, allowing detection of early response to services as well as delayed response (i.e., positive response several months after services ended).

Additionally, measuring constructs with multiple instruments possessing strong psychometric properties is a best practice. For some of the research questions, the feasibility of doing so prevented alignment with the practice. The most notable example is for the outcome evaluation in the Well-being domain. Reliance on the CANS-DSS alone limits knowledge on the full extent of the effects of HFW. Although the CANS-DSS permits an assessment of the child's and the caregiver's functioning, HFW is posited to have an effect on family functioning, outcomes that are not well-assessed with the CANS-DSS. Unfortunately, challenges with implementing additional and/or new assessment tools precluded inclusion of broader assessment tools. Another potential limitation related to the CANS-DSS is the aforementioned VDSS practice of administering the CANS to only one child per family. This means that in the families with more than one child requiring in-home services, well-being outcomes will be measured for only the child for whom in-home services was indicated.

6. REFERENCES

Anderson, R.L., Lyons, J.S., Giles, D.M. et al. Reliability of the Child and Adolescent Needs and Strengths-Mental Health (CANS-DSS-MH) Scale. *Journal of Child and Family Studies 12*, 279–289 (2003). https://doi.org/10.1023/A:1023935726541

Bartlett, N. A., & Freeze, T. B. (2019). Examining Wraparound Fidelity for Youth with Mental Health Needs: An Illustrative Example of Two Rural Canadian Schools. *International Journal of Special Education*, *33*(4), 846-868.

Brown, C. C., Wang, E. W., & Goad., C. (2022) A Review of the Psychometric Properties of the Child and Adolescent Needs and Strengths (CANS-DSS): Perspectives on the Present State of the Literature and Future Directions, *Residential Treatment for Children & Youth, 39:3*, 331-346, DOI: 10.1080/0886571X.2022.2038337

Bruns, E.J., Weathers, E.S., Suter, J.C., Hensley, S., Pullmann, M.D., & Sather, A. (2014). Psychometrics, reliability, and validity of a wraparound team observation measure. Journal of Child and Family Studies, 24, 979-991.

Coldiron, J. S., Bruns, E. J., & Quick, H. (2017). A comprehensive review of Wraparound care coordination research, 1986–2014. *Journal of Child and Family Studies*, 1-21. doi:10.1007/s10826016-0639-7

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, *39*, 175-191.

Lyons, J.S. (1999). *The Child and Adolescent Needs and Strengths for children with mental health challenges and their families*. Chicago, IL: Northwestern University.

Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullmann, M. D., Suter, J. C., & Bruns, E. J. (2021). Systematic review and meta-analysis: effectiveness of Wraparound care coordination for children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry. https://doi.org/10.1016/j.jaac.2021.02.022

Sather, A., Bruns, E.J., & Hensley, S. (2012). *Pilot test of the Wraparound Fidelity Index: Brief version (WFI-EZ)*. Portland, OR: National Wraparound Initiative. Retrieved at https://nwi.pdx.edu/pdf/WFI-EZ-summary-of-initial-results.pdf

Virginia Office of Children's Services (OCS). (2016). Virginia Child and Adolescent Needs and Strengths (CANS) Assessment, DSS-Enhanced Manual. Retrieved: https://csa.virginia.gov/Content/doc/CANS_DSS-Enhanced_Item_and_Rating_Definitions_Manual_Ages_(5-21).pdf

Curriculum Vitae
for the Director of the Evaluation

MICHAEL ARTHUR SOUTHAM-GEROW
Professor
Virginia Commonwealth University

CONTACT DETAILS

VCU Department of Psychology
806 W. Franklin St.
Richmond, VA 23284-2018

Pronouns: he/him
Voice: (804) 827-0585 (voice)
Fax: (804) 828-2237 (fax)
Email: MASouthamGer@vcu.edu
Web: https://michaelsoutham-gerow.com
Twitter: @MikeSG_VCU

EDUCATION

- University of Michigan-Ann Arbor, MI. **AB in Psychology** with High Honors, conferred May 1989
- Temple University-Philadelphia, PA. **Ph.D. in Clinical Psychology** (APA approved), conferred August 1997
- **Predoctoral Clinical Internship**. University of California-San Diego/VA Medical Center Consortium, San Diego, CA (APA approved), 1996-1997
- **Post-doctoral Training**. University of California-Los Angeles, Department of Psychology, Los Angeles, CA. 1997- 2001

CURRENT POSITIONS

- **Professor**, Department of Psychology, Virginia Commonwealth University. 2013-present.
- **Chair,** Department of Psychology, Virginia Commonwealth University. 2018-present.
- **Director**, Center for Evidence-based Partnerships in Virginia. 2019-present

PROFESSIONAL LICENSURE

Commonwealth of Virginia, Clinical Psychology License, #0810003041

RELEVANT EMPLOYMENT HISTORY

- **Associate Chair,** Department of Psychology, Virginia Commonwealth University. 2015-2018
- **Director of Graduate Studies**, Department of Psychology, Virginia Commonwealth University. 2010-2018.
- **Co-Director**, Anxiety Clinic, Department of Psychology, Virginia Commonwealth University. 2003-2017
- **Associate Professor**, Department of Psychology, Virginia Commonwealth University. 2006-2013.
- **Assistant Professor**, Virginia Commonwealth University. 2001- 2006.
- **Assistant Research Professor**, University of California-Los Angeles (UCLA), Department of Psychology, 2000-2001
- **Postdoctoral Fellow**, UCLA, Department of Psychology (PI: John R. Weisz, Ph.D.) 1997-2001

RESEARCH FUNDING

Active Grants and Contracts

Contract--Southam-Gerow (PI) **2022-2023**
Source: Virginia Department of Social Services
Title: Capacity building of evidence-based programs
Role: PI
Direct costs: $2,003,132

Contract--Southam-Gerow (PI) **2021-2025**
Source: Virginia Department of Social Services
Title: Fidelity monitoring for FFPSA
Role: PI
Direct costs: $1,123,000

Contract--Southam-Gerow (PI) **2021-2023**
Source: Virginia Department of Behavioral and Developmental Services
Title: Center for Evidence-based Partnerships infrastructure
Role: PI
Direct costs: $354,126

Grant--R24 Hogue (PI) **2020-2025**
Source: National Institute on Drug Abuse
Title: Family-Based Recovery Support Service Network for Youth with OUD
Role: Consultant

Completed Grants and Contracts

Contract--Southam-Gerow (PI) **2021-2022**
Source: Virginia Department of Social Services
Title: Capacity building of evidence-based programs
Role: PI
Direct costs: $1,576,993

Grant--Southam-Gerow (co-PI with Webster-Garrett & Reynolds) 2020-2022
Source: State Council of Higher Education in Virginia
Title: College to Career: Building a Blueprint for Career Readiness through the Disciplines.
Award type: Commonwealth Innovative Internship Fund and Program
Award number: CIIFP-FY20-010
Role: Co-PI
Direct costs: $25,000

Contract--Southam-Gerow (PI) **2020-2021**
Source: Virginia Department of Behavioral and Developmental Services
Title: Evidence-based practices in behavioral health consultation
Role: PI
Direct costs: $162,658

Grant--R34 Hogue (PI) **2018-2021**
Source: National Institute of Mental Health
Title: Fidelity Training and Feedback System for Adolescent Externalizing Problems
Role: Consultant

Grant--R34 Hogue (PI) **2017-2020**
Source: National Institute Drug Abuse
Title: Validating a Pragmatic Therapist-Report Measure and Implementation Feedback System to Increase EBP Fidelity in Usual Care for Adolescents
Role: Consultant

Grant--R01 Hogue (PI) **2015-19**
Source: National Institute of Drug Abuse
Title: Local quality assurance tool for family therapy in usual care for adolescent substance use
Award number: R01 DA037496

Role: Co-I
Direct costs: $1,645,806

Grant--R21 McLeod and Chapman (co-PIs) **2015-19**
Source: National Institute of Mental Health
Title: Development of a Pragmatic Treatment Integrity Instrument for Child Therapy
Award number: R21-MH109666
Role: Co-I
Direct costs: $431,244

Grant--R01 Hogue (PI) **2015-19**
Source: National Institute of Mental Health
Title: Development and Validation of Treatment Integrity Measures for Classroom-Based Interventions
Award number: R01 DA037496
Role: Co-I
Direct costs: $1,645,806

Grant--Goal 5 McLeod (PI) **2014-2018**
Source: Institute for Educational Sciences (IES)
Title: Development and Validation of Treatment Integrity Measures for Classroom-Based Interventions
Award number: R305A140487
Role: Co-I
Direct costs: $1,599,923

Grant--Supplement to R01 Southam-Gerow (co-PI with McLeod) **2011-2014**
Title: Diversity Supplement to Development and Validation of Child Therapy Integrity Measures.
Source: National Institute of Mental Health (NIMH)
Award number: R01MH086529-S1
Role: PI
Direct costs: $145,842

Grant--R01 Southam-Gerow (co-PI with McLeod) **2010-2016**
Title: Development and Validation of Child Therapy Integrity Measures.
Source: National Institute of Mental Health (NIMH)
Award number: R01MH086529
Role: PI
Direct costs: $1,125,000

Grant--R21 Chapman & Schoenwald (co-PIs) **2012-2015**
Title: Measuring and improving supervisor adherence and competence.

Source: National Institute of Mental Health (NIMH)
Award number: R21MH097000
Role: Consultant
Direct costs: $181,000

Grant--K23 Southam-Gerow (PI) **2005-2010**
Title: Adaptation of Evidence-Based Child Therapy in Context.
Source: National Institute of Mental Health (NIMH)
Award number: K23MH69421
Role: PI
Direct costs: $599,655

BIBLIOGRAPHY

Total N=99
*Student (or former student) authors in ***bold italics***

Books and edited volumes, n=2

2019 (n=1)

1. **Southam-Gerow, M. A.** (2019). *Exposure therapy with children and adolescents*. New York: Guilford Press.

2013 (n=1)

2. **Southam-Gerow, M. A.** (2013). *Practitioner's guide to emotion regulation in children and adolescents*. New York: Guilford Press. (translated into Dutch 2014, Korean 2016; released in paperback 2016).

Peer reviewed articles, n=76

In press (n=1)

1. Hogue, A., Bobek, M., Porter, N., Dauber, S., **Southam-Gerow, M. A.**, McLeod, B. D., & Henderson, C. E. (in press). Core elements of family therapy for adolescent behavioral health problems: Validity generalization in community settings. *Journal of Clinical Child and Adolescent Psychology*. https://doi.org/10.1080/15374416.2021.1969939

2022 (n=3)

2. McLeod, B. D., Sutherland, K. S., Broda, M., Granger, K. L., ***Cecilione, J.***, Cook, C. R., Conroy, M. A., Snyder, P. A., & **Southam-Gerow, M. A.** (2022). Examining the correspondence between teacher- and observer-report treatment integrity measures. *School Mental Health, 14, 20–34*. https://doi.org/10.1007/s12310-021-09437-7
3. McLeod, B. D., Sutherland, K. S., Broda, M., Granger, K. L., Martinez, R. G., Conroy, M. A., Snyder, P. A., & Southam-Gerow, M. A. (2022). Development and initial psychometrics of a generic treatment integrity measure designed to assess practice elements of evidence-based interventions for early childhood settings. *Prevention Science, 23,* 488–501.

https://doi.org/10.1007/s11121-021-01304-w

4. McLeod, B. D., ***Martinez, R.***, **Southam-Gerow, M. A.**, Weisz, J. R., & Chorpita, B. F. (2022). Can a single measure estimate protocol adherence for two psychosocial treatments for youth anxiety delivered in community mental health settings? *Behavior Therapy, 53,* 119-136. https://doi.org/10.1016/j.beth.2021.06.008

2021 (n=3)

5. McLeod, B. D., ***Cecilione, J.***, Jensen-Doss, A., Southam-Gerow, M. A., & Kendall, P. C. (in press). Reliability, factor structure, and validity of an observer-rated alliance scale with youth. *Psychological Assessment. 33(10)*, 1013–1023. https://doi.org/10.1037/pas0001036.
6. ***Cecilione, J. L.***, McLeod, B. D., **Southam-Gerow, M. A.**, Weisz, J. R., & Chorpita, B. F. (in press). Examining the relation between technical and global competence in two treatments for youth anxiety. *Behavior Therapy, 52, 1395-1407*. https://doi.org/10.1016/j.beth.2021.03.009
7. **Southam-Gerow, M. A.**, Chapman, J. E., ***Martinez, R. G.***, McLeod, B. D., Hogue, A., Weisz, J. R., & Kendall, P. C. (2021). Are therapist adherence and competence related to clinical outcomes in cognitive-behavioral treatment for youth anxiety? *Journal of Consulting and Clinical Psychology, 89(3)*, 188–199. https://doi.org/10.1037/ccp0000538

2020 (n=4)

8. ***Bourdon, J. L.***, Hettema, J. M., Prom-Wormley, E., & **Southam-Gerow, M. A.** (2020). Assessing stakeholder perceptions of the utility of genetic information for the clinical care of mental health disorders: We have a will but need to see the way. *Administration and Policy in Mental Health and Mental Health Services, 48,* 363–376. https://doi.org/10.1007/s10488-020-01058-7
9. **Southam-Gerow, M. A.**, Bonifay, W., McLeod, B. D., ***Cox, J. R., Violante, S.***, Kendall, P. C., & Weisz, J. R. (2020). Generalizability and decision studies of a treatment adherence instrument. *Assessment, 27,* 321-333. https://doi.org/10.1177/1073191118765365
10. Weisz, J. R., Bearman, S. K., Ugueto, A. M., Herren, J. A., Evans, S. C., Cheron, D. M., Alleyne, A. R., Weissman, A. S., Tweed, J. L., Pollack, A. A., Langer, D A., **Southam-Gerow, M. A.**, Wells K. C., & Jensen-Doss, A. (2020). Testing robustness of Child STEPs effects with children and adolescents: A randomized controlled effectiveness trial. *Journal of Clinical Child & Adolescent Psychology, 49,* 883-896. DOI:10.1080/15374416.2019.1655757
11. Cox, J. R., McLeod, B. D., Jensen-Doss, A., Srivastava, V., Southam-Gerow, M. A., Kendall, P. C., & Weisz, J. R. (2020). Examining how core CBT interventions for anxious youth are delivered across settings. *Behavior Therapy, 51*, 856-868. https://doi.org/10.1016/j.beth.2019.11.008

2019 (n=2)

12. Hogue, A., Bobek, M., Dauber, S., Henderson, C. E., McLeod, B. D., & **Southam-Gerow, M. A.** (2019). Core elements of family therapy for adolescent substance use: Empirical distillation of three manualized treatments. *Journal of Clinical Child and Adolescent Psychology, 48:1*, 29-41. https://doi.org/10.1080/15374416.2018.1555762
13. McLeod, B. D., **Southam-Gerow, M. A.**, Jensen-Doss, A., Hogue, A., Kendall, P. C., & Weisz, J. R. (2019). Benchmarking treatment adherence and therapist competence in individual cognitive-behavioral treatment for youth anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 48,* S234-246. https://doi.org/10.1080/15374416.2017.1381914

2018 (n=3)

14. ***Cox, J. R., Martinez, R. G.***, & **Southam-Gerow, M. A.** (2018). Treatment integrity in

psychotherapy research and implications for the delivery of quality mental health services. *Journal of Consulting and Clinical Psychology*. doi:10.1037/ccp0000370

15. ***Brown, R.C.***, **Southam-Gerow, M.**, McLeod, B. D., ***Wheat, E. B., Tully, C. B.***, Reise, S. P., Kendall, P. C., & Weisz, J. R. (2018). The Global Therapist Competence Scale for Youth Psychological Treatment: Development and initial validation. *Journal of Clinical Psychology, 74,* 649-664. doi: 10.1002/jclp.22537
16. McLeod, B. D., **Southam-Gerow, M. A.**, ***Rodriguez, A., Quinoy, A., Arnold, C.***, Kendall, P. C., & Weisz, J. R. (2018). Development and initial psychometrics for a therapist competence instrument for CBT for youth anxiety. *Journal of Clinical Child and Adolescent Psychology, 47*, 47-60. https://doi.org/10.1080/15374416.2016.1253018

2017 (n=4)

17. McLeod, B. D., **Southam-Gerow, M. A.**, & Kendall, P. C. (2017). Observer, child, and therapist perspectives on the alliance in CBT for youth anxiety. *Psychological Assessment, 29(12)*, 1550-1555.
18. ***Smith, M. M.***, McLeod, B. D., **Southam-Gerow, M. A.**, Jensen-Doss, A., Kendall, P. C., & Weisz, J. R. (2017). Does the delivery of CBT for youth anxiety differ across research and practice settings? *Behavior Therapy, 48*, 501-516. doi:10.1016/j.beth.2016.07.004
19. McLeod, B. D., Sutherland, K. S., ***Martinez, R. G.***, Conroy, M. A., Snyder, P. A., & **Southam-Gerow, M. A.** (2017). Identifying common practice elements to improve social, emotional, and behavioral outcomes of young children in early childhood classrooms. *Prevention Science, 18*, 204-213. doi:10.1007/s11121-016-0703-y
20. Hogue, A., Bobek, M., Dauber, S., Henderson, C. E. McLeod, B. D., & **Southam-Gerow, M. A.** (2017, online). Distilling the core elements of family therapy for adolescent substance use: Conceptual and empirical solutions. *Journal of Child & Adolescent Substance Abuse, 26,* 437-453. http://dx.doi.org/10.1080/1067828X.2017.1322020

2016 (n=3)

21. McLeod, B. D., Jensen-Doss, A., ***Tully, C. B.***, **Southam-Gerow, M. A.**, Weisz, J. R., & Kendall, P. C. (2016). The role of setting versus treatment type in alliance within youth therapy. *Journal of Consulting & Clinical Psychology, 84,* 453-464. http://dx.doi.org/10.1037/ccp0000081
22. Morelen, D., Zeman, J., & **Southam-Gerow, M. A.** (2016). Child emotion regulation and victimization: The moderating role of child sex. *Journal of Child and Family Studies, 25*, 1941-1953. DOI: 10.1007/s10826-016-0360-6.
23. **Southam-Gerow, M. A.**, McLeod, B. D., ***Arnold, C. A., Rodríguez, A., Cox, J. R.***, Reise, S. P., Bonifay, W. E., Weisz, J. R., & Kendall, P. C. (2016). Initial development of a treatment adherence measure for cognitive-behavioral therapy for child anxiety. *Psychological Assessment*, *28,* 70-80. DOI: 10.1037/pas0000141

2015 (n=3)

24. ***Hourigan, S. E.***, **Southam-Gerow, M. A.**, & ***Quinoy, A. M.***, (2015). Emotional and behavior problems in an urban pediatric primary care setting. *Child Psychiatry and Human Development, 46*, 289-299. doi:10.1007/s10578-014-0469-z
25. Chu, B. C., Crocco, S. T., ***Arnold, C. C., Brown, R. C.***, **Southam-Gerow, M. A.**, & Weisz, J. R. (2015). Sustained implementation of evidence-based treatments: Learning from therapists in the field. *Professional Psychology: Research & Practice, 6, 70-79. doi: 10.1037/a0038000*
26. McLeod, B. D., ***Smith, M. M.***, **Southam-Gerow, M. A.**, Weisz, J. R., & Kendall, P. C. (2015).

Measuring differentiation for implementation research: The Therapy Process Observational Coding System for Child Psychotherapy Revised Strategies scale. *Psychological Assessment, 27*(1), 314-325. doi: 10.1037/pas0000037

2014 (n=5)

27. **Southam-Gerow, M. A.** & Prinstein, M. J. (2014). Evidence-based treatment updates: The evolution of the evaluation of psychological treatments for children & adolescents. *Journal of Clinical Child & Adolescent Psychology, 43*, 1-6.
28. **Southam-Gerow, M. A.**, Daleiden, E. L., Chorpita, B. F., Bae, C. Mitchell, C., Faye, M., & Alba, M. (2014). MAPping Los Angeles County: Taking an evidence-informed model of mental health care to scale. *Journal of Clinical Child & Adolescent Psychology*, *43*, 190-200.
29. **Southam-Gerow, M. A.**, ***Arnold, C. C.***, ***Rodríguez, A., & Cox, J. R.*** (2014). Acting locally *and* globally: Dissemination and implementation around the world and next door. *Cognitive & Behavioral Practice, 21*, 127-133.
30. **Southam-Gerow, M. A.** & Dorsey, S. (2014). Qualitative and mixed methods research in dissemination and implementation science: Introduction to special series. *Journal of Clinical Child & Adolescent Psychology, 43,* 845-850.
31. ***Rodríguez, A.***, **Southam-Gerow, M. A.**, O'Connor, M. K., & Allin, R. B. (2014). An analysis of stakeholder views on children's mental health services. *Journal of Clinical Child & Adolescent Psychology, 43*, 862-876.

2013 (n=5)

32. **Southam-Gerow, M. A.** & McLeod, B. D. (2013). Advances in applying treatment integrity research for dissemination and implementation science: Introduction to Special Issue. *Clinical Psychology: Science & Practice, 20,* 1-13.
33. McLeod, B. D., **Southam-Gerow, M. A.**, ***Bair, C. E., Rodríguez, A., & Smith, M. M.*** (2013). Making a case for treatment integrity as a quality indicator. *Clinical Psychology: Science & Practice, 20,* 14-32.
34. ***Hourigan, S. E., Helms, S. W., Christon, L.***, & **Southam-Gerow, M. A.** (2013). Improving nutrition in toddlers with Cystic Fibrosis: Feasibility of a behavioral parent training intervention. *Clinical Practice in Pediatric Psychology, 1*, 235-249.
35. White, S. W., Ollendick, T., Albano, A., Oswald, D., Johnson, C., **Southam-Gerow, M. A.**, Kim, I., & Scahill, L. (2013). Randomized controlled trial: Multimodal anxiety and social skill intervention for adolescents with autism spectrum disorder. *Journal of Autism and Developmental Disorders, 43,* 382-394.
36. ***Brown, R. C.***, Yaroslavsky, I., ***Quinoy, A. M.***, Friedman, A. D., Brookman, R. R., & **Southam-Gerow, M. A.** (2013). Psychometric evaluation of measures of anxiety and depression symptoms in an urban African American sample. *Child Psychiatry and Human Development, 44,* 525-536.

2012 (n=3)

37. **Southam-Gerow, M. A.**, ***Rodríguez, A***., Chorpita, B. F., & Daleiden, E. (2012). Dissemination and implementation of evidence based treatments for youth: Challenges and recommendations. *Professional Psychology: Research and Practice, 43,* 527-534.
38. ***Christon, L.M.***, ***Robinson, E.M., Arnold, C.C., Lund, H.G.***, Vrana, S.R., & **Southam-Gerow, M.A.** (2012). Modular cognitive behavioral treatment of an adolescent female with selective mutism and social phobia: A case study. *Clinical Case Studies, 11,* 474-491.
39. Weisz, J.R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K.,

Daleiden, E. L., Ugueto, A. M., Ho, A., Martin, J., Gray, J., Alleyne, A., Langer, D. A., **Southam-Gerow, M. A.**, Gibbons, R. D., & the Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy with youth depression, anxiety, and conduct problems: A randomized effectiveness trial. *Archives of General Psychiatry, 69,* 274-282.

2011 (n=6)

40. Schoenwald, S. K., Garland, A. F., **Southam-Gerow, M. A.**, Chorpita, B. F., & Chapman, J. E. (2011). Adherence measurement in treatments for disruptive behavior disorders: Pursuing clear vision through varied lenses. *Clinical Psychology: Science & Practice, 18,* 331-341.
41. ***Eonta, A. M., Christon, L. M., Hourigan, S. E., Ravindran, N.,*** Vrana, S. R., & **Southam-Gerow, M. A.** (2011). Using everyday technology to enhance evidence-based treatments. *Professional Psychology: Research & Practice, 42*, 513-520.
42. ***Hourigan, S. E., Goodman, K. L.,*** & **Southam-Gerow, M. A.** (2011). Discrepancies in parents' and children's reports of child emotion regulation. *Journal of Experimental Child Psychology, 110,* 198-212.
43. Ehrenreich, J. T., **Southam-Gerow, M. A.**, ***Hourigan, S. E.***, Wright, L. R., Pincus, D. B., & Weisz, J. R. (2011). Examining similarities and differences in characteristics of anxious and depressed youth in two different clinical contexts. *Administration and Policy in Mental Health and Mental Health Services Research, 38*, 398-411.
44. Schoenwald, S. K., Garland, A. F., Chapman, J. E., Frazier, S. L., Sheidow, A. J., & **Southam-Gerow, M. A.** (2011). Toward the effective and efficient measurement of implementation fidelity. *Administration and Policy in Mental Health and Mental Health Services Research, 38,* 32-43.
45. Nakamura, B. J., Chorpita, B. F., Hirsch, M., Daleiden, E., Slavin, L., Amundson, M. J., Rocco, S., Mueller, C., Osiecki, S., **Southam-Gerow, M. A.**, Stern, K., & Vorsino, W. M. (2011). Large-scale implementation of evidence-based treatments for children ten years later: Hawaii's evidence based services initiative in children's mental health. *Clinical Psychology: Science and Practice, 18,* 24-35.

2010 (n=2)

46. **Southam-Gerow, M. A.**, Weisz, J. R., Chu, B. C., McLeod, B. D., Gordis, E. B., & Connor-Smith, J. K. (2010). Does CBT for youth anxiety outperform usual care in community clinics?: An initial effectiveness test. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 1043-1052.
47. ***Goodman, K. L.*** & **Southam-Gerow, M. A.** (2010). The regulating role of negative emotions in children's coping with peer rejection. *Child Psychiatry and Human Development, 41*, 515-534.

2009 (n=3)

48. McLeod, B. D., **Southam-Gerow, M. A**., & Weisz, J. R. (2009). Conceptual and methodological issues in treatment integrity measurement. *School Psychology Review, 38*, 541-546.
49. Weisz, J. R., **Southam-Gerow, M. A.**, Gordis, E. B., Connor-Smith, J. K., Chu, B. C., Langer, D. A., McLeod, B. D., Jensen-Doss, A. Gelbwasser, A., & Weiss, B. (2009). Cognitive-behavioral therapy versus usual clinical care for youth depression: An initial implementation test in community clinics. *Journal of Consulting & Clinical Psychology, 77*, 383-396.
50. **Southam-Gerow, M. A**., ***Hourigan, S. E***., & Allin, R. B. (2009). Adapting evidence-based treatments for youth in partnership with mental health stakeholders. *Behavior Modification, 33*, 82-103.

2008 (n=4)

51. ***Miller, L. M.,* Southam-Gerow, M. A.**, & Allin, R. B. (2008). Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency. *Child & Youth Care Forum, 37*, 153-170.
52. ***Ong, J. C.,*** Wickwire, E., **Southam-Gerow, M. A.**, Schumacher, J. A., & Orsillo, S. (2008). Developing cognitive-behavioral treatments: A primer for early career psychologists. *The Behavior Therapist, 31*, 73-77.
53. **Southam-Gerow, M. A.**, Chorpita, B. F., ***Miller, L. M.,*** & Gleacher, A. A. (2008). Are children with anxiety disorders privately-referred to a university clinic like those referred from the public mental health system? *Administration and Policy in Mental Health and Mental Health Services Research, 35,* 168-180.
54. Garner, P. W., Dunsmore, J. C., & **Southam-Gerow, M**. (2008). Mother-child conversations about emotions: Linkages to child aggression and prosocial behavior. *Social Development, 17*, 259-277.

2007 (n=1)

55. Suveg, C., **Southam-Gerow. M. A., *Goodman, K. L***., & Kendall, P. C. (2007). The role of emotion theory and research in child therapy development. *Clinical Psychology: Science & Practice, 14*, 358-371.

2006 (n=6)

56. Martin, J. L., Weisz, J. R., Chorpita, B. F., Higa, C. K., Wells, K. C., **Southam-Gerow, M. A.**, & the Research Network on Youth Mental Health. (2006, Winter). Moving evidence-based practices into everyday clinical care settings: Addressing challenges associated with pathways to treatment, child characteristics, and structure of treatment. *Report on Emotional & Behavioral Disorders in Youth, 7*, 5-8, 21.
57. Ho, A. C. Weisz, J. R., Austin, A. A., Chorpita, B. F., Wells, K. C., **Southam-Gerow, M. A.**, & the Research Network on Youth Mental Health. (2006, Winter). Bridging science and community practice: Clinician and organizational engagement in community clinics in the Clinic Treatment Project. *Report on Emotional & Behavioral Disorders in Youth, 7*, 13-16, 19.
58. **Southam-Gerow, M. A.** & ***Miller, L. M***. (2006). Review of Principles of change that work. *Psychological Medicine, 36,* 1811-1812.
59. **Southam-Gerow, M. A.**, Ringeisen, H. L., & Sherrill, J. T. (2006). Introduction to Special Issue: Integrating interventions and services research: Progress and prospects. *Clinical Psychology: Science and Practice, 13*, 1-8.
60. **Southam-Gerow, M. A.**, Silverman, W. K., & Kendall, P. C. (2006). Client similarities and differences in two childhood anxiety disorders research clinics. *Journal of Clinical Child and Adolescent Psychology, 35*, 528-538.
61. Wood, J. J., Piacentini, J. C., **Southam-Gerow, M**., Chu, B., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 314-321.

2005 (n=1)

62. **Southam-Gerow, M. A**. (2005, Summer). Using partnerships to adapt evidence-based mental health treatments for use outside labs. *Report on Emotional & Behavioral Disorders in Youth, 5*, 58-60, 77-79.

2004 (n=2)

63. **Southam-Gerow, M. A.** (2004). Solid resource for training mental health professionals: *Clinical Behavior Therapy: Adults and Children. Contemporary Psychology*.
64. **Southam-Gerow, M. A.** (2004). Some reasons that mental health treatments are not technologies: Toward treatment development and adaptation outside labs. *Clinical Psychology: Science and Practice, 11*, 186-189.

2003 (n=2)

65. **Southam-Gerow, M. A.**, Weisz, J. R., & Kendall, P. C. (2003). Youth with anxiety disorders in research and service clinics: Examining client differences and similarities. *Journal of Clinical Child and Adolescent Psychology, 32*, 375-385.
66. **Southam-Gerow, M. A.**, Flannery-Schroeder, E. C., & Kendall, P. C. (2003). A psychometric evaluation of the parent report form of the State-Trait Anxiety Inventory for Children--trait version. *Journal of Anxiety Disorders, 17*, 427-446.

2002 (n=2)

67. **Southam-Gerow, M. A.** (2002.). Theories of negative emotion: Issue relevant to measurement. *Child and Adolescent SIG Newsletter, 1 (Sept.)*, 6-7.
68. **Southam-Gerow, M. A.** & Kendall, P. C. (2002). Emotion regulation and understanding: Implications for child psychopathology and therapy. *Clinical Psychology Review, 22*, 189-222.

2001 (n=2)

69. Weisz, J. R., **Southam-Gerow, M. A.**, & McCarty, C. A. (2001). Control-related beliefs and self-reported depressive symptoms in clinic-referred children and adolescents. *Journal of Abnormal Psychology, 110*, 97-109.
70. **Southam-Gerow, M. A.**, Kendall, P. C., & Weersing, V. R. (2001). Examining outcome variability: Correlates of treatment response in a child and adolescent anxiety clinic. *Journal of Clinical Child Psychology, 30*, 422-436.

2000 (n=2)

71. **Southam-Gerow, M. A**. & Kendall, P. C. (2000a). A preliminary study of the emotion understanding of youth referred for treatment of anxiety disorders. *Journal of Clinical Child Psychology, 29*, 319-327.
72. **Southam-Gerow, M. A.** & Kendall, P. C. (2000b). Cognitive-behavior therapy with youth: Advances, challenges, and future directions. *Clinical Psychology and Psychotherapy, 7*, 343-366.

1997 (n=2)

73. Kendall, P. C., Flannery-Schroeder, E. C., Panichelli-Mindel, S. P., **Southam-Gerow, M. A.**, Henin, A., & Warman, M. J. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology, 65*, 366-380.
74. **Southam-Gerow, M. A**., Henin, A., Chu, B., Marrs, A., & Kendall, P. C. (1997). Cognitive-behavioral therapy with children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 6*, 111-136.

1996 (n=1)

75. Kendall, P. C. & **Southam-Gerow, M. A**. (1996). Long-term follow-up of a cognitive-behavioral

therapy for anxiety-disordered youth. *Journal of Consulting and Clinical Psychology, 64*, 724-730.

1995 (n=1)

76. Kendall, P. C. & **Southam-Gerow, M. A.** (1995). Issues in the transportability of treatment: The case of anxiety disorders in youth. *Journal of Consulting and Clinical Psychology, 63*, 702-708.

Chapters & non-peer reviewed papers, n=21

In press (n=1)

1. ***Riley, T.*** & **Southam-Gerow, M. A.** (in press, 2022). Emotion regulation and therapy. In G. L. Shiewer, J. Altarriba, & B. C. Ng (Eds.), *Handbook of language and emotion*. Berlin: Degruyter.

2020 (n=2)

2. ***Cox, J. R.*** & **Southam-Gerow, M. A.** (2020). Dissemination of evidence-based treatments for children and families in practice settings (pp. 331-344). In R. G. Steele and M. C. Roberts (Ed.), *Evidence based therapies for children and adolescents: Bridging science and practice* (2nd Ed.). Switzerland: Springer.
3. **Southam-Gerow, M. A.**, ***Cox, J. R.***, & Kinnebrew, A. (2020). Managing and Adapting Practice. In T. W. Farmer, M. A. Conroy, E. M. Z. Farmer & K. S. Sutherland (Eds.), *Handbook of Research on Emotional & Behavioral Disabilities: Interdisciplinary Developmental Perspectives on Children and Youth*. New York: Routledge.

2019 (n=1)

4. ***Cox, J. R.*** & **Southam-Gerow, M. A.** (2019). Dissemination and implementation (pp. 418-439). In S. N. Compton, M. Villabo, & H. Kristensen, (Eds.), *Pediatric anxiety disorders.* London: Academic Press

2017 (n=2)

5. ***Arnold, C. C.*** & **Southam-Gerow, M. A.** (2017). Anxiety in childhood: Psychological factors. In A. Wenzel (Ed.), *The SAGE Encyclopedia of Abnormal and Clinical Psychology.* New York: Sage.
6. ***Rodriguez, A.*** & **Southam-Gerow, M. A.** (2017). Anxiety in childhood: Gender differences. In A. Wenzel (Ed.), *The SAGE Encyclopedia of Abnormal and Clinical Psychology.* New York: Sage.

2014 (n=2)

7. **Southam-Gerow, M. A.**, ***Arnold, C. C., Tully, C. B., & Cox, J. R.*** (2014). Dissemination and implementation of child/adolescent mental health treatments (pp. 73-90). In C. Alfano & D. Beidel (Eds.), *Comprehensive Evidence-Based Interventions for School-aged Children and Adolescents*. New York: Wiley.
8. ***Brown, R. C., Parker, K. M.,*** McLeod, B. D., & **Southam-Gerow, M. A.** (2014). Building a positive therapeutic alliance with child, adolescent, or parent. (pp. 63-78). In E. Sburlati, H. Lyneham, C. Schniering & R. Rapee (Eds.), *Evidence-Based CBT for Anxiety and Depression in Children and Adolescents: A Competencies Based Approach*.

2013 (n=1)

9. McLeod, B. D., **Southam-Gerow, M. A.**, ***Christon, L., Rodriguez, A., & Archer, E.*** (2013).

Treatment effectiveness. (pp. 3169-3176). In F. Volkmar (Ed.), *Encyclopedia of autism spectrum disorders*.

2012 (n=1)

10. ***Hourigan, S. E.,*** Settipani, C., **Southam-Gerow, M. A.**, & Kendall, P. C. (2012). Coping Cat: A cognitive-behavioral treatment for childhood anxiety disorders. In A. Rubin (Ed.) *Empirically supported programs and interventions in child welfare*. (pp. 91-104). New York: Wiley.

2011 (n=1)

11. **Southam-Gerow, M. A.**, McLeod, B. D, ***Brown, R. C., Quinoy, A. M., & Avny, S. B.*** (2001). Cognitive-behavioral therapy for adolescents. In Brown, B.B & Prinstein, M.J. (Eds.), *Encyclopedia of Adolescence, Vol. 3 (pp. 100-108)*. London: Elsevier.

2008 (n=2)

12. **Southam-Gerow, M. A.**, ***Marder, A. M.,*** & Austin, A. A. (2008). Transportability and dissemination of evidence-based manualized treatments in clinical settings. In R. G. Steele, T. D. Elkin, & M. C. Roberts (Eds.), Handbook of evidence based therapies for children and adolescents (pp. 447-469). New York: Springer.
13. **Southam-Gerow, M. A**., Austin, A. A., & ***Marder, A. M.*** (2008). Transportability and dissemination of psychological treatments: Research models and methods. In D. McKay (Ed.), Handbook of research methods in abnormal and clinical psychology (pp. 203-224). Newbury Park, CA: Sage.

2007 (n=1)

14. **Southam-Gerow, M. A**. & Chorpita, B. F. (2007). Anxiety in children and adolescents. In E. J. Mash & R. A. Barkley (Eds.), Assessment of childhood disorders (4th Ed.), (pp. 347-397). New York: Guilford Press.

2006 (n=2)

15. Chorpita, B. F. & **Southam-Gerow, M. A.** (2006). Treatment of anxiety disorders in youth. In E. J. Mash & R. A. Barkley (Eds.), Treatment of childhood disorders (3rd Ed.), (pp. 271-335). New York: Guilford Press.
16. **Southam-Gerow, M. A.** & Kendall, P. C. (2006). Supervising a manual-based treatment program: Experiences from university-based and community-based clinics. In T. K. O'Neill (Ed.), Helping others help children: Clinical supervision of child psychotherapy (pp. 123-136). Washington, DC: American Psychological Association.

2003 (n=2)

17. **Southam-Gerow, M. A**. (2003). Child-focused cognitive-behavioral therapies for antisocial children. In C. A. Essau (Ed.), Conduct and oppositional defiant disorders in children and adolescents: Epidemiology, risk factors, and treatment (pp. 257-277). Mahwah, NJ: Erlbaum.
18. Weisz, J. R., **Southam-Gerow, M. A.**, Gordis, E. B., & Connor-Smith, J. K. (2003). Primary and Secondary Control Enhancement Training for youth depression: Applying the Deployment-Focused Model of treatment development and testing. In A. E. Kazdin & J. R. Weisz (Eds.), Evidence-based treatments for children and adolescents (pp. 165-183). New York: Guilford.

2001 (n=1)

19. **Southam-Gerow, M. A.** (2001). Generalized anxiety disorder in youth. In C. A. Essau & F. Petermann (Eds.), Anxiety disorders in children and adolescents: Epidemiology, risk factors, and treatment (pp. 219-260). East Sussex, UK: Brunner-Routledge.

1997 (n=1)

20. **Southam-Gerow, M. A.** & Kendall, P. C. (1997). Parent-focused and cognitive-behavioral treatments of antisocial youth. In D. Stoff, J. Breiling, & J. D. Maser (Eds.), Handbook of antisocial behavior (pp. 384-394). New York: John Wiley & Sons.

1995 (n=1)

21. Kendall, P. C., Panichelli-Mindel, S. M., & **Gerow, M. A.** (1995). Cognitive-behavioral therapies with children and adolescents: An integrative overview. In H. P. J. G. van Bilsen, P. C. Kendall, & J. H. Slavenburg (Eds.), Behavioral approaches for children and adolescents Challenges for the next century (pp. 1-18). New York: Plenum Press.

PRESENTATIONS/COLLOQUIA

Peer Reviewed (n=113)

1. Southam-Gerow, M. A. (2021, Nov.). Panelist, Bringing Evidence-based Practices to the Community: An Implementation Science Approach. Presented at the Association of Behavioral and Cognitive Therapies (ABCT), ONLINE.
2. Southam-Gerow, M. A. (2021, Nov.). Discussant for symposium,Family Involvement in the Treatment of Youth Opioid Use Disorders, A. Hogue & C. Henderson (Co-Chairs). Presented at the Association of Behavioral and Cognitive Therapies (ABCT), ONLINE.
3. Southam-Gerow, M. A. (2020, Nov.). Discussant for symposium, Expanding the Reach of Transdiagnostic Interventions: Adapting the Unified Protocols for Children and Adolescents to Non-Internalizing Disorders and Alternative Treatment Delivery Formats, S. Kennedy (Chair). Presented at the Association of Behavioral and Cognitive Therapies (ABCT), ONLINE.
4. Southam-Gerow, M. A. (2020, Nov.). Participant in "CBT Campfire Storytelling Session" Clinical roundtable moderated by S. Rego, presented at the Association of Behavioral and Cognitive Therapies (ABCT), ONLINE.
5. Southam-Gerow, M. A. (2019, Nov.). Participant in "Exposures Gone Awry: Rallying and Recuperating from Unforeseen, Unanticipated, and Uncommon Blunders!" Clinical roundtable moderated by S. Rego, presented at the Association of Behavioral and Cognitive Therapies (ABCT), Atlanta, GA.
6. Cecilione, J., Violante, S., McLeod, B., Southam-Gerow, M., Weisz, J., & Chorpita, B. (2019, November). Distinguishing Between Technical and Global Competence in Youth Treatment. Symposium presented at the Association of Behavioral and Cognitive Therapies (ABCT), Atlanta, GA.
7. Southam-Gerow, M. A. (2019, Nov.). Participant in panel discussion, The MAP Toolkit For Enhancing the Connections Between Science and Practice: Common Elements and Much More. Presented at the Association of Behavioral and Cognitive Therapies (ABCT), Atlanta, GA.
8. Southam-Gerow, M. A. (2019, Nov.). Discussant for symposium, Exposure Therapy: From Bench to Bedside, J. Kaye (Chair). Presented at the Association of Behavioral and Cognitive Therapies (ABCT), Atlanta, GA.
9. Finn, N., Hailu, S., Bernstein, A., & Southam-Gerow, M. (2019, Nov.) Utilizing Practice Element Profiles to Identify Training Targets in a Community Child Mental Health Agency. Poster presented at the Association of Behavioral and Cognitive Therapies (ABCT), Atlanta, GA.
10. Cox, J. R., & Southam-Gerow, M. A. (September, 2019). Training future mental health professionals in Managing and Adapting Practice, an evidence-informed system of care. Poster session accepted for

presentation at the 5th biennial convention of the Society for Implementation Research and Collaboration, Seattle, WA.

11. Cox, J. R., Brosnan, P., & Southam-Gerow, M. A. (2018. Nov.). Training Mental Health Professionals: An Evidence-Informed System of Care. In F. M. Espil (Chair), Training Novice and Lay Professionals in Cognitive- Behavioral Therapy. Symposium presented at the Association of Behavioral and Cognitive Therapies (ABCT), Washington, DC.
12. Finn, N. K., Hailu, S., Bernstein, A., & Southam-Gerow, M. A. (2018). Identifying targets for quality improvement in a community child mental health agency. Poster presented at the Special Interest Group Exposition, Association for Behavioral and Cognitive Therapies Convention, Washington, DC.
13. Violante, S., Cox, J. R., Granger, K., de Gree, M., Srivastava, V., McLeod, B. D., Southam-Gerow, M. A., Weisz, J. R., & Chorpita, B. F. (2018, Nov.). Youth-Therapist Alliance: EBT Manuals in Psychosocial Treatment for Youth Anxiety. Poster presented at the Association of Behavioral and Cognitive Therapies (ABCT), Washington, DC.
14. Southam-Gerow, M. A. (2018, Nov.). Discussant in symposium entitled "Out of the Ivory Tower, and Into the Real World: Effectiveness and Sustainability of CBT in Naturalistic Settings," J. Tyler (Chair). Symposium presented at the Association of Behavioral and Cognitive Therapies (ABCT), Washington, DC.
15. Yankah, S. E., Derlan, C. L., Lozada, F. T., Southam-Gerow, M., & Dick, D. (2018, July). Ethnic-racial identity and relationship satisfaction among diverse emerging adults. Poster submitted to be presented at the Fifth Biennial Conference of the American Psychological Association Society for the Psychological Study of Culture, Ethnicity, & Race, Austin, TX.
16. Cox, J. R., Srivastava, V., Erny, D., Southam-Gerow, M. A., & McLeod, B. D. (2017, September). Use of specific delivery strategies in cognitive behavioral therapy for anxious youth in different therapy settings. Poster session presented at the 4th biennial meeting of the Society for Implementation Research Collaboration, Seattle, WA.
17. Keister, D., Bacalso, A., Violante, S., McLeod, B. D., Southam-Gerow, M. A. (November, 2017). Reliability and validity of an adapted version of the Cognitive-Behavioral Treatment for Anxiety in Youth Competence Scale (CBAY-C). Poster accepted for presentation at the Annual Conference of the Association for Behavioral and Cognitive Therapies, San Diego, CA.
18. Violante, S., Miller, C., Melo, L., Southam-Gerow, M. A., McLeod, B. D., Chorpita, B. F., & Weisz, J. R. (2017). *Reliability and validity of the Cognitive-Behavioral Therapy for Anxiety in Youth Adherence scale (CBAY-A) adapted for use with modular treatments.* Poster presented at the Society for Implementation Research Collaboration 4th Biennial Conference, Seattle, WA.
19. Melo, L., Miller, C., Violante, S., Southam-Gerow, M. A., McLeod, B. D., Chorpita, B. F., & Weisz, J. R. (2017, April). Reliability and validity of the Cognitive-Behavioral Therapy for Anxiety in Youth Adherence scale (CBAY-A) adapted for use with modular treatments. Poster presented at the VCU Poster Symposium for Undergraduate Research and Creativity, Richmond, VA.
20. Wu, E.G., Martinez, R.G., Hicks, C.P., Violante, S., McLeod, B.D., Southam-Gerow, M.A., Chorpita, B.F., Weisz, J.R. (2017). *Comparing treatment differentiation and adherence instruments across two youth anxiety treatments in community settings.* Poster presented at the Association for Behavioral and Cognitive Therapy 51st Annual Convention, San Diego, CA.
21. Martinez, R.G., Wu, E.G., Hicks, C.P., Violante, S., McLeod, B.D., Southam-Gerow, M.A., Chorpita, B.F., & Weisz, J.R. (2017). *Comparing treatment differentiation and adherence instruments across two youth anxiety treatments in community settings.* Poster presented at the Society for Implementation Research and Collaboration. Seattle, WA.
22. Srivastava, V., Cox, J. R., Erny, D., Southam-Gerow, M. A., McLeod, B. D. (2017, November). *Use of Specific Delivery Strategies in Cognitive Behavioral Therapy for Anxious Youth in Different Therapy Settings.* Poster session presented at the meeting of the Child & Adolescent Anxiety Special Interest Group of the Association for Behavioral and Cognitive Therapies, San Diego, CA.
23. Cox, J. R., Brosnan, P., Southam-Gerow, M. A., Farmer, E. M. Z., & Kinnebrew, A. (2016, October). Training future mental health professionals in an evidence-informed system of care. Poster session presented at

the preconference of the Dissemination and Implementation Science Special Interest Group preconference meeting, New York, NY.

24. Srivastava, V., Cox, J. R., Southam-Gerow, M. A., McLeod, B. D. (2016, October). Do different types of treatment manuals undermine the alliance in CBT for youth anxiety? Poster session presented at the meeting of Dissemination and Implementation Special Interest Group of the Association for Behavioral and Cognitive Therapies, New York, NY.
25. Ng, M. Y., McLeod, B. D., Southam-Gerow, M., Langer, D. A., Chu, B. C., & Weisz., J. R. (2016, November). Therapist strategies and youth coping in a randomized effectiveness trial of cognitive behavioral therapy vs. usual care for youth anxiety and depression: A moderated mediation model. Paper to be presented at the annual meeting of the North American Society for Psychotherapy Research, Berkeley, CA.
26. Southam-Gerow, M. A. (2015, Nov.) Moderator of: Implementing Exposure-Based CBT Across Health Care Settings: Challenges and Solutions to Training Clinicians. Panel presented at the 49th Annual Association for Behavioral and Cognitive Therapies Conference, Chicago, IL.
27. Southam-Gerow, M. A. (2015, Nov.). Panelist in: Strengthening the Reciprocal Relationship between Practice and Research: Logistics, Challenges, and Benefits from Treatment Effectiveness and Dissemination Studies. Roundtable presented at the 49th Annual Association for Behavioral and Cognitive Therapies Conference, Chicago, IL.
28. Smith, M. M., Rodriguez, A., McLeod, B. D., & Southam-Gerow, M. A. (2015, Nov.). Do pretreatment characteristics affect therapist treatment delivery? Poster presented at the 49th annual meeting of the Association for Behavioral and Cognitive Therapies, Chicago, IL.
29. Cox, J. R., Southam-Gerow, M. A., & McLeod, B. D. (2015, Nov.). Measuring order: Therapist adherence to CBT for anxious youth across a case. Symposium presented at the 49th annual meeting of the Association for Behavioral and Cognitive Therapies, Chicago, IL.
30. McLeod, B. D., Southam-Gerow, M. A., Kendall, P. C., & Weisz, J. R. (2015, Oct.). Characterizing the delivery of CBT for youth anxiety in community settings. Symposium presented at the 3rd Biennial Society for Implementation Research Collaboration, Seattle, WA.
31. Cox, J. R., Smith, M. M., Southam-Gerow, M. A., & McLeod, B. D. (2015, Oct.). Successful usual care: Therapeutic interventions and contextual factors. Symposium presented at the 3rd Biennial Society for Implementation Research Collaboration, Seattle, WA.
32. Martinez, R. G., McLeod, B. D., Sutherland, K. S., Conroy, M. A., Snyder, P., & Southam-Gerow, M. A. (2015, Oct.). A treatment integrity measure for early childhood education settings. Symposium presented at the 3rd Biennial Society for Implementation Research Collaboration, Seattle, WA.
33. Southam-Gerow, M. A., Bernstein, A., Hailu, S. (2015, Oct.). Which treatments do I need? A preliminary look with one agency. Symposium presented at the 3rd Biennial Society for Implementation Research Collaboration, Seattle, WA.
34. Arnold, C.C., Rodriguez, A., Southam-Gerow, M.A. & McLeod, B.D. (2014, November). *Exploring the relationship between therapist adherence to and competence with CBT for youth anxiety.* Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, Philadelphia, PA.
35. Ng, M., McLeod, B. D., Southam-Gerow, M. A., Langer, D. A., Chu, B. C., & Weisz, J. R. (2014, November). *Mediators in an effectiveness trial comparing CBT and usual care for youth internalizing disorders.* Symposium presented the 48th annual meeting of the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.
36. Smith, M. M., Islam, N. Y., McLeod, B. D., & Southam-Gerow, M. A. (2014, November). *Do pre-treatment child factors influence CBT implementation?* Poster session presented at the 48th Annual Association for Behavioral and Cognitive Therapies Conference, Philadelphia, PA.
37. Southam-Gerow, M. A. (2014, November). Panelist in *Training Clinicians in the Practice of CBT With Young Patients* (Chairs: R. Friedberg & M. Thordarson). Panel presented at the 48th Annual Association for Behavioral and Cognitive Therapies Conference, Philadelphia, PA
38. Morelen, D., Zeman, J., & Southam-Gerow, M. A. (2014, November). Links Among Emotion Regulation, Bullying, and Victimization: Moderating Role of Gender. Poster session presented at the 48th Annual Association for Behavioral and Cognitive Therapies Conference, Philadelphia, PA.
39. Sanchez, K.S., Tully, C.B., Wheat, E., Southam-Gerow, M.A., & McLeod, B.D. (2013). *Evaluation of*

therapist common factors competence across settings. Poster presented at the 48th annual Association for Behavioral and Cognitive Therapies conference, Nashville, TN.

40. Southam-Gerow, M. A., & McLeod, B. D. (2013, November). Co-Chair, Applications of treatment integrity research to dissemination and implementation research. Symposium presented at the 47th annual meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.
41. Smith, M. M., Southam-Gerow, M. A., & McLeod, B. D. (2013, November). Characterizing the Implementation of CBT for Youth Anxiety in Research and Practice Settings. Symposium presented at the 47th Annual Association for Behavioral and Cognitive Therapies Conference, Nashville, TN.
42. Smith, M. M., Sanchez, K. S., Southam-Gerow, M. A., & McLeod, B. D. (2013, November).The Effects of Treatment Setting on the Competent Delivery of Core Cognitive Behavioral Therapy Interventions. Poster presented at the 47th Annual Association for Behavioral and Cognitive Therapies Conference, Nashville, TN.
43. Cox, J. R., Smith, M. M., Rodriguez, A., Arnold, C., McLeod, B. D., & Southam-Gerow, M. A. (2013, November). The extensiveness of therapist adherence to a cognitive behavioral therapy protocol for youth anxiety across skills training components. Poster presented at the 47th Annual Convention of the Association for Behavioral and Cognitive Therapies, Nashville, TN.
44. Arnold, C.C., Rodriguez, A., Southam-Gerow, M.A. & McLeod, B.D. (2013, November). *Adherence differences in community versus research clinics for CBT youth anxiety.* Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies,Nashville, TN.
45. Wheat, E., Tully, C.B., McLeod, B.D., & Southam-Gerow, M.A. (2013). *Relation between client involvement and therapist competence with youth anxiety.* Poster presented at the 48th annual Association for Behavioral and Cognitive Therapies conference, Nashville, TN.
46. Islam., N. Y., Southam-Gerow, M. A., Flores, L. Y., Vrana, S. R. (November 2013). Incorporating iPads when Implementing CBT: Experiences and Considerations from an Anxiety Disorders Training Clinic. In Higa McMillan, C. (Chair). Harnessing the Synergy of Technology and Training in Evidence-Based Practice. Symposium at the 47th annual meeting of the Association for Behavioral and Cognitive Therapies, Nashville, TN.
47. Southam-Gerow, M. A. (2012, Nov.) Discussant for Common Element Methodologies for Steering Youth Mental Health Dissemination and Implementation Efforts in Public-Sector Settings, B. Nakamura (Chair). Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
48. Implementing EBTs With Youth and Families in Poverty: Challenges and Lessons Learned. Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
49. Antecedent Variables and Mechanisms of Behavior Change in Youth Psychotherapy. Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
50. Wheat, E., Bair, Bair, Brown, R. C., McLeod, B. & Southam-Gerow, M. A. (2012, November). The Effect of Therapist Competence on Client Involvement in Community Settings for Youth with Anxiety Diagnoses. Poster presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
51. Bair, C, Wheat, E., Rodriguez, A., McLeod, B. & Southam-Gerow, M. A. (2012, November). Differences in Therapist Responsiveness in Implementing Child Anxiety Treatments with Youth from Different Cultural Backgrounds. Poster presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
52. Southam-Gerow, M. A. (2012, November). Discussant in symposium, Low Resources and High Stress: Meeting the Needs of Low Socioeconomic Youth Through Evidence-Based Protocols, A. Polo (Chair). Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, National Harbor, MD.
53. Islam, N. Y., Smith, M. M., Lerner, M. D., Parker, K. M., Rodriguez, A., Arnold, C. C., McLeod, B. D., & Southam-Gerow, M.A. (2012, October). The Role of Pre-treatment Factors in Alliance and Client Involvement in CBT for Youth Anxiety Delivered in Community Clinics. Poster presented at the *National Conference in Clinical Child and Adolescent Psychology*, Lawrence, KS, October 18-20.

54. Arnold, C. C. & Southam-Gerow, M. A. (2011, November). How evidence based is usual care assessment?: A program evaluation. Symposium presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, Toronto, Canada.
55. Arnold, C. C. & Southam-Gerow, M. A. (2011, November). The Strength of Measure (SoM) Scale: The development of a systematic method for evaluating the strength of psychological assessment measures within clinical practice. Poster presentation at the annual meeting of the Association of Behavioral and Cognitive Therapies, Toronto, Canada.
56. Bair, C.E., Wheat, E., McLeod, B.D., & Southam-Gerow, M.A. (2011, November). Observational fidelity rating measures: Reliability of independent raters in audio versus video recordings. Poster session presented at the 45th annual Association for Behavioral and Cognitive Therapies conference, Toronto, Canada.
57. Islam, N. Y., Wheat, E. J., McLeod, B. D., Southam-Gerow, M., & Weisz, J. R. (2011, November). Disentangling Alliance and Client Involvement in Youth Anxiety Treatment. Poster session presented at the 45th annual Association for Behavioral and Cognitive Therapies conference, Toronto, Canada.
58. Southam-Gerow, M. A. (2010, November) Panelist in Y. Watabe (Chair), Measuring Treatment Integrity in Clinic- and School-Based Treatments for Children. Panel discussion presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA
59. Quinoy, A. M., Hourigan, S. E., Brown, R. C., & Southam-Gerow, M. A. (2010, November). Using Functional Analysis to Guide Treatment Using Elements from Evidence-Based Treatments. In C. Higa-McMillan (Chair), Revisiting Evidence-Based Practices: Enhancing the Relevance of Treatment Criteria and Treatment Design in Community Mental Health Settings for Children and Adolescents. Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
60. Hourigan, S. E., Quinoy, A. M., & Southam-Gerow, M. A. (November, 2010). Mental health problems in pediatric primary care settings: Youth symptom prevalence and parent beliefs. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
61. Southam-Gerow, M. A. (2010, November) Panelist in Y. Watabe (Chair), Measuring Treatment Integrity in Clinic- and School-Based Treatments for Children. Panel discussion presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, San Francisco, CA.
62. Southam-Gerow, M. A., Chorpita, B. F., Daleiden, E., Hershberger, A. M., & Nygaard, P. (2009, November). Adventures in dissemination: Training practitioners in the Managing and Adapting Practices system. In A. D. Herschell (Chair), Innovations in integrating evidence-based practices in real-world systems. Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
63. Southam-Gerow, M. A. (2009, November) Panelist in K. Koerner (Chair), Scaling Up: What Is Successful, Promising, and Problematic About Our Dissemination and Implementation Efforts. Panel discussion presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
64. Hourigan, S. E., Goodman, K. L, Quinoy-Boe, A. M., Brown, R. C., & Southam-Gerow, M. A. (2009, November). Associations among child report of poor emotion awareness and discrepancies in parents' and children's reports of child emotion regulation. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
65. Hourigan, S. E., Goodman, K. L, Quinoy-Boe, A. M., Brown, R. C., & Southam-Gerow, M. A. (2009, November). Discrepancies in parents' and children's reports of child anger regulation. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
66. Arnold, C. A., Quinoy-Boe, A. M., Brown, R. C., Chu, B. C., McLeod, B. D., Weisz, J. R., & Southam-Gerow, M. A. (November, 2009). Therapist perceptions and use of manualized treatments after participating in an effectiveness trial. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
67. Quinoy-Boe, A. M., Southam-Gerow, M. A., Hourigan, S. E., Brown, R. C., & Allin, R. B. (2009). Who is training whom?: Partnering with community mental health therapists in a test of evidence-based treatments. In M. Khanna (Chair), Building an evidence base for clinician training and supervision procedures. Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.

68. Quinoy-Boe, A. M., Brown, R. C., & Southam-Gerow, M. A. (2009, November). A confirmatory factor analysis of the Revised Child Anxiety and Depression Scale in a pediatric African-American sample. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
69. Brown, R. C., Marder, A. A., McLeod, B. D., & Southam-Gerow, M. A. (2009, November). Development of an observer-rated measure of common-factor therapist competence. In R. C. Brown & M. A. Southam-Gerow (Chairs), The use of observational measures in youth psychotherapy process research. Symposium presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, New York, NY.
70. Southam-Gerow, M. A., Chorpita, B. F., Daleiden, E. L. & Nygaard, P. (2009, August). A Minnesota story: The evolution of the PracticeWise approach to training and consultation. In A. M. Marder (Chair), Demonstration of mapping and traversing the science--practice gap. Symposium presented at the annual meeting of the American Psychological Association, Toronto, ON, Canada.
71. Southam-Gerow, M. A., Haskell, A., MacPhee, M., Hourigan, S. E., Brown, R. C., & Allin, R. B. (2008, November). Resistance to CBT for youth: Case examples from a transportability study. In S. R. Shirk (Chair), Responding to resistance in youth CBT. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
72. Southam-Gerow, M. A. (2008, November). Moderator of Clinical Round Table, What do you mean, think about my thinking? Making abstract concepts come to life in CBT for children. Presented at the annual meeting of the Association of Behavioral and Cognitive Therapies, Orlando, FL.
73. Southam-Gerow, M. A. & Marder, A. M. (2008, November). Treatment integrity in clinical trials for youth internalizing disorders: Review and recommendations. In B. D. McLeod (Chair), Treatment integrity research in child psychotherapy. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
74. Southam-Gerow, M. A. & Vrana, S. R. (2008, November). How (and how not) to run an evidence-based anxiety clinic in an urban, university-based setting. In S. M. Panichelli-Mindel (Chair), Graduate training clinics serving the community: How we integrate science and practice. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
75. Chu, B. C., Southam-Gerow, M. A. & Weisz, J. R. (2008, November). An effectiveness trial of CBT versus usual clinical care for youth depression. In S. K. Bearman (Chair), Bridging the gap for youth depression: Using the Deployment-Focused Model (DFM) of treatment development and testing in children's mental health. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
76. Southam-Gerow, M. A., Chorpita, B. F. & Nygaard, P. (2008, November). Implementation of EBTs and innovative outcome tracking tool: Data from a state-wide implementation project. In A. M. Marder & B. Nakamura (Chairs), Implementation of evidence-based treatments in community settings. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
77. Hourigan, S. E., Brown, R. C., Boe, A. Q., Goodman, K. L., & Southam-Gerow, M. A. (2008, November). Predictors of discrepancies in parents' and children's reports of child emotion regulation. In C. Suveg (Chair), Assessment of emotion regulation in youth: The feasibility of several progressive strategies. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Orlando, FL.
78. Brown, R. C., Marder, A. M., McLeod, B. D., & Southam-Gerow, M. A. (2008, November). The development of a child therapist competence measure. Poster presented at the annual meeting of the Association of Behavioral and Cognitive Therapies, Orlando, FL.
79. Boe, A.Q., Brown, R.C., Marder, A.M., & Southam-Gerow, M.A. (2008, November). Factor structure of the Strengths and Difficulties Questionnaire in an African-American pediatric sample. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Orlando, FL.
80. Brown, R.C., Boe, A.Q., Marder, A.M., & Southam-Gerow, M.A. (2008, November). Predictive validity of the Strengths and Difficulties Questionnaire in an African-American Sample. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies in Orlando, FL.
81. Hourigan, S.E., Boe, A.Q., Brown, R.C., Arnold, C.C., & Southam-Gerow, M.A. (2008, November). Examining differences between clinic-referred and non-referred youths on the Child Emotion Management Scales. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Orlando, FL.

82. Boe, A.Q., Hourigan, S.E., Southam-Gerow, M.A., Marder, A.M., Brown, R.C., Haskell, A., et al. (2008, November). Single case design test of multi-focus modular CBT for childhood disorders in a public mental health setting. Poster presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Orlando, FL.
83. Brown, R. C., Marder, A. M., Southam-Gerow, M. A., & McLeod, B. D. (November, 2007). Therapist adherence and competence in the treatment of child anxiety. In A. Przeworski & L. W. Coyne (Chairs), Therapeutic Process in the treatment of childhood anxiety. Symposium presented at the annual meeting of the Association for Cognitive and Behavior Therapies, Philadelphia, PA.
84. Hourigan, S. E., Southam-Gerow, M. A., Wright, L. R., Ehrenreich, J. T., Pincus, D. B., & Weisz, J. R. (2007, November). Examining similarities and differences in characteristics of anxious youth in research and service clinics. Poster session presented at the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.
85. Wright, L. R., Ehrenreich, J. T., Pincus, D. B., Hourigan, S. E., Southam-Gerow, M. A., & Weisz, J. R. (2007, November). Examining differences and similarities for youth with depressive disorders in research and service clinics. Poster session presented at the Association for Behavioral and Cognitive Therapies, Philadelphia, PA.
86. Southam-Gerow, M. A. (2007, August). Discussant. What's happening in usual care psychotherapy?: Implications for EBP translation (A. F. Garland, Chair). Symposium presented at the American Psychological Association Conference, San Francisco, CA.
87. Brown, R. C., Marder, A. M., Hourigan, S. E., Webb, M. L., Friedman, A. D. Brookman, R. R., & Southam-Gerow, M. A. (2007, August). Concurrent validity of RCADS and MASC: Measures of child anxiety. Poster presented at the American Psychological Association Conference, San Francisco, CA.
88. Hourigan, S. E., Brown, R. C., Webb, M. L., Friedman, A. D., Brookman, R. R., & Southam-Gerow, M. A. (2007, August). Anxiety, depression, and substance use symptomatology in a pediatric primary care setting. Poster presented at the American Psychological Association Conference, San Francisco, CA.
89. Goodman, K. L., Brown, R. C., Southam-Gerow, M. A., & Garner, P. W. (2007, August).Perceiving rejection through rose-colored glasses: Positive reappraisal as coping. Poster presented at the American Psychological Association Conference, San Francisco, CA.
90. Southam-Gerow, M. A., Discussant. (November, 2006). In S. M. Kehle & B. C. Chu (Chairs), The effectiveness of cognitive-behavioral treatments for anxiety disorders. Symposium presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
91. Southam-Gerow, M. A., Panelist. (2006, November). In R. D. Friedberg (Chair), Developing blueprints for disseminating effective treatments to the community: Moving beyond hammers and nails. Clinical roundtable presented at the meeting of the Association for of Behavioral and Cognitive Therapies, Chicago, IL.
92. Miller, L. M., Hourigan, S. E., & Southam-Gerow, M. A. (2006, November). Who stays in therapy? Predictors of youth client retention and attrition in a community mental health center. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
93. Brown, R. C., Goodman, K. L., Newgen, J., Southam-Gerow, M. A., & Garner, P. (2006, November). The role of coping strategies in response to negative peer experiences. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
94. Southam-Gerow, M. A., Chorpita, B. F., Brown, L. A., Newgen, J. C., Taylor, K. A., & Burns, K. (November, 2006). Evidence-based assessment of anxiety in children: A quantitative review of the literature. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
95. Hershberger, A. M., Bettencourt, A. F., Brown, R. C., McLeod, B. D., Southam-Gerow, M. A., & Weisz, J. R. (November, 2006). The PASCET program: Therapist adherence & treatment outcomes. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
96. Goodman, K. L., Brown, R. C., Newgen, J. C., Southam-Gerow, M. A., & Garner, P. W. (November, 2006). Children's awareness and management of emotion in the prediction of anxiety and depression. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Chicago, IL.
97. Sherrill, J. T. & Southam-Gerow, M. A., Chairs. (August, 2006). Implementation and outcomes in child/adolescent community mental health. Symposium presented at the meeting of the American Psychological Association, New Orleans, LA.

98. Southam-Gerow, M. A., Allin, R., Hershberger, A. M., Haskell, A., MacPhee, M., & Morgan, J. R. (August, 2006). Using partnerships to adapt evidence-based treatments for practice settings. In J. T. Sherrill & M. A. Southam-Gerow (co-chairs), Implementation and outcomes in child/adolescent community mental health. Symposium presented at the meeting of the American Psychological Association, New Orleans, LA.
99. Southam-Gerow, M. A., Discussant (November, 2005). In A. J. Doss (Chair), Moving toward dissemination: An assessment of the youth therapy evidence base. Symposium presented at the meeting of the Association for Behavior and Cognitive Therapies, Washington, DC.
100. Southam-Gerow, M. A., Discussant (November, 2005). In B. F. Chorpita (Chair), Bridging science and community practice: An overview of the Child STEPs Clinic Treatment Project. Symposium presented at the meeting of the Association for Behavior and Cognitive Therapies, Washington, DC.
101. Chu, B. C., Weisz, J. R., & Southam-Gerow, M. A. (November, 2005). In S. A. Lauderdale (Chair), Anxiety across the life span: Diagnostic prevalence, service use, attitudes toward treatment, and treatment utilization of anxious children, young adults, and older adults in diverse settings. Symposium presented at the meeting of the Association for Behavior and Cognitive Therapies, Washington, DC.
102. Goodman, K., Newgen, J., Hershberger, A., Brown, R., Southam-Gerow, M., & Garner, P. (2005, November). Predictors of report discrepancies in the assessment of child anxiety and depression. Poster presented at the meeting of the Association for Behavior and Cognitive Therapies, Washington, DC.
103. Hershberger, A.M., Bettencourt, A. F., McLeod, B. D., Southam-Gerow, M. A., & Weisz, J. R. (2005, August). Measuring adherence in manual-based child-therapy: A preliminary test. Poster presented at the American Psychological Association Conference, Washington, DC.
104. Hinton, T., Garner, P., Southam-Gerow, M., & Mills, K. (2005, April). Bullying and victimization : The result of emotional incompetence? Poster presented at the Biennial Meeting of the Society for Research in Child Development, Atlanta, GA.
105. Southam-Gerow, M. A., Goodman, K. L., & Garner, P. W. (2004, November). Preliminary findings from the VCU Child Emotion Study: Relations of emotion and adjustment in a child sample. In J. Zeman (Chair), Emotion regulation: Implications for psychological maladjustment. Symposium presented at the Association for the Advancement of Behavior Therapy Convention, New Orleans, LA.
106. Goodman, K. L., Southam-Gerow, M. A., & Garner, P. W. (2004, November). Coping with peer rejection: Preliminary findings from a comparative Study of clinic-referred and non-referred children. Poster presented at the Association for the Advancement of Behavior Therapy Convention, New Orleans, LA.
107. Southam-Gerow, M. A., Chair. (July, 2004). Integrating interventions and services research: Progress and prospects. Symposium presented at the meeting of the American Psychological Association, Honolulu, HI.
108. Southam-Gerow, M. A., Hawley, K. M., Weisz, J. R., Chu, B. C., & Miller, L. M. (2003, November). Who stays in therapy? Prediction of treatment retention in community clinics. In M. K. Nock & A. L. Krain (Chairs), Issues related to the initiation of, and adherence to, treatments for childhood disorders. Symposium conducted at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.
109. Southam-Gerow, M. A., Hershberger, A. M., Nelson, C. A., & Miller, L. M. (2003, November). Single case design test of adapted CBT for childhood internalizing disorders. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.
110. Southam-Gerow, M. A., Silverman, W. K., & Kendall, P. C. (2003, November). Client differences and similarities in two childhood anxiety disorders research clinics. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.
111. Taylor, A. A., Francis, S. E., Chorpita, B. F., Southam-Gerow, M. A., & Lam, C. (2003, November). Examining differences between publicly and privately referred youth at a university-based clinic. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.
112. Chu, B. C., Flannery-Schroeder, E. F., Southam-Gerow, M. A., & Kendall, P. C. (2003, November). Therapist experience, therapeutic relationship, and treatment outcome in cognitive-behavioral treatment for anxious youth. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.
113. Southam-Gerow, M. A., Discussant. (2003, November). Innovative treatments of separation anxiety and panic disorder in youth. Symposium presented at the Association for the Advancement of Behavior Therapy Convention, Boston, MA.

114. Southam-Gerow, M. A. (2002, November). The development of emotion regulation. In B. Abbott (Chair), Incorporating emotion regulation into couple therapy. Symposium conducted at the Association for the Advancement of Behavior Therapy Convention, Reno, NV.
115. Southam-Gerow, M. A., Weisz, J. R., Valeri, S. M., McCarty, C. A., & Lau, A. S. (2002, November). Parent-youth agreement on youth depressive and conduct disorders: Rates and moderators of agreement. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Reno, NV.
116. Hudson, J. L., Southam-Gerow, M. A., & Kendall, P. C. (2002, August). Evaluation of a tripartite model of childhood anxiety and depression. Poster presented at the American Psychological Association Convention, Chicago, IL.
117. Southam-Gerow, M. A., Kendall, P. C., & Weersing, V. R. (1998, October). Why treatment fails: Factors associated with poor outcomes in a child anxiety clinic. Poster presented at the Kansas Conference on Clinical Child Psychology, Lawrence, KS.
118. Sugarman, A., Kendall, P., Flannery-Schroeder, E., Henin, A., Southam-Gerow, M., & Warman, M. (1996, November). Attrition from a cognitive-behavioral treatment for childhood anxiety disorders. Poster presented at the Association for the Advancement of Behavior Therapy Convention, New York, NY.
119. Warman, M., Kendall, P., Flannery-Schroeder, E., Southam-Gerow, M., Henin, A., & Sugarman, A. (1996, November). Anxiety disorders in youth: Diagnostic consistency across DSM-III-R and DSM-IV. Poster presented at the Association for the Advancement of Behavior Therapy Convention, New York, NY.
120. Kendall, P. C., Gerow, M. A., & Gosch, E. (1995, July). Two- to five-year follow-up of a cognitive-behavioral treatment for anxiety-disordered youth. Paper presented at World Congress of Behavioral and Cognitive Therapies Meeting, Copenhagen, Denmark.
121. Gerow, M. A., Kendall, P. C., & Gosch, E. (1994, November). Long-term follow-up: Treatment efficacy and client-perceived curative factors. Poster presented at the Association for the Advancement of Behavior Therapy Convention, San Diego, CA.
122. Panichelli, S. M., Kendall, P. C., Ashmore-Callahan, S., Levin, M. R., & Gerow, M. A. (1993, November). Social behavior scale for anxious children: Initial development and validation. Poster presented at the Association for the Advancement of Behavior Therapy Convention, Atlanta, GA.
123. Kendall, P. C. & Gerow, M. A. (1993, October). Bringing psychotherapy treatment research from the laboratory into the community. Paper presented in a Symposium at the American Academy of Child and Adolescent Psychiatry Convention, San Antonio, TX.

<u>Invited</u>

1. Southam-Gerow, M. A. (2020, March). *Effective exposure therapy for child and adolescent anxiety: Do's and Don'ts*. Workshop delivered via Zoom to Medipsy Psychological Services, Montreal, PQ.
2. Southam-Gerow, M. A. (2020, Feb.). Improving Services for Kids and Families Through Implementation Science: Working on the Irrigation System. Keynote talk at the Miami International Child & Adolescent Mental Health Conference, Miami, FL.
3. Southam-Gerow, M. A. (2020, Feb.). Clinical Strategies for Developing Socioemotional Competence in Youth. Workshop presented at the Miami International Child & Adolescent Mental Health Conference, Miami, FL.
4. Ward, A. M. & Southam-Gerow, M. A. (May, 2019). Evidence-based implementation: Virginia in a national context of systems transformation. Workshop presented at the Virginia Association of Community Service Boards Training & Development Conference, Williamsburg, VA. Southam-Gerow, M. A. (2018, August). Mental wellness in our schools: Obstacles and opportunities. Keynote delivered at Mental Health & Wellness Symposium, Richmond, VA.
5. Southam-Gerow, M. A. (2018, August). Anxiety in schools: How to recognize and intervene. Workshop delivered at Mental Health & Wellness Symposium, Richmond, VA.
6. Southam-Gerow, M. A. (2015, August). Building Emotional Competence: Helping Families Support Emotional Development. Invited workshop, Batavia, NY (invited by NYS OMH Children, Youth and Families Evidence-Based Practice Project Advisory Board).

7. Southam-Gerow, M. A. (2014, October). How dissemination and implementation science can change the world (and improve child/adolescent mental health). Keynote talk, National Conference in Clinical Child and Adolescent Psychology, Lawrence, KS.
8. Southam-Gerow, M. A. (2014, October). Building Emotional Competence: Interventions to Strengthen Child/Adolescent Emotion Regulation Invited workshop, Batavia, NY (invited by NYS OMH Children, Youth and Families Evidence-Based Practice Project Advisory Board)
9. Southam-Gerow, M. A. (2014, Mar-April). Building Emotional Competence: Interventions to Strengthen Child/Adolescent Emotion Regulation. Invited two-day workshop, Melbourne, Australia
10. Southam-Gerow, M. A. (2014, April). Building Emotional Competence: Interventions to Strengthen Child/Adolescent Emotion Regulation. Invited two-day workshop, Sydney, Australia.
11. Southam-Gerow, M. A. (2014, April). Building Emotional Competence: Interventions to Strengthen Child/Adolescent Emotion Regulation. Invited two-day workshop, Brisbane, Australia.
12. Southam-Gerow, M. A. (2010, January). Evidence-based practices for children's mental health: Using partnerships to adapt treatments in context. Invited talk, Department of Psychology, Boston University, Boston, MA.
13. Southam-Gerow, M. A. (2009, December). Evidence-based practices: How they fit into flexible packages of care for children. Invited talk, Governor's Conference on Children's Services Transformation, Richmond, VA.
14. Southam-Gerow, M. A. (2009, October). The why, what, and how of evidence-based treatments (EBTs) for children and adolescents and their families. Invited talk, Comprehensive Services Act meeting, Richmond, VA.
15. Southam-Gerow, M. A. (2009, September). Evidence-based practices for children's mental health: Using partnerships to adapt treatments in context. Invited talk, Department of Psychology, University of Virginia, Charlottesville, VA.
16. Southam-Gerow, M. A. (2009, September). Evidence-based practices for children's mental health: Managing and adapting practices. Fairfax County Public Schools, Fairfax, VA.
17. Southam-Gerow, M. A. (2009, September). Evidence-based practices for children's mental health: Using partnerships to adapt treatments in context. Invited talk, Fairfax/Falls Church Community Services Board, Fairfax, VA.
18. Southam-Gerow, M. A. & O'Connor, M. A. (2009, February). Using focus group interviews: Design and analysis issues in the context of a mixed methods study. Seminar presented for the Center for the Advancement of Research Methods and Analysis, Richmond, VA.
19. Southam-Gerow, M. A. (2007, June). Engaging and helping children with disruptive behavior problems and their families: Engagement strategies. Keynote speaker for the 1st Annual School-based Behavioral Health Conference, Honolulu, HI.
20. Southam-Gerow, M. A. (2007, June). Engaging and helping children with disruptive behavior problems and their families: Intervention strategies. Keynote speaker for the 1st Annual School-based Behavioral Health Conference, Honolulu, HI.
21. Southam-Gerow, M. A. (2007, June). Parent-based strategies for youth with disruptive behavior problems. Workshop at the 1st Annual School-based Behavioral Health Conference, Honolulu, HI.
22. Southam-Gerow, M. A. (2007, June). Child-based strategies for youth with disruptive behavior problems. Workshop at the 1st Annual School-based Behavioral Health Conference, Honolulu, HI.
23. Southam-Gerow, M. A. (2005, October). Anxious and acting out: Treating anxiety in troubled children. Keynote speaker for the 3rd Annual Fall Conference in Child Psychiatry, Richmond, VA.
24. Southam-Gerow, M. A. (2003, November). Adapting children's mental treatments for use outside the lab. Invited presentation at Child and Adolescent Anxiety Special Interest Group Annual Meeting, Association for the Advancement of Behavior Therapy Convention, Boston, MA.
25. Southam-Gerow, M. A. (2002, November). Top 5 reasons why we should care about effectiveness research (and how we can do it). Invited presentation at Child and Adolescent Anxiety Special Interest Group Annual Meeting, Association for the Advancement of Behavior Therapy Convention, Reno, NV.

26. Southam-Gerow, M. A. (2002, October). Evidence-based practice in community settings: The UCLA Project. Invited colloquium at the Department of Psychology, Virginia Polytechnic Institute and State University, Blacksburg, VA.
27. Southam-Gerow, M. A. (2002, October). Current findings and future directions on evidence-based treatments: Improving mental health service for children and families. Grand Rounds, Chesterfield County Community Services Board, Chesterfield, VA.
28. Southam-Gerow, M. A., Weisz, J. R., Connor-Smith, J. K., & Gordis, E. B. (2002, August). The UCLA Project: The nuts and bolts of an effectiveness trial. In S. Hinshaw (Chair), Empirically supported treatments: Transporting effective procedures into practice. Symposium conducted at the American Psychological Association Convention, Chicago, IL.
29. Southam-Gerow, M. A. (2000, Sept.). Current findings and future directions on evidence-based treatments: Improving mental health service for children and families. Intern seminar, Didi Hirsch Community Mental Health Center, Culver City, CA.
30. Southam-Gerow, M. A. (2000, August). Participant in A. Marrs-Garcia & A. Gelbwasser (Chairs), Career options in child and adolescent clinical psychology. Symposium conducted at the American Psychological Association Convention, Washington, DC.
31. Southam-Gerow, M. A. (2000, Aug.). Evidence-based child anxiety treatment in the UCLA community clinic project. In Chair (Chair), Making evidence-based treatments work in clinical practice. Symposium conducted at the American Psychological Association Convention, Washington, DC.
32. Southam-Gerow, M. A. (1999, Apr.). Empirically supported treatments for childhood psychological problems. In-service seminar, Saint John's Child and Family Development Center, Santa Monica, CA.
33. Southam-Gerow, M. A. (1998, Aug.). Empirically supported treatments for childhood psychological problems. Intern seminar, Child and Family Guidance Center, Los Angeles, CA.
34. Southam-Gerow, M. A. (1998, Aug.). Empirically supported treatments for childhood psychological problems. Intern seminar, Didi Hirsch Community Mental Health Center, Culver City, CA.
35. Southam-Gerow, M. A. (1998, Apr.). Issues in the treatment of anxiety-disordered youth. Seminar, Department of Psychology, California State University-Northridge, Los Angeles, CA.
36. Southam-Gerow, M. A. (1998, Jan.). Developmental psychopathology and treatment research on anxiety disordered youth. Brown Bag Seminar, Department of Psychology, University of California at Los Angeles, Los Angeles, CA.
37. Southam-Gerow, M. A. (1997, March). Anxiety disorders in youth: Clinical and developmental research directions. Colloquium, Washington State University, Pullman, WA.
38. Southam-Gerow, M. A. (1997, Feb.). Behavioral management principles for use with children in inpatient psychiatric settings. In-service training, Child and Adolescent Psychiatric Service, University of California-San Diego.
39. Southam-Gerow, M. A. (1996, Oct.). The development of emotion understanding. In-service training. Central Burlington Co. Region School District, NJ
40. Southam-Gerow, M. A. (1996, Oct.). The development of emotion understanding. In-service training, Mt. Holly, NJ School District.
41. Southam-Gerow, M. A. (1996, Aug.). Cognitive-behavioral treatment of youth. (Aug. 1996). Psychology Intern Training Seminar. VA Medical Center San Diego, CA.
42. Southam-Gerow, M. A. (1996, Apr.). The development of emotion understanding In-service training, Westhampton, NJ School District.
43. Southam-Gerow, M. A. (1996, Feb.). Coping with anger. Staff training seminar, Nehemiah Youth Mission, Philadelphia, PA
44. Kendall, P. C., Gerow, M. A., Panichelli-Mindel, S., & Flannery, E. (1994, Dec.). Anxiety disorders in youth: Assessment and treatment issues. In-service training, Burlington Co., NJ School District.

CLINICAL TRAINING, SUPERVISION, AND CONSULTATION ACTIVITIES

- **Co-Director, Anxiety Clinic at VCU**, (2003-2017). Provide supervision and co-direct a specialty anxiety clinic located within the training clinic for the VCU doctoral programs in clinical and counseling psychology. The Anxiety Clinic provides evidence-based assessment and intervention services across the lifespan.
- **Director of Quality and Performance, PracticeWise, LLC** (2010-2015). Coordinate trainer quality monitoring for PracticeWise, LLC, a private company that provides trainings and consultation to mental health providers, mental health agencies, and localities.
- **Training Director, PracticeWise, LLC** (2008-2010). Coordinated trainer development, managed trainer and consultant staff, coordinated staffing of trainings, and maintained and improved the training curriculum for PracticeWise, LLC, a private company that provides trainings and consultation.
- **Trainer, PracticeWise, LLC** (2005-present). Conduct trainings (n=35) for PracticeWise, LLC, a private company that provides training and consultation to mental health providers, mental health agencies, and localities. Trainings are provided in different approaches to evidence-based treatment. Training also involves the use of tools for identifying evidence based treatment strategies and tracking outcomes. Trainings (n=35) I have conducted to date are listed in the table.
- **Practice Consultant, PracticeWise, LLC** (2005-present). Conduct phone consultation with mental health providers, mental health agencies, and localities after trainings. Consultation involves clinical supervision as well as consultation on the use of the core PracticeWise tools.
- **Expert Consultant, Child STEPs Project, Phase III** (2008-2011). Provided consultation to clinical supervisors for a randomized controlled trial testing the effects of an evidence-based manual-based treatment for anxiety and depression. Also provided training to therapists participating in the trial. Study took place in the state of Maine.
- **Expert Consultant, Child STEPs Project, Phase II** (2004-2008). Provide consultation to clinical supervisors for a randomized controlled trial testing the effects of several evidence-based manual-based treatments for anxiety and depression. Also provide training to therapists participating in the trial. Study took place in Boston, MA and Honolulu, HI.

PROFESSIONAL AFFILIATIONS

- American Psychological Association (APA), Member
- APA, Division 12 (Society of Clinical Psychology), Member
- APA, Division 53 (Society of Clinical Child Psychology), Member
- Association for Behavioral and Cognitive Therapies (ABCT), Member

TEACHING

- Abnormal Psychology (undergraduate)
- Abnormal Child Psychology (undergraduate)
- Introduction to Psychology (undergraduate)
- Child and Adolescent Therapy (graduate)
- Clinical Practicum (graduate)

MENTORSHIP

Thesis (Committee Chair)

- Lauren Miller, VCU, 2006

- Alyssa Ward, VCU, 2004
- Kimberly Goodman, VCU, 2006
- Shannon Hourigan, VCU, 2009
- Alexis Quinoy, VCU, 2011
- Cassidy Arnold, VCU, 2011
- Adriana Rodríguez, VCU, 2012
- Julia Cox, VCU, 2014
- Selamawit Hailu, VCU, 2017
- Natalie Finn, VCU, 2019
- Gabriela Aisenberg, ongoing
- Juliet Wu, ongoing

Dissertation (Committee Chair)

- Alyssa Ward, VCU, 2007
- Ruth Brown, VCU, 2011
- Shannon Hourigan, VCU, 2012
- Alexis Quinoy, VCU, 2015
- Cassidy Arnold, VCU, 2015
- Carrie Tully, VCU PhD, 2015
- Adriana Rodríguez, VCU, 2016
- Julia Cox, VCU, 2019
- Sandra Yankah, 2022
- Natalie Finn, ongoing

Undergraduate (Committee Chair)

- Catherine Kirk, VCU Honors Thesis, 2006-2008

High School Intern/Mentor

- Stacey Jefferson, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2006-08
- Darrius Jones, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2008-09
- Caitlyn Patey, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2010-11
- Ruhan Farsin, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2014-15
- Abigail Mister, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2016-17
- Sarah Boyt, AP Capstone Mentor, Woodbridge Senior High School, Woodbridge, VA 2018-19
- Payton Beam, Maggie L. Walker High School Senior Mentorship Program, Richmond, VA 2019-20

PROFESSIONAL SERVICE ACTIVITIES

Grant Review Committees

- **Standing member,** National Institute of Mental Health Services Panel (SERV)
  2019-present
- **Ad Hoc Member**, National Institute of Mental Health Special Emphasis Panels
  Oct. 2011
  Feb. 2012, Oct. 2012

Sep. 2013
Feb. 2015, June 2015, Oct. 2015
June 2016, Sept. 2016,
Feb. 2017, June 2017, Oct. 2017
Feb. 2019, Mar. 2019
Jun. 2020

- **Ad Hoc Member**, PCORI Panels
  Aug. 2018
  Dec. 2018
  May 2019
  July 2019
- **Chair and Ad Hoc Member**
  National Institute of Mental Health Review Panel for RFA: Innovative Treatment Development (R21/R33), May 2014
  Training grant (R36/F31) panel, Oct. 2017
- **Ad Hoc Member**, Centers for Disease Control Review Panel CE8-003, April 2008.

Editorships

- **Associate Editor**, *Implementation Research and Practice* (2019-present)
- **Associate Editor**, *Journal of Consulting and Clinical Psychology* (2014-2022)
- **Associate Editor**, *Journal of Clinical Child & Adolescent Psychology*, (2012-2016)
- **Editor**, *In Balance (Society of Clinical Child and Adolescent Psychology [APA Division 53] Newsletter)*, 2004-2009

Masthead Editorial Boards

- *American Psychologist* (2021-present)
- *Clinical Psychology: Science and Practice* (2003-2012)
- *Journal of Consulting and Clinical Psychology* (2014-present)
- *Journal of Clinical Child & Adolescent Psychology* (2007-present)
- *Clinical Psychology & Psychotherapy* (2021-present)

OTHER SERVICE ACTIVITIES

Service to the Clinical PhD Program

- Member, Admissions Committee (2001-2007)
- Coordinator, Preliminary Examinations, (2002-2005)
- Member, Ad Hoc Committee on Clinical Training (2001-2002)
- Year-round clinical supervisor, Anxiety Clinic (2003-2017)
- Chair, Ad hoc Assessment Training Committee (2006-2007)
- Member, Ad Hoc Committee on the Clinical Preliminary Examination (2008-2009)
- Director, Clinical Child/Adolescent Concentration (2008-2010)

Service to the Psychology Department

- Chair (2018-present)
- Associate Chair (2016-2018)
- Director of Graduate Studies (2010-2018)
- Member, Personnel Committee (2008-2011, 2018)
- Psi Chi Advisor (2002-2008)
  - Psi Chi earned the University award for Student Organization Service Excellence in 2002-2003
  - I was named Student Organization Advisor of the Year for the 2003-2004 academic year
- Member, Undergraduate Committee (2004-2007)
- Member, Diversity Interest Group (2006-2011)
- Member, Faculty Development Committee (2002-2003)
- Chair, Third Year Review Committee for Terri Sullivan-2009-10
- Member, Third Year Review Committee for Natalie Shook-2010-11
- Chair, Search Committee for Clinical Child/Adolescent Position (2010-11)
- Member, Search Committee for Assistant Director of Undergraduate Advising Position (2010-11)
- Member, Search Committee for Three (3) Collateral Teaching Faculty Positions (2010-11)
- Chair, Search Committee for Department Service Center Director of Operations (2012)
- Chair, Search Committee for the Associate Director of Graduate Operations (2017)

Service to VCU's College of Humanities & Sciences

- Chair, Search committee, Three associate dean positions (2020)
- Member, Promotion and Tenure Committee, Dr. Tara Stamm, Department of Sociology, (2018-19)
- Member, Search Committee for Associate Dean of Research (2012)
- Chair, College Graduate Academic Committee (2012-2013, 2016-17)
- Member, College Graduate Academic Committee (2010-present)
- Member, Ad hoc grade appeal committee (2005)
- Member, Phi Kappa Phi Undergraduate Scholarship Review Committee (2003-2007)

Service to the University

- Search committee member, Dean of Graduate School search 2020
- Serve as a Recruitment Inclusive Champion for the department and college, 2017-
- Member, Work group on National Research Prominence (2017-2018)
- Member, Promotion and Tenure Committee, Dr. Andrew Daire, School of Education, (2016)
- Member, Electronic Thesis & Dissertation Task Force (2012-2014)
- Member, Promotion and Tenure Committee, Dr. Martin Reardon, School of Education, (2011-2012)
- Member, Ad hoc committee to charter Phi Beta Kappa Chapter for VCU (Aug. 2011-2013)

Service to the Profession: Local, State, & National

- President, Society of Clinical Child & Adolescent Psychology (American Psychological Association Division 53), 2020-2022
- Member, Governor's Behavioral Health Workforce Advisory Group, 2019-present
- Participant, National PTA-APA Mental Health Recognition Webinar: 2014
- Member, Y-APA Violence Prevention Workgroup: 2013
- Member, Revision of the Lesbian Gay Bisexual Transgender APA Resolution Work Group: 2012-2014
- Member, APA Committee on Children, Youth, and Families (CYF), 2012-2014
- Non-voting member, Board of the Society of Clinical Child and Adolescent Psychology (APA Division 53), 2004-2009
- Liaison for APA Division 53 to the APA Committee on Children, Youth, and Families (CYF), 2006-2011
- Planning committee member, Systems of Care and Evidence-Based Practices Conference, state-wide conference sponsored by the VA Department of Mental Health, Mental Retardation, and Substance Abuse Services and the Virginia Commission on Youth, 2007
- Advisory Board, Commission on Youth, served on advisory board for state legislative commission related to producing a biennial report on evidence-based treatments for children and adolescents, Aug. 2007-present
- Ad Hoc Advisory Committee Member, State Council of Higher Education for Virginia, participated in writing a report on state universities and colleges emphasis of evidence-based assessments and treatments, requested by state legislative body, Commission on Youth, Aug. 2011-Oct. 2011

Service to the Community

- Member, Vice-President (2005), and President (2006), Board for Agoraphobics Building Independent Lives (ABIL), (www.anxietysupport.org). Richmond, Virginia. (2004-2006)
- Vestry Member, St. Thomas' Episcopal Church, Richmond, VA: 2006-2008
- Trustee, Board of Trustees, Seven Hills School, Richmond, VA: 2011-2015
- Vice President, Board of Trustees, Seven Hills School, Richmond, VA: 2013-2014
- Secretary, Board of Trustees, Seven Hills School, Richmond, VA: 2014-2015
- Trustee, Board of Trustees, Orchard House School, Richmond, VA: 2014-2020
- Secretary, Board of Trustees, Orchard House School, Richmond, VA: 2016-2018