

Unlocking the “Prevention Services” in the Family First Prevention Services Act

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In recent years, there has been a deliberate shift to move our public systems that support child and family well-being upstream. These efforts reflect the growing consensus that true and lasting progress toward a nation where everyone can thrive requires we get to the root of the barriers that keep people and communities from achieving their potential. A foundational building block of this effort is the work happening to advance prevention strategies within child welfare agencies. By stopping child abuse and neglect before it happens, we can reduce adverse childhood experiences that too often have lifelong consequences on a child’s future. Many prevention programs are still working their way further upstream—currently focusing on secondary or tertiary prevention strategies that mitigate the risk factors or impacts of maltreatment. True primary prevention, which proactively supports the formation and stability of healthy and thriving families, remains an area of much needed investment. Expanding a continuum of prevention services that can ultimately eliminate child abuse and neglect requires public agencies and community partners to work together, in partnership with families, to achieve a paradigm shift in child welfare.¹ In this brief, we focus on the challenges and opportunities that the Family First Prevention Services Act (Family First) offers to accelerate the shift toward a prevention-oriented child well-being system.



act touches on a range of child welfare topics, its most transformational element concerns funding for prevention services. Under Family First, states, territories, and tribes can spend Title IV-E dollars directly on the prevention of child abuse and neglect, with the goal of keeping families together and out of the child welfare system. The law is limited to four specific types of prevention activities: in-home parenting programs, mental health services, substance abuse prevention and treatment, and kinship navigator services.

With its focus on prevention, Family First represents an ambitious and welcomed effort to target federal funds toward services that address the causes—and not just the consequences—of child maltreatment. By providing trauma-informed supports that address many of the underlying needs facing families, Family First is an important step toward moving child welfare upstream. While services are limited

Family First Prevention Services Act— A Federal Framework to Advance Prevention in Child Welfare

In February 2018, Congress passed the Family First Prevention Services Act (Family First) as part of the Bipartisan Budget Act of 2018. While the

¹ See APHSA’s [Transforming Family Well-Being Through Primary Prevention](#) brief, published in partnership with the Association of State and Territorial Health Officers (ASTHO) for an overview of strategies for partnering across systems to advance primary prevention.



to “candidates” for foster care—broadly defined as children at imminent risk of entry into foster care—the legislation offers a bridge towards a population-based primary prevention system that prevents issues before they happen and can support families in building and maintaining a safe and stable household.

To guide the use of prevention services, Family First established an evidence review process to identify and rate the effectiveness of programs to determine their eligibility for federal reimbursement. This clearinghouse—known as the Title IV-E Prevention Services Clearinghouse (IV-E Clearinghouse)—maintains a publicly accessible database of its evaluation findings, that dictates which prevention services are eligible for federal reimbursement and which prevention programs do not pass muster according to its inclusion criteria. The bar for approval is high: as of October 2021, nearly 40 percent of programs evaluated by the clearinghouse have been deemed ineligible for IV-E funding.

Family First also addresses how children are cared for if they do enter the child welfare system, by supporting state and local efforts to place children in the least restrictive setting that is appropriate for their needs. For children whose needs go beyond what a family-like placement can address, Family First establishes new federal standards for residential care programs, called Qualified Residential Treatment Programs (QRTPs). QRTPs must have trauma-informed models, work with families during and after care, and offer onsite nursing and clinical staff equipped to support

children with behavioral needs. For the purposes of this policy brief, we focus our attention on the strategies needed to fulfill the promise of the prevention components of Family First. However, overcoming the obstacles to advancing trauma-informed care in the least restrictive settings possible remains a critical priority to achieving the broader mission of Family First.

Getting to the Root of Challenges in Family First Implementation

Family First has the potential to transform the way children and families interact with the child welfare system. Yet, almost four years since enactment, having reached the October 2021 mark when new Family First restrictions on IV-E foster care maintenance payments take full effect, only 17 states have approved Prevention Plans and have begun drawing down IV-E funds for prevention services. States have taken concrete steps to get started and numerous changes are underway to reassess standards of care, build provider capacity, adapt funding and service models, update data collection and reporting standards, and train the child welfare workforce. At the same time, it is abundantly apparent that certain provisions of Family First have thrown unintended roadblocks in the path of agencies seeking to build their preventive services capacity.

Although Congress has tried to support Family First implementation through the 2019 Family First Transition Act (FFTA) and more recently through provisions in COVID-19 relief packages, the changes made—while important and helpful in their own right—offer temporary resources and flexibilities rather than resolving the underlying flaws in Family First’s design. Realizing the potential of Family First will require something more than short-term fixes. In this brief, we suggest a number of legislative and administrative solutions that we believe will enable child welfare agencies to leverage Family First to accelerate their shift toward a prevention-focused child well-being system.

Our recommendations focus on three key aspects of Family First implementation: the IV-E Clearinghouse, aligning systems through a primary prevention lens, and building capacity to successfully administer Family First.





The IV-E Clearinghouse: Re-centering Focus on People and Communities

As part of its emphasis on evidence-based practices, Family First created the IV-E Clearinghouse to evaluate and catalogue prevention programs. From a practical standpoint, the clearinghouse also acts as the arbiter in determining whether a given prevention program is eligible for Title IV-E reimbursement.



The IV-E Clearinghouse follows a detailed, multistep evaluation methodology—established through statute and put into practice through a Handbook of Standards and Procedures—to determine what services are eligible for review, their prioritization for review, and their evidence rating. To be considered for inclusion, studies must evaluate outcomes in at least one of the four eligible program areas set forth in statute, using a randomized or quasi-experimental group design with at least one intervention condition and at least one comparison condition. Studies are generally prioritized for review based on factors, including their design, sample size, duration of sustained effects, and number of measured outcomes. Modifications to adapt services to specific communities or via different modes must be separately considered by the IV-E Clearinghouse. Only studies that the clearinghouse determines to have “high” or “moderate” causal evidence and

meet specific sample size and administrative unit requirements are eligible for a positive rating from the clearinghouse.

The cumulative effects of these highly prescriptive requirements result in the IV-E Clearinghouse acting as a gatekeeper that often precludes underserved communities from accessing federal funding for many of the programs they most critically need. The issues tie back to both the parameters by which the IV-E Clearinghouse is bound and the procedures that have been put in place to implement it.

Fundamentally, the narrowness of the IV-E Clearinghouse to only consider mental health and substance abuse prevention and treatment services, in-home parent skill-based programs, and kinship navigator programs means that child welfare agencies are working with an incomplete deck of cards to solve complex, interwoven problems. Financial hardships and other disruptive life events are significant risk factors for child maltreatment and evidence clearly shows that when families receive concrete and economic supports, they are less likely to experience child maltreatment or result in a child being placed into foster care.² Our country’s ability to help families weather economic struggles is a key strategy to building a more equitable nation and is an essential ingredient for tackling disproportionality in child welfare. The high rates of poverty experienced by children of color continue to be a factor in the long-standing disparities in child welfare reports, investigations, and foster care placements by race.

The rules set forth in law that determine what eligible programs meet the rating criteria for inclusion in the IV-E Clearinghouse also raise major barriers to accessing the full array of services families need. The uniform reliance on randomized control trials and quasi-experimental program designs stacks the deck against culturally specific services that work with specialized populations and communities. Purveyors of these services typically lack the same access to academic researchers and institutions that are needed to fund such robust

2 Examples of literature that demonstrate the effectiveness of concrete and economic supports on child welfare outcomes include *The Influence of Concrete Supports on Child Welfare Program Engagement, Progress, and Recurrence* (Rostad, Rogers, and Chaffin, 2017); *Effects of Approach and Services Under Differential Response on Long Term Child Safety and Welfare* (Loman and Siegel, 2015); *Housing and Child Welfare: Emerging Evidence and Implications for Scaling up Services* (Fowler, Farrell, Marcal, Chung, and Hovmand, 2017)



evaluations. Further, the specialized treatment needs for culturally specific communities make it particularly onerous for programs to design interventions large enough to include comparison groups, meet sample size requirements, and conform to administrative unit requirements that necessitate that multiple providers deliver services. The sum of these challenges results in structural barriers that have contributed to the continued lack of availability of population and culturally specific services through Family First.

Prevention programs regularly rated favorably by other nationally recognized clearinghouses regularly are deemed ineligible by the IV-E Clearinghouse and many of the programs considered best practices in the substance use disorder treatment field are similarly found ineligible by the IV-E Clearinghouse. As of October 2021, 73 programs and services have been fully evaluated by the clearinghouse. Of them, 29, or nearly 40 percent, were found not to comply with Family First criteria. Another 18 received the lowest rating of “Promising.” Only 11, or just over 15 percent, were approved at the highest level of “Well Supported.” A review of clearinghouse ratings shows that in many cases, programs were found to be noncompliant not because they were poorly designed or shown to be ineffective, but because they had not been academically studied in the manner and to the degree that the clearinghouse’s methodology requires. These rules that narrowly constrict which prevention programs qualify for federal funding are further compounded by a IV-E Clearinghouse process that excludes the voices of people with lived expertise and makes it difficult to meet the clearinghouse’s charge to consider “culturally specific, or location- or population-based” adaptations of prevention programs. The Clearinghouse’s Handbook of Standards and Procedures does not currently prioritize such programs in its review and has no advisory body of people with lived expertise to consult with, relying only on literature reviews, environmental scans, and annual calls for programs and services to inform its process of selecting programs for review. HHS’ recent public comment to review the [Title IV-E Prevention](#)



[Services Clearinghouse Handbook of Standards and Procedures](#) offers an opportunity for ACF to use feedback received to more systematically examine and reform the clearinghouse review process through an equity lens.

This array of challenges proves particularly detrimental to tribal nations that operate under an agreement with a state IV-E program. Whereas tribes operating IV-E programs directly through the federal government are not subject to the practice criteria for evidence-based prevention services that apply to states, the same is not true when under agreement with states. This arbitrary difference makes it nearly impossible for impacted tribal communities to access culturally appropriate and inclusive services through Family First. Currently, there is only one tribal-specific program rated favorably in the IV-E Clearinghouse. This policy problem, in turn further compounds the long-standing disproportionality in the child welfare system to which tribal communities are subject.³

The challenges we must confront to reform the IV-E Clearinghouse are included into its very design; unlocking its potential to equip child welfare agencies with the tools they need to move upstream to prevent child maltreatment and combat the persistent disproportionality in the child welfare system requires bold and systematic action from Congress and the Administration.

3 For more information on disproportionality among tribal communities in child welfare, see <https://www.nicwa.org/wp-content/uploads/2017/09/Disproportionality-Table.pdf>



Recommendations: Title IV-E Prevention Services Clearinghouse

Amend the IV-E Clearinghouse Rating Criteria

Ensure that culturally or location- or population-specific programs and services are not bound by evaluation standards (RCTs and quasi-experimental designs) or sample size, replicability, and administrative unit requirements that make it particularly difficult for underserved communities to gain access to appropriate services suited to their needs.

Create a Pathway for States to Pilot Emerging Evidence-Based Practices

For promising programs and services that do not yet have sufficient evidence to meet the academic rigor set forth in the clearinghouse, states should be able to request waivers to implement such services should they meet an unmet need identified in their community. States should be funded and required to rigorously evaluate selected services and make findings available to support future consideration from the clearinghouse.

Broaden the Types of Services Eligible for Consideration

To ensure access to evidence-based services that promote individual and family protective factors that lesson the likelihood of child maltreatment: include concrete and economic supports proven to address poverty-based risk factors.

Exempt Services for Tribal Communities From Evidence Standards

Regardless of whether a tribal community directly administers a IV-E program or is under agreement with a state.

Prioritize Culturally and Location- and Population-Specific Services for Review

By amending the Handbook of Standards and Procedures to explicitly prioritize such services for review and for ensuing representation of such services within the IV-E Clearinghouse. One concrete step to advance this would be for the clearinghouse to adopt outcome measures that consider whether a service reduces

disproportionality when screening and prioritizing programs being reviewed.

Consult People With Lived Expertise in the IV-E Clearinghouse Review

By creating a formal structure for the clearinghouse to consult people with lived expertise to inform the process for identifying and reviewing services.

Build and Align the Evidence Base to Include Best Practices in Substance Abuse and Mental Health Programs in the Clearinghouse

Whereas the substance abuse and mental health field has well-established best practices in evidence-based approaches, these services do not meet clearinghouse standards, in part due to the lack of focus of past research on child welfare outcomes. Concerted efforts should be made to ensure states have access to these approaches and the funding and research connected needed to rapidly build on the evidence to measure child welfare outcomes of such programs.





Prevention-Centered Cross-Systems Alignment

Family First does not remove a critical barrier that has long impeded progress toward a comprehensive prevention-led child well-being model: the lack of true cross-program alignment of financing and policies that promotes wrap-around support for families experiencing hardship. Such coordination would enable agencies and providers to collaborate across institutional and fiscal boundaries to evolve innovative and effective services that draw on the strengths and resources of multiple organizations. The programs most useful to promoting and maintaining well-being (e.g., Medicaid, public health, income supports, education) are administered by separate agencies and teams, siloed from child welfare. The current service delivery structure makes it challenging to harmonize funding, policies, and program models. Though there have been many efforts to improve the way health and human services systems align,⁴ fundamentally different programs supporting the same families leave states and localities to piece together funding sources, make sense of changing regulations, and struggle to build a cohesive, family-centered, evidenced-based array of services for children.

One prominent example would be the significant misalignments between Medicaid and Family First. Guidance issued by the Administration for Children and Families (ACF) shortly after passage of Family First clarifies that IV-E funding be the “payor of last resort” detailing that if any other source of funding, including private insurance, can pay for the service, it should be used before IV-E is used. This guidance reinforced Medicaid’s role as a critical part of financing prevention services but included little planning for how to support state and local agencies in aligning across funding streams to build a continuum of supports to families at risk of child welfare involvement. Furthermore, while Medicaid pays for many prevention services eligible for Family First, Medicaid funding cannot be counted toward federal requirements that at least 50 percent of evidence-based programs used by states are rated “well-supported” by the clearinghouse. Many states currently rely on Medicaid to fund

mental health, substance use, and in-home parent services now eligible for reimbursement through Family First. The result is a federal structure that leads to siloed data collection and reporting that will make it harder for states to focus on evidence-informed, cross-system investments.

Though Family First was never intended to tackle these formidable and long-running problems, the fragmentation of programs key to its success complicates its mission considerably. Meaningful and lasting progress to build a family-centered primary prevention framework requires a rethinking of how policies and technical assistance span across federal agencies with shared objectives, strategies, and outcome metrics. Now we can get started tackling the near-term challenges impeding Family First implementation while working toward the long-term vision on which we must keep our focus.

Recommendations: Prevention-Centered Cross-System Alignment

Fix Siloed Family First Evidence Requirements

By allowing states to count Medicaid-funded evidence-based practices toward states’ 50 percent well-supported requirements

Clarify Payor of Last Resort Rules

Addressing responsibilities and cost-sharing structures between IV-E and Medicaid payments.

Strengthen Coordination Between ACF, CMS, and SAMHSA

To develop joint guidance and technical assistance that aligns all the tools available through Medicaid, public health, and child welfare for the purpose of coordinating care for children who are at risk for or experiencing abuse or neglect.

⁴ See, for example, the [Joint CMS and ACF Information Bulletin on Family-Focused Residential Treatment](#) and the collaborative [National Center on Substance Abuse and Child Welfare](#).



Gearing Up to Meet Family First Administrative Requirements

Family First requires considerable administrative capacity-building for agencies to reengineer their practice, policy, and funding mechanics. Take, for example, new prevention data collection and reporting requirements. States must now report the services that were provided to each child, the cost of services, the duration, the status of each child 12 months after the prevention plan start date, whether the child entered foster care within two years of the prevention plan start date, whether the child is pregnant or parenting, and certain demographic characteristics.

Satisfying these requirements alone will require significant IT work and restructuring for states, and those states with county-administered models of service delivery will face especially daunting challenges. While some Family First data elements are already tracked in child welfare information systems, they are not necessarily defined or tracked in the child-specific manner Family First requires. Capacity to enhance data collection and develop new extract reports varies widely across agencies, many of which are still grappling with inflexible, decades-old legacy systems. While many states are in the midst of replacing their old SACWIS systems with modern solutions under CCWIS, these are very long-term projects that will not help with Family First needs any time soon. Interoperability challenges further compound the problem: building bridges to pull data from external provider systems, or from county systems in county-administered states, is rarely easy or quick. These technical challenges are interrelated with critical policy and reporting questions that need to be resolved. Whereas claiming for IV-E prevention services is generated from CCWIS systems, candidates for prevention services typically originate in and are tracked through other people-serving systems. Charting a pathway for how data from other sources can be used to document eligibility and claim reimbursement under IV-E prevention funding—and doing so in a manner that is family-centered and trauma-informed—remains an important need for the field to responsibly and equitably maximize Family First funding.

At the same time, policy and program teams must undertake the difficult work of reimagining service delivery infrastructure and producing defensible, evidence-based prevention plans attuned to each jurisdiction's unique needs. Contractual relationships with private providers must be re-evaluated and perhaps renegotiated. New facility and professional licensing procedures need to be promulgated and approved. Fund accounting and financial reporting processes need in-depth attention. In some cases, legislative or state executive action are still needed to put the necessary regulatory changes or capital investments in place.

For many agencies implementing Family First, this is all a heavy lift—all the more so in the midst of a slow-burning pandemic that has placed unprecedented stresses on human services organizations. Much work remains to be done before most states, territories, and tribes have the infrastructure in place to actually deliver Family First-funded services.

Recognizing the administrative burden and need for additional support to implement Family First, Congress passed, in December 2019, the Family First Transition Act (FFTA). The FFTA gave states some relief from Family First evidence requirements by temporarily suspending the mandate that 50 percent of prevention services carry the highest clearinghouse rating of “well-supported.” Instead the mandate will be phased in, with lesser evidence ratings initially counting toward the 50 percent requirement, by 2024. The FFTA increased funding to the clearinghouse by \$2.75 million and provided \$20 million for grants aimed at accelerating development of kinship navigator programs. Another \$500 million in one-time, flexible funding was added to help states, territories, and tribes defray internal costs in migrating to Family First; this money was offered without a match requirement. Other provisions included easing the transition for jurisdictions that participated in expiring Title IV-E Waiver Demonstration Projects. Later, in response to the COVID-19 pandemic, Congress enacted temporary flexibilities through the Supporting Foster Youth and Families During the Pandemic Act to waive state match requirements for IV-E prevention services and waive the evidence requirement for kinship navigator services during the public health emergency.⁵

5 The Supporting Foster Youth and Families During the Pandemic Act was incorporated as Division X of the Consolidated Appropriations Act of 2021.



These short-term solutions offered important support to states during the years leading up to Family First implementation and during the height of the COVID-19 pandemic. However, the capacity-building work to create sustainable state models for IV-E prevention services will continue beyond their scope—pandemic-era state match flexibilities expired well before many states had begun claiming IV-E prevention funding and FFTA supports do not address much of the structural flaws that have led to Family First’s slow rollout to date. Taking a long-term view, further work is needed to help Family First take root in solid ground as a permanent, growing feature driving child welfare upstream.

Recommendations: Gearing Up to Meet Family First Administrative Requirements

Extend Temporary Enhanced Matching of Prevention Services During Early Family First Implementation

Continuing the 100 percent federal match for IV-E prevention services, currently authorized through the public health emergency, through September 30, 2023, and aligned with the transition of evidence standard requirements set forth in the Family First Transition Act.

Provide Dedicated Technical Assistance and Guidance on Aligning CCWIS and Non-CCWIS Systems

To help child welfare agencies establish the right linkages and appropriate guardrails across systems to identify and track eligible candidates for IV-E prevention services and to claim funding.

Fulfilling the Promise of Family First

The Family First Prevention Services Act embodies years of research into what does and does not work in child welfare practice. By funding prevention services, shifting away from traditional group congregate care, imbuing child welfare models with a trauma-informed perspective, and insisting on evidence-based program designs, Family First seeks to dramatically improve outcomes for children and families.

As is to be expected with any new statute of such complexity and high ambition, Family First will require refinement as states, territories, and tribes start to translate it into practice. COVID-19 has amply demonstrated that changing conditions on the ground can upend even the best-laid plans; even without a global health emergency, the logistics of reengineering the existing service and administrative infrastructure for Family First would be truly daunting. While federal funding is essential, it is only the beginning of what is certain to be a long transition process, one that will surely include needed adjustments along the way.

There is every reason to believe that introducing a federally funded, trauma-informed, prevention-focused framework into child welfare practice can make a dramatic improvement in the lives of many families and children. For such a move to succeed, it must speak to the unique needs of families across the full spectrum of languages, cultures, regions, and economic circumstances that make up the American landscape. Through evidence-informed, community-centered planning, it must also recognize and elevate effective prevention programs, tapping into the tremendous creativity and innovative thinking of families and human services professionals.

To fulfill the promise of Family First, we must remove the roadblocks that are impeding child welfare organizations, and the system they work alongside, from making full use of what it offers. Our recommendations are aimed at refining what is, in many respects, a breakthrough statute, one with enormous potential to reduce the number of children in care, and foster cross-system coordination that supports healthy, thriving families.



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