The Nicholson Foundation

Changing Systems, Changing Lives

COVER SHEET

Request for Proposals

In-Home Recovery Program

This document includes the following components:

1. Request for Proposals (RFP) for the ***In-Home Recovery Program***, which includes instructions for completing The Nicholson Foundation Grant Proposal;
2. Appendix A: The Nicholson Foundation 18-Month Budget Template;
3. Appendix B: Sample Budget;
4. Appendix C: Project Timeline;
5. Appendix D: Case Vignettes; and
6. Appendix E: Family-Based Recovery Logic Model.

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Request for Proposals

In-Home Recovery Program

I. PURPOSE

The Nicholson Foundation, in partnership with New Jersey Department of Children and Families (NJDCF), is issuing this Request for Proposals (RFP) to solicit proposals for a family-based recovery program from New Jersey–based mental health and substance use disorder treatment providers serving adults, families, and/or young children.

The goals of the *In-Home Recovery Program* (the Program) are to improve outcomes for parents who have a substance use disorder and are actively parenting a child under 36 months old and to expand the service array for these families through the following strategies:

- funding the implementation of a specific evidence-informed, in-home treatment program (the Project);
- supporting the technical assistance and training for the Project staff; and
- partnering with NJDCF to evaluate the cost and implementation of the Project, including post-intervention changes on parental substance use and involvement with child protective services (NJDCF will fund the evaluation component of the Project).

II. OVERVIEW OF THE NICHOLSON FOUNDATION

The Nicholson Foundation is dedicated to improving the health and well-being of vulnerable populations in New Jersey. The Foundation's primary goal is to improve outcomes in health and early childhood. Our strategic approach is to transform service delivery systems by informing policy and developing sustainable models that better serve vulnerable populations.

III. DESCRIPTION OF THE GRANT OPPORTUNITY

The Nicholson Foundation will fund one award for the implementation of two (2) Project sites managed by one agency. Each Project team will treat a caseload of twelve (12) families concurrently and serve a minimum of eighteen (18) families over the 18-month grant period, beginning on September 1, 2019, for a budget not to exceed $1,064,855.

An important objective of the Program is to demonstrate the effectiveness of a trauma-informed in-home treatment for families involved with the NJDCF Division of Child Protection and Permanency (DCP&P) who have an index parent (client) with a substance use disorder and an index child (child) under the age of 36 months. Outcome measures will include parental substance use, child placement at discharge, and a client's repeat involvement with child protective services.

IV. ELIGIBLE APPLICANTS

The Nicholson Foundation intends to fund two teams that will be operationalized by the same agency but serve two different Division of Child Protection and Permanency (DCP&P) local offices in Ocean County. Interested applicants must be New Jersey–based mental health and substance use disorder treatment providers serving adults, families, and/or children and must have an office(s) in the service area.

Applicants may include the following:

- licensed substance use disorder treatment programs with experience providing mental health services, and
- licensed mental health agencies with experience providing substance use disorder services.

Priority will be given to mental health and substance use disorder treatment providers with experience in the following areas:

- providing in-home services;
- working with young children utilizing an infant mental health approach;
- implementing an evidence-based, trauma-informed treatment model;
- working with NJDCF, including providing services to families involved with the NJDCF DCP&P; and/or
- utilizing an electronic health record;
- serving families in Ocean County.

NOTE: Eligible applicants, as defined above, are referred to as "Project team" throughout the remaining portion of this RFP and its attachments.

V. REGISTER FOR A WEBINAR

The Nicholson Foundation will host a webinar on **June 25, 2019, at 1:00 pm** to provide an overview of the Project and answer questions from potential applicants. If you would like to participate in the webinar, please email Shannon Ayers, Senior Program Officer at The Nicholson Foundation, at sayers@thenicholsonfoundation.org to register.

VI. BACKGROUND AND NEED

In 2017, 30.4% of NJDCF-involved children experienced a substance abuse caregiver risk factor and 13.7% had an alcohol abuse risk factor, according to the National Data Archive on Child Abuse and Neglect.[1] Ninety percent of young children (children aged 0–3) who entered care in New Jersey between 2009 and 2012 and experienced reentry within 12 months of reunification had a caregiver with a substance use issue. In addition, 50% of the DCP&P's families with children aged 0–3 receiving in-home services also had a

[1] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment.

caregiver with a substance use issue.[2] In particular, in Ocean County the number of referrals for assessment of substance use disorder of a parent/caregiver in 2018 was nearly 1,200, with 1,160 caregivers subsequently being referred for treatment. Ocean County has long been a county of concern with regard to the opioid crisis in New Jersey, and has been identified by DCP&P staff as in need of more effective and readily available interventions.

The needs of parents who use substances and the potential impact on their young children are well documented.[3,4] One of the most challenging responsibilities for a Child Protective Services (CPS) social worker is weighing the developmental needs of a child against the risk associated with parental substance use in determining whether the child needs to be removed. Historically, child protection has focused primarily on the physical safety of children without taking into consideration the need to balance that with psychological safety and well-being. Children removed due to parental substance use typically remain in foster care longer and are less likely to be reunified than children removed for other reasons.[5,6] In fact, for many children, foster care placement has not resulted in positive outcomes.[7,8] Additionally, the child's placement outside of the home might have an unintended negative impact on the mother's recovery process and sense of well-being and therefore an impact on successful reunification. Some mothers may increase substance use to manage the loss experienced from removal and their sense of being judged as a less-than-competent parent. Diminished motivation to participate in treatment after a child is removed may lead to an increase in adverse life events.[9,10]

Child welfare knowledge and case practice have evolved to recognize that parent and child do not need to be separated for a parent to achieve substance use recovery and for the child to remain safe.

VII. THE PROGRAM

In partnership with NJDCF, The Nicholson Foundation is embarking on a multipronged, two-generation, trauma-informed initiative to support parental substance use disorder (SUD)

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[2] State of New Jersey Department of Children and Families, 2019.
[3] Seay, K.D., & Kohl, P.L., 2015. The comorbid and individual impacts of maternal depression and substance dependence on parenting and child behavior problems. *Journal of Family Violence*, *30*(7):.899–910.
[4] Whitaker, R.C., Orzol, S.M., & Kahn, R.S., 2006. Maternal mental health, substance use, and domestic violence in the year after delivery and subsequent behavior problems in children at age 3 years. *Archives of General Psychiatry*, *63*(5): 551–560.
[5] Lloyd, M.H., Akin, B.A., & Brook, J., 2017. Parental drug use and permanency for young children in foster care: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review*, *77*: 177–187.
[6] Vanderploeg, J.J., Connell, C.M., Caron, C., Saunders, L., Katz, K.H., & Kraemer Tebes, J., 2007. The impact of parental alcohol or drug removals on foster care placement experiences: A matched comparison group study. *Child Maltreatment*, *12*(2): 125–136.
[7] Villodas, M.T., Litrownik, A.J., Newton, R.R., & Davis, I.P., 2015. Long-term placement trajectories of children who were maltreated and entered the child welfare system at an early age: Consequences for physical and behavioral well-being. *Journal of Pediatric Psychology*, *41*(1): 46–54.
[8] Weiler, L.M., Garrido, E.F., & Taussig, H.N., 2016. Well-Being of Children in the Foster Care System. In M.R. Korin (Ed.), *Health Promotion for Children and Adolescents* (pp. 371–388). New York, NY: Springer.
371–388.
[9] Donohue, B., Azrin, N.H., Bradshaw, K., Van Hasselt, V.B., Cross, C.L., Urgelles, J., Romero,V., Hill, H.H., & Allen, D.N., 2014. A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. *Journal of Consulting and Clinical Psychology*, *82*(4): 706.
[10] Nicholson, J., Finkelstein, N., Williams, V., Thom, J., Noether, C., & DeVilbiss, M., 2006. A comparison of mothers with co-occurring disorders and histories of violence living with or separated from minor children. *The Journal of Behavioral Health Services & Research*, *33*(2): 225–243.

recovery, healthy attachment, family stability, and positive child development. The initiative is composed of three components:

1) the Project,
2) technical assistance (TA) and consultation, and
3) evaluation supported by NJDCF.

This RFP is for the Project, an evidence-informed, in-home treatment model to address parental substance use and the parent-child dyadic relationship, which is described below. The Project with be composed of two clinical teams at one agency.

A. <u>The Required In-Home Family Project</u>

In 2006, the Connecticut State Department of Children and Families (CTDCF) recognized the need to address the dual challenges of parenting and achieving recovery if the child placement rate in Connecticut was to decrease. The CTDCF brought together faculty members from Johns Hopkins University, the University of Maryland, and the Yale Child Study Center (YCSC) to develop a treatment model that integrated contingency management substance use disorder treatment with in-home, attachment-based parent-child therapy.

Johns Hopkins University's Reinforcement-Based Treatment (RBT)[11] is an evidence-based, comprehensive behavioral substance use treatment model that incorporates interventions from the Community Reinforcement Plus Vouchers Approach,[12] relapse prevention,[13] and motivational interviewing.[14] The staff from Johns Hopkins University (JHU) developed RBT in 1997. The conceptual foundation of RBT is based on operant conditioning. Positive reinforcement is the most effective means of producing behavior change. The RBT approach is to replace the reinforcement of substances with healthier alternative activities that are incompatible with substance use.

RBT was originally developed as a clinic-based treatment model for clients diagnosed with opioid use disorder exiting detoxification programs in Baltimore, Maryland. Two randomized controlled studies revealed that clients in RBT were more likely to be abstinent from substances, had longer treatment length of stay, and worked more days at 3, 6, and 12 months post-admission to treatment than clients in standard community-based treatment programs.[15,16] RBT has been adapted to treat pregnant substance-using women and has achieved similar treatment outcomes.[17]

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[11] Tuten, L.M., Jones, H.E., Schaeffer, C.M., & Stitzer, M.L., 2012. *Reinforcement-based treatment for substance use disorders: A comprehensive behavioral approach*. American Psychological Association.
[12] Budney, A.J., & Higgins, S. T., 1998. *Therapy Manuals for Drug Addiction, Manual 2: A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction*. Rockville, MD: National Institute on Drug Abuse.
[13] Irvin, J.E., Bowers, C.A., Dunn, M.E., & Wang, M.C., 1999. Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *67*, 563–570.
[14] Miller, W.R., & Rollnick, S., 2002. *Motivational Interviewing: Preparing People for Change, 2nd Ed*. New York: Guilford.
[15] Gruber, K., Chutuape, M.A., & Stitzer, M.L., 2000. Reinforcement-based intensive outpatient treatment for inner city opiate abusers: A short-term evaluation. *Drug and Alcohol Dependence*, *57*(3), 211–223.
[16] Tuten, M., Defulio, A., Jones, H., & Stitzer, M., 2011. A randomized trial of reinforcement-based treatment and recovery housing. *Addiction, 107*(5), 973–982.
[17] Jones, H.E., O'Grady, K.E., & Tuten, M., 2011. Reinforcement-based treatment improves the maternal treatment and neonatal outcomes of pregnant patients enrolled in comprehensive care treatment. *The American Journal on Addictions, 20*(3), 196–204.

The YCSC developed the Coordinated Intervention for Women and Infants (CIWI) program in 1990 with funding from the Abandoned Infants Assistance Act, administered by the Department of Health and Human Services. CIWI was an intensive, in-home, trauma-informed clinical service for women with a history of substance use who were pregnant or had an infant under the age of 12 months. The principles of attachment theory guided the clinical work. Teams focused on the caregiver's ability to provide appropriate care, nurturing, and emotional availability to the child. Parents were asked to explore how their own experience being parented impacted their parenting behaviors. Staff utilized an infant mental health approach to assist mothers to focus on the needs and feelings of the child in the present moment. Data from 2004 to 2006 revealed that 63% of children lived with a biological parent at the time of discharge. The CIWI program ended in 2008.

YCSC, JHU, and CTDCF integrated RBT and CIWI into a new model, Family-Based Recovery (FBR),[18] which is based on two foundational principles: attachment is critical to healthy development and substance use treatment works. The FBR model was originally implemented in 2007 by six community-based agencies. Each agency had one FBR team; each team carried a caseload of 12 families. In 2013, CTDCF expanded FBR statewide. There are currently 17 FBR teams providing this clinical in-home service. YCSC continues to provide quality assurance oversight, training, and model fidelity with FBR Services. Data provided by FBR sites and analyzed by FBR Services reveals statistically significant changes in several pre-/post-intervention assessment scores for clients in the areas of depression, parenting stress, and parental bonding. Toxicology results show a steady increase in negative screens after the first 15 weeks in FBR, suggesting a primary goal of the project is being met. In Fiscal Year 2017–2018, 84% of children lived with a biological parent at discharge. FBR is currently undergoing a randomized control trial with funding from a social impact bond project in collaboration with Social Finance, LLC, CTDCF, and the University of Connecticut.

Participating teams in New Jersey will use an adapted version of FBR called the *In-Home Recovery Program* (IHRP). Project teams will be expected to perform the set of services outlined below.

B. Project Staff and Responsibilities

The Project requires the following staff for model implementation for ***each*** team (note that the agency will have ***two*** teams):

- one half-time licensed master's level clinical supervisor;
- two full-time licensed master's level clinicians for whom substance use disorder treatment is within their scope of practice (licensed clinical social worker [LCSW], licensed professional counselor [LPC], licensed psychologist, licensed marriage and family therapist [LMFT], licensed clinical alcohol and drug counselor [LCADC]);

[18] Hanson, K.E., Saul, D.H., Vanderploeg, J.J., Painter, M., & Adnopoz, J., 2015. Family-based recovery: An innovative in-home substance abuse treatment model for families with young children. *Child Welfare, 94*(4), 161–183.

- one full-time bachelor's level family support specialist; and
- one part-time (.1 FTE) psychiatrist or advanced practice registered nurse (APRN).

1. The IHRP clinical supervisor (.5 FTE) will be a licensed clinician (e.g., a master's or doctoral level behavioral health professional) with at least five years' experience providing clinical and/or substance use services to children and families. Prior supervisory experience is required. This individual will be responsible for the following activities:

a. oversee the Project and its staff,
b. provide weekly reflective supervision to the team,
c. ensure treatment follows the FBR model and tools and measures are complete and timely,
d. develop a strong collaborative relationship with the DCF DCP&P local office's IHRP liaison,
e. review all referrals to determine eligibility,
f. attend DCP&P reviews to guide team around discussion topics,
g. submit monthly reports on clients' progress toward treatment goals to DCP&P staff,
h. oversee data collection and provide data to the Project evaluator,
i. provide direct clinical care at the weekly parent-child outpatient group (called Social Club) and in the home when needed due to clinical acuity or staff absence,
j. attend required trainings, and
k. participate in technical assistance meetings and calls.

2. The two clinicians will be master's level behavioral health professionals for whom substance use disorder treatment is within their scope of practice. Clinicians may include licensed clinical social workers, licensed professional counselors, licensed psychologists, licensed marriage and family therapists, or licensed clinical alcohol and drug counselors who are qualified to practice independently in New Jersey. Each clinician will be cross-trained and will act as the parent-child clinician for six clients and the individual/substance use clinician for six clients. The two (2) clinician roles are as follows:

a. <u>Parent-Child</u>
   i. Deliver treatment to facilitate positive parent-child interactions and optimal child development
   ii. Promote reflective capacity utilizing an infant mental health approach
   iii. Conduct developmental screenings
   iv. Address safe sleep and other safety issues
   v. Focus on the client's relationship with the child and the systems that interact with the child
   vi. Co-facilitate weekly parent-child therapy group (Social Club)
   vii. Attend required trainings
   viii. Submit all required data to supervisor and evaluator
   ix. Participate in technical assistance (TA) meetings and calls

b. Individual/Substance Use
   i. Deliver treatment that targets parental recovery and psychological well-being
   ii. Utilize FBR tools to inform and guide treatment
   iii. Use FBR-specific abstinence-related tracking tools, such as graphing
   iv. Provide individual psychotherapy to address comorbid mental health issues
   v. Co-construct treatment goals related to recovery, education, employment, healthy relationships, family communication, and/or legal issues
   vi. Refer client to medication-assisted treatment (MAT) as appropriate
   vii. Collaborate with other systems to coordinate care to support the client and child, including with the MAT provider as needed
   viii. Co-facilitate weekly parent-child therapy group (Social Club)
   ix. Attend required trainings
   x. Submit all required data to supervisor and evaluator
   xi. Participate in technical assistance meetings and calls

3. The IHRP family support specialist (FSS) will be a bachelor's level paraprofessional with experience or training in human services. The FSS will work with all 12 clients on one team. The FSS will fulfill the following responsibilities:
   a. support the clinical work by facilitating/co-facilitating home visits;
   b. utilize abstinence-related tracking tools to graph recovery-related activities;
   c. assist clients with identifying and accessing basic needs and utilize online databases (e.g., Aunt Bertha, Benefits Kitchen) as needed;
   d. assist clients in school and job preparation;
   e. attend required trainings;
   f. submit all required data to the supervisor and evaluator;
   g. maintain contact with the client's MAT provider, as appropriate;
   h. assist clients in applying for NJ FamilyCare, as needed;
   i. connect clients to a medical home;
   j. refer children to Early Intervention Services, as needed; and
   k. participate in technical assistance meetings and calls.

4. The part-time (.1 FTE) psychiatrist or APRN will provide consultation to the team on cases. A practitioner with a DATA 2000 waiver is preferred. The participating provider may be reimbursed for obtaining a DATA 2000 waiver. The psychiatrist or APRN will fulfill the following responsibilities:
   a. conduct clinical psychiatric evaluations; and
   b. provide pharmacotherapy, including MAT, as needed to clients.

C. Target Population

The target population for the Project is DCP&P-involved parents (client) who have a substance use disorder and a young child. Only one child per family will be enrolled in the Project. The client might have

other children, but the youngest child will be the target of treatment. Service level approximates ASAM 2.1l. The IHRP is considered an alternative to an intensive outpatient program (IOP) or a mother-child residential treatment program. Inter-partner violence and homelessness are not exclusionary criteria for this model.

1. Inclusion Criteria

a. Client

i. The client is a mother and/or father assessed by the Child Protection Substance Abuse Initiative (CPSAI) with a substance use disorder diagnosis.

ii. The client's CPSAI assessment result indicates that he/she may be served in an IOP level of care or higher, per ASAM criteria for Level 2.1 outpatient services, or an ASAM Level 4 residential program.

iii. The client is not involved in another treatment program or is willing to discharge from the program to enter the IHRP. Clients whose recovery is supported by medication-assisted treatment are expected to continue to receive these services.

iv. The client has the capacity to engage in the treatment model.

v. The client is in a caregiving role to the child at least 50% of the time.

b. Child

i. The child is under 36 months old.

ii. The child resides in the client's home, or if the child is placed outside the home, there is a plan for reunification within 30–45 days or less from the time of the referral.

2. Exclusion Criteria

a. A client whose psychiatric symptoms require immediate attention and stabilization prior to IHRP treatment.

b. A client who requires medical withdrawal management in a residential or acute care setting. Once the client has been medically cleared, he/she can be referred to the IHRP.

c. A client who is participating in a duplicate service and whose enrollment in IHRP would be overwhelming.

D. Service Provision

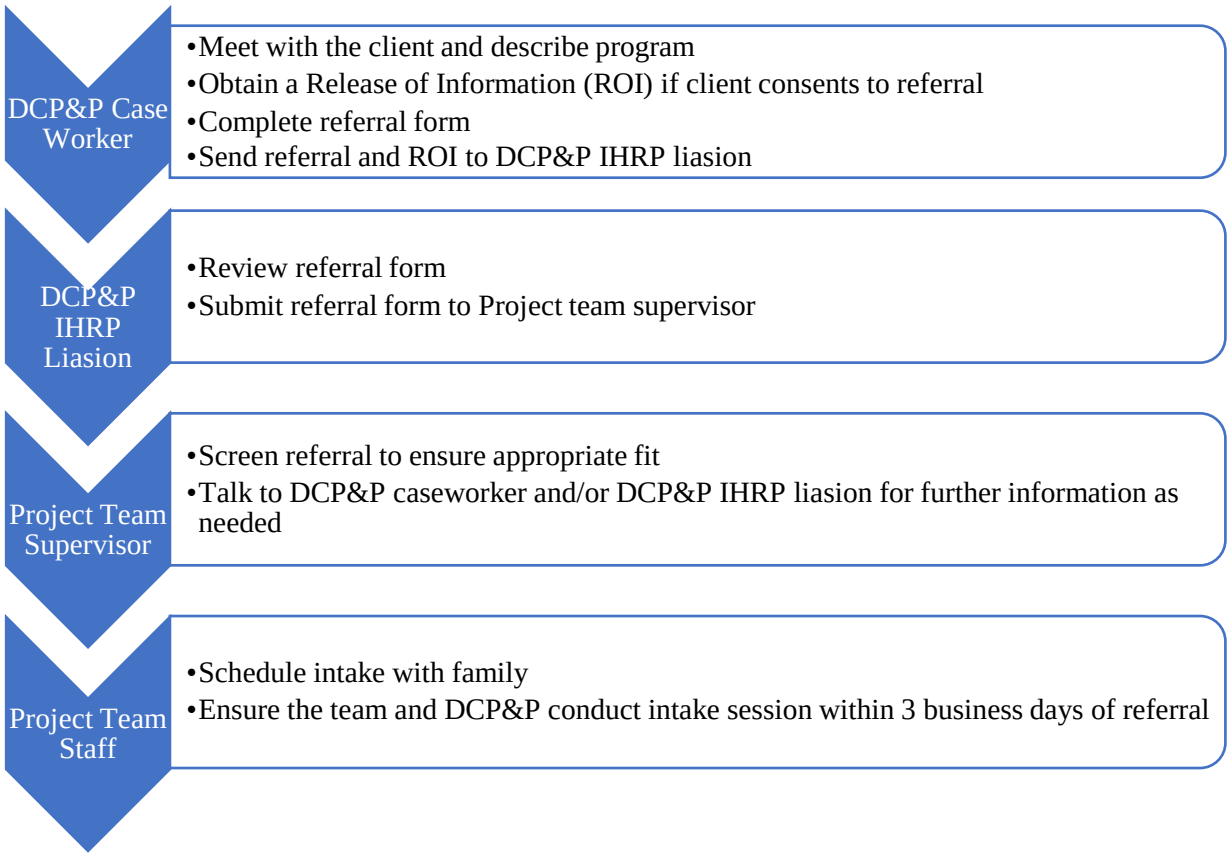
Team responsibilities:

1. Offer treatment sessions minimally from 8:00 a.m. to 7:00 p.m., Monday through Friday
2. Ensure flexibility in scheduling sessions before 8:00 a.m. and after 7:00 p.m. to best meet the needs of the clients served
3. Provide services 52 weeks per year
4. Provide 24/7 phone coverage for crisis intervention

5. Provide treatment to each client for six to nine months depending on time of enrollment

E. Referrals

Eligible clients will be identified and screened by DCP&P staff. Admission criteria are outlined above in **Section C. Target Population.** The contractor will not maintain a waiting list.



F. Intake Session

The intake session is scheduled by the IHRP team. The IHRP team and DCP&P caseworker attend the intake session at the client's home to review with the client the reason for referral, targeted substance(s), safety agreements, and the treatment model. The client may elect to consent for treatment, ask for a period of time of no more than 24 to 48 hours to consider treatment options, or decline IHRP treatment.

If the client elects to enroll in the IHRP during the intake session, the client will sign a consent form for treatment, complete a toxicology screen with an IHRP staff person, sign a release of information to the DCP&P, and complete intake forms. Clients enrolled in MAT at another agency will also sign consent for disclosure to/from the IHRP and the MAT provider. If a client asks for a period of time to consider enrolling in the IHRP, the DCP&P caseworker will communicate with the

client within the agreed-upon time frame and inform the IHRP staff. If the client agrees to participate, the protocol outlined above for the intake session will be followed.

G. Key Model Components

1. Substance Testing
   Toxicology testing is for clinical purposes only. All IHRP staff are required to conduct urine toxicology screens with clients. Clients will be asked to submit a urine sample for screening at every encounter. IHRP staff will observe the toxicology screen when the staff member is the same gender as the client. The IHRP will utilize a combination of CLIA-waived rapid tests and chain-of-custody procedures for testing within a licensed clinical laboratory to screen for a minimum of 12 substances. Further processes for urine toxicology testing for the DCP&P will be determined during training and in consultation with local offices. Breathalyzers will be used at each visit for clients who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other clients.

2. Vouchers
   Contingency management therapy provides positive reinforcement for evidence of behavioral change. The IHRP provides a $10 gift card/voucher for each negative toxicology screen during the first phase of treatment. Vouchers are one incentive for recovery and are seen as a means to jump-start recovery and engagement at the beginning of treatment. Clients earn up to $700 in vouchers for negative toxicology screens. The provider must have gift cards available to dispense at all times. It is expected that other reinforcers for recovery will be in place consistently by the time the client has received this amount. The client will earn a $20 gift card for completion of all discharge measures.

3. Collaboration with DCF
   Clients referred to the IHRP by NJDCF are considered to be at risk for neglect due to parental substance use. While NJDCF has the legal mandate to ensure that children are safe and have minimal exposure to risk, the IHRP team will collaborate and communicate with NJDCF to support the ongoing DCP&P safety risk assessment process. Multiple levels of engagement with clients will inform decision-making and are intended to decrease risk.

   The IHRP team and DCP&P local and area office staff will work in close collaboration from the time of referral until the client is discharged from the IHRP. The IHRP team will frequently communicate with the assigned DCP&P caseworker via phone and/or encrypted email (to ensure confidentiality) about the client's progress and/or any concerns about the client's functioning. The IHRP team will be required to notify the DCP&P caseworker when a client relapses and collaborate with the DCP&P to ensure the child's or children's

safety. The DCP&P caseworker will likewise keep the IHRP team informed of any significant changes in the client's case status.

The IHRP team, DCP&P staff, and client will meet monthly to review progress toward goal achievement. The IHRP team will attend, when asked, any case planning meetings scheduled during the case episode, as well as child and family team meetings requested by the client. In addition, the IHRP team, DCP&P caseworker, supervisor, and DCP&P/IHRP liaison will meet monthly in the DCP&P local office to review case progress.

DCP&P case closure for clients engaged in the IHRP shall be determined according to the DCP&P Case Closure in Cases with Substance Use Disorder (SUD) Issues Policy, available here.

4. Collaboration with Medication-Assisted Treatment Providers
   IHRP clinicians and/or FSS will also collaborate with the client's MAT provider, if applicable, and participate in case conferences telephonically or in person at least once a month.

5. Outreach
   Since the IHRP is a home-based treatment, many of the barriers to accessing treatment are removed for IHRP clients. However, clients can avoid treatment by rescheduling frequently or not being home during scheduled home visits. Thus, the Project team will make multiple attempts to engage clients in treatment as outlined by the model. Staff may reach out via letter or phone call and attend scheduled sessions with the DCP&P caseworker.

6. Measures
   IHRP clinicians utilize standardized measures to inform and guide treatment and identify and track symptoms over the course of the intervention. Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:
   a. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
   b. child: development, resilience, behaviors, and trauma exposure; and
   c. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

7. Tools
   a. A three-generation **genogram** provides a structure for obtaining family history and a preliminary understanding of the fit between the client and the client's family system. The genogram will be co-constructed by the client and the parent-child clinician in the early stages of treatment and encourages a client to think about the early influences of family and environment in terms of caregivers, stability,

important relationships, mental and physical health, and substance use.

H. The Three Phases of the IHRP

1. Assessment Phase (four to six weeks)

The IHRP team will meet with the client three times a week. The team will conduct a comprehensive evaluation of each client and child participating in the IHRP, which will result in the formulation of a DSM-5 diagnosis for the client and an individualized treatment plan. The evaluation will provide a clinical integration of the client's medical, psychosocial, substance use, legal, educational, and treatment histories, as well as an assessment of the child's development and parent-child interaction and attachment style. The evaluation should be comprehensive enough to address the needs of the child and client within the context of the family and social community. The team will complete FBR measures and tools.

Recovery planning will be a critical part of the IHRP team's work with clients and the DCP&P. IHRP staff and the clients will develop a plan to be implemented at times when clients are experiencing strong cravings and are at high risk of relapse and/or are in crisis and need to ensure safety for themselves and their child(ren). The IHRP team will work with the client to identify an alternative caregiver for the child if the client chooses to use substances. The team will discuss with the client how to manage a relapse if it should occur. The plan will be shared with the DCP&P.

2. Treatment Phase

The team conducts three home visits a week for at least the first six months of treatment. After six months of treatment, the client may be stepped down to two visits a week. Treatment consists of five components:

a. Parent-Child Component

The IHRP will not utilize a parenting curriculum. The IHRP team will use naturally occurring parent-child interactions as opportunities for reflection and support. The purpose of each parent-child session is to observe the back and forth of communication between client and child, how the client interprets the child's cues, and how the client and child deal with ruptures and misunderstandings. The parent-child clinician will conduct a session with the client and child once a week in the home or in the community (e.g., pediatrician visit, library). The child might have siblings residing in the home. The IHRP recognizes that all children might need assessment, possible interventions, and advocacy with systems, and this is the domain of the parent-child clinician. The parent-child clinician will facilitate assessments and referrals to all children in the home as needed but will not be expected to provide treatment to all children in the household. The parent-child work will focus on the following:

i. understanding of child development,
ii. child and household safety,
iii. child health/well-child care,
iv. understanding of and response to child cues and needs,
v. positive parent-child interactions for secure attachment, and
vi. consistency in household routines and arrangements for child care.

b. Substance Use Component

The substance use clinician will provide individual, trauma-informed psychotherapy in addition to substance use treatment for the client. The IHRP will use tools and principles from Reinforcement-Based Treatment. Treatment goals are designed to replace the function (or purpose) of substance use for the individual. Experiencing the tangible benefits parents receive from being substance free— first and foremost, being able to parent their child—provides powerful motivation and focus to recovery. The substance use clinician will utilize a variety of tools to inform and guide the clinical work. These include the following:

i. Brief Substance Use Assessment (BSUA)

This tool will be used by the clinician to assess how long a client has used each substance and how much the client has spent on substances in an average day. This tool provides valuable information for contracts and treatment goals. Every 90 days, the clinician and client will complete a BSUA Follow-Up Tool.

ii. The Functional Assessment (FA)

The FA will provide the clinician with critical information regarding the "function(s)" that substance use serves in the client's life. It examines how substance use fits into the client's daily routine; what people, places, events, and feelings are associated with use; and which substances are commonly paired together. By completing the FA, the clinician will obtain information that will guide the clinical work (contracts, treatment plan, psychiatric evaluation, and management).

iii. Graphs

FBR Graphs are a cognitive-behavioral tool that keeps abstinence and abstinence-related goals tangible and salient to the client.

iv. Contracts

Contracts are written agreements between the IHRP team and the client designed to improve the likelihood that he/she will engage in a particular behavior.

c. Psychiatric Evaluation and Pharmacotherapy

The psychiatrist/APRN will be available to conduct a psychiatric evaluation on all clients. The psychiatrist/APRN will provide pharmacotherapy and medication-assisted treatment (MAT) as needed. The psychiatrist/APRN will refer clients to an affiliated MAT provider as appropriate.

d. Basic Needs Assessment and Support

Many IHRP clients need assistance with obtaining basic needs for themselves and their family. The IHRP recognizes that clients need to have many of their basic needs met in order to maintain recovery and parent their children in a competent manner. The team is expected to offer assistance with referrals, as needed, in the following areas: housing, health care, education, employment, utility bills, social services, energy assistance programs, Early Intervention Services, and child care. Staff will assist clients with obtaining important documents (Social Security cards, birth certificates, driver's licenses, and Green Cards) as needed. The IHRP team will transport clients to offices and appointments, when appropriate.

Numerous clients are involved with the legal system due to criminal charges, housing matters, child support, domestic violence, and probation. The IHRP team will offer support to the clients in their interactions with the legal system and will communicate and collaborate with court officers when authorized by the client.

e. Social Club

Social Club is a weekly, two-hour group that provides the client another form of positive reinforcement for recovery. Clients must have a negative toxicology screen on the day of group in order to attend. While the group is not mandatory, all clients will be asked to sample Social Club at least once. Clients will be encouraged to bring their child to group. All IHRP staff members will attend the group. In addition to clinical group time, the Social Club will consist of clients, children, and staff sharing a meal together. Initially, while a core group is building, staff may need to provide a more structured format, using ice breakers, recovery-related games, or art therapy as tools to initiate topics for discussion. Whatever the topic or activity, a goal of Social Club is for the conversation to ultimately link to issues of parenting and/or recovery. Depending on the age of the children and the activity and/or topic, children may remain with clients during the therapy portion of the group. At other times, it will be more appropriate for the children to move into another room under the supervision of a staff member.

3. Discharge Phase (four to six weeks)

The client can be stepped down to Phase III, which consists of one home visit a week, four to six weeks prior to discharge. The length of service in this phase will be based on the clinical needs of the client and child. Discharge planning should be a collaborative endeavor between the client, the IHRP, and the DCP&P. Prior to discharge, the recovery plan will be reviewed with the client and updated as needed. A client will be considered as successfully graduating from the IHRP if at the time of discharge the child lives with the client, the client has 12 consecutive negative toxicology screens, and the client has achieved one other co-constructed goal.

VIII. RELATED PROJECT ACTIVITIES – SEPARATELY FUNDED EVALUATION and TECHNICAL ASSISTANCE

A. Program Evaluation

The Program also includes a separate evaluation component. If the evaluation demonstrates evidence of clinical effectiveness and positive child welfare outcomes, including decreased costs for foster care, a case could be made to the State of New Jersey for more widespread support of an in-home treatment model that addresses parental substance use and the parent-child dyadic relationship. Requirements for Project teams for the Program evaluation are detailed below.

B. Technical Assistance

The Program includes funding to provide technical assistance (TA) to each Project team. The TA will include reflective consultation to the supervisor and clinical staff to ensure model fidelity. Other areas of focus for the TA will be start-up procedures and skill development. Requirements for Project teams for the TA are detailed below.

IX. REQUIRED PROJECT DELIVERABLES

The provider will be required to meet the specific deliverables described below. The provider will employ two teams. Each team will serve 18 families located in two distinct catchment areas. At times, both parents (clients) will be referred to the IHRP for treatment. This will be considered one case. The information provided in this section will be used for completing the **Project Proposal Template** in **Section XII**.

A. Hire or Reassign Required Staff

The Project requires the following staff for ***each team*** for model implementation (see **Section VII. B** for full description of roles and responsibilities):

- 2 full-time master's level clinicians for whom substance use disorder treatment is within their scope of practice (LCSW, LPC, licensed psychologist, LMFT, LADC);
- 1 full-time bachelor's level family support specialist;
- 1 half-time licensed master's level clinical supervisor; and

- 1 part-time (.1) psychiatrist or APRN.

Thus, ***in total***, the agency will require the following staff:

- 4 full-time master's level clinicians for whom substance use disorder treatment is within their scope of practice (LCSW, LPC, licensed psychologist, LMFT, LCADC);
- 2 full-time bachelor's level family support specialists;
- 1 full-time licensed master's level clinical supervisor; and
- 1 part-time (.2) psychiatrist or APRN.

B. Participate in Required Trainings
    1. Initial training will be provided by Family-Based Recovery Services (FBR Services) faculty at the Yale Child Study Center (YCSC), which is part of the Yale School of Medicine, in early December 2019.
        a. FBR Services will provide a 24-hour training for all staff. Staff will be trained in the treatment approach and specific tools and measures that guide each component of the model.
        b. Training will be conducted on three consecutive days in a location to be determined. Training will be provided at no cost to grantees.
    2. Staff will attend at least one DCP&P-specific training (details to be provided upon award).
    3. Staff will attend additional trainings on specific measures as identified.
    4. Staff will participate in quarterly remote training opportunities via video links to the YCSC, as appropriate.
    5. Supervisors are recommended to obtain training in reflective supervision, if available.
    6. Staff are required to participate in a Nurtured Heart Approach training provided by NJDCF.

C. Enroll Participants and Deliver the Required Project
    1. Each of the two teams is required to treat 18 clients during the Project.
    2. Each team must successfully enroll 75% of all referred clients. "Enrolled" is defined as completion of an intake session and three subsequent home visits.
    3. Teams must complete the required Project as described in **Section VII** above for at least 40% of enrolled participants. "Completion" is defined as the client receiving a minimum of four months of IHRP treatment, being in good standing with the DCP&P, having 12 consecutive negative toxicology screens, having custody of the child, and completing one other co-constructed treatment goal.

D. Participate in Technical Assistance (TA)
    1. Each team will engage in a weekly call with a TA consultant.
    2. Team members will send completed model tools and measures to the TA consultant prior to each phone consultation.
    3. Team members will submit service intensity data to the TA consultant.
    4. Team clinicians will submit a video recording of a parent-child session to the consultant during the third and fourth quarters of the grant period.

5. The team supervisor will contact the TA consultant with questions related to model components as needed.

E. Provide Data for the Project Evaluations

More detailed information about data requirements for the separately funded evaluations will be shared with teams during the training and technical assistance sessions. Measures are used to inform and guide the clinical work in addition to providing valuable data for program evaluation. Measures are divided into three domains: client, child, and parent-child relationship. Areas of focus in the three domains are as follows:

1. client: depression, anxiety, post-traumatic stress, and childhood trauma history;
2. child: development, resilience, behaviors, and trauma exposure; and
3. parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

X. ANTICIPATED PROJECT TIME FRAME

A. Notification of Grant Award

1. Three months after notification of the grant award, Project teams will have accomplished the following:
   a. hired and/or reassigned staff;
   b. identified and implemented trainings as appropriate;
   c. established and adopted policies and protocols for the Project in partnership with NJDCF and YCSC;
   d. developed strong working relationships with the DCP&P local and area offices and CPSAI;
   e. established a management team structure and regular meeting schedules with NJDCF staff and the TA provider;
   f. purchased materials determined by the Project;
   g. worked with the evaluator to finalize Memorandum of Understanding and IRB requirements; and
   h. planned the data collection process and protection of data with the evaluator and YCSC.
2. The Project will enroll the first clients in January 2020.

B. 18-Month Project Timeline for Grant Period

1.	September 2019	Beginning of grant period
2.	December 2019	Project staff are hired and/or reassigned
3.	December 2019	Project staff complete model training
4.	December 2019	Project staff complete Nurtured Heart Approach training
5.	January 2020	Family enrollment begins
6.	September 2020	Family enrollment ends

7. February 28, 2021 Grant period ends

XI. ANTICIPATED GRANT APPLICATION TIMELINE

1. June 25, 2019 Information webinar
2. July 15, 2019 Proposals due to The Nicholson Foundation
3. August 15, 2019 Notification of grant awards
4. September 1, 2019 Beginning of grant period
5. February 28, 2021 End of grant period

XII. PROJECT PROPOSAL TEMPLATE

Submit the proposal via email to Shannon Ayers, Senior Program Officer at The Nicholson Foundation, at sayers@thenicholsonfoundation.org by July 15, 2019.

Submit the budget portion of your proposal as a separate Microsoft Excel document using the Microsoft Excel budget template that is provided in Appendix A. Complete the budget template with the first 12 months and then the last 6 months in the respective columns.

A. Date of the Proposal
Specify the date of this proposal's submission to The Nicholson Foundation.

B. Project Name
Insert your organization name above the name of this project, as shown below:

Insert the name of your organization:
The *New Jersey In-Home Recovery Program* Pilot Project.

C. Individual Responsible for the Project
Provide the name, title, address, email, and telephone number of the individual(s) responsible for the Project.

D. Organization and Individual Receiving and Disbursing the Grant Funds
Provide the name and address of the 501(c)(3) organization receiving the grant funds and the name, title, address, telephone number, and email of the individual receiving and disbursing the grant funds.

E. Name and Description of the Organization Requesting Funding
1. Legal name of the organization requesting funding. As appropriate, include acronym in parentheses.
2. Name of the contact person and his or her title, address, telephone number, and email address.
3. Organization's website address.
4. Detailed description of the mission and current principal activities of the organization.

F. Amount of the Proposal

Provide the total dollar amount requested from The Nicholson Foundation for this grant proposal.

G. Project Summary

Provide a concise summary of the Project. It should include a brief description of the Project, its overall goals and objectives, the population(s) it will serve, and collaborating agencies.

H. Statement of Need/Target Community

Describe the prevalence of families impacted by substance use disorders and trauma in the target community(ies). Also, describe the clients currently being served by your agency who are involved with the DCP&P, are impacted by parental substance use, and/or have a child under the age of 36 months. Cite any data, literature, and/or official reports that support your statement of need, and provide references.

I. Project Description

Include a detailed narrative description of your proposed Project by answering the questions or addressing the issues specified below.

1. Project Goals and Objectives
    - State the overall goal and specific objectives of your project.
        - Explain how using the specified evidence-informed model will meet the needs of your target population and achieve the intended outcomes.
    - Describe how this current initiative is consistent with your mission and vision.
    - Describe how this current initiative is consistent with your current programming.

2. Project Planning and Implementation
    - Integration of the Project within your existing mental health and/or substance use disorder service array.
      Describe the following:
        - the mental health, substance use, and/or parenting treatment that you currently provide;
        - how the in-home treatment model will interact with your current treatment programs;
        - if existing clinical resources will be made available to the *In-Home Recovery Program* Pilot Project, and if so, how;
        - past or present experience(s) providing in-home treatment to parents, children, and/or adults, if applicable;
        - past or present experience in serving families involved with the DCP&P, including how collaboration and communication are accomplished; and

- how you will partner with NJDCF to help identify eligible clients.

- Onboarding of required staff
  Describe your plan to accomplish the following:
  - hire or reassign the required staff and onboard staff within 3 months of the grant start date;
  - ensure the staff participate in the required training when scheduled;
  - ensure that staff have dedicated time to participate in the required additional training and support activities;
  - address cultural competence and language barriers to treatment;
  - encourage staff retention; and
  - recruit, hire, and train new staff in the event of staff turnover.
- Implementation of the in-home treatment model and data collection (as specified in **Section VII** of the RFP)
  Please include the following:
  - Describe how the requirements of this initiative will be met through your existing collaborations, partnerships, and collaborative efforts with other community and systems partners.
  - Describe how you will maintain fidelity to the required in-home treatment model described in **Section VII** of the RFP.
  - Explain the strategies you will use to engage and retain clients throughout the course of the entire Project.
  - If applicable, refer to your experiences from other treatment models or programs where you have worked and provided clinical care to parents and/or children aged 0–3 who are involved with DCP&P.
  - Provide retention rates (if available) from prior initiatives.
  - Describe challenges you experienced in those programs and how you addressed them. Provide examples of successes with other programs to engage and retain other target populations in home-based services. Note your track record with retention and attrition.
  - Describe how you will ensure that patients who are clinically indicated for MAT will receive this service.
  - Describe how you will partner with the prescriber to ensure continuity of care.
  - Describe how you might serve clients who do not speak English or who are bilingual.
  - Describe how you will manage client transportation.
  - Describe your plans (location, staffing) for Social Club.

- Describe how you will provide referrals to other levels of SUD care if needed.

- Adherence to the timelines
    - Include a detailed timeline describing the time frames for achieving the key deliverables.
    - Discuss lessons learned from other projects on ability to adhere to clinical and data timelines.
    - See Appendix C: Project Timeline.

J. Measurable Objectives

A Model Measurable Objectives Chart has been included below. Review the model chart and submit a similar Measurable Objectives chart with your proposal that is specific to your Project plan. You may include additional objectives and suggest payment points(See Section XIII) for achieving these objectives in their Project proposal. If you make any modifications or revisions to the benchmarks and time frames in the Model Measurable Objectives Chart, provide a rationale for those changes. For details on how to insert budget amounts in the Measurable Objectives Chart, see **Section XIV** below.

K. Staffing

Describe the staff who will implement this Project and indicate whether each staff member will be hired or reassigned. Attach résumés for identified staff to be funded under the grant, and include the information below for each staff member.

1. Job title (e.g., clinical supervisor, clinician)
2. Role(s) and responsibilities
3. Credentials, skills, and training required
    a. If you already have staff who will be reassigned to the Project, indicate whether they have received training in substance use, mental health, infant mental health, motivational interviewing, and reflective supervision, and if so, describe the training previously received and if it has led to certification and/or licensure. As described in the RFP, the YCSC will provide an initial three-day training to all staff.
4. Name of the agency and operational unit that is the employer of record.

Following the descriptions of each staff member, explain any internal organizational processes that will need to be implemented to complete the hiring or reassignment process and your anticipated time frame for completing these tasks.

L. Approach to Continuous Quality Improvement

During the execution of a project, issues often arise that are not expected and may even be out of the project's control. Describe how you will use information, data, and feedback during Project implementation to identify and address known, or unanticipated, obstacles and barriers to meeting your

objectives and to ensure that quality improvements are made and assessed on an ongoing basis.

M. Partnership with NJDCF

Teams will need to form a close partnership with NJDCF local and area offices and caseworkers. Please describe your experience partnering with NJDCF.

1. Include experience with NJDCF contracts.
2. If applicable, discuss how you addressed any areas of concern with NJDCF contract/project implementation, including failure to meet required timelines or corrective action plan requirements.

N. Other Project Collaborators

As part of the required treatment model, the clinical team will provide information and assist clients to access available community resources to address basic needs, health care, family social opportunities, and medication-assisted treatment. Each grantee will be required to develop a Resource List that can be used by the clinical team when needs are identified and linkages are required. The Resource List may include, but does not have to be limited to, the following:

1. housing organizations;
2. shelters (family and domestic violence);
3. pediatricians;
4. MAT providers;
5. parenting supports (e.g., Mommy and Me groups);
6. childcare organizations (e.g., Head Start and Early Head Start);
7. child development/health organizations (e.g., Birth to Three, Visiting Nurse Association);
8. food assistance (e.g., Supplemental Nutrition Assistance Program, Women, Infants and Children [WIC], food banks);
9. rental assistance programs;
10. utility assistance;
11. furniture assistance;
12. clothing assistance;
13. infant and child furniture/supplies assistance;
14. code enforcement assistance;
15. legal services;
16. law and public safety; and
17. libraries.

Describe any existing partnerships or new collaborations that you plan to develop to help address families' access to basic needs and community resources.

O. Budget

1. Complete the budget by using the Microsoft Excel template file that is provided in Appendix A to this RFP. Submit the completed Excel budget template along with the narrative portion of your proposal.

Include an 18-month budget with implementation of services for 14 months. No new families will be enrolled with this funding after September 1, 2020.

- Include the grant name and date.
- For each staff member, specify the FTE, annualized salary, and fringe benefit amounts.

2. Include a budget narrative that describes the following:
    - Staff and fringe (see required staff in **Section IX. A.** Hire or Reassign Required Staff). For each staff person:
        - Name (if person is known)
        - Job title
        - Percentage of staff person's time that is assigned to the Project and salary
        - If you plan to hire part-time clinicians and/or FSS staff, please explain how you plan to ensure model fidelity, communication, and collaboration.
    - Operating expenses
        - Reimbursement for cell phone expenses for clinical staff, if appropriate
        - Supplies
            - 12-panel CLIA-waived urine toxicology screens (3 screens per week per client, approximately 24 clients per week, over 14 months)
            - Breathalyzers with mouthpieces (3 breathalyzers a week for clients diagnosed with alcohol use disorder and at least twice a month for all other clients)
            - GenoPro for each clinician (GenoPro 2018, 4-user license @ $149.00) https://www.genopro.com/buy/
        - Assessments
            - Childhood Trauma Questionnaire (25 Ready Score Answer Documents @ $76.50) https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Childhood-Trauma-Questionnaire%3A-A-Retrospective-Self-Report/p/100000446.html
            - Parenting Stress Index, Fourth Edition Short Form (PSI-4 SP @ $716 and response sheets @ $114) https://www.parinc.com/Products/Pkey/335
            - Electronic Devereux Early Childhood Assessment (eDECA) (Annual License Fee @ $299.95 and $1.00 assessment)

https://www.kaplanco.com/store/trans/productDetailForm.asp?CatID=17%7CEA1000%7C0&PID=16701

- Ages & Stages Questionnaires, Third Edition (ASQ-3) (Starter Kit @ $295) https://agesandstages.com/products-pricing/asq3/
- Child Behavior Checklist for Ages 1.5–5: (Preschool Computer-Scoring Starter Kit @ $430, Score Sheets @ $35) https://store.aseba.org/Child-Behavior-Checklist-l-5/products/22/

- Transportation
  - Mileage at $0.58 per mile for travel to home visits and meetings/trainings, and, as appropriate, funds for (1) additional automobile insurance for transporting clients and (2) car seats.
- Meeting expenses
  - Food for Social Club
- Client reinforcement (gift cards)
  - Up to $700 for each client for reinforcement of negative toxicology screens and $20 for completion of discharge measures
- Administrative overhead
  - It is The Nicholson Foundation's policy to limit administrative overhead to 10% of your budget. Add this line item as a percentage of the total budget.

- Other cash funding
  - Explain the source of these funds and how the funds will be released and made available to the Project.
- In-kind funding
  - Describe the services, space, or materials that are being contributed, who is providing the support, and the dollar value of the support.

P. Case Vignettes

Please select two of the five case-specific examples in Appendix D and submit answers to the questions listed after each example.

XIII. INFORMATION ABOUT THE NICHOLSON FOUNDATION FUNDING METHODOLOGY

The Foundation's grants are performance based, meaning that a portion of the grant is awarded only if the objectives you have established are achieved within the time frames you have specified. The performance component of this grant is 25%. Once you have developed your budget, please set aside a minimum of 25% of your Project budget for performance payments. Distribute the amount of that performance payment set aside among

the performance benchmarks listed in your Measurable Objectives chart. When assigning the dollar value to each performance payment, allocate a higher value to the benchmarks that take more effort to achieve.

XIV. MEASUREABLE OBJECTIVES

Model Measurable Objectives Chart

List All Objectives Chronologically (Quantify # and %)	Documentation to Verify Achievement of Each Process Objective	Completion Quarter for Objective	Performance Benchmark $ Amount (If Applicable)
Hire and/or reassign required staff: • 4 full-time master's level clinicians for whom substance use disorder treatment is within their scope of practice (LCSW, LPC, licensed psychologist, LMFT, LCADC) • 2 full-time bachelor's level family support specialists • 1 full-time licensed master's level clinical supervisor • 1 part-time (.2) psychiatrist or APRN	Copy of the official letter hiring or reassigning staff	Q1	
Develop policies and procedures for the Project internally and in collaboration with the DCP&P	Written policies and procedures document (including protocols for referrals, enrollment, MAT when clinically indicated, discharge, communication, supervision)	Q1	
Ensure staff, including supervisors, complete required training (including sessions from Yale Child Study Center and Nurtured Heart Approach)	Record of attendance of staff in all required trainings and certificate received for staff provided by Yale Child Study Center	Q1	
Establish data collection systems for the in-home treatment model	Evidence that a data capture system has been established (e.g., screenshot of data system)	Q1	No payment
Enroll a minimum of 6 clients per team for a total of 12 (completion of the intake session with the DCP&P caseworker plus 3	De-identified service level reports	Q2	

home visits)			
Conduct basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q2	
Ensure the IHRP team, DCP&P staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q2	
Ensure the IHRP team and DCP&P staff meet monthly to discuss cases	Meeting dates and attendance lists	Q2	
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary	Q2	
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q2	
Maintain an active caseload of 12 clients per team for a total of 24 clients (assessment and treatment phases)	De-identified service level reports	Q3	No payment
Complete the basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q3	
Ensure the IHRP team, DCP&P staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q3	
Ensure the IHRP team and DCP&P staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q3	
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary and email confirming the Project team clinicians' submission of a video recording of a parent-child session	Q3	
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q3	
Maintain an active caseload of 12 clients per	De-identified service level reports	Q4	No payment

team for a total of 24 clients (assessment and treatment phases)			
Conduct Social Club with an average of 30% of eligible clients per team in attendance	De-identified service level reports	Q4	
Complete the basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q4	
Ensure the IHRP team, DCP&P staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q4	
Ensure the IHRP team and DCP&P staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q4	
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary and email confirming the Project team clinicians' submission of a video recording of a parent-child session	Q4	
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q4	
Complete the basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q5	
Ensure the IHRP team, DCP&P staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q5	
Ensure the IHRP team and DCP&P staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q5	
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary	Q5	
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q5	
Serve a minimum of 18 clients	De-identified service level	Q5	

per team for a total of 36 clients from Q2 through Q4	reports		
Ensure the IHRP team, DCP&P staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q6	
Ensure the IHRP team and DCP&P staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q6	
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary	Q6	
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q6	
Successfully discharge 40% of all clients enrolled between Q2 and Q6 Successful discharge: • The client received a minimum of four months of treatment. • The client is in good standing with the DCP&P. • The client has 12 consecutive negative toxicology screens. • The client has custody of the child. • The client has successfully completed one other treatment goal co-constructed with an IHRP team member.	De-identified service-level reports	Q6	