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Obstacles to and Facilitators of Services in Child Welfare in the Context of the Family First Prevention Services Act

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Obstacles to and Facilitators of Services in Child Welfare in the Context of the Family First Prevention Services Act

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Abstract

OBSTACLES TO AND FACILITATORS OF SERVICES IN CHILD WELFARE IN THE CONTEXT OF THE FAMILY FIRST PREVENTION SERVICES ACT

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The child welfare system has generally focused on child wellbeing and protection in the context of abuse or neglect allegation, supporting caregivers with child rearing, and finding a stable, permanent home for children. Because children and caregivers involved with the child welfare system typically have complex needs, public departments of social services often collaborate with other entities to provide services to families. However, connecting families to services has often been difficult, with many barriers along the way that prevent families from receiving the services they need. The enactment of the Family First Prevention Services Act (FFPSA) in 2018 aimed to increase the availability of and accessibility to high quality evidence-based prevention services for families, but barriers still remain along the pathway. This study used Andersen's Healthcare Utilization model to examine barriers to and facilitators to the service pathway in the context of FFPSA implementation in Virginia. Quantitative data were provided by the Virginia Department of Social Services (VDSS), and qualitative data were gathered from focus groups with relevant stakeholders including: (a) families, (b) service brokers, (c) provider agency staff members, and (d) state agency staff members. Quantitative results revealed a significant relationship between rurality and Title IV-E service eligibility (i.e., foster care candidacy determination) ($B = 2.51$, $\text{Exp}(B) = 12.32$, $p = .02$). Additionally, results revealed a significant relationship between race (i.e., multiracial status) and Title IV-E service utilization ($B = -1.81$, $\text{Exp}(B) = 0.16$, p .023), and age and Title IV-E service utilization ($B =$

0.10, Exp(B) = 1.11, $p = .002$). Qualitative results revealed several themes: a) infrastructure factors, b) workforce factors, c) funding logistics, d) family-specific factors, e) service specific factors. Several findings emerged from the study, including the need for (a) a new data system to increase data quality, (b) more clear guidance from state and federal agencies to local workers, (c) continued initiatives to support and grow the workforce initiatives, and (d) collaboration from other social service agencies to reduce barriers for families needing services.

Introduction

Connecting Child Welfare Families to Services

Many children who come into contact with the child welfare system have complex behavioral health needs that unfortunately remain unmet (Horwitz et al., 2012; Stein et al., 2016). About one of every two children involved in the child welfare system meets criteria for mental health disorders such as disruptive disorder, conduct disorder, oppositional defiant disorder, anxiety and depressive disorders, ADHD, or PTSD, a proportion four times higher than the general population (Bronsard et al., 2016). Additionally, children with a history of an out-of-home placement are over two times more likely to report a mental health problem than children without a history of out-of-home placement (Bronsard et al., 2016). Similarly, caregivers of children involved with the child welfare system typically have extensive unmet mental health needs, with over half meeting criteria for major mood disorders, which can impact parenting skills and child wellbeing (Burns et al., 2010; Libby et al., 2006; Marcenko et al., 2011; Oyserman et al., 2000). Caregivers with mental health challenges are also more likely to be involved in the child welfare system than those without (Park et al., 2006). Further, caregiver mental health challenges can become obstacles for engagement in case planning, decision making, and other child welfare related services (Sheppard, 2002).

Despite the high prevalence of mental health needs among both children and caregivers involved with the child welfare system, only one in ten children receive needed mental health services (Raghavan, 2010). Further, only one third of all children entering the system are assessed for mental health needs (Raghavan, 2010) and only about 25-33% of caregivers with mental health needs receive necessary services (Burns et al., 2010; Libby et al., 2006). Although the child welfare system has historically attempted to connect children and families to mental health interventions, many challenges remain along the service pathway that prevent them from receiving needed services. Andersen's healthcare utilization model highlights a variety of important factors that facilitate or create challenges for families seeking services, including individual and contextual level predisposing, enabling, and need-related factors (Andersen, 2008). Individual predisposing factors include demographics and attitudes toward mental health care, and oftentimes, individuals who belong to racial/ethnic minority groups are skeptical about mental health services and have lower rates of mental health service utilization (Altman, 2003; Cairney & Wade, 2002; Rosen et al., 2004; Staudt, 2006). Individual enabling factors include the resources available to the client such as transportation, and need factors include perceived and assessed mental health needs which may impact help-seeking behaviors (Andersen, 2008).

To achieve positive outcomes for caregivers and children involved in the child welfare system, it is integral that they both are engaged in behavioral health interventions, as connecting caregivers to mental health care in their communities can increase the chances of family reunification and reduce child maltreatment (Marsh et al., 2006). The creation of the Family First Prevention Services Act (FFPSA), described shortly, aimed to leverage government funding to facilitate the connection between families and necessary high quality evidence-based services.

Background of the Family First Prevention Services Act (FFPSA)

The FFPSA was enacted in 2018 as part of the Bipartisan Budget Act with the goal of revolutionizing the approach of the nation's state-based child welfare agencies and revised many sections of Title IV-E (National Center on Substance Abuse and Child Welfare, n.d.). Historically, federal funding has focused on helping children already in the foster care system, and the FFPSA aimed to expand the use of federal funds to include evidence-based prevention programs to support and strengthen families with children at-risk of being removed from their homes (Bipartisan Budget Act, 2018). In short, the FFPSA greatly expanded the reach of funding for services in the child welfare system, permitting a wide range of prevention-related services designed to provide services to families without removing the children from homes. To achieve this goal, the FFPSA authorized the use of Title IV-E funds for prevention services such as mental health treatment, and in-home parenting skills training. The FFPSA also allowed for states to use Title IV-E funds to target caregiver substance abuse through the placement of children with their parents in a family-based substance abuse residential treatment facility (Weiser & Spielfogel, 2021). The FFPSA also sought to move away from non-familial congregate or group care, emphasizing instead family foster homes and kinship care (FFPSA, 2018).

The FFPSA also aimed to improve the quality of available services through new requirements for evidence-based programs (EBPs), a goal that led to the creation of the Title IV-E Prevention Services Clearinghouse (FFPSA, 2018). The Clearinghouse uses a systematic review process to examine the research on child and family programs and provide an objective rating (does not currently meet criteria, promising, supported, and well supported) for each prevention service EBP (Garcia et al., 2020). Each EBP is required to: (a) be trauma-informed, (b) have a manual, (c) not have a risk of harm, and (d) meet a series of research standards to demonstrate reliable and valid outcome measures. Additionally, the FFPSA encouraged states to focus on transitioning their available services to only include well-supported EBPs. For fiscal years 2020 and 2021, the Family First Transition Act allowed for FFPSA funds to be used for promising, supported, or well-supported programs. However, for FY 2022 and 2023, 50% of FFPSA funding must be towards supported or well-supported programs, and by FY 2024, 50% of FFPSA funding must be toward only well-supported programs (H.R. Resolution, 2020).

Successful FFPSA implementation is designed to increase the availability of and accessibility to high quality evidence-based prevention services for families. The logic model that follows is that availability and access leads to family engagement in services, successful service completion, and in the end, families receiving the supportive services they need to take care of their children in their own homes. To understand the significant changes designed to ensure from the FFPSA, a brief review of the approach of the child welfare system prior to FFPSA is instructive.

Background of Child Welfare Services Before FFPSA

The United States public child welfare system comprises a group of four different types of services: (a) child protection services (CPS), (b) services and support for families, (c) foster care, and (d) adoption (Petersen, 2014). Broadly speaking, the child welfare system focuses on the protection of children, generally in the context of investigation of allegations of abuse or neglect. The system also has the twin goals of supporting families in childrearing and achieving a permanent home for children. Public departments of social services or child and family services often work with other entities such as private agencies and community-based organizations to provide services to families to help strengthen them and enhance child safety and wellbeing (Children’s Bureau, 2022). The Children’s Bureau, nested within the U.S. Department of Health and Human Services’ Administration for Children and Families (ACF), works to implement Federal child and family legislation through the development of programs. Although the Federal Government provides program funding and legislative initiatives to states, each state is primarily responsible for their own state’s child welfare services (Children’s Bureau, 2022). As such, each state has their own set of laws, regulations, and systems that guide definitions of child abuse and neglect, individual reporting obligations, and the required interventions (Children’s Bureau, 2022).

In 2000, the United States Department of Health and Human Services (US DHHS) began conducting statewide assessments called child and family services reviews (CFSRs) to monitor state child welfare programs related to key federal goals (i.e., safety, permanency, and wellbeing; Ahn et al., 2017). CFSRs evaluate state policies and practices through qualitative and quantitative data that involve case reviews, interviews with families and their children, and interviews with community stakeholders to analyze outcomes and systemic factors. Outcomes include whether children in state custody are protected from maltreatment and neglect, receiving adequate physical and mental health services, living condition stability, family relationship preservation, and family capacity to care for their children effectively, and systemic factors include case review, quality assurance, child welfare staff and agency community responsiveness, and training for parents and stakeholders (Petersen, 2014). Once strengths and weaknesses are identified, if a state is not performing substantially, a Program Improvement Plan (PIP) is developed and implemented and if a state is not able to achieve required improvements, they sustain penalties under Federal regulation (Ahn et al., 2017). The first round of reviews between 2001 and 2004 found that there were no states that were complying substantially to standards and there was a major gap in services that served children in their own homes, requiring all states to follow PIPs (Petersen, 2014). CFSRs continue to be conducted, with the most recent occurring from 2015-2018 and the fourth round of CFSRs expected to launch in FY 2023 (Children’s Bureau, 2015).

Because CFSRs are focused on ensuring that state-level provision of services leads to the fulfillment of safety, permanency, and well-being outcomes for children and families, they are also integral to the evaluation and improvement of the services pathway that connects families to required services to achieve these outcomes. Another key piece to the service pathway is service funding–and in the case of child welfare, funds from Title IV-E play a major role.

Title IV-E Funding Before FFPSA

Title IV-E of the Social Security Act is the largest federal stream of child welfare funding and was enacted in 1980 to allow states to seek federal reimbursement for foster care, adoption assistance, and kinship guardianship assistance for children who meet federal eligibility criteria along with assistance for youth transitioning out of foster care to adulthood (Stoltzfus, 2012). The Title IV-E Foster Care Program provides states with partial reimbursement for costs associated with maintenance payments for shelter, food, and clothing, child placement services and administrative costs related to foster care, and expenses for training staff and foster parents (Child Trends, 2018).

In addition to Title IV-E funding, The Family Preservation and Family Support Provisions of the Social Security Act in 1993 (creating Title IV-B Part 2) was passed to encourage states to allocate funding to programs aiming to keep children from being removed from their families and promote reunification in a more timely manner. Programs included community-based family support programs, drop-in centers, early screening, and programs working to strengthen at risk or in crisis families. However, this funding was very limited and states varied immensely in how this was implemented, how funds were allocated, whether or not program models were implemented, and which populations were targeted through programming (Petersen, 2014). Additionally, although the legislation required Family Preservation and Family Support Programs to be evaluated by the Secretary of Health and Human Services, the variations in implementation made evaluation difficult (Petersen, 2014).

To be deemed eligible for funding under the original Title IV-E foster care program guidelines, a child must meet all four of following criteria (a) be in an out-of-home placement, (b) have been removed from a *needy* family (as defined by public assistance guidelines from 1997), (c) placed into care through voluntary placement or a judicial determination, and (d) be in licensed or approved foster care placements (Jordan & Connelly, 2016). Although Title IV-E funding provided a large amount of federal funding for states, the original eligibility guidelines for Title IV-E funding were viewed as problematic because many children in foster care were not deemed eligible in their states for Title IV-E due to reasons such as not meeting financial criteria or not having been removed from their home yet but still requiring child welfare services. To mitigate these, a Child Welfare Waiver program was first authorized in 1994 under Section 1130 of the Social Security Act and reauthorized again in 2006 under the Adoption and Safe Families Act and in 2011 under the Child and Family Services Improvement and Innovation Act. Title IV-E waivers gave states the ability to use Title IV-E funds more flexibly; for example, the funds could be used before children were removed from their home. The waiver program opened the system to innovative welfare approaches, initiatives, and interventions (Jordan & Connelly, 2016). Between 2012 and 2019, 27 states implemented Title IV-E waivers which delinked the Aid to Families with Dependent Children (AFDC) assistance program eligibility criteria (Title IV-E Spending - Child Trends, 2018).

Title IV-E waivers were introduced to generate new knowledge and drive the implementation of alternative service strategies such as services for caregivers with substance use disorders, subsidized guardianship/kinship permanence, and intensive in-home and reunification services (James Bell Associates, 2021). Further, this legislation put more federal focus on implementing and evaluating established or emerging EBPs and programs and the 27 state waivers included a variety of programs and services such as trauma-informed services, family-centered services, intensive case management, and different organizational initiatives (James Bell Associates, 2021). The waivers also required evaluations with process, outcome, and cost analysis components. To be considered for a waiver, states needed to indicate explicit intent to increase permanency for all foster care children, increase positive outcomes for children in their homes and community, and prevent child abuse and neglect and the reentry of children into foster care (James Bell Associates, 2021).

Many of the states that implemented waivers demonstrated both statistically significant and positive findings in child safety, permanency, and wellbeing, such as fewer out of home placements, less maltreatment reports, reduced placement duration, increased placement stability, more placements with relatives or kin, increased parenting knowledge/skills, and reduced stress/anxiety among parents and children (James Bell Associates, 2021).

The Title IV-E waivers influenced Congress to use the FFPSA to make large changes to the original Title IV-E program such as limits on foster care payments for children placed in congregate care and authorize open-ended funds to pay for evidence-based mental health/substance abuse, in-home parenting skill building, and kinship navigator programs (James Bell Associates, 2021). Further, the evaluation component of the Title IV-E waivers demonstrated the feasibility of rigorous child welfare program evaluations and encouraged effective innovations in child welfare programming through evaluations (James Bell Associates, 2021). The push for rigorous evaluation of child welfare programming is now reflected in the FFPSA.

Child Welfare in Virginia: Implementation of In-Home Services and The Family First Prevention Plan

As described, the FFPSA ushered in a new era of child welfare programming, codifying emphases on keeping children in their homes, with their families or in kinship care, and leveraging available funds to support families much more broadly defined than past federal law and regulation. The focus for child welfare under FFPSA broadened from child protection to include and emphasize family stability and capacity. Even though the FFPSA was enacted more than four years ago, implementation has been slow and challenging for most states. Although designed to create a clear pathway for families to receive quality services to support them in their childrearing, all states have had to work through both common and unique challenges as they aim to optimize the service pathway for families.

In most states, the responsibility of administering child welfare services to families is given to the state department of social services and thus, changes to the child welfare system are also implemented at a state level and are standardized across localities. However, Virginia is one of nine states in which local or county level agencies are responsible for administering social services; the other eight are North Carolina, California, Colorado, New York, Minnesota, North Dakota, Ohio, and Pennsylvania (Marsh-Carter et al., 2018). Such state systems are referred to as county-administered (Child Welfare Information Gateway, 2018). County-administered states face implementation challenges for laws like FFPSA, as there is much less central control over the process. In Virginia, the Virginia Department of Social Services (VDSS) oversees the administration of social services, but the Local Departments of Social Services (LDSS) are the entities that actually administer and deliver services to children and families (Marsh-Carter et al., 2018). As a result, local agencies have considerable sway over the success of FFPSA (or any initiative). And because Virginia has 133 localities (95 counties and 38 cities), there is considerable room for variability in implementation.

The federal CFSR for VDSS found that an area of weakness in local DSS practice was a lack of service provision to families with identified needs because of difficulties in engaging families in services. This led to the development of the PIP by VDSS, which included the new In-Home model as a solution for a more family-focused method of delivering services (OCS, 2021). The new In-Home model incorporates requirements from FFPSA, and all child protective services, foster care prevention services, and cases with court-ordered foster care prevention services, are now served through this model (OCS, 2021).

In Virginia, there are two doors through which children can enter foster care: (a) a founded abuse/neglect investigation or (b) being in need of services (including foster care prevention or behavioral/emotional treatment) (Wilson, 2022). The Child in Need of Services (CHINS) status is determined through a court determination or a CHINS checklist completed by a Family Assessment and Planning Team (FAPT) (Wilson, 2022). Foster care funding in Virginia comes from two sources: Title IV-E and the Children's Services Act (CSA). FFPSA service requirements for Title IV-E cover mental health services, substance use disorder services, and in-home parenting skill-based programs (VDSS, 2021). The CSA is designed to work in tandem with Title IV-E foster care funds, and provide funding for individuals and services who do not meet requirements for Title IV-E foster care prevention. Additionally, Title IV-E funding is considered the last resort funding for prevention services that would have been paid for by private insurance or Medicaid (VDSS, 2021). The CSA was enacted in Virginia in 1993 and established a single state pool of funds combined with local community funds, to pay for services for at-risk youth and families (Children’s Services Act, 1993). The Office of Children’s Services is the state agency that implements policies that support the Children’s Services Act (CSA).

The CSA also emphasized a holistic and collaborative system of care for services for children and led to the creation of FAPTs. FAPTs are multidisciplinary and interagency teams that consist of representatives from the family, service providers, local departments of social services, schools, and Court Services Units that work to assess a family, determine eligibility, and create an individual family service plan to recommend services (OCS, 2021). FAPTs are responsible for conducting the Child and Adolescent Needs and Strengths (CANS), a structured, evidence-based functional assessment mandated by the CSA and used to identify a family’s strengths and needs, plan, manage, provide services, measure progress, and determine which services a child/family should receive. It also aims to enhance communication between families and their service providers. (OCS, 2021). Under the In-home model, each LDSS uses the Structured Decision Making (SDM) Risk Assessment to open cases that are classified as “high” or “very high” (OCS, 2021). VDSS also requires the CANS to be administered to children and caregivers in the In-Home model within the case opening, and for all In-Home cases to be reviewed by a multidisciplinary team in order to access Title IV-E prevention funds through the FFPSA (OCS, 2021).

Identification and Referral of Eligible FFPSA Families

The FFPSA changed the eligibility criteria for Title IV-E funding, which now includes children who are foster care candidates (VDSS, 2021). A “Candidate for Foster Care" is a child in a prevention plan who is at imminent risk of entering foster care and is able to stay in their own home safely or in a kinship placement as long as necessary services or programs that prevent the child from entering foster care are provided to the family (CSA, 2021). The FFPSA does not define exactly what "imminent risk for entering foster care" means and places responsibility on each state to define the term. Virginia's definition is: "a child and family's circumstances demand that a defined case plan is put into place within 30 days that identifies interventions, services and/or supports and absent these interventions, services and/or supports, foster care placement is the planned arrangement for the child" (VDSS, 2021). For families to receive prevention service EBPs under FFPSA, they must be referred to a service provider for a specific EBP that is identified as the best fit for them. Once a child and family is designated as a "Candidate for Foster Care," they are eligible for foster care prevention services through any funding source. The implementation of FFPSA does not prevent the provision of other In-Home foster care prevention services through other funds, and there are also a wide range of other supports such as financial assistance, housing, transportation, or mentoring (OCS, 2021).

The initial VDSS Prevention Plan implemented in Virginia on July 1, 2021 included Parent Child Interaction Training (PCIT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) (OCS, 2021). These three programs are all rated as well-supported by the Title IV-E Prevention Services Clearinghouse. A revised Virginia Prevention Plan is under review and will include HomeBuilders (HB), Motivational Interviewing (MI), Family Check-Up (FCU), High Fidelity Wraparound (HFW), and Brief Strategic Family Therapy (BSFT). Of these, all are well-supported with the exception of HFW, which is considered promising.

Family First Services Pathway in Virginia

The FFPSA created new ways for child welfare agencies to assess, plan, and deliver services to families. One notable goal was to facilitate a prioritized path from initial identification of a family needing support to engagement in quality, evidence-based services. Although such a path is easy to describe in the abstract, a myriad of challenges face those seeking to make the path easily traversed. The current study sought to shed light on Virginia's efforts toward this path by examining performance of the process beginning with initial identification and then across the several checkpoints along the path, including: (a) identified family referred to an EBP; (b) family initiation of services in the EBP, and (c) family completion of EBP services. Due to a variety of barriers, a family could fall off the path at any of these checkpoints. Though the focus on EBPs is relatively unique to FFPSA, the basic flow from identification to referral to service initiation to service completion is a common service flow in child welfare. In the following section, what is known about barriers and facilitators to the described flow process is reviewed.

Child and Family Referral to Services

In the child welfare system, referrals are pivotal and influence family reunification - if families are not referred to and thus connected to services that they need to address risk factors and family functioning, problems often occur fulfilling case plan requirements, thereby leading to a delay in reunification (Lovato-Hermann et al., 2017). Additionally, children and families need referrals to be linked to providers that can provide services to them. The literature indicates that children of color have been overrepresented in the child welfare system for over 50 years, a phenomenon called racial disproportionality (Cénat et al., 2020; Dettlaff & Boyd, 2020; Ganasarajah et al., 2017; Wells, 2011). Additionally, racial disparities occur when one racial group experiences inequitable outcomes when compared to another racial group and occurs throughout each checkpoint of the child welfare services pathway (Dettlaff and Boyd, 2020). Researchers have noted several explanatory factors for both racial disproportionality and disparity, including implicit and explicit racial bias, discrimination by systems workers (e.g., caseworkers, mandated reporters), child welfare system factors such as a lack of resources for families of diverse racial/ethnic backgrounds, policy and legislation, and structural racism such as historical policies and cultural dynamics (Child Welfare Information Gateway, 2021). Agency level factors are also implicated, including institutional racism, and organizational culture and infrastructure. For example, a study in California highlighted several institutional features of child welfare agencies that negatively impact Hispanic children and families specifically, such as a failure to engage effectively with the families and communities being served, a lack of accessible and preventative services, and a low amount of bilingual workers (Center for the Study of Social Policy, 2016). Further, policies such as the original Social Security Act in 1935 often had requirements to maintain racial oppression in the child welfare system (Dettlaff & Boyd, 2020). Several policies have historically been discriminatory against Black children and families and continue to exacerbate and maintain racial inequities throughout child welfare systems.

Additionally, research has found other factors with an impact on the referral of children involved in the child welfare system to mental health services. Fong et al. (2018) found that older child age, child out-of-home placement, caregiver mental health problems, prior caregiver maltreatment reports, and clinically significant child behavioral problems were significantly associated with increased odds of caseworker referral, and a lack of insurance (vs. private insurance) was associated with decreased odds of caseworker referral (Fong et al., 2018).

Child welfare caseworkers serve a key role in this checkpoint of the services pathway as they are in the position to link youth and families to appropriate services for their needs. In addition to the structural/systemic factors described earlier that influence caseworker behavior, caseworker level of familiarity with evidence-based programs and knowledge of how to match client needs with an appropriate EBP has been found to affect appropriate referrals (Whitaker et al., 2015). Because public child welfare agency staff often serve as service brokers for children and families, their knowledge of the availability, content, and target populations for each EBP is essential. Dorsey et al. (2012) found that when public child welfare caseworkers were trained on an EBP and increased awareness of that EBP, there was a trend toward better identification of referrals suitable for an EBP, and Kerns et al. (2014) noted that caseworkers requested additional tools or consultation to help them identify agencies that provide child welfare-related services, along with information on how to match specific services to a specific child. Perceived quality and effectiveness of community mental health providers and frustration with the mental health agency referral and appointment process were other reported barriers to referral (Kerns et al., 2014). Myers et al. (2020) also found that caseworker openness to EBPs and perceived difficulty to surmount barriers to making a referral were other significant predictors of the likelihood of a caseworker making a referral to an EBP.

Caseworkers also often have a large breadth of responsibilities such as service planning, case management, visitation coordination, and permanency planning, which compound with systemic barriers such as high turnover in community providers, waitlists, limited appointment hours, and other difficulties with access (Dorsey et al., 2012). Caseworkers also are limited by their large caseloads and excessive paperwork, and may not have formal collaborative ties to mental health agencies, as this also has been found to be correlated with caseworker decisions to refer children to mental health services (Fong et al., 2018; Stiffman et al., 2001). Additionally, agency of employment and agency norms and expectations were also significantly associated with referral to an EBP or service, as was interagency collaboration and communication (Garcia et al., 2015; Myers et al., 2020; Palinkas et al., 2014). These barriers may prevent caseworkers from making appropriate referrals even if they have the knowledge and awareness of mental health needs and corresponding referral options.

Family Initiation of Services

Even if a referral to mental health or other support services is made, oftentimes, a referral alone is not enough for the family to actually be able to initiate those referred services or attend the first session. Previous research has found that even though caregivers need and want their child to receive services, there are often many difficulties that parents face when trying to begin services. Studies found that initial mental health treatment session non-attendance rates ranged from 28% to 62%, despite parents wanting and needing treatment for their child (Harrison et al., 2004; McKay et al., 1996, 2005). Several barriers prevent families from engaging in referred mental health services and attending their first session.

As with the previous checkpoint, race/ethnicity is a common predictor for family service initiation, the reason for which may stem from multiple sources including worker (e.g., case-worker, judge or other service broker), assumptions about racial/ethnic differences or a lack of linguistically or culturally appropriate services, and biased assessment techniques (Garland et al., 2003). Harrison, McKay, and Bannon (2004) found that in families who had been referred to mental health treatment, historically underserved populations such as Black and Latino families, were less likely to attend their first appointment. Garland et al. (2003) also noted that culturally driven help-seeking behaviors and patterns potentially contribute to disparities in receiving mental health services. For example, minority caregivers may be deterred from following through with treatment referrals due to perceived stigma and attitudes about a psychiatric diagnosis and formal mental health treatment, in addition to low trust in medical professionals (Eiraldi et al., 2006). Although research has highlighted disparities in family service initiation among different racial and ethnic groups, there are several posited mechanisms through which this occurs, including systemic biases in service delivery and accessibility, and socio-cultural driven family attitudes and perceptions about mental health diagnosis and treatment.

Ofonedu et al. (2016) found that in a primarily Black or multi-racial, low-income population, expectations about the treatment, and delays in treatment availability emerged as barriers for attending their child's first treatment session. Furthermore, parents who never attended their child's first mental health treatment session were younger in age, more likely to live with more than four adults and children (indicating poverty and merging of households), and have more depressive symptoms (Ofonedu et al., 2016). Carroll et al. (2001) also found that caregivers in need of substance abuse treatment were more likely to initiate treatment if Motivational Interviewing techniques were delivered during their evaluation.

The length of time between intake or referral and first scheduled appointment is another barrier for initial treatment engagement for families, associated with increased odds of absence at the first appointment (Foreman & Hanna 2000; Redko et al. 2006; Westin et al. 2014). A prolonged waiting time may lead to families becoming disengaged, and the opportunity to provide services may be lost. Westin et al. (2014) also found that waiting time was significantly associated with treatment refusal.

Family Completion/Engagement of Services

Once a family has initiated treatment or services or attended a few sessions, this does not guarantee that they will participate in the treatment to completion. Oftentimes, barriers prevent families from continuing to participate in services (Kazdin et al., 1997). In fact, dropout rates from children's mental health services vary from 28-88% (De Haan et al., 2013). There are several consequences of premature termination from services such as an increased likelihood of symptom persistence and worsening of long-term outcomes (Boggs et al., 2005; De Haan et al., 2013).

Race and ethnicity are also associated with family engagement and completion of services. As with the previous checkpoints, there are multiple factors that contribute to this finding, including a low availability of minority mental health providers and lack of culturally competent and linguistically appropriate workforce, along with aforementioned structural racism-related barriers (Child Welfare Information Gateway, 2021).

Because caregivers are responsible for their child's care, many of the challenges that families face in engaging in services can be viewed as, in part, caregiver-level struggles. Such challenges include lack of support from service systems, perception that therapists do not listen to them, low perceived influence on the case plan, poor relationship with the case manager, and overall dissatisfaction with their child's mental health services (Baker-Ericzén et al., 2013; Estefan et al., 2012; Prinz & Miller, 1994). Additionally, social support and parental skill efficacy, along with caseworker and therapist characteristics have also been found to affect a family's service pathway engagement (Fong et al., 2018; Harrison et al., 2004; Ofenedu et al., 2017). Stevens et al. (2006) also found that perceived relevance of treatment and quality of therapist-family relationship were factors related to premature dropout from services. Furthermore, lack of transportation and financial resources have been reported as major barriers by families and suggest that in-home, community-based services would increase engagement (Estefan et al., 2012; Kerns et al., 2014). In addition to these barriers, other caregiver predictors of attrition from services are single-parent status, symptom severity (both child and caregiver), social isolation, parenting stress, marital distress, and availability of services (Fernandez & Eyberg, 2009; Pellerin et al., 2010; Snell-Johns et al., 2004).

Youth engaged in services, whose buy-in is important for treatment engagement, often face challenges as well. Previous negative experiences with therapy, placement changes, wariness around new adults, or feelings of stigma for receiving mental health services were common barriers for youth (Kerns et al., 2014). Furthermore, consistent with the other checkpoints, child ethnicity, symptom severity, gender, and age are predictors of treatment duration as well (McKay and Bannon, 2004; Miller et al., 2008; Pellerin et al., 2010). For example, Pellerin et al. (2010) found that children with higher impairment in functioning and psychiatric symptoms were more likely to drop out of treatment.

In terms of facilitators for family engagement, a review by Ingoldsby (2010) found that interventions that included motivational interviewing and enhanced family stress and coping support strategies produced long-term impact on engagement. Ingoldsby (2010) noted that strategies that focus on family engagement through highlighting discrepancies between present behavior and desired outcomes, eliciting self-motivational statements, collaborating on behavior change plans, and addressing engagement barriers, treatment motivations and life stressors have yielded positive and promising results in strengthening family commitment to treatment.

Although the research highlights several unique factors that influence child and family navigation through each of the three service checkpoints: (a) referral, (b) service initiation, and (c) service completion, there are commonalities reflected in all three checkpoints. For example, race/ethnicity was a major predictor of service referral and utilization patterns, which may be driven by bias on many levels. On the individual level, bias is displayed by the workers involved with the child welfare system (e.g., case-worker, judge, or other service broker). On a systemic and agency level, accessibility and availability of culturally and linguistically appropriate workers and resources is a key driver of racial/ethnic disparities. Furthermore, caregiver/family-level characteristics such as caregiver mental health were found to be predictors of progression through each checkpoint. Additionally, general accessibility to appropriate mental health services and providers as a whole was revealed to be a major barrier to the completion of each checkpoint.

In addition to the barriers described for each specific service checkpoint, living in a rural area represents another barrier families face when accessing mental health services. Research has indicated that individuals living in the most rural areas often do not receive as much treatment for their mental health concerns as those who reside in metropolitan areas, despite having a similar (or even higher) need for services (Hauenstein et al., 2007; SAMHSA, 2016). Although each rural community is different, one major and commonly experienced barrier to accessing mental health services in rural areas is a shortage of available providers - more than 85% of federally designated mental health professional shortage areas in the United States are considered rural (Thomas et al., 2012). Other challenges associated with living in rural areas include long required travel distances for services, inadequate internet infrastructure, limiting topographical characteristics (e.g., difficult to navigate mountain roads), population instability, reduced anonymity in receiving services in a small population, lack of available providers, limited training for providers, and lack of culturally appropriate treatment (Hauenstein et al., 2007, SAMHSA, 2016).

Additionally, in a study by Hauenstein et al. (2015), researchers found many disadvantages for children living in the most rural settings. For example, they were less likely to receive in-home services and to remain in their home community for treatment. In addition, they were not only more likely to be placed in out-of-home care, and they were more likely to stay in these settings for longer (Hauenstein et al., 2015). Furthermore, once discharged from out-of-home placements, Hauenstein et al. (2015) found that children from rural areas were less likely to receive follow-up care than children from non-rural areas.

Mixed Methods Research on Service Pathways

Research illuminating barriers and facilitators to a pathway to services like the one prioritized by FFPSA suggests a number of possible targets for implementation science. However, given how recently FFPSA has been influencing services and the paucity of data on the pathway in the context of FFPSA, it is not clear how generalizable past work is to this new child welfare reality. Often in such situations, scientists opt for a mixed methods approach to examine whether past evidence applies to the new context. Mixed method research approaches incorporate the collection and analysis of both qualitative and quantitative data in a single study. Leveraging the strengths of both methods offers a potentially richer understanding than either approach alone (Shorten & Smith, 2017). Specifically, the explanatory sequential type of mixed methods approach first collects and analyzes quantitative data and then uses qualitative data to provide context to the quantitative data (Shorten & Smith, 2017). Mixed methods are often and increasingly used in mental health or human services research (Palinkas, 2014). Furthermore, mixed methods designs are especially useful in implementation research as a way to understand facilitators and barriers to implementation and the process and outcomes of implementation (Aarons et al., 2012; Palinkas et al., 2011). Accordingly, this study employed a mixed methods approach to examine the implementation of FFPSA in Virginia during its first few years.

The Present Study

The review of existing literature has illuminated numerous barriers and facilitators throughout the general services pathway for children and families requiring behavioral health services. Research indicates that there are several unique factors at each checkpoint that influence whether or not a family ultimately initiates and completes the services that they are referred to. First, several posited factors that influence whether families are referred to services are systemic barriers such as interagency collaboration and service availability, caregiver demographics and perceptions, in addition to caseworker characteristics such as knowledge of available services, and perceived service quality. Second, the literature shows that after referral, factors that influence whether the family initiates treatment include demographic variables such as race/ethnicity and age, along with delay between referral and services. Following the initiation of services, families often encounter other barriers such as logistical issues such as transportation or financial resources, child and caregiver symptom severity, therapist/family relationships, lack of support, dissatisfaction with services, stigma, and parental skill efficacy that prevent them from ultimately completing the necessary services. However, because the existing research on service pathways often is in the broader context of children and families in general, or the broader child welfare context, this study aims to identify and understand the unique facilitators and barriers for children and families involved in the child welfare services pathway for in-home prevention services influenced by the FFPSA. Further, to gain a deeper understanding of why and how these barriers and facilitators influence a family's service outcome, stakeholder focus groups will be conducted with those directly involved with and impacted by the FFPSA child welfare services pathway.

The proposed study sought to address the following aims:

Specific Aim 1. Examine Virginia's performance (i.e., retention across the path) across the three identified checkpoints: (a) referral to services, (b) service initiation and (c) service completion.

Specific Aim 2. Conduct focus groups with relevant partners to identify facilitators and barriers at each checkpoint of the service pathway.

Method

Project Summary

The study sought to address the aforementioned aims across a mixed method sequential study. The quantitative study involved analysis of state data related to the performance of the system across the three checkpoints. The qualitative study was designed to identify the specific barriers and facilitators perceived at each of the checkpoints in Virginia.

Quantitative Study: Overview

First, quantitative data were analyzed to provide descriptive information about each service phase and to identify the most troublesome checkpoint in which the most FFPSA eligible children are lost and do not progress further in the pathway. Data for the quantitative portion of the study were collected by the Virginia Department of Social Services (VDSS) and housed in the Online Automated Services Information System (OASIS) database. OASIS is an online case record that authorized LDSS users may access statewide and contains information related to family services cases relating to child protective services, foster care, adoption, prevention, and foster and adoptive families. OASIS contains data on several key variables such as demographic information, candidacy for foster care, service status, service start date, and service end date on the children and families involved with the FFPSA services pathway in Virginia. It is the primary tool that LDSS workers use and is the primary source of data for reporting and planning on a federal, state, and LDSS level. VDSS has an ongoing research partnership with the Center for Evidence-based Partnerships (CEP-Va) led by Dr. Michael Southam-Gerow and Dr. Rafaella Sale at Virginia Commonwealth University (VCU) to roll out EBP implementation in Virginia, and a data-sharing agreement was enacted for transfer of deidentified data. This study received institutional review board approval from both VCU and VDSS.

Quantitative Study: Operationalizing the Services Pathway Variables

To operationalize the dependent variable (i.e., the four checkpoints), meetings were conducted with key VDSS staff members familiar with the OASIS database and variables. The number of children in the initial checkpoint, in-home status/eligibility, was measured by examining the number of children deemed as a “candidate for foster care.” For a child to be eligible for Title IV-E prevention services, they must have this candidacy status. There are three total prevention service categories eligible for Title IV-E funding: in-home parent skill-based training, mental health prevention/treatment services, and substance/drug abuse treatment. These are indicated under the *Service Type* variable. To determine how many children make it to the first checkpoint, family referral to an EBP, we used the *Service Status* variable which indicates whether a Title IV-E prevention service is in progress, completed, or declined. The number of children in this checkpoint was determined by looking at how many children have a service status of "in progress or completed." To operationalize the second checkpoint, service initiation, we looked at how many children had a Title IV-E service start date listed, and for the third checkpoint, service completion, we looked at how many children had a Title IV-E service end date listed.

Quantitative Study: Predictors/Descriptives

Participants were included in this study if their service start and end dates were between July 1st, 2021, and June 31st, 2023. The initial VDSS Prevention Plan was implemented in Virginia on July 1, 2021 and this study investigates the first two years of FFPSA implementation. The demographic data available from the OASIS data were race, ethnicity (i.e., families identified as either Hispanic/Latino or not Hispanic/Latino), age, gender, and county code of family residence. These variables were included in the pool of possible predictors to investigate the influence of social determinants of health on the family service pathway outcomes. It is important to note that social determinants of health include other variables but this study only utilizes variables available from the OASIS database.

The existing race variable from OASIS allowed for individuals to have more than one designated race. Prior to analysis, the race predictor was re-coded and participants were categorized into one of six categories: 1) American Indian, 2) Asian, 3) Hawaiian/Pacific

Islander, 4) White, 5) Black, and 6) Multiracial. Those who had more than one race listed were categorized as multi-racial. The logistic regression included race categories that were larger than 5% of the total sample. Thus, analyses compared Black (24.5%) vs. non-Black participants, White (59.1%) vs. non-White, and multiracial (7.3%) vs. monoracial participants. Table 1 summarizes the race of the participants. Because of how ethnicity and race data were collected, ethnicity and race were analyzed as separate variables. For example, if an individual was listed as both Black and Latinx, they were not included in the multi-racial group.

Age was calculated by subtracting the birthdate from the earliest service start date listed for a client. The mean age of the total participant sample was 8.00 years old (*SD* = 5.30). The mean age of the participant sample analyzed in the logistic regression was 9.70 years old (*SD* = 5.22). Gender was categorized by female and male. The sample gender distribution is summarized in Table 1.

Family residence and service zip codes were used as proxy measures to estimate rurality using 2023 Rural-Urban Continuum Codes (RUCCs). The 2023 RUCC codes are divided into metro and nonmetro counties, which are then divided into three metro and six nonmetro categories based on the 2023 Office of Management and Budget’s (OMB) categorization of metro areas (United States Department of Agriculture [USDA], 2024). RUCC codes are assigned to each county and census-designated county-equivalent in the United States and provide classification for analyzing rurality and metro proximity trends (USDA, 2024). Because Virginia’s child welfare system is state-led, locally administered, these codes help identify differences between counties. Family residence location was calculated using the OASIS location code listed for each participant. These location codes were converted into FIPS codes, which were then converted to RUCC codes. If a family had multiple location codes listed, the mode was calculated and used. If there was more than one mode, the smaller number (more metro) was used as the location code. Furthermore, for families with missing location codes but had an LDSS location code (LDSS responsible for the case) listed, this code was used as a proxy to estimate their location. RUCC codes were then condensed into two categories: metro and non-metro following the USDA categorization (USDA, 2024). Using this system, RUCC codes 1, 2, and 3 were labeled as *metro*, and RUCC codes 4-9 were labeled as *non-metro*. Table 1 reports the data for the RUCC codes and also for the recoded variable.

Table 1.
Descriptive Statistics of Child Demographics.

	Total Sample		Analyzed Sample	
Demographics	*n*	%	*n*	%
Gender				
Female	3746	49.6	53	48.2
Male	3784	50.4	57	51.8
RUCC Code				
1	2562	34.3	23	20.9
2	1698	22.7	18	16.4
3	1565	21.0	45	40.9
4	206	2.8	2	1.8
5	0	0	0	0
6	468	6.3	10	9.1
7	331	4.4	1	0.9
8	371	5.0	9	8.2
9	268	3.6	2	1.8
Rurality Status				
Metro	5825	22.0	24	21.8
Non-Metro	1644	78.0	86	78.2
Race				

American Indian	7	0.1	0	0
Asian	37	0.5	0	0
Black	1615	21.6	27	24.5
Hawaiian/Pacific Islander	17	0.2	2	1.8
White	4947	66.2	65	59.1
Multi-Racial	499	6.7	8	7.3
Black and White	465	93.2	8	100
Black, White, Unknown	11	2.2	0	0
White and Asian	8	1.6	0	0
Black and Asian	4	0.8	0	0
White and American Indian	4	0.8	0	0
Black and Hawaiian/Pacific Islander	2	0.4	0	0
Black, Asian, and White	1	0.2	0	0
Black, Hawaiian/Pacific Islander, and White	1	0.2	0	0
Black and American Indian	1	0.2	0	0
White and Hawaiian/Pacific Islander	1	0.2	0	0
White, Hawaiian/Pacific Islander, and Unknown	1	0.2	0	0
Unknown or Declined	347	4.6	8	7.3
Ethnicity				
Hispanic	701	9.3	12	10.9
Non-Hispanic	6197	82.3	89	80.9
Unknown	528	7.0	6	5.5
Declined	104	1.4	3	2.7

Note: Participants were considered multi-racial if their demographic information indicated more than one race.

Quantitative Study: Analytic Plan

Pathway Performance Data Inspection

Using the approach described earlier, we determined the number of children at each checkpoint. We anticipated that at every checkpoint after the initial checkpoint, there would be attrition and thus planned to report the number of families that fell out of the service pathway over time. As an example, if checkpoint 1 had 1500 families eligible, a lower number would make it to the next checkpoint (i.e., referred to a Title IV-E service), and so on.

Predicting Pathway Disruption

We planned to conduct logistic regression analyses to predict outcome at each of the three checkpoints. For these analyses, we used logistic regression models to predict success or not at each checkpoint. As noted earlier, potential predictor variables for these analyses included race, ethnicity, age, gender, and metro/non-metro residence. Biserial correlation and phi coefficients were calculated as a means to reduce the pool of predictors for the planned regression analysis. Predictors with a correlation coefficient significant at the $p < .15$ level were retained for the logistic regression analysis. The p-value cut-off was determined to be .15 to be more liberal with included predictors due to data quality, in addition to all of the predictors being implicated in previous literature as influences to service utilization.

Transition Plan from Quantitative to Qualitative

Following the quantitative analysis, qualitative focus groups were conducted with relevant stakeholders to follow up and probe the contributing factors to the child and family attrition at each of the three checkpoints, in addition to supplementing the quantitative data and existing literature. Ultimately, the combination of the quantitative and qualitative portions of the study will be used as evidence for improving FFPSA implementation in Virginia.

Qualitative Study: Overview

A descriptive, exploratory qualitative approach was used. Qualitative data were collected via focus groups conducted in 2024 consisting of four groups of stakeholders: (a) service brokers, (b) provider agency staff members, (c) state agency staff members, and (d) families. These stakeholder groups were identified prior to the quantitative data analysis and were selected from two localities because of the time and resource constraints of a master's thesis project. The moderator and interviewer team consisted of a faculty investigator and a doctoral student. The doctoral student conducted all interviews and focus groups with the supervision of the faculty investigator. A semi-structured interview guide was used for data collection.

Qualitative Study: Procedures

A combination of purposive and convenience sampling was used, as described shortly for each stakeholder group. All participants in this study completed an informed consent process before each focus group. Four focus groups with a total of nine (9) individuals were conducted.

Service Broker Recruitment

Service broker participants included service planners, case managers and workers, and FAPT team members that coordinate services in the chosen localities. Emails were sent out by the VDSS Family First Project Manager to the two local departments of social services to request participation for the focus groups. The email was sent out to four (4) service coordinators in one locality and three (3) service coordinators in another. In the end, two focus groups were conducted - one for each locality, with each having two participants each (i.e., n = 4 total).

Provider Agency Staff Member Recruitment

Provider agency staff members eligible for the study included therapists and intake workers from the chosen localities who worked at a private or public provider company. An email requesting participation was sent to thirteen (13) different individuals across ten (10) different provider companies. Responses were received from six (6) individuals, and three (3) participants confirmed participation. One focus group was conducted with two service providers; one participant did not attend the meeting and did not reschedule for an individual interview.

State Agency Staff Member Recruitment

State agency staff members eligible for the study included staff from the Virginia Department of Social Services who are involved in the state implementation of FFPSA and/or the systems related to FFPSA data collection and analysis. An email was sent to eligible staff members at VDSS (n = 9) to request participation from the group. One focus group was conducted and consisted of three (3) participants.

Family Recruitment

Family representatives were recruited from the chosen localities. To qualify as a family representative, the participant had to be a primary caregiver in their family with a child or adolescent that is currently receiving or has received FFPSA services. The family representatives may also have received services themselves. Primary caregivers were recruited by asking participants from the Service Coordinators and Service Providers stakeholder focus groups to assist, per the IRB approved procedure. Two participants from the Service Coordinators stakeholder group offered to gauge interest in participation at their local office, and emails were sent to them. However, no parent participants connected with the study. Additionally, one participant from the Provider Agency focus group provided the contact information for two separate individuals who indicated interest in participation. However, when contacted, neither parent replied and in the end neither scheduled an interview. Thus, despite these efforts, no data were collected from primary caregivers of families.

Qualitative Study: Questioning Route

The project was introduced to all participants as a way to understand the barriers and facilitators of the child welfare services pathway in the context of the FFPSA for VDSS to make changes that will allow the pathway to better connect and engage families to the services that they need. Questioning routes were developed in advance based on past findings. Although the questioning route for all four participant groups contained common topic areas focused on barriers and facilitators of the FFPSA services pathway, each questioning route was also tailored to each group's unique perspective with the pathway. For example, questions for families included a focus on their experience with the system whereas the questions for the state agency employees included a focus on data systems. The questioning routes for each stakeholder group are included in the appendix. Sample questions are provided below:

- As a therapist or intake coordinator, what do you feel are the biggest challenges you experience when providing services to clients? We want to know about in general, but also specifically about providing families with Title IV-E related services.
- How do sociodemographic factors influence the service planning process?
- What can be done to reduce some of the challenges and barriers that are making it difficult to roll out FFPSA services to Virginia families?
- As a state agency staff member, what do you feel are major barriers to the delivery of Title IV-E services across Virginia?
- What else do you feel that we should know?

The questioning route for service coordinators was piloted with a lab employee with previous service coordinating experience as part of a qualitative methods course. This led to the refinement of this particular stakeholder's group's questions and adaptation of probing questions.

Qualitative Study: Analytic Plan

Purpose

The study's purpose was to examine the perceptions of each stakeholder group of what facilitates a family through the pathway and what prevents families from continuing on the pathway to completion. Findings from the literature for each checkpoint involving relevant contributing factors to a family's navigation through the pathway were described in the literature review to facilitate the conversations and develop the coding manual, in addition to considering additional themes that were not previously identified.

Code Development

This study used both inductive and deductive thematic analysis. Some a priori codes were determined from existing literature regarding potential barriers and facilitators such as payment/insurance, logistical concerns, and caregiver attitudes toward services. In addition, because this was a sequential mixed-methods study, additional probes and codes emerged from the quantitative data analysis. However, due to the limited knowledge of these factors in the context of child welfare and FFPSA, there was room for new themes to emerge and for additional codes to be added. This study used a thematic analysis because among the factors highlighted through research, exists overarching themes that split the facilitators and barriers into distinct categories.

Procedure

All focus groups were conducted and recorded using HIPAA-compliant Zoom. Sessions lasted between 60-90 minutes. Quick notes were taken by an additional CEP-Va staff member using a pre-developed note-taking template during the interviews to capture key themes and quotations, and Zoom transcriptions were used to verify content and themes across each focus group. The note template was developed from quantitative results, the pilot interview, and the existing literature regarding barriers and facilitators.

Trustworthiness and Rigor

Methodological decisions were documented throughout the research process to increase trustworthiness of findings (Doyle et al., 2020). Methods suggested by Lincoln and Guba (1985) were also incorporated to enhance trustworthiness and rigor. For example, for increased credibility, documented peer debriefing was conducted with a labmate to discuss emerging themes, confirm agreement among codes, and verify coding methodology. An audit trail and reflexivity notes were done to increase dependability and confirmability. Reflexivity notes were also used to prompt reflection of the researcher’s identities and experiences and how this may impact the results.

Results

Quantitative Study: FFPSA Service Pathway

Data Cleaning

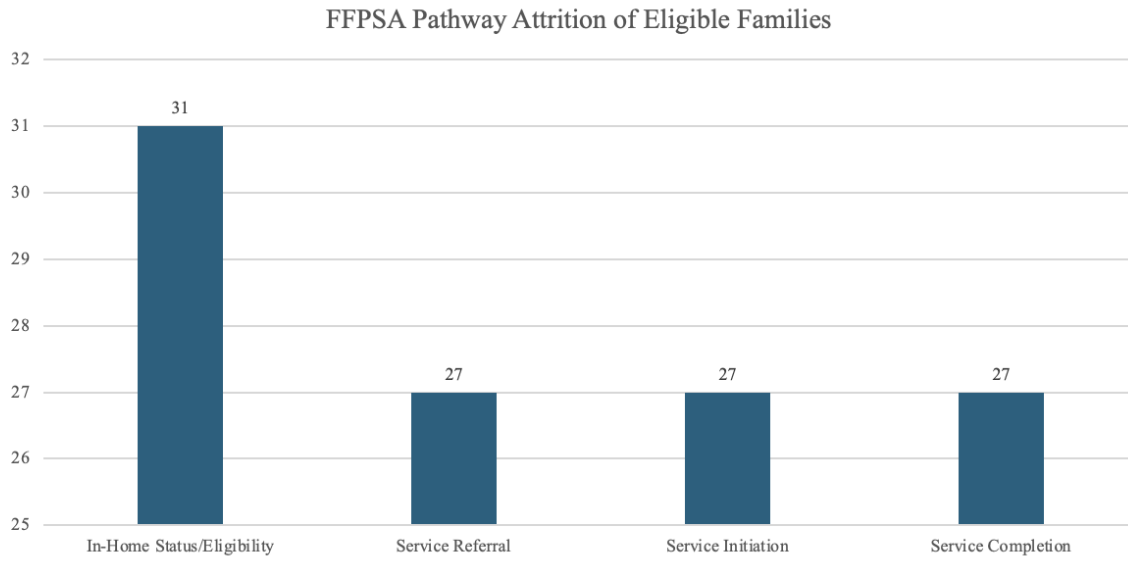
First, the total database of participants was filtered by service start and end date between July 1, 2021 and June 31st, 2023 (n = 8131). Data cleaning was then conducted. Participants with missing or unknown gender, birth date, and race were excluded (n = 349). In addition, those with a residence location code of 821 were also excluded (n = 90), as these exist in the data system as test cases. Cases with a CL_ID of 1 (n = 155) were removed because they represent cases of “out-of-family” investigation (abuse or neglect of a child in an out-of-family setting) which are purged from the data system after 30 days. Furthermore, cases were excluded if calculated age resulted in a negative value (n = 37). As noted in the Method, age was calculated by subtracting the birthdate from the earliest service start date listed for a client. Participants were also excluded if they were 21 years old or older (n = 31), as a result of eligibility criteria for the Family First Prevention Services Act. After applying these exclusionary criteria, 7469 participants remained (i.e., 662 cases excluded). Given the focus on the FFPSA pathway, a final data reduction strategy was completed to remove all participants for whom candidacy status was missing. This led to a final sample of 110 participants (i.e., 7359 cases excluded). Participant demographic information is presented in Table 1.

Movement Through FFPSA Checkpoints

The first predetermined checkpoint was foster care candidacy status, which indicates whether a child is eligible for Title IV-E services. Fewer than 1% (0.4%) of total participants had a foster care candidacy determination (n = 31). The second checkpoint was whether the client was referred to an Title IV-E service. Participants were considered referred to a Title IV-E service if they had a Title IV-E service listed, and if the service status was in progress, completed, application pending, or waiting list. Fully 25.7% (n = 1920) of the participants had a Title IV-E service listed. The third checkpoint was whether they had a Title IV-E service listed in addition to a service status of in progress or completed. The fourth checkpoint was service completion, which was categorized by whether the participant had a Title IV-E service listed, in addition to a service status of completed. Because there was no difference between the participants in checkpoints two, three, and four, a child that was referred to Title IV-E services in all cases listed, successfully completed services. It is noteworthy that checkpoint 1 contains fewer families than subsequent checkpoints, a fact that should not be technically possible and a data anomaly discussed later. Checkpoint movement is displayed in Figure 1 (analyzed sample across all checkpoints) below.

Figure 1.

Movement Through the Family First Prevention Services Act (FFPSA) Pathway (Analyzed Sample; n=110).



Logistic Regression

Two binary logistic regressions were conducted to predict outcomes at each checkpoint.

Examining Assumptions. Prior to conducting the binary logistic regression analyses, data were checked for assumption violations. The between-subjects design meets the assumption of independent observations and in the case that one participant had several observations listed, their data were combined into a single observation to avoid duplicate responses. There were no outliers. Furthermore, there was no multicollinearity detected (VIF<10) and there were no correlations among predictors above 0.70.

Preliminary Analyses. A total of n = 110 participants were included in the analyses, 1.5% of the total sample. An independent sample t-test was conducted to test whether the sub-sample included in the analyses (n = 110) was significantly different from the excluded sample in age (n = 7359). Results indicated that the difference in mean ages was not significantly different at the $p = .05$ level ($t = 3.39$, $p = .823$, $d = 0.33$). Chi-squared analyses also tested whether the analyzed sub-sample was significantly different from the total sample in RUCC codes, race, gender, ethnicity, and rurality status. Results indicated that the sub-sample was significantly different in RUCC codes ($\chi^2(7) = 37.25$, $p <.001$) and race ($\chi^2(1) = 16.10$, $p =.013$), but not for gender, ethnicity, and rurality. Specifically, for RUCC codes, at a $p = .005$ level, significantly fewer participants in the analyzed sample resided in RUCC code 1 areas (counties in metro areas of 1 million population or more) than expected (standardized residual = -2.4), and significantly more analyzed sample participants belonged to RUCC code 3 (counties in metro areas of fewer than 250,000 population) than expected (standardized residual = 4.6). For race, significantly more Hawaiian/Pacific Islander individuals were in the sub-sample than expected (standardized residual = 3.5). Additionally, a chi-squared analysis was done to examine whether the composition of the multiracial category differed between the subsample and the excluded sample. Results suggested that there was no significant difference between the two samples ($\chi^2(20) = 20.19$, $p = .446$).

As mentioned, biserial and phi correlation coefficients were calculated and examined to reduce the pool of predictors to be used for the planned regression analysis. The initial pool of predictors included: (a) race, (b) ethnicity, (c) gender, (d) age, and (e) rurality. Participants were excluded if they had “unknown” or “declined” listed for ethnicity. Predictors with a correlation coefficient significant at $p < .15$ were retained for the logistic regression analysis.

Checkpoint 1: Foster Care Candidacy Status

Of the five possible predictors, only one was retained: rurality. Tables 2 and 3 display the correlation coefficients.

Table 2. Correlations Between 5 Predictors and Foster Care Candidacy Status

Predictor	1
1. Foster Care Candidacy Status/Checkpoint 1	–
2. Race	0.13
3. Ethnicity	-0.05
4. Gender	0.08
5. Age	0.01
6. Rurality	0.28*

Note: * $p < .15$

Table 3. Correlations Between Race and Foster Care Candidacy Status

Predictor	1
1. Foster Care Candidacy Status/Checkpoint 1	–
2. Black vs. Non-Black	0.00
3. White vs. Non-White	-0.10
4. Multiracial vs. Monoracial	0.13

Note: * $p < .15$

The first binary logistic regression model tested predicted whether a child was deemed a candidate for foster care. The overall model was found to be statistically significant (χ^2 (1) = 11.28, p <.001, with Nagelkerke R-squared value of 0.14. The model explained 14% of the variance in the candidacy designation and correctly classified 71.8% of cases. Rurality was found to be a statistically significant predictor of a child being designated a candidate for foster care. The logistic regression analysis showed that participants residing in a metro county had significantly higher odds of being labeled as a candidate for foster care than those who lived in a non-metro area (B = 2.51, Exp(B) = 12.32, p = .02).

Checkpoint 2: Title IV-E Service Utilization

For the second regression model, two of the five possible predictors were retained: race (i.e., multiracial or not) and age. Tables 4 and 5 display the results of the correlational analyses.

Table 4. Correlations Between Predictors and Title IV-E Service Utilization

Predictor	1
1. Title IV-E Service Utilization	–
2. Race	0.21*
3. Ethnicity	-0.08
4. Gender	-0.08
5. Age	0.21*
6. Rurality	0.10

Note: * $p < .15$

Table 5. Correlations between race and Title IV-E Service Utilization

Predictor	1
1. Title IV-E Service Utilization	–
2. Black vs. Non-Black	-0.06
3. White vs. Non-White	-0.10
4. Multiracial vs. Monoracial	0.24*

Note: * $p < .15$

The second binary logistic regression was conducted to see whether a child's race (i.e., multiracial or not) categorization and age predicted the likelihood that a child completed a Title IV-E service. The overall model was found to be statistically significant (χ^2 (2) = 9.35, $p = .009$), with Nagelkerke R-squared value of 0.13. The model explained 13% of the variance in Title IV-E service utilization and correctly classified 76.5% of cases. Both race and age were found to be statistically significant in predicting a child's odds in utilizing a Title IV-E service. Specifically, the logistic regression analysis showed that participants who were multiracial were less likely to have a Title IV-E service listed than participants who were not (*B* = -1.81, Exp(*B*) = 0.16, *p* = .023). Additionally, older participants had statistically significantly higher odds of service utilization than younger participants (*B* = 0.10, Exp(*B*) = 1.11, *p* = .002).

Secondary statistical analyses were also conducted with the total sample of individuals (n = 7469) to investigate whether the predictors influenced Title IV-E service utilization. Eligibility for Title IV-E services requires the participant to be deemed a candidate for foster care, and because 1920 participants had Title IV-E services listed but missing candidacy determinations, these analyses assume that these participants were all candidates for foster care. Rurality (*p* <.001) and ethnicity (*p* = .112) were retained as predictors, and the overall model was statistically significant (χ^2 (2) = 17.88, *p* <.001) with Nagelkerke R-squared value of .004. The model explained 0.4% of the variance in Title IV-E service utilization and correctly classified 74.2% of cases. Rurality and ethnicity were both found to be statistically significant in predicting a child's odds in utilizing Title IV-E services. Specifically, participants in a metro area were more likely to access Title IV-E services than participants who were not (*B* = 0.27, Exp(*B*) = 1.30, *p* < .001), and Hispanic participants were less likely to access Title IV-E services than non-Hispanic participants (*B* = -0.19, Exp(*B*) = 0.83, *p* = .049).

Qualitative Study: Barriers and Facilitators

Data Coding and Reduction

The identification of common themes occurred concurrently with the qualitative data collection process as the note-taker categorized barriers and facilitators into a priori or new codes in the note-taking template. After all focus groups were conducted, codes were developed through the modification of *a priori* codes to better fit the content of the interviews. Content was coded only if a facilitator or barrier was mentioned. Inter-rater reliability was established through peer debriefing with another graduate student of the identified themes and coding. Both graduate students coded each focus group interview individually. Once coding was complete, discussions were held to compare transcripts and ensure agreement with coding strategies. Furthermore, codes were compared with the notes taken during the focus groups to ensure agreement. Microsoft Word was used to organize and code each transcript using the developed codebook. Codes are presented by stakeholder groups to provide additional context.

Thematic Analysis Results

Several salient themes emerged from the focus group interviews and were largely consistent among the three stakeholder groups. Results are organized by theme in the following order: a) infrastructure factors, b) workforce factors, c) funding logistics, d) family-specific factors, e) service specific factors. Within each theme, results are presented by the stakeholder group.

Theme A: Infrastructure Factors

Barriers and facilitators were identified relating to specific system, agency, and locality level factors. This theme included sub themes such as (a) information dissemination to local departments of social services from VDSS or the federal government, (b) policy requirements, (c) locality-specific factors, (d) community-related factors, and (e) communication/collaboration between systems.

Infrastructure Factors: Service Coordinator Group. A first major challenge identified in the service coordinator focus groups was the perceived lack of useful guidance and information from state and federal agencies about how to navigate Title IV-E funding. For example, one participant noted that their agency did not know “where to get started,” even though they knew that “this is funding [they] should be utilizing.” Additionally, they reported that there was not much oversight or feedback from the state. They further indicated that it would have been helpful if there was more communication from the state regarding the low utilization of funds. Another participant expressed that there has not been a “clear cut way or pathway or even guidance on how to use these [funds],” and although they receive communication from providers advertising their services, they would prefer for clear information to the local DSS “to come more clearly from the state.”

Participants proposed solutions to the issue, such as having regional consultants come to their agency in person to break down the process for them and walk through the steps of utilizing Title IV-E funds. Additionally, one participant reported that although they had received infographics and short training videos from VDSS, having their CSA coordinator funnel information from VDSS to their agency would be a more effective method of information dissemination.

Another barrier that emerged was the use of the existing data system (OASIS). Two participants reported that OASIS is “a really difficult system to use” and that there were issues with approving cases in OASIS. For example, one participant explained that a supervisor needs to go into the system and approve cases, but they are not receiving notifications from the system when cases are ready to be reviewed and that they need to “repetitively” try to send the case to the supervisor before it makes it to the supervisor. Furthermore, there are components of the system that allows workers to bypass screens without entering information, which leads to missing data. One participant suggested that having the system provide reminders, in addition to a screen that “pops up and does not let you move past it until you answer certain questions” would be useful. Additionally, although participants were aware that data reporting in OASIS is necessary for the use of Title IV-E funds, they explained that this was not a priority for them because they primarily use Medicaid funding instead.

Infrastructure Factors: VDSS Staff Group. A prominent sub theme emerging from the VDSS focus group regarding infrastructure was policy. First, because FFPSA was federally enacted without much warning or planning, VDSS staff did not have adequate time to prepare and develop the appropriate infrastructure to manage implementation. One participant talked about the scramble to incorporate policy changes into the data collecting system:

> *"It was a time crunch, getting it into the system and figuring out the ins and outs of what Family First . . . The people involved with the decision making had little time to, I guess, decipher everything that may be needed. And so we put into the system what we believed would work and be the best way to document these things, and as you know, a couple years later, we're realizing that we need to make some changes and we're not gathering the information as seamlessly as we could be."*

Furthermore, participants noted that the OASIS system was not conducive to implementing new policy changes. For example, one participant noted that "if you make a change, you don't know what you're going to break on five other screens, and so every time we try to make something a little better, we risk making things a lot worse." One participant also reported that the OASIS system presents challenges for federal reporting because of discrepancies between the data system structure and federal requirements. The incorporation of FFPSA policy into OASIS also created difficulties for workers to document their cases and increased stress due to the new requirements. For example, the new guidelines for FFPSA complicated categorization of case types because six different "case types" were now required to fit into only two categories. VDSS participants perceived that this change was a barrier for caseworkers because they had to adjust to the new categories and reassess how their agency handled the case.

Another challenge reported by state VDSS workers concerned difficulties with the state-led, locally-administered structure of Virginia social services. One participant discussed how each locality operates differently and uses different language for different things, which causes confusion and significant variation amongst localities. For example, some agencies considered “prevention case types" as a more broad designation, and other localities were more or less liberal in what they considered a “prevention case.” Additionally, although the state distributed information about Family First to localities, the state had limited ability to tell each locality how to go about the process, and that they needed to work with their local Office of Children’s Services (OCS) to design and implement a locality specific process for accessing funds. One participant noted that this presented challenges, as the OCS is not always part of a locality’s social services system. Furthermore, although federal practice consultants exist in certain regions to provide guidance to localities in addition to strategies to monitor compliance and outcomes, there is a lack of accountability and incentive for agencies to comply with guidelines. Another participant explained that a major challenge of FFPSA implementation is supporting local agencies through change efforts, and tension between state and federal priorities.

Another barrier identified by state VDSS workers related to Virginia’s social services infrastructure was communication from the state to the localities. Although VDSS distributed guidance to localities through email, participants did not view this as an effective method. As one participant mentioned, people often do not read emails and even when they do, local staff members have the freedom to disagree with the information and do things their own way.

Participants provided several suggestions that they believed would facilitate effective communication. First, one participant explained that informational websites with a good user interface are important because they have seen that “younger workforces are very user interface-focused.” Furthermore, one participant mentioned that better partnerships between provider agencies and LDSS may allow LDSS workers to be more familiar with available services and providers to work more collaboratively with service planners.

Infrastructure Factors: Provider Staff Group. Infrastructure was a less common theme among providers, but information dissemination was a notable sub theme amongst this stakeholder group as well. When asked about what the state could do to help alleviate troubles that providers are facing, one participant reported that they often do not feel equipped with resources: “I sometimes find myself having a hard time knowing what resources are really out there to help with these families. . . I think easier access to what’s out there . . . would probably be helpful.”

Theme B: Workforce Factors

Workforce factors were a second major theme emerging from the interviews. Specific barriers identified by participants included (a) a lack of knowledge of EBPs and Title IV-E, (b) high caseload, (c) high worker turnover, (d) issues with reimbursement, (e) buy-in from workers, (f) lack of providers and (g) lack of training.

Workforce Factors: Service Coordinator Group. Service coordinators noted that high turnover in local offices (e.g., CSA workers, LDSS) has negatively impacted the implementation of Family First. As one participant noted, when an individual leaves an agency, their knowledge leaves with them. They explained that when FFPSA was first rolled out, their local DSS had a completely different leadership. When that leadership and almost all of the staff from that time left, there was a loss of historical knowledge. Furthermore, another participant explained that they often train new service coordinators at their local DSS, only for them to leave shortly after.

Additionally, local departments have had difficulties with hiring sufficient numbers of in-home workers. Two participants explained that they do not get many applicants for positions, but that they had recently increased the minimum salary and implemented a pay progression plan in the hopes that more people will be enticed to join their agency. Participants also reported that because of vacancies at their agency, especially after the COVID-19 pandemic, workers have too many responsibilities on their plate and adding new things is a challenge unless it is "easy to do, and [it] doesn't feel easy to do right now."

The participants discussed other challenges that emerged from insufficient staffing:

> Participant 1: *"I don't think that we have sufficient staffing for the volume of work that [follows] the workload standards that are put in policy and code that are literally the law . . . if Participant 2's got like, 5 or 6, in-home workers with, you know, 400 people, we have to make contact with a month, like that's just impossible. I mean, I think they do it like they, you know, they get it all, but . . . we're just constantly overwhelming people in the system and are you super effective if you're just cramming in visits just to get them done to be the standard, you know, or high quality? And I think they do their best. I'm not saying that they're not, but, you know, it's not fair to the families, it's not fair to the staff. And there's not really a lot of advocacy on behalf of agencies, local agencies to fix that. Yeah."*
>
> Participant 2: *"I think sometimes we wish we could do more but there's not enough hours in the day and not enough of us to be 10 places at once"*

Because of the high workload, several participants reported that they relied on providers that they have used in the past and with whom they were comfortable, stating that they did not feel "knowledgeable to go outside of those things." One participant explained that they often use the same services and providers because they do not know about alternatives. They added that they would be open to other services for their clients.

Service coordinators experience also noted that the workforce challenges extended to provider companies who they claimed were also not adequately staffed. For example, they explained that many provider companies have closed down because "they just can't keep adequate staff" and that "providers will state that they offer these services, but they don't have the staff to provide it when the families need it." Lastly, service coordinators reported that there is uneven distribution of available providers amongst service types, and report many more providers in their community that provide less intensive services such as outpatient counseling or medication management rather than more intense services. They explained that because there are more providers available for less intensive services, families are more likely to be referred to these services, even if they need more intensive care. One service coordinator perceived this as detrimental to families because this often leads families to become in a state of crisis or remain in a state of crisis. This then leads to hospitalizations or outpatient crisis stabilization services because they are unable to receive the services that they need.

Participants also discussed regular supervision and communication with providers as potential facilitators for service coordinators. One participant noted that monthly supervision meetings where coordinators and their supervisors discuss a family's services, needs, progress, and barriers were beneficial. However, one participant noted that although supervision was an "excellent tool" for workers, their agency required one supervisor to oversee double the recommended amount of staff. Another participant noted that reaching out to providers for help on pairing families with appropriate services was useful because the provider could make suggestions for what type of services would be most appropriate for the family.

Workforce Factors: VDSS Staff Group. State agency VDSS staff members echoed workforce challenges with Title IV-E implementation. First, participants indicated that high local worker loads were a major barrier. For example, one participant stated, “as a previous worker, I don’t wanna have to go through all these people just to figure out what I need to do for this,” and another felt that the localities that were slow to adopt were the most heavily impacted by the workforce crisis. Additionally, another participant explained that because Title IV-E funding is newer, a barrier of implementation is that workers are “overburdened with a lot of things and so whenever changes happen, if it’s not laid out very simply for them, it’s hard to learn the new process.” Furthermore, two participants stated that they felt that workers were not properly trained on what each Title IV-E service is and how they can be utilized, and recommended more education and training. They also suggested training workers to properly document the services that they are providing.

Another workforce challenge identified by this stakeholder group was related to the service landscape in Virginia. Because many of the evidence-based services that were in the Clearinghouse either did not exist in Virginia or served a very limited area or population, it was difficult to provide full coverage to families across the state due to limited providers. Additionally, workforce attitude and worker compensation were reported as barriers for implementation:

> *“There was a big opportunity and shift in Virginia to focus on evidence-based services versus other types of services to meet family's needs. And so you're not only like*

> *implementing this new funding source, you're also trying to implement this huge like culture shift, right? . . . there's some trepidation on their [workers] part, right? Like evidence-based services are expensive to be trained, ongoing, sustaining that training, is, can be expensive, can be perceived as expensive and I think we as an entire system, not just providers and not just the funding source, like we haven't figured out a good way to navigate that, to make sure that the cost for service will sustain not only the employee in a living wage who is providing a service, but also the company."*

Workforce Factors: Provider Staff Group. Provider agency participants echoed workforce challenges including high caseloads and difficulties in hiring qualified staff. One participant explained that because providers have so many families on their caseloads, it is difficult for them to manage each family effectively and many are often forgetful of which families they work with. They also added that there was a job advertisement at their agency that went without an applicant for two or three months. Additionally, one provider participant explained that they often find themselves wearing multiple hats and doing work that could be completed by a caseworker such as helping them find a primary care provider. Another provider participant noted that having engagement case managers at their agency was a facilitator for engaging families effectively.

Theme C: Funding Logistics

Funding logistics were a third common theme across all stakeholders as a challenge of FFPSA implementation. Participants discussed challenges in utilizing Title IV-E funding because of the complicated nature of the utilization process, in addition to the specificity of Title IV-E guidelines and interaction with other funding sources.

Funding Logistics: Service Coordinator Group. Two major challenges that emerged from service coordinators focus groups were a lack of knowledge of how to utilize Title IV-E funding and a lack of coordination between multiple funding sources such as CSA funding (including FAPT), Medicaid funding, and Title IV-E. One participant mentioned that their locality had not utilized Title IV-E funding at all because the funding is very specific and is the payor of last resort, and they had not figured out a good way to utilize the funds. Additionally, they explained that their locality has not built a plan to utilize the funds because of the very specific requirements and that they primarily use Medicaid because the evidence-based programs are funded by Medicaid and the vast majority of their clients qualify for Medicaid:

> *"To me, it's just been like 'here's the funds just figure it out' type thing. And then the more when I research it, I was like, I can't even use these because the only three that are on there are Medicaid funded…"*

This participant also noted that if they were actually able to use their funding, this would in turn improve the data reporting at their agency because it would become a priority.

Participants also explained that their funding challenges were primarily with finding providers that accept Medicaid. Additionally, they noted that the services provided through Medicaid or through approval from FAPT or CSA are not always the best fit for the families, but that they are all the family is able to receive through Medicaid. One participant noted that because they found it challenging to get justifications for funding for other services, they did not often attempt to do that because it is too difficult to navigate. The participant also explained that their locality had not expanded the use of Title IV-E funds since the enactment of FFPSA. However, they did recognize benefits to using Title IV-E funding and reported being open to learning how to use the funds:

> *"Here's the thing, I think I can see the benefits . . . Say we made a referral tomorrow. . . How do we access the funding? Or is it already paid for? . . . My thought is, do they [providers] have them? If we say we're gonna use this, do they automatically just accept our client . . . and they pull down the IV-E funds or does our agency do that? I'm confused. Who pulls down the funding?"*

Funding Logistics: VDSS Staff Group. The VDSS participants also reported challenges with the limited scope of Title IV-E funds along with a lack of collaboration of federal Title IV-E funding with other federal funding services:

> *"There wasn't a lot of collaboration with other particular funding sources that provide similar services. So for instance, like Medicaid, right? And so Medicaid funds some of the same services here in Virginia. So I think that's one issue, is that in general, Title IV-E, the Title IV-E Prevention Program is really limited in scope of how it can really serve our families"*

> *"Medicaid is being probably the primary funding source. I think most of the families we serve are eligible for Medicaid. And I think when family needs that service, that's the funding source they're using first."*

Additionally, VDSS participants explained that it was difficult to monitor the provision of Title IV-E services across Virginia because they could be delivered to families but funded through a different funding source such as Medicaid.

Funding Logistics: Provider Staff Group. The provider participants reported limited knowledge about Title IV-E funding, but echoed challenges with insurance and multiple funding sources. One participant noted that a challenge they encountered was the insurance authorization process, because it often led to a one or two month gap of services support for families. For example, they stated that providers are often unable to schedule an intake appointment until Medicaid authorizes a service, and the Medicaid authorization process often takes about two to three weeks. Another participant voiced concerns with challenges braiding or combining with multiple funding sources such as CSA and Medicaid, stating that it was rare for the funding sources to be combined to fund services for a family despite that being possible.

Theme D: Family-Specific Factors

The fourth category emerging from the data was family-specific factors that impact a family's navigation of the services pathway, service coordination, and provision of services. The codes for this factor included (a) family demographics, (b) logistical issues, and (c) family attitudes.

Family-Specific Factors: Service Coordinator Group. Several family-specific factors came up in the service coordinators focus groups. First, financial-related barriers emerged, including transportation. One participant mentioned that although they have a bus line in their locality, transportation was still a challenge for families. Another participant mentioned that a large number of their clients did not have their own car.

One facilitator mentioned was providing bus passes for their clients. Additionally, one participant mentioned that service provision to families through schools has helped to reduce the transportation barriers.

Other financial barriers discussed included housing and income. One participant mentioned that a portion of their clients are unhoused and lack a steady source of income, which makes it difficult to provide other services because housing and income are the most pressing issues. The participant explained that other social service programs and supports outside of CPS and foster care, such as financial assistance, Temporary Assistance for Needy Families (TANF), employment programs, and Supplemental Nutrition Assistance Program (SNAP) were helpful facilitators in connecting families with resources.

Another barrier that emerged from was perception/attitude about the child welfare system and services. For example, one participant explained there is a stigma and stereotype of CPS/social services involvement, and many families are scared and distrustful of the social services system, a sentiment that was echoed by other participants. One participant described the promise of the recent VDSS initiative focused on motivational interviewing as a potential way to mitigate this notable challenge. The participant noted that MI allows the workers to meet people where they are and give them a voice in the work. Another suggestion was to change the language surrounding CPS and social services: “Maybe we don’t call it CPS anymore . . . people are scared, like I would be scared of the system and I work in this system.”

An additional common barrier across was long (several months) waitlists for services, particularly for more specialized services such as ABA therapy. Participants reported challenges with getting families connected with services in a timely manner. An additional challenge, echoed by multiple participants, is the lack of service provider diversity, making it difficult to connect families with providers that are a cultural match for them. For example, one participant noted a lack of Spanish speaking providers, and another described a shortage of male or African-American providers.

Other barriers that emerged included difficulties with scheduling around a family’s availability, parent mental health or substance use treatment needs. Additionally, another participant expressed that they often base their service recommendations on the services that a family already has in place. Last, one participant mentioned that open communication with a family's previous providers is useful in monitoring progress or service compliance. However, some families are not as open to signing records releases, which can present challenges in continuity of care and service planning.

Family-Specific Factors: VDSS Staff Group. Family-specific level factors were less commonly raised by state VDSS participants. One participant did note that families who require services but have not reached a crisis that would be in the jurisdiction of CPS or foster care often fall through the cracks.

Family-Specific Factors: Provider Staff Group. Provider participants also endorsed the family category. One family-specific challenge was difficulty with getting in touch with a family's collateral sources such as family members or caseworkers. One participant noted that because probation officers or DSS workers are sometimes only able to touch base with collateral sources about once a month, which negatively impacts their service provision to families. Providers also spoke about other family-specific challenges such as parent mental health difficulties and self-referred families who do not have an existing case manager. Furthermore, one participant explained how their service provision varies depending on the level of help a family wants to receive. For example, they noted that some families are resistant to "too many people coming in the home," but others specify that they "need as much help as they can get." Additionally, families may change their minds, but that getting the family to buy into treatment was important all around.

Theme E: Service-Specific Factors

The final category of themes was service specific factors, including facilitators and barriers to the implementation of specific Title IV-E prevention services such as training, communication, and buy-in.

Service-Specific Factors: Service Coordinator Group. Service coordinators discussed the factors that led to their successful implementation of Motivational Interviewing (MI) throughout their locality. One participant explained that their agency had gone through the training for this evidence-based program because the state has been intentional and communicative with the information and training. They felt that MI had been brought to their attention because there was "information at every turn" and because MI was consistently talked about at statewide meetings and in emails from the state. Additionally, the participant explained that there was a lot of worker buy-in with this specific EBP because of an incentive of reimbursement, in addition to an existing familiarity with the benefits of MI.

Service-Specific Factors: VDSS Staff Group. Service-specific factors were not discussed by VDSS state participants.

Service-Specific Factors: Provider Staff Group. Provider participants also endorsed some service-specific factors. One provider noted that a difficulty with intensive in-home versus evidence-based programs such as FFT, was that most of the workforce who provide intensive in-home in their community are "budding therapists" that are starting at the ground level. The provider explained that this is a hindrance to families because they primarily serve older parents and families that are not receptive to "young college students coming in to tell them how to parent." Multiple provider participants spoke highly of Functional Family Therapy (FFT) and High Fidelity Wraparound (HFW). Specifically, they appreciated the training and structure of these service models. One participant specializing in FFT noted that the training for FFT was "out of this world" and they appreciated the "forever learning model," in addition to the guidance throughout the service process from beginning to end. They explained that their FFT training made it very clear how to engage families from the very beginning, identify risks, communicate with families, and bring in supports for their transition out of services. Furthermore, they explained that it was a more structured, client-focused approach that taught specific techniques that work long-term with families. Additionally, they found it beneficial that they are available to families during emergency moments and have seen better outcomes than they did when they provided intensive in-home services. Another provider participant noted that the FFT and HFW were more comprehensive and community based than intensive in-home which worked well for the families they serve. Multiple provider participants emphasized the importance and efficacy of utilizing collaterals.

Discussion

The current mixed-methods sequential study examined the movement of Virginia child-welfare involved families throughout the Family First Prevention Services Act pathway and investigated the barriers and facilitators of FFPSA implementation from the perspective of multiple stakeholder groups. The former question, movement across the FFPSA pathway, was assessed via two binary logistic regression analyses. The questions concerning barriers and facilitators were addressed via focus groups with three stakeholder groups (a) service coordinators, (b) VDSS staff, and (c) providers. Because the FFPSA has only recently been implemented, the present study adds a unique lens and context to existing knowledge regarding family service pathways.

A few key findings emerge from the quantitative study. First, and most importantly, there were significant data problems that greatly undermined the effort to characterize the performance of the FFPSA pathway in Virginia. Although the dataset available had around 7500 cases, only 110 had valid data for a key variable (foster care candidacy status) for determining the functioning of the FFPSA pathway. From the data that did exist, the findings suggest that children living in metro areas were more likely to be deemed a candidate for foster care, participants who were multi-racial were less likely to have received a Title IV-E service, and older participants were more likely to receive Title IV-E services than younger participants. A secondary analysis was conducted with all cases and indicated that participants residing in a metro area were more likely to receive a Title IV-E service and Hispanic participants were less likely to receive Title IV-E services. However, these findings should be interpreted cautiously. The assumption that all participants who had Title IV-E services listed were candidates for foster care may not be accurate due to poor data quality. Additionally, the model had a low Nagelkerke R-squared value, indicating that the model only explained 0.4% of the variance of Title IV-E service utilization based on rurality and ethnicity.

Results from the qualitative analysis indicated that multiple factors impeded smooth operation of the FFPSA pathway, including infrastructure factors (e.g., communication between federal agencies to local departments of social services, policy requirements, locality specific factors, community-related factors, and collaboration between systems), workforce factors (e.g., lack of knowledge of EBPs/Title IV-E, high caseload, high worker turnover, reimbursement challenges, worker buy-in, lack of providers, and lack of training), funding logistics, family-specific factors, and service-specific factors are significant contributors to FFPSA implementation across all three stakeholder groups. Consistencies with Andersen's healthcare utilization model were found in the focus group results. In the next sections, the findings are discussed thematically, future directions are outlined, and study limitations are enumerated.

Data Challenges in Documenting the FFPSA Service Pathway in Virginia

The effort to understand the FFPSA pathway analysis was significantly hampered by data-related limitations. This finding emerged from both the quantitative and qualitative studies.

OASIS is acknowledged as an outdated system that does not meet current needs of the field (VDSS, 2015) and has a difficult user interface that hinders how local workers report child welfare data. For example, policy indicates that for a child to be eligible for Family First services, they must be designated as a candidate for foster care. However, because the number of children that had this designation was significantly lower than the children who were reported as referred to those services, it is possible for children in the data system to be recorded as having received Title IV-E services, but were not marked as eligible in the first place in the data system. Additionally, we had expected that there would be classification differences in the data system between families who were foster care candidates, families who were referred to services, families who initiated services, and families who completed services, but the last three categories contained the same families, implying that if a family was referred to a service, they not only attended but completed the service. Although this finding would be great news, it would be extremely unexpected, given the attrition rates reported in children's mental health services ranging from 28-88% (De Haan et al., 2013). Per conversations with the data team at VDSS, this unlikely finding may be due to data reporting policies only requiring for children to be entered into the system once they have fully completed services or once the case is closed. That is, some data policies reduce the informational value related to the service pathway planned for FFPSA.

Another data limitation consistent with the focus group findings is the significant variation in OASIS utilization and data reporting between each local department of social services. That is, each local department categorizes services differently, enters data differently and uses OASIS in different ways, depending on the norms of their locality. For example, some agencies may incorrectly mark a specific EBP as counseling rather than a Title IV-E service. One VDSS participant explained: "it'll say in the comments like Jim Bob and Billy Bob were participating in MST services, and right above it, it says their service is counseling. It does not have [Title IV-E] listed out." Furthermore, as indicated by both VDSS staff and services coordinators in the focus groups, not all of the data fields in OASIS are required, including certain demographic fields. As a result, local workers are able to move past data screens without entering all relevant data, leading to missing data. This is consistent with the Joint Legislative Audit and Review Commission (JLARC)'s report that data errors from local agency workers were very common because of OASIS screen navigating challenges (JLARC, 2000). Additionally, this challenge is often exacerbated by usability challenges because it is difficult for workers to return to screens with incomplete or incorrect data to change them (JLARC, 2000). Missing data has significant implications, because as one VDSS participant noted, if "they're not properly documenting the services that they are providing . . . which means when the data gets pulled . . . nothing's there, so they're not gonna get funding for something that they didn't document or document correctly."

The aforementioned data challenges are also consistent with Virginia's Five Year State Plan for Child and Family Services for years 2015-2019 and 2020-2024. The 2015 report stated that "the lack of accurate foster and adoptive family data in OASIS continues to be problematic." For example, local staff reported that the choices available in the data field "pick lists" were often not adequate to accurately document cases. This meant that for certain mandatory fields, local workers often needed to select inaccurate choices to move forward in the system (JLARC, 2000).

In addition to lower data accuracy, the poor user interface of OASIS has several other implications such as reduced compliance with data entry. A VDSS focus group participant explained the importance of user interface: "We've learned that our workers, our younger workers especially, are very user interface focused." Additionally, according to Virginia's Five Year State Plan for Child and Family Services for years 2015-2019 and 2020-2024, OASIS no longer meets the needs of the child welfare system, and is a barrier for practice change implementation. One specific need is that the OASIS data does not include the funding source for services listed, making it impossible to identify funding sources for children listed in OASIS as receiving FFPSA prevention services. This makes it difficult for the state to investigate the distribution of families using Medicaid vs. Title IV-E funding for services.

Furthermore, both 2015 and 2020 VDSS reports described challenges with modifying OASIS because of its aged and obsolete software. One VDSS participant echoed this concern: "our data systems in government are . . . generally like, so far behind." The 2020 report specifically noted that OASIS has become "difficult to support and expensive to maintain, enhance, and expand" and does not have the capability to perform automatic updates. Additionally, it lacks major operational capabilities for data entry, financial management, electronic document management, mobile utilization, and interoperable functions. These challenges are consistent with a VDSS focus group participant explaining that "if you make a change [in OASIS], you don't know what you're going to break on five other screens." Despite these many documented shortcomings, the 2020 report explained that OASIS use will be continued until a new system can be implemented.

Lastly, OASIS was transferred to Virginia from Oklahoma and was implemented hastily without adequate modifications to account for Virginia's locally-administered system (JLARC, 2000). The state versus local tension is also indicated in both the focus group findings and the JLARC report. Specifically, one participant said: "I do think it would have been helpful to have clear communication to the local departments . . . come more clearly from the state," which echoed the report’s finding that local agencies expressed concerns about a lack of communication from the central office (JLARC, 2000).

Factors Associated with FFPSA Pathway Success

These limitations are formidable and mean that the quantitative findings reported here are tentative at best. The findings that did emerge suggested that rurality (i.e., whether or not a family lived in a metro area), race (i.e., multi-racial vs. not), and age were associated with progress through the FFPSA pathway. Specifically, families who lived in a metro area had significantly higher odds of being labeled as a candidate for foster care than those who lived in more rural, non-metro areas. This finding is consistent with past work wherein access to services in more rural and less populated areas is compromised (Hauenstein et al., 2015; Heflinger et al., 2015). Because children in rural areas are less likely to be designated as a candidate, they are in turn less likely to receive Title IV-E in-home prevention services. Heflinger et al. (2015) found that rural children were more likely to receive only out-of-home care than those in more metro areas, and Hauenstein et al. (2015) found that children in rural settings were less likely to receive only in-home services and stay in their home community for treatment.

Additionally, the analysis provided some evidence that race may influence prevention service access as well. Specifically, participants who were multiracial were less likely to receive Title IV-E services than participants who were not. Research on multiracial American individuals is severely lacking, partly because multiracial individuals were often placed into arbitrary monoracial categories (Nakamura et al., 2022). However, the qualitative analysis results are consistent with existing findings that individuals who are multiracial receive less mental health services than non-hispanic whites (Nakamura et al., 2022; Sheehan et al., 2018). Not only do multiracial individuals have lower rates of mental health service utilization, research also indicates that while multiracial individuals have higher rates of mental health problems than their white, mono-racial counterparts (Fisher et al., 2014, Harris et al., 2005; Jackson, 2023). This indicates that multiracial individuals have higher unmet mental health needs.Additionally, multiracial individuals may face unique stressors including invalidation of their racial identities and rejection from racial groups (Franco & O'Brien, 2018; Iwai, 2019; Navarrete & Jenkins, 2011).

Last, age was indicated to influence Title IV-E prevention service access. Specifically, older participants were more likely than younger participants to receive Title IV-E services. This was consistent with child welfare literature that older children are more likely to be referred by a caseworker (Fong et al. 2018). Furthermore, Hulburt et al. (2004) found that older children involved with child-welfare had increased service use than younger children.

Stakeholder Reported Facilitators and Barriers of the FFPSA Service Pathway

Interviews with multiple key stakeholders across two different localities revealed many reasons for the current status of the FFPSA pathway in Virginia, some of which map on to Andersen's (2008) healthcare utilization model. Specifically, Andersen's model described individual predisposing factors such as demographics and attitudes about mental health services, and contextual characteristics such as health organization and provider-level factors (Andersen, 2008), factors important in the implementation of FFPSA. These are each discussed in turn.

First, several focus group participants mentioned family demographics and attitudes as major influences on a family's navigation of the FFPSA services pathway. For example, participants described difficulties with matching families with culturally appropriate providers. Additionally, several participants mentioned that many families are scared and distrustful of the social services system, which influences their service utilization. Furthermore, Andersen's model implicates individual enabling factors such as income and transportation assistance, other common barriers indicated in the focus groups. Last, contextual factors were often discussed amongst focus group participants such as the need for more workers, more clear guidance from the state, and better training.

The literature indicates that interagency collaboration and communication is significantly associated with referral to an EBP or service (Garcia et al., 2015; Palinkas et al., 2014), a finding reflected in the focus groups. One barrier that emerged was that clear guidance and communication between the federal, state, and local agencies has been lacking, difficult and ineffective in Virginia. Service coordinators, VDSS staff, and providers all discussed breakdowns in communication and information dissemination across various infrastructure levels. VDSS staff described a lack of guidance from the federal government, service coordinators described a lack of information from VDSS, and providers felt that they did not receive adequate resources from the state. All stakeholders indicated that more clear and simple guidance would be helpful to them.

Another major theme indicated by the literature (e.g., Frank et al., 2020) was workforce-level barriers. One factor is a caseworker's familiarity with EBPs, and literature has shown that that additional training led to an increase of more appropriate referrals (Dorset et al., 2012; Frank et al., 2020; Whitaker et al., 2015). This was reflected in the focus groups, as many of the participants indicated that they did not feel that they had sufficient knowledge to refer families to services beyond those with which they were familiar. One service coordinator participant explained: "And we obviously have our go-to's in the community. But I definitely don't think that we are knowledgeable really to…to go outside of those things." Additionally, participants commonly voiced that because workers had so many responsibilities and such a high caseload, they did not have time to learn about new services for their clients unless resources were concise and easy to access. For example, another service coordinator participant stated:

> *"When do you find the time of day to start this new thing? . . . Like, you know, we've got a million other things or program changes unwinding with all of those services we've got, you know, a million different things going on right now. We got, you know, 180 kids in foster care. . . in-home workers with 400 people we have to contact with a month, you can't ever get out of a hole because you're constantly trying to survive . . . So it's kind of like there's no time to dig in right now, unless it's easy to do, and that doesn't feel easy to do right now."*

Furthermore, since the COVID-19 pandemic, workforce capacity has been implicated as a major barrier to providing services across the state of Virginia, and common challenges across state and local agencies is lack of funding to offer competitive pay, lack of consistent and sufficient resources and high turnover (Sale et al., 2023). Results from the focus groups were consistent with previous literature indicating additional workforce-level barriers affecting service delivery to families, in addition to high caseload, a large breadth of responsibilities and service access difficulties such as long waiting lists and limited appointment hours (Dorsey et al., 2012; Kerns et al., 2014; Meyers et al., 2020). One service coordinator participant said:

> *"We have these private providers . . . they were still saying, you know, make referrals, but it's gonna be 6-8 weeks before your client is going to be pulled off this wait list and offered any services."*

Additionally, a FFPSA-specific barrier was both service coordinator and agency knowledge of how to utilize Title IV-E funding. For example, increased agency turnover also creates loss of information (i.e., when an agency loses staff that knows how to use Title IV-E funding, they also lose knowledge). One participant said:

> *"That's also a lot of transition between our agency, like our director and our deputy director, and then most of our services supervisors were gone and so we . . . started over a lot of things so that's definitely a gap. I would say significant turnover . . . a ton of knowledge, in pieces, gone."*

Another workforce-level factor was the match between providers and the specific families they serve. Participants noted a lack of diversity in providers, which led to increased difficulties between providers and families. For example, one participant explained that a lack of some Spanish speaking providers was a limiting factor: "Spanish speaking has been a really really big challenge. We don't have a lot of Spanish speaking providers, so that is definitely a limiting factor." Another participant noted:

> *"If I was looking for a male counselor for a father who wanted a male counselor or even like a team male who wanted a male counselor, that is challenging to come by. . .our service providers similarly aren't incredibly diverse as it comes to race either. . .it's certainly easier to find Caucasian service providers. So if I was looking for someone, specific to have the same kind of culture or race as my client, it does become more challenging.*

These findings were consistent with previous research showing that race/ethnicity is a common barrier to family service initiation due to many factors such as a lack of culturally or linguistically appropriate services (Garland et al., 2003).

Focus group participants also mentioned facilitators for implementation of specific services such as Motivational Interviewing (MI) and Functional Family Therapy (FFT).

Specifically, participants noted that quality training for specific services, and communication and resources from the state were beneficial. One service coordinator said:

> *"We got emails. And the state really talked about every meeting . . .like every director's meeting or whatnot, [it was] something that we talk[ed] about consistently at every statewide meeting, and I think there's just a lot of conversation about it, emails from the state, what not. Yeah, something we're…there's information in every turn. So . . . that was brought to my attention.*

Service coordinators mentioned that MI was successfully implemented in their locality for many reasons. First, they felt that the state had been intentional in communicating information and providing training for MI because it was constantly talked about. Furthermore, they perceived more worker buy-in because of existing familiarity with MI benefits, in addition to reimbursement incentives. There is an abundance of literature that highlights long-term impacts of MI on family stress/coping strategies and engagement (Ingoldsby, 2010). Worker buy-in was also mentioned in the provider focus group, as a participant noted that she found the FFT training model to be very helpful in engaging families.

Family-specific factors were also salient in the qualitative analysis, including family attitudes. For example, some populations may be less trustful of providers and social services workers than others (Eiraldi et al., 2006). Several focus group participants echoed this sentiment through their discussion of attitudes toward the social services system. As one participant noted,

> *"Maybe the challenge is that, you know, working with in-home here, you come with working with social services. So sometimes there's a stigma with that, you know, like I don't want CPS in my life. . . so we have to kind of work through, like, 'we're here to help.'"*

Another participant explained: “a lot of families don’t want people in their house, or you know, are very distrustful of the government or DSS or CPS.” These are consistent with the literature that many caregivers may be deterred from following through with mental health treatment referrals due to perceived stigma and attitudes toward formal mental health treatment (Eiraldi et al., 2006). Additionally, many youth have negative attitudes toward services as well stemming from previous negative experiences with therapy, placement changes, and wariness around new adults (Kerns et al., 2014).

Additional family-level factors described by focus group participants included transportation difficulties (e.g., not having a car, poor public transportation) and income, consistent with findings from Estefan et al. (2012) and Kerns et al. (2014). Focus group participants noted that transportation was a major challenge for their clients, and that providing bus passes to clients was a facilitator for service utilization. One participant noted, “Transportation is a big piece. . . but we do have the bus line. We’ll provide a bus pass for services . . . to eliminate those barriers.” Additionally, participants explained that many of their clients are unhoused and lack a steady source of income which complicates service coordination. For example, many families lack a source of income, which is typically a higher priority for them than receiving mental health services. Lastly, another mentioned family-specific barrier was difficulty in accessing collateral information for families. One participant noted that it was difficult to get in touch with a family’s collateral sources, which negatively impacted their service provision to families, a finding reflected in Petrik et al. (2015).

Implications and Recommendations

The findings from this study suggest several implications. Although the child welfare and FFPSA contexts are unique from general mental health service utilization, many of the findings mirror existing literature. For example, a major barrier for successful FFPSA implementation in Virginia is a lack of mental health providers. Workforce difficulties have been repeatedly indicated by several agencies in state needs assessments and reports (e.g., Kirchner et al., 2018; Sale et al., 2023; Virginia Health Care Foundation, 2022). It is important that Virginia continues to work to recruit and retain mental health professionals, through several recommended ways, including referral bonuses, partnerships between schools and colleges to create school-to-work pathways, student loan repayment programs, and improving wages for workers (Buche et al., 2017; Butryn et al., 2017; Kadis, 2001). Additional recommendations include an increase of residency slots and funding for psychiatry, increased Medicaid reimbursement for behavioral health needs, promotion of team-based care, reducing barriers to pursuing behavioral health careers, an expansion of tuition support, support for faculty and clinical preceptors, and loan forgiveness (Andrew et al., 2014). Kadis (2001) also highlights the importance of training, recognition, advancement, and mentorship as key components of retaining staff. These and other workforce initiatives should aim to diversify the behavioral workforce to reflect the population served (Office of the Surgeon General, 2001), including via pipeline programs that foster partnerships with more diverse educational institutions along with developing and implementing organizational values that champion diversity, equity, and inclusion (Ware, n.d.).

Additionally, it is clear that there is a strong need for a new Comprehensive Child Welfare Information System (CCWIS) data system to replace OASIS in a timely manner, as it has been a major barrier for Virginia's child welfare system for over 25 years (JLARC, 2000). It is essential for data reporting to be improved, as it is currently extremely challenging to understand child welfare outcomes in the state due to many problems in data reporting. Additionally, data systems are essential to measuring and addressing disproportionality, sustaining effective practices and/or modifying or stopping practices that do not obtain expected outcomes (Child Welfare Information Gateway, n.d.).

Another recommendation for successful FFPSA implementation is ongoing training and coaching for navigating the FFPSA pathway and services. For example, it is evident that existing and previous FFPSA-related communication has not been fully effective in preparing the workforce to implement the plan. Local agencies require clear and intentional communication from the state on how to utilize Title IV-E funds, refer families to different EBPs, and how to report data accurately. Such information could be communicated through hands-on coaching from a regional consultant that works with local agencies to break down the process and walk them through the FFPSA pathway step by step. The National Implementation Research Network (NIRN) indicates that coaching is essential for effective implementation (NIRN, 2020).

Last, it is recommended that local child welfare agencies work to collaborate with other social service programs outside CPS and foster care such as financial assistance, housing assistance, employment programs, SNAP and TANF. It is clear that major barriers for families are basic needs such as food, housing, income, and transportation and integration of these programs would decrease barriers. Research suggests that SNAP, TANF, and other economic support programs have preventative benefits against child maltreatment (Macguire-Jack et al., 2022)

Study Limitations

The study possessed multiple strengths including (a) sequential quantitative/ qualitative design; (b) initial quantitative dataset representing the population of families in the Virginia child welfare system; (c) multiple stakeholder groups sampled; and (d) perhaps the first mixed methods study investigating FFPSA implementation in Virginia. However, there were also multiple limitations present and the findings and their interpretation must be considered with these in mind. In addition to the aforementioned data limitations, another data limitation was the challenge in establishing a residence location for families because many families in the child-welfare system often move a significant amount, there were limitations in assigning a RUCC code to each child. Several children had multiple location codes listed, indicating that their residence changed several times throughout their service provision, which may influence the services that the child may receive. Although a proxy variable was created to assign a RUCC code to each child, there are limitations.

Although the qualitative portion of the study supported much of the existing evidence relating to family barriers to service utilization, there are a number of limitations. First, this study has a small sample size, and may not be representative of Virginia as a whole. Although VDSS's jurisdiction extends to the rest of the state, their insights do not necessarily generalize to other state agencies such as OCS. Additionally, because participants from the service coordinator and provider focus groups were recruited from two localities in Virginia, the findings may not be generalizable across the state and other localities. Another limitation of this study is that there were many challenges with recruitment, and those who participated in the focus groups may have been different than those who did not choose to participate. Furthermore, it was exceptionally difficult to recruit participants for the family stakeholder group due to confidentiality concerns. However, it is integral that family voices are heard, as they are the population that is directly impacted by the FFPSA implementation. Previous attempts to incorporate family voice have been conducted, such as the Linking Systems of Care (LSC) Listening Tour initiative in 2018, and revealed family barriers that were echoed in this study's focus group such as challenges navigating systems, lengthy waiting lists, logistics, and a lack of diversity in providers (Cody & Barbarji, 2019). It is essential that studies that incorporate family voice need to continue throughout the implementation of Family First. The formation of a family advisory committee where participants are encouraged to openly share about their experiences is recommended to improve the service pathway process for families.

Conclusion

This study revealed many barriers and facilitators of Virginia's FFPSA implementation throughout the six years post FFPSA enactment. First, the quantitative data revealed that families living in metro areas were more likely to be designated as a foster care candidate than those in non-metro areas, multiracial families were less likely to receive a Title IV-E service than monoracial families, and that older children had higher likelihood of Title IV-E service utilization than younger children. Additionally, the quantitative data revealed that there was no way to distinguish between families who had only been referred to services, families who had initiated services but did not complete services, and families who completed services. This makes it currently impossible to use the existing data system to evaluate family attrition and movement through the services pathway. This is also made more challenging due to the variability in knowledge, Title IV-E fund usage, and data reporting across localities. The data system also does not allow the identification of children who received Title IV-E services through Title IV-E funding and children who received the services through Medicaid funding. As previously discussed, attrition is a key indicator of family outcomes and should be examined when investigating service provision.

The qualitative data revealed common factors reflected across stakeholder groups including a) infrastructure factors, b) workforce factors, c) funding logistics, d) family-specific factors, e) service specific factors. Future research should include a larger sample size that is representative of the Commonwealth of Virginia as a whole and include participants from each locality. Furthermore, because the FFPSA is a national policy, there is a nationwide implication of implementation. Similar studies should be conducted in each of the 50 states, to compare and contrast the barriers and facilitators of connecting families to FFPSA services across different contexts. Additionally, because there are eight other states that assign social service responsibility to its counties, it is also recommended for studies to be conducted in these other states to investigate whether these facilitators and barriers are specific to this governmental structure or solely the Commonwealth of Virginia.

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Appendices

Appendix A. Acronym List

ACF - Administration for Children and Families

BSFT - Brief Strategic Family Therapy

CANS - Child and Adolescent Needs and Strengths

CEP-Va - Center for Evidence Based Partnerships in Virginia

CFIR - Consolidated Framework for Implementation Research

CFSR - Child and Family Service Review

CHINS - Child in Need of Services

CPS - Child Protective Services

CSA - Children’s Services Act

DHHS - Department of Health and Human Services

EBP - Evidence Based Program

FAPT - Family Assessment and Planning Team

FCU - Family Check-Up

FFPSA - Family First Prevention Services Act

FFT - Functional Family Therapy

HB - HomeBuilders

HFW - High Fidelity Wraparound

HIPAA - Health Insurance Portability and Accountability Act

LDSS - Local Department of Social Services

MI - Motivational Interviewing

MST - Multisystemic Therapy

OASIS - Online Automated Services Information System

OCS - Office of Children’s Services

PCIT - Parent Child Interaction Training

PIP - Performance Improvement Plan

SDM - Structured Decision Making

SNAP - Supplemental Nutrition Assistance Program

TANF - Temporary Assistance for Needy Families

VCU - Virginia Commonwealth University

VDSS - Virginia Department of Social Services

Appendix B. Focus Group Protocol - Group 1: Service Planners

Welcome and thanks for coming today. We appreciate your time and expertise. I am NAME1 and this is my colleague NAME2. We work together on this research project. Right now, I will assign each of you a participant ID for privacy and reference purposes. Please remember your ID throughout this interview.

Does anyone have any last minute questions before we begin?

As you know from the Information Sheet, we are recording this Zoom meeting so we don't miss any of your comments. If you are not comfortable with sharing video, you are allowed to keep your video off. I am going to hit record right now after I receive a verbal "yes" or a typed "yes" in the chat box. Great! We will get started.

I am here to ask questions, listen, and make sure everyone has a chance to share. We are interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you.

Remember that your comments are confidential. Also, remember that we are interested in any comments you have, and there are no right or wrong answers.

1. Okay. Let's start by having you talk a little bit about your current position and experience?
2. Great, so we are here to talk about service planning. We would like to hear about your approach for all families but also specifically about connecting families to FFPSA and Title IV-E related services. Let's hear your big picture perspective and hear about the challenges and things that are working.
3. Let's talk about this as a series of checkpoints – determining eligibility, referral to services, initiating services, service completion. Can you talk me through these checkpoints?
    a. Probe them about each one "I haven't heard you mention the other checkpoints, you've been talking about this one….transition to other ones"
    b. Probe: challenges
    c. Probe: what are some improvements that could be made
    d. Probe: supervision?
    e. Probe: things that the STATE could do to help
    f. Probe: things that are already working
    g. Probe: specific challenges for different type of service (MST, FFT, PCIT, HB, FCU, MI, HFW, BSFT) ----- why?
    h. Probe: how do sociodemographic factors influence the process?
4. Now let us pivot to the family perspective, what do you think families would consider the biggest challenges throughout the process?
5. Is there anything specific that you do as a service planner with the intention of making things easier for families?
6. What else do you feel that I should know? What are your closing thoughts as we wrap up this interview?

Thank you. This has been helpful! As we stated at the beginning, we are assessing the barriers and facilitators of connecting Virginia families to Title IV-E services and will share some of these suggestions with the Virginia Department of Social Services to work on improving some of these challenges and providing more support to service coordinators.

Appendix C. Focus Group Protocol - Group 2: State Agency Staff Members

Welcome and thanks for coming today. We appreciate your time and expertise. I am NAME1 and this is my colleague NAME2. We work together on this research project. Right now, I will assign each of you a participant ID for privacy and reference purposes. Please remember your ID throughout this interview.

Does anyone have any last minute questions before we begin?

As you know from the Consent Form, we are recording this Zoom meeting so we don't miss any of your comments. If you are not comfortable with sharing video, you are allowed to keep your video off. I am going to hit record right now after I receive a verbal "yes" or a typed "yes" in the chat box. Great! We will get started.

I am here to ask questions, listen, and make sure everyone has a chance to share. We are interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you.

Remember that your comments are confidential. Also, remember that we are interested in any comments you have, negative and positive, and there are no right or wrong answers.

1. Okay. Let's start by having everyone tell us your first name and a little bit about your current position and experience?
2. Great, thanks everyone. The first question that I have for everyone is, as a state agency staff member, what do you feel are major barriers to the delivery of Title IV-E services across Virginia?
    1. Please describe the challenges that you are facing when trying to incorporate and implement FFPSA into what you have already been doing?
3. What can be done to reduce some of the challenges and barriers that are making it difficult to roll out FFPSA services to Virginia families?
4. What policy-related challenges are you facing?
5. What about administrative challenges? For example, how is the data system being used working?
6. What about training-related challenges?
7. What else do you feel that we should know? What are your closing thoughts as we wrap up this focus group?

Thank you. This has been helpful! As we stated at the beginning, we are assessing the barriers and facilitators of connecting Virginia families to Title IV-E services. We will share some of these suggestions with the Virginia Department of Social Services to work on improving some of these challenges.
Focus Group Protocol - Group 4: Provider Agency Staff Members

Welcome and thanks for coming today. We appreciate your time and expertise. I am NAME1 and this is my colleague NAME2. We work together on this research project. Right now, I will assign each of you a participant ID for privacy and reference purposes. Please remember your ID throughout this interview.

Does anyone have any last minute questions before we begin?

As you know from the Information Sheet, we are recording this Zoom meeting so we don't miss any of your comments. If you are not comfortable with sharing video, you are allowed to keep your video off. I am going to hit record right now after I receive a verbal "yes" or a typed "yes" in the chat box. Great! We will get started.

I am here to ask questions, listen, and make sure everyone has a chance to share. We are interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you.

Remember that your comments are confidential. Also, remember that we are interested in any comments you have, negative and positive, and there are no right or wrong answers.

1. Okay. Let's start by having everyone tell us your first name and a little bit about your current position and experience?
    1. Which in-home services do you provide?
        1. PROBE: WHY
2. Great, thanks everyone. As a therapist or intake coordinator, what do you feel are the biggest challenges you experience when providing services to clients? We want to know about in general, but also specifically about providing families with Title IV-E related services.
    1. What are some steps that your agency can take to make the process easier for you?
    2. What about things the state could do?
3. As we talk about some of the difficulties that you all face with providing Title IV-E services, what do you do when you are facing these difficulties?
    1. PROBE: How have things changed, if at all, since FFPSA?
    2. PROBE: TRAINING?
4. Now let us pivot to the family perspective, what do you think families would consider the biggest challenges in receiving services?
    1. Is there anything specific that you do with the intention of making things easier for families?
5. In thinking about your experiences providing services to families, please describe any difficulties with the following processes for families being seen via FFPSA/Title IVE:
    1. Receiving referrals
        1. PROBE: working with service coordinators in general
    2. Service initiation for families
    3. Families completing services?
    4. For each, how could these problems be fixed or made better?
6. What specific challenges exist related to each type of service (e.g., Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Parent Child Interaction

Training (PCIT), HomeBuilders (HB), Motivational Interviewing (MI), Family Check-Up (FCU), High Fidelity Wraparound (HFW), and Brief Strategic Family Therapy (BSFT)) that you provide? Why are these different challenges unique to each service?

7. What else do you feel that we should know? What are your closing thoughts as we wrap up this focus group?
8. Input/Advice on finding parent participants for a focus group/interview?

Thank you. This has been helpful! As we stated at the beginning, we are assessing the barriers and facilitators of connecting Virginia families to Title IV-E services and will share some of these suggestions with the Virginia Department of Social Services to work on improving some of these challenges and providing more support to therapists and intake coordinators.

Appendix D. Focus Group Protocol - Group 4: Provider Agency Staff Members

Welcome and thanks for coming today. We appreciate your time and expertise. I am NAME1 and this is my colleague NAME2. We work together on this research project.

Does anyone have any last minute questions before we begin?

As you know from the Information Sheet, we are recording this Zoom meeting so we don't miss any of your comments. If you are not comfortable with sharing video, you are allowed to keep your video off. I am going to hit record right now after I receive a verbal "yes" or a typed "yes" in the chat box. Great! We will get started.

I am here to ask questions, listen, and make sure everyone has a chance to share. We are interested in hearing from each of you. So if you are talking a lot, I may ask you to give others a chance. And if you aren't saying much, I may call on you.

Remember that your comments are confidential. Also, remember that we are interested in any comments you have, negative and positive, and there are no right or wrong answers.

1. Okay. Let's start by having everyone tell us your first name and a little bit about your current position and experience?
    1. Which in-home services do you provide?
        1. PROBE: WHY

2. Great, thanks everyone. As a therapist or intake coordinator, what do you feel are the biggest challenges you experience when providing services to clients? We want to know about in general, but also specifically about providing families with Title IV-E related services.
    1. What are some steps that your agency can take to make the process easier for you?
    2. What about things the state could do?

3. As we talk about some of the difficulties that you all face with providing Title IV-E services, what do you do when you are facing these difficulties?
    1. PROBE: How have things changed, if at all, since FFPSA?
    2. PROBE: TRAINING?

4. Now let us pivot to the family perspective, what do you think families would consider the biggest challenges in receiving services?
    1. Is there anything specific that you do with the intention of making things easier for families?

5. In thinking about your experiences providing services to families, please describe any difficulties with the following processes for families being seen via FFPSA/Title IVE:
    1. Receiving referrals
        1. PROBE: working with service coordinators in general
    2. Service initiation for families
    3. Families completing services?
    4. For each, how could these problems be fixed or made better?

6. What specific challenges exist related to each type of service (e.g.,Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Parent Child Interaction Training (PCIT), HomeBuilders (HB), Motivational Interviewing (MI), Family Check-Up (FCU), High Fidelity Wraparound (HFW), and Brief Strategic Family Therapy (BSFT)) that you provide? Why are these different challenges unique to each service?

7. What else do you feel that we should know? What are your closing thoughts as we wrap up this focus group?

8. Input/Advice on finding parent participants for a focus group/interview?

Thank you. This has been helpful! As we stated at the beginning, we are assessing the barriers and facilitators of connecting Virginia families to Title IV-E services and will share some of these suggestions with the Virginia Department of Social Services to work on improving some of these challenges and providing more support to therapists and intake coordinators.

Vita

Education:

- BS in Biopsychology, Cognition, and Neuroscience from the University of Michigan, minor in Spanish Language and Culture, 2017
- MPH in Health Behavior from UNC Gillings School of Global Public Health, 2020
- MS in Psychology (Child and Adolescent Psychology) from Southern New Hampshire University, 2022

Publications:

Southam-Gerow, M.A., Sale, R., Robinson, A., Sanborn, V, **Wu, J.**, Boggs, B., Riso, A., Scalone, M. & Sandman, A. (2024) Science for behavioral health systems change: evolving research-policy-public partnerships. Front. Public Health. 12:1359143. doi: 10.3389/fpubh.2024.1359143

Cuddeback, G.S., **Wu, J.C.** (2021). The psychometric properties of the Assertive Community Treatment Transition Readiness Scale (ATR). Community Mental Health Journal. https://doi.org/10.1007/s10597-021-00806-9

Gottfredson, N.C., Reyes, H.L.M., **Wu, J.C. (2021)**. Predictive associations between adolescent profiles of violent and non-violent deviant behavior with convictions in adulthood. Journal of Interpersonal Violence. https://doi.org/10.1177/0886260521997453

Cuddeback, G. S., Simpson, J. M., & **Wu, J. C.** (2020). A comprehensive literature review of Forensic Assertive Community Treatment (FACT): Directions for practice, policy and research. International Journal of Mental Health, 49(2), 106-127. https://doi.org/10.1080/00207411.2020.1717054

Technical Assistance Reports/Research Briefs:

Sale, R., **Wu, J.**, Robinson, A., Finn, N., Aisenberg, G., Kaur, N., Riso, A., & Southam-Gerow, M. A. (2023). Workforce and Other Factors Impeding Implementation and Sustainment of FFPSA Evidence-Based Programs: A Study of Obstacles and Opportunities.

Southam-Gerow, M.A., Finn, N.K., **Wu, J.**, Boggs, B., Sanborn, T., Riso, A., Scalone, M., Sale, R. (2023). US states' approaches to mental health staff without master's degree training: Review and comparison. Report prepared for the Right Help, Right Now Workforce workstream.

Conferences/Presentations:

Wu, J., Riso, A., Sale, R., & Southam-Gerow, M.A. (2024, May). The State Needs Assessment Information Library: Helping Virginia Child-Serving Agencies Collaborate. [Poster session. Society for Prevention Research (SPR) 32nd Annual Meeting: Advancing

Partnerships and Collaborative Approaches in Prevention Science. Washington DC, United States.

Sale, R., **Wu, J.**, & Robinson, A. (2023). Funding for Evidence-Based Programs through Title IV-E Prevention Services Training Awards [Webinar]. Virginia Department of Social Services. [https://www.youtube.com/watch?v=AT2yAW8LF4k].

Jagannathan, V., Golden, S., Carpenter, K., Drewry, M., **Wu, J.**, Rothschild, A. (2020, January 24). Addressing Adverse Childhood Experiences and Trauma in Rural Eastern North Carolina – A presentation with Rural Opportunity Institute and the UNC Capstone Team [Oral presentation]. Connect, Engage, Transform: Rural Community Partnerships. Chapel Hill, NC, United States.

Wu, J. (2019, November 8). Incarcerated Individuals with Intellectual and Developmental Disabilities and Co-occurring Mental Illnesses: Community Re-entry Outcomes after Prison Release [Poster session]. Thomas Carsey Graduate Research Symposium. Chapel Hill, NC, United States.

Experience:
2023-2024
Center for Psychological Services and Development (Richmond, VA)
Doctoral Level Student Clinician

2022-present
Center for Evidence-based Partnerships in Virginia (Richmond, VA)
Graduate Research Assistant and Lab Manager

2021-2022
American Institutes for Research: Youth, Family, and Community Development Division
Research Associate

2019-2021
University of North Carolina School of Social Work (Dr. Gary Cuddeback)
Graduate Research Assistant, Research Associate

2019-2020
Year-Long Service-Learning Partnership with Rural Opportunity Institute in Edgecombe County
Program Evaluation Deliverable Lead, Capstone Team Member

2019-2019
University of North Carolina Health Behavior (Dr. Nisha Gottfredson)
Project Manager, Graduate Research Assistant

2017-2018
ABA Pathways, LLC (Ypsilanti, MI)
Behavior Technician

2016-2016
University of Michigan Translational and Developmental Neuroscience Lab (Dr. Chris Monk and Kristen Stauffer)
Research Assistant

2015-2015
University of Michigan Family, Cultural, and Development Lab (Dr. Sandra Tang and Dr. Pamela Davis-Kean)
Research Assistant

<u>Mentoring:</u>
Peer mentor, VCU Clinical Psychology Program, 2023-present