1. INTRODUCTION

The Administration for Children’s Services (ACS) protects and promotes the safety and well-being of New York City’s children and families by providing child welfare, juvenile justice, and early care and education services. In child welfare specifically, ACS’s Division of Child Protection conducts more than 55,000 investigations of suspected child abuse or neglect annually. ACS contracts with private nonprofit organizations to support and stabilize families in crisis to prevent foster care placement and to provide foster care services for children not able to safely remain at home.

During the next two years, ACS will re-procure the majority of contracts across the child welfare system, including contracts for delivering prevention services, family-based foster care services, and residential foster care services. These procurements are an opportunity for ACS to build on the success of existing services for children and families, to design a shared framework across prevention and foster care services, and to implement new strategies to improve safety, permanency, and well-being outcomes for New York City children and families. In anticipation of these procurements, ACS has undertaken an intensive research and planning process, which involved consultation with stakeholders throughout the child welfare continuum including the formation of a Provider Advisory Committee through which prevention and foster care agency staff at all levels provided extensive input on system strengths, gaps, and opportunities.

ACS is committed to establishing a shared framework across prevention and foster care services that results in a more robust, comprehensive and seamless system and that enables children and families to experience improved outcomes for safety, permanency and well-being. The three procurements for prevention, family-based foster care, and residential foster care services are being designed to reflect and advance this shared framework.

Importantly, ACS does not expect all providers to deliver both prevention and foster care services. ACS encourages a broad range of community-based nonprofits to apply to deliver prevention services. For those agencies who choose to deliver both prevention and foster care, ACS expects organizations to anticipate how they will coordinate these and related human services in a manner that best supports the needs of the families and children they serve. This includes considering the types of services they will offer; the geographic, cultural and linguistic characteristics of the populations they will serve; and the potential for collaboration among the programs themselves. For organizations that seek to provide only prevention services, ACS expects them to anticipate how their programs will collaborate with foster care providers and other human services providers to best support the needs of children and families—including individual strengths and challenges as well as geographic, cultural, and linguistic considerations.

This Prevention Services Concept Paper launches the first of the three procurements. The Prevention Services Request for Proposals (RFP) will be released later in 2019 with new contracts to be in place as of July 1, 2020. The Concept Papers for Family-Based Foster Care and Residential Foster Care will be released later in 2019, with the RFP to be released in 2020, and new contracts to be in place as of July 1, 2021.

This Prevention Services Concept Paper is being offered to New York City’s nonprofit community, including social service, medical, and clinical providers, to frame the vision for the RFP that ACS expects to release in 2019, for implementation of prevention services to children and families in 2020. This Concept Paper outlines ACS’s vision for prevention services for children and families across New York City, informed by the voices of families, nonprofit staff, experts, and advocates. ACS offers this Concept Paper in service of building a stronger and more socially just
system of care for children, families, and communities, and we welcome your feedback and suggestions in advance of the RFP. Thank you for your interest in joining us in this work.

II. BACKGROUND

ACS is responsible for protecting the safety and promoting the well-being of New York City’s children. To achieve child safety and well-being, we must support the physical, psychological, and emotional needs of children through an ecological lens with a focus on families and communities. As part of the collective responsibility for keeping children safe, we must address the underlying factors that may lead to child maltreatment and ensure children have the support they need to thrive in the families and communities in which they live. As a central part of its mission, ACS contracts with community-based organizations to provide prevention services to approximately 20,000 families per year. Prevention services aim to support families in their communities, promote family stability and well-being, and reduce the need for placement in foster care. These services may include case management, counseling, and clinical interventions offered primarily in-home and in a manner aligned with the diverse cultures and needs of NYC families.

ACS and its network of providers have achieved great success in serving some of NYC’s most vulnerable families. This Concept Paper signals ACS’s intention to build upon that success while modernizing the way we meet the changing needs of families across our city. ACS is committed to delivering child welfare services in a socially just and culturally competent manner and believes a community-based approach to services furthers these goals. ACS leads the country in the implementation of evidence-based, evidence-informed, and promising practice prevention programs. Over the past six years, these research-based programs have demonstrated success in meeting ACS’s goals of reducing the likelihood of a child entering foster care or experiencing abuse or neglect, often in a shorter timeframe than traditional case management services. Through the upcoming procurement, ACS intends to expand the use of evidence-based and evidence-informed practices citywide. To support this work, ACS seeks to invest in the expansion of practice frameworks and programmatic supports necessary to sustain high-quality implementation at a citywide scale.

This Concept Paper is a product of extensive collaboration and research. It is informed by the voices of more than 300 stakeholders, including families, parent councils, all levels of prevention provider staff, subject matter experts, legal advocates, and clinicians. Over the past year, ACS conducted more than 50 focus groups and listening sessions, over 100 expert interviews in addition to literature reviews, jurisdictional scans, and comprehensive data analysis. Additionally, the concepts below are aligned with federal and state policy as of November 2018, with the understanding that we are planning for compliance with the federal Family First Prevention Services Act (“FFPSA”) and that funding, legislative, and regulatory requirements are subject to change. ACS seeks to ensure that prevention services are rooted in evidence and effectively meet the needs of the families we serve.

III. PURPOSE OF CONCEPT PAPER

In advance of releasing a request for proposals, ACS offers this Concept Paper as a statement of our vision and goals for the future of prevention services in NYC. ACS is seeking feedback from providers and the community at large on the concepts outlined herein, which are rooted in research, stakeholder engagement and ACS’s experience delivering prevention services.

ACS is committed to the following goals and actions:

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ACS seeks to ensure that prevention services are rooted in evidence and effectively meet the needs of the families we serve.

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ACS Prevention Services Concept Paper

- To address concerns that may place children at risk of harm and could potentially lead to a child’s placement in foster care, ACS will make every effort to engage families in prevention services. ACS seeks to support families so that children are safe and able to thrive in stable, nurturing homes and communities;
- Prevention services providers will employ and supervise staff who are well-trained and prepared to abide by ACS child welfare goals, including assessing the safety of children throughout the life of a case;
- When children enter foster care, ACS and its providers seek to offer families needed services before, during, and after reunification, as appropriate, so that families receive the support they need to reunify and remain together in a stable home. Prevention and foster care services will be coordinated with the goal of providing seamless services for children and families;
- Families who need support to keep their children safe will receive that help in a manner consistent with their goals, values, beliefs, and culture;
- Families who engage with prevention services will have opportunities to build economic mobility, social connectedness, health, well-being, and educational advancement. Providers who deliver prevention services will listen to families’ goals and needs and work alongside them to achieve success;
- Children and families engaged in prevention services will have access to the available resources they need to meet their concrete and emotional needs, and ultimately thrive;
- Prevention services providers will receive the resources they need to deliver high-quality services in a socially just manner to meet families’ needs;
- ACS will partner with and provide support to prevention services providers in the form of technical assistance, quality assurance, continuous quality improvement, and customer service; and
- ACS is committed to ongoing collaboration and communication to address emerging needs.

The upcoming RFP will seek to partner with nonprofit organizations, including social service and clinical providers to deliver these critical services to families. ACS encourages a diverse array of applicants to ensure services reflect the cultures, languages, communities, and needs of families in New York City.

Contracts resulting from this RFP will focus on three major types of services:
- Family Support (formerly referred to as “General Preventive”)
- Therapeutic and Treatment Models
- Clinical Enhancements

Each of these areas is detailed in Section VI. Proposed Program Approach below.

IV. POPULATIONS TO BE SERVED

Prevention services are intended for families with children from birth to age eighteen (0-18). For children exiting foster care, services may extend until age twenty-one (21). The target populations are explained in depth below for each program type.

V. GOALS AND OBJECTIVES OF THE RFP

ACS is seeking to contract for services in a way that aligns with and advances the continued reform and innovation of the City’s child welfare system. To this end, the following goals and expectations will drive design and delivery for potential providers of ACS prevention services across all three service areas:

Programmatic Goals and Expectations:
• **Monitoring and assessing child safety and risk.** In delivering prevention services, ACS requires priority attention by providers to assessing the safety and well-being of children, and to take necessary and appropriate measures to ensure their ongoing protection and safety. This includes, but is not limited to, actions required of all New York State Mandated Reporters and collaboration with ACS staff, including child protection teams, conference facilitators, and others.

• **Family voice and choice.** Through prevention services, families will be treated with respect and dignity. Providers will ensure families have a voice and choice in every aspect of their service experience. Providers will use best practices in engaging parents which may include: parents serving on hiring committees, a parent advisory board, family focus groups, regular conversations with families throughout and beyond their engagement in services, and/or as active participants in the referral and decision-making processes surrounding their engagement with services.

• **Data and evidence.** Prevention services will harness research, quantitative and qualitative data (including family and community feedback) to drive quality assurance and continuous improvement in programmatic and practice decision-making. Quality Assurance staff will play a significant role in building capacity to use data and dashboards to guide planning and case practice within agencies. Programs will participate in the ACS-facilitated continuous quality improvement program, which includes development and implementation of annual improvement plans rooted in qualitative data, including the findings of ACS's semi-annual qualitative reviews of case practice, and quantitative outcomes data also provided by ACS.

• **Racial equity.** Prevention services will recognize and work to redress the historical legacy of current racial inequities that results in differences in application of practices, policies, and experiences of prevention families. Prevention services will examine factors that drive these differences among children and families in prevention and deploy strategies to correct them.

• **Social justice.** Prevention services will provide a high quality of service and care that is inclusive of, but not limited to, the history; traditions; values; family systems; race and ethnicity; immigration and refugee status; religion and spirituality; sexual orientation; gender identity or expression; social class; and mental or physical abilities of client populations. Prevention services will be aware of the impact of social systems, policies, practices, and programs on multicultural client populations, advocating for, with, and on behalf of multicultural clients. Further, prevention services will ensure that the quality of services provided is of such quality that a family would voluntarily enroll in and even pay for services, regardless of system involvement.

• **Celebrating success and rewarding innovation.** Prevention services will develop a culture of service delivery that celebrates the success of the children and families at all levels of progress and rewards provider innovation. Additionally, prevention services will celebrate the success of staff—at all levels, but especially among front-line staff—in supporting families to achieve their goals. Building relationships between ACS, providers, and parents in their communities is paramount, and prevention services should reward community outreach that results in appropriate walk-ins and referrals.

**Family-Centered Goals and Expectations:**

Through prevention services, families will be supported in accessing resources, supports, and opportunities that enable them to achieve the following goals:

• **Building protective factors and preventing Adverse Childhood Experiences:** Preventive programs will assess families for safety, risk, and protective factors, as well as for the presence of adverse childhood experiences. Providers will educate families about adversity, resilience, and protective factors and will work to prevent children from experiencing adverse childhood experience by building family strengths.

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3 [https://cssp.org/our-work/project/strengthening-families/](https://cssp.org/our-work/project/strengthening-families/).
Economic mobility: Prevention services will provide families with access to educational, employment, and career advancement opportunities that promote financial security and build economic mobility. Contracted providers will use evidence-informed practices to support economic mobility and/or build partnerships with organizations that offer economic mobility services.

Family well-being and success: Contracted providers will assess families’ well-being including: mental, physical, social, and emotional health, as well as family self-perception of well-being; and work with families to identify goals to improve well-being as appropriate. Providers should engage families in co-designing service plans that enable them to achieve success, and celebrate that success at critical milestones.

Meeting concrete needs: Contracted providers will assess and support families to ensure their basic needs for income, food, diapers, clothing, furniture, housing, and transportation are met. Additionally, contracted providers will support families’ navigation of, and access to, essential community services such as child care, health services, and housing.

Success of families in foster care and juvenile justice: Contracted providers are expected to engage in cross-systems collaboration and support for foster care and juvenile justice-involved families in accessing the services they need to succeed, especially during times of transition.

Positive relationships and social connections: Contracted providers will engage families in conversation about their supportive relationships and social connections and support families in building social capital. Contracted providers will build associations with stakeholders, organizations, and institutions in their communities that enable families to access resource networks and promote child safety, family well-being, and success.

Operational Goals and Expectations:

Listening and customer service. In serving prevention families, organizations will be expected to provide a high level of customer care and satisfaction to the children and families they serve. Organizations will be expected to develop formal feedback loops that capture the experiences of the families they serve and demonstrate how this feedback continuously informs programmatic and operational improvement plans.

Collaboration and interdisciplinary practice. Providers will work collaboratively with stakeholders in the communities and systems that impact family stability and well-being. Providers will engage and develop partnerships with courts, schools, medical and mental health services, social services, and other institutions and experts as needed to support families across NYC.

Training. Provider direct service staff and supervisors will participate in the ACS-mandated onboarding core training, and will also fulfill the annual training requirements outlined in ACS policies, standards and guidance.

Complex needs. Prevention services will identify and expand partnerships with government agencies, community-based organizations, and other entities to ensure that families with complex needs have access to the services and supports necessary for their success.

Staff well-being. Organizations will support provider staff by providing high quality, individualized supervision and peer group support, well-being programming, and professional development opportunities.

Monitoring, evaluation, and quality improvement. Organizations will have or demonstrate plans to build performance monitoring, evaluation and quality improvement capacity. This includes the ability to leverage the right technology, business processes, and resources required for successful operationalization of these tasks. Providers will participate in ACS collaborative quality improvement, learning collaboratives, contract management activities, and all other required processes to ensure high-quality performance, desired outcomes, and continuous program improvement.

Partnership and mutual accountability. Organizational leadership will encourage genuine commitment by all staff levels to programmatic goals, build team-driven accountability for achieving these goals, and
forge effective relationships with valuable external child welfare stakeholders in service of supporting families in achieving their goals.

- **Contract management.** Providers will be accountable for programmatic outcomes, fidelity to program models, and compliance with all ACS policies and standards. ACS will engage in consistent monitoring activities and feedback loops to understand provider progress and compliance with programmatic and fiscal contract requirements. Both parties will endeavor to identify and build on what works and share best practices.

- **Technology.** Providers will use ACS and OCFS systems of record for documentation, and will utilize the Safe Measures dashboard to manage performance. Providers will ensure staff and clients have access to the technology necessary to achieve success. ACS and providers will work collaboratively to keep pace with new technological innovations and continuously seek to improve service delivery.

**Framework for Building a Full Continuum of Support for Families in New York City:**

Through our research, we have learned that families’ needs cannot be holistically met solely by ACS services, and that families across both foster care and prevention struggle with similar challenges. ACS understands and is committed to addressing these outstanding needs through a shared framework, across the Division of Prevention Services and Division of Family Permanency Services that will result in a more robust and seamless continuum of services. This framework includes:

- Ensuring alignment of services within ACS Foster Care and Prevention contracts to ensure that we seamlessly meet the needs of families who move through both systems;
- Improving the foster care placement process and the prevention service matching process to better align families’ needs with the services they receive in order to shorten lengths of stay and promote family stability;
- Leveraging the expertise of the prevention continuum and implementation supports to inform how foster care services support reunification and successful transition to the community;
- Building a more robust network of support for families in communities by strengthening partnerships between ACS and its providers with other city agencies and CBOs; and
- Ensuring providers and families have knowledge of resources available in their communities.

**VI. PROPOSED PROGRAM APPROACH**

ACS is seeking to provide services across New York City in a manner that enables providers to deliver high-quality services, is responsive to families’ stated needs, and complies with federal, state, and local requirements. The proposed program approach outlined in this Concept Paper reflects our plans to meet the needs we heard articulated across communities in NYC, while also ensuring alignment with best practice, leading research, and legal requirements.

In the upcoming RFP, ACS intends to contract for three areas of prevention services: Family Support, Therapeutic and Treatment Programs, and Clinical Enhancements. These three areas were developed through research of available evidence-based practices and consideration of the services used in recent years in New York City. ACS is seeking to build a continuum of services that support families and promote child safety across varying levels and types of needs. The models below were chosen based on a track record of supporting families in New York City, adaptability of the models for a child welfare context and with a child safety lens, and a foundational evidence base that can be built upon over the next two years. ACS expects that all contracted providers will collaborate with an ACS-funded implementation support team to ensure fit and integration of new models, sustain existing models, and build a greater evidence base for all programs citywide.

**1. FAMILY SUPPORT**
Program Approach: Family support services will replace existing “general preventive” services and will enable a broad range of providers to combine case management, evidence-based and/or evidence-informed case practice, and a commitment to cultural connection. Family support programs will assess children’s safety, promote their well-being, and address risks as they emerge. These programs will provide services tailored to the needs of families and children through case management, resource navigation, service referrals, parenting skills, and support with concrete needs, as well as regular in-home assessments of child safety and well-being. Providers will help parents meet concrete needs; offer peer support, and educate parents about trauma, stress, and attachment. Services will address the individual needs of the child(ren) and the needs of the family members residing with the child(ren) while involving key stakeholders to identify and address behaviors placing children at risk for foster care placement. Providers will be expected to integrate a research-informed case practice framework into all family support programs. Services are anticipated to range from 6-12 months. All contracted programs will be expected to prioritize the assessment and monitoring of child safety, risk and well-being on an ongoing basis.

Providers will be required to choose one of the following case practice frameworks*:

A. Mobility Mentoring

Economic Mobility Pathways (EMPath), based in the Boston area, has created and implemented a research-based framework called the Bridge to Self-Sufficiency⁴, which guides the Mobility Mentoring practice by providing a structured approach for low-income individuals to plan, reach, and sustain economic self-sufficiency in five core areas;

1. family stability,
2. well-being,
3. education and training,
4. financial management, and
5. employment and career management.

Mobility Mentoring is the coaching component of the model. It places participants with trained mentors to support them in meeting their goals. Mentors work in close partnership with participants, creating high levels of trust along with high expectations (a “growth mindset”), to help participants succeed.⁵

Rooted in both research and the practical understanding that trauma and chronic stress negatively impact brain development and executive functioning, Mobility Mentoring incorporates motivational interviewing, cognitive behavioral therapy, and principles of trauma-informed care to help people facing significant stress function more effectively and get out of poverty.⁶ With both adult- and child-focused components, the intervention is a developmentally appropriate, whole-family approach to helping people develop a greater sense of self, enhance decision-making skills, build social capital, and develop self-sufficiency.⁷


Providers wishing to implement Mobility Mentoring will participate in the Economic Mobility Exchange, a formal learning community developed by EMPath to enable all implementation sites to learn about best practices, share adapted tools, and design improvements.

For more information on Mobility Mentoring, see https://www.empathways.org/approach/mobility-mentoring.

B. Solution-Based Casework

Solution-Based Casework (SBC) is a casework practice model for families in child welfare. The model is based on three theoretical underpinnings;

1. solution-focused family therapy,
2. family life cycle theory, and
3. relapse prevention.8

SBC encourages child welfare workers to form full partnerships with families; focus the partnership on everyday family life safety concerns; and develop detailed plans of action with families to create the requisite behavior change to ensure the safety and well-being of their children.9 To assist in forming partnerships with families, case planners are encouraged to collaboratively track problem pattern sequences, search for exceptions to that sequence and separate intentions from actions.10 The theory is that if clients are engaged in the case planning process, they will be more likely to use their case plan and achieve their safety outcomes.

SBC teaches case planners to use engagement techniques while helping clients identify the details of unsafe behavioral patterns. The SBC model assumes that families face common developmental challenges, which occur as patterns instead of isolated incidents. Families learn strategies to interrupt old ways of trying to meet these challenges and replace those behaviors with more productive methods for managing high-risk situations that could impact family functioning and/or child safety. Individual caretakers are assisted in learning how to manage their own behaviors in these situations. This is done by identifying high-risk situations; identifying early warning signals; and developing strategies to prevent high-risk situations; interrupt those they could not prevent, and escape (or exit) those they could not interrupt.11

For more information on Solution-Based Casework, see http://www.cebc4cw.org/program/solution-based-casework/.

C. Family Connections

Family Connections is a multi-faceted community-based service program designed to prevent child maltreatment. It works with both low- and moderate-risk families. Case Planners emphasize engaging with families to create an alliance that respects cultural differences. Standardized tools are used to

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identify risks associated with child neglect or maltreatment and a comprehensive family assessment is completed. Tailored outcome-driven service plans with specific, measurable, attainable, realistic and timely (SMART) goals are developed with each family. Interventions include in-home counseling and advocacy on behalf of families with community-based services. Emergency and concrete service needs are addressed and families are seen weekly in their homes for at least one hour.

For more information on Family Connections, see http://www.cebc4cw.org/program/family-connections/.

*Note: Subject to ACS approval, providers may employ an alternate case practice framework if they present sufficient verifiable evidence demonstrating efficacy with the target population.

**Target Population:** Family support programs will engage families in their homes and communities, and will partner with families to build skills, navigate resources, and develop social capital to ensure children are safe, healthy, and nurtured. The target population will include families whose children are at risk of removal and entry into foster care, including those referred by ACS’s Division of Child Protection during or following an investigation as well as families whose children have returned home following a stay in foster care. Contractors will also work with families referred by community partners, or who seek services on their own accord. In addition, the contractors must be prepared to work with families that have adopted children or are serving as guardians (including kinship guardians) and would benefit from services to help stabilize and support permanency for that family.

Family support services will be provided to families across NYC with children ages 0-18, or, if exiting foster care, up to age 21. ACS is seeking providers for family support services that will serve families in the communities where they live and in a way that reflects the culture, language, religion, and community norms of each family. Some communities to be served will be defined geographically while others can be defined by applicants using one or more dimensions, including: religion; language; culture or country of origin; disability or medical need; or others as needed. The purpose of this flexibility is to enable providers to identify and serve target communities wherever they reside to ensure the City has widely responsive programming across diverse populations.

Through our research and engagement, ACS has learned that many families have more complex needs than can be addressed through low-intensity services. To meet these needs, family support providers will have access to the clinical enhancements (described below in Section 3) which will allow them to engage clinicians to deliver treatment in the home as needed to supplement the existing family support services. Family support providers are also expected to be familiar with other essential, existing community-based services and capable of successfully referring families to these services as needed.

**Anticipated Service Catchment Areas:** ACS will seek to award contracts for family support services for geographic catchment areas, and for target population-focused catchments as outlined below:

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Practice Model Options</th>
<th>Catchment and/or Target Population</th>
<th>Anticipated Maximum Total Slots</th>
<th>Program size</th>
<th>Anticipated Available Annual Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support</td>
<td>Mobility Mentoring; Solution-Based Casework; or Family Connections</td>
<td>Catchment areas based on Community Districts: providers may apply for multiple community districts in each borough.</td>
<td>5,120</td>
<td>Either 64 or 128 slots</td>
<td>$74,375,000</td>
</tr>
<tr>
<td>Family Connections</td>
<td></td>
<td>Target population catchments based on:</td>
<td>1,024 slots:</td>
<td>Either 64 or 128 slots</td>
<td>$14,875,000</td>
</tr>
</tbody>
</table>
medical needs and developmental
disability,
OR
language, culture, religion, or
other special populations as
defined by providers.

| • 512 slots
designated for
medical needs,
intellectually/dev
elopmentally
disabled
• 512 slots
designated for
provider-defined
communities |

2. THERAPEUTIC AND TREATMENT PROGRAMS

Program Approach: ACS is seeking providers to implement and sustain evidence-based and evidence-informed in-home therapeutic and treatment models to support families with complex needs through clinical approaches to service delivery. As with all ACS prevention programs, these providers will assess children’s safety, promote their well-being, and address risks as they emerge. Therapeutic and treatment programs will be high-intensity and lengths of service are expected to range from 4-12 months based on the model’s prescribed measures to achieve intended impact. Providers will be expected to deliver therapeutic and treatment programs in alignment with model fidelity, as well as ACS policies pertaining to child safety and well-being. In some cases, provider programs may be expected to participate in Family Court proceedings and ACS Division of Child Protection family team conferences.

The models listed below have demonstrated evidence of efficacy with the identified target populations and in the context of New York City’s child welfare system. Additional information on each of these models can be found at the links listed below. The California Evidence-Based Clearinghouse provides information about research studies, model requirements, and target populations. Interested providers are strongly encouraged to visit this website and read the relevant research prior to applying. In addition to the model requirements as defined by developers, ACS requires providers to deliver services in a manner that meets ACS requirements for assessment and monitoring of child safety and risk, as well as in alignment with all ACS policies and oversight measures. The delivery of services in alignment with model fidelity as well as ACS requirements will require providers to collaborate closely with ACS, as well as model developers, to maintain quality practice while appropriately monitoring and planning for safety.

Providers will be required to choose one of the following program model options:

A. Brief Strategic Family Therapy (BSFT)

The BSFT® model is a brief family intervention for children and youth with serious behavior problems and/or drug use. The BSFT intervention works well for families with poor behavior management and problematic relationships. The intervention identifies patterns of family interaction and improves them to restore effective parental leadership and involvement with the youth. BSFT also seeks to reduce drug use and delinquency in youth. BSFT therapists meet weekly with families and work with all family members.

For more information about BSFT: http://www.cebc4cw.org/program/brief-strategic-family-therapy/

- Ages served: 6 to 18 years old
- Average length of service: 4-6 months

12 California Evidence Based Clearinghouse: http://www.cebc4cw.org/
B. **Child Parent Psychotherapy (CPP)**

CPP is an intervention model for children aged birth-5 years old who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems. CPP examines how the child’s and/or caregivers’ trauma histories affect the parent-child relationship and the child’s development. CPP supports and strengthens the caregiver-child relationship to restore the child’s sense of safety, attachment, and improve the child’s functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (for example: cultural, socioeconomic, and immigration-related stressors are addressed). Treatment focuses on safety and stabilization and incorporates case management.

- Ages served: Birth to 5 years old
- Average length of service: 12 months

C. **Family Treatment and Rehabilitation (FTR)**

FTR is appropriate for high-risk families where the primary issue is a caretaker or child’s substance use or mental health concern.

For more information about FTR: [https://www1.nyc.gov/assets/acs/policies/init/2016/D.pdf](https://www1.nyc.gov/assets/acs/policies/init/2016/D.pdf)
- Ages served: Birth to 18 years old
- Average length of service: 12 months

D. **Functional Family Therapy (FFT)**

FFT is a family therapy intervention for the treatment of violent, criminal, behavioral, school, and conduct problems with youth and their families. Both intra-familiar and extra-familial factors are addressed. An FFT belief is that the motivation of a family is also the responsibility of the therapist not just the family. The intervention is home-based. The frequency of contacts between therapist and the family depends on the stage of treatment, with more frequent contacts in the beginning of the intervention.

For more information about FFT: [http://www.cebc4cw.org/program/functional-family-therapy/](http://www.cebc4cw.org/program/functional-family-therapy/)
- Ages served: 12 to 18 years old (with younger siblings included in treatment)
- Average length of service: 3-5 months

E. **Adaptations of Functional Family Therapy (FFT)**

Adaptations of FFT must include a basis in the Functional Family Therapy model but with adaptations made to better serve a child welfare population. Any adaptation proposed must be rooted in research demonstrating positive outcomes with the target population.

For more information on Functional Family Therapy: [http://www.cebc4cw.org/program/functional-family-therapy/](http://www.cebc4cw.org/program/functional-family-therapy/)

F. **Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)**
MST-CAN is an adaptation of Multisystemic Therapy ® (MST®) and was developed to treat families with teens that have come to the attention of Child Protective Services due to high risk and safety issues. MST-CAN is reserved only for very high-risk cases. MST-CAN therapists complete a functional assessment of the family and safety plans. Therapists provide treatment in the home, including parent training, safety planning, substance abuse treatment, Post-Traumatic Stress Disorder (PTSD) treatment for youth and adults, anger management, marital therapy, and family therapy. There are limited outside referrals. Therapists have very small caseloads to allow for intensive involvement with a family.

- Ages served: 12-18 years old
- Average length of service: 6-9 months

G. Adaptations of Multisystemic Therapy (MST)

Adaptations of MST must include a basis in the Multisystemic Therapy model but with adaptations made to better serve a child welfare population. Any adaptation proposed must be rooted in research demonstrating positive outcomes with the target population.

For more information on Multisystemic Therapy: [http://www.cebc4cw.org/program/multisystemic-therapy/](http://www.cebc4cw.org/program/multisystemic-therapy/)

H. Trauma Systems Therapy (TST)

TST is a trauma–informed clinical intervention for families with adolescents who have been exposed to traumatic events and are experiencing emotional and behavioral problems as a result. TST focuses on the interaction between the child’s difficulties regulating his/her emotions and the deficits within the child’s social environment (home, school, and neighborhood). Trauma-informed psychotherapy and casework strategies are used in TST. Families are engaged as allies in the treatment.

For more information about TST: [http://www.cebc4cw.org/program/trauma-systems-therapy-tst/](http://www.cebc4cw.org/program/trauma-systems-therapy-tst/)
- Ages served: 12 to 18 years old
- Average length of service: 6-9 months

Target Population: Therapeutic and treatment programs are designed to serve families and children in specific age groups with complex needs including substance use, mental health, trauma, domestic violence, and other serious challenges that make parenting difficult.

Anticipated Service Catchment Areas: ACS is seeking to award contracts for the programs, catchment areas, and target populations listed below. At least one contract for each model will be awarded in every borough, for a total of up to 40 contracts Citywide. Providers must apply to serve an entire borough, and if seeking contracts for multiple models or multiple boroughs, separate proposals will be required. Providers must choose among the models listed below, as they are the only models, in this category, that ACS plans to procure at this time.
<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Program Model Options</th>
<th>Catchment Areas</th>
<th>Anticipated Maximum Total Slots Citywide</th>
<th>Anticipated Available Annual Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic and Treatment Models</td>
<td>Brief Strategic Family Therapy (BSFT)</td>
<td>Borough-wide in each of the following boroughs: Brooklyn, Bronx, Manhattan, Queens, and Staten Island</td>
<td>600</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child-Parent Psychotherapy (CPP)</td>
<td></td>
<td>600</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Treatment/Rehabilitation (FT/R)</td>
<td></td>
<td>2,560</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional Family Therapy (FFT)</td>
<td></td>
<td>256</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional Family Therapy Adaptation(s) with relevance to the child welfare population</td>
<td></td>
<td>1000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multisystemic Therapy Adaptation(s) - with relevance to the child welfare population</td>
<td></td>
<td>300</td>
<td>$129,140,000</td>
</tr>
<tr>
<td></td>
<td>Trauma Systems Therapy (TST)</td>
<td></td>
<td>256</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)</td>
<td>One citywide contract to serve all five boroughs (Brooklyn, Bronx, Manhattan, Queens, and Staten Island)</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>

3. CLINICAL ENHANCEMENTS

**Program Approach:** ACS is seeking providers to offer clinical and therapeutic services to families in prevention services using a combination of clinic-based, in-home, and telehealth modalities for the therapeutic models and clinical approaches listed below. Recognizing that many families receiving prevention (particularly family support) services have more complex or underlying needs than can be addressed through case management, ACS is seeking to contract with at least one provider of clinical services as an enhancement to a family’s underlying prevention services program. The provider(s) will be expected to hire a multidisciplinary staff to offer clinical services in the

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13 The number of slots for each model by borough will be listed in the RFP. At this time ACS is completing a needs assessment to inform these slot allocations.


17 Functional Family Therapy Adaptations must include a basis in the Functional Family Therapy model but with adaptations made to better serve a child welfare population. Any adaptation proposed must be rooted in research demonstrating positive outcomes with the target population. More information on Functional Family Therapy can be found here: [http://www.cebc4cw.org/program/functional-family-therapy/](http://www.cebc4cw.org/program/functional-family-therapy/).

18 Multisystemic Therapy adaptations must include a basis in the Multisystemic Therapy model but with adaptations made to better serve a child welfare population. Any adaptation proposed must be rooted in research demonstrating positive outcomes with the target population. More information on Multisystemic Therapy can be found here: [http://www.cebc4cw.org/program/multisystemic-therapy/](http://www.cebc4cw.org/program/multisystemic-therapy/).


following domains: trauma, mental health, intellectual/developmental disability, and medical. Provider(s) will be responsible for delivering services in a manner that is reimbursable by Medicaid and private insurance. Families will not be turned away due to lack of insurance coverage; thus, provider(s) will be responsible for providing services to these families as well. Provider(s) will be expected to deliver clinical enhancements in alignment with model fidelity, as well as ACS policies pertaining to child safety and well-being. Providers will be expected to collaborate with ACS-contracted family support programs in the assessment of children’s safety, promotion of their well-being, and in efforts to address risks as they emerge.

Families will be able to receive services in clinics licensed by the New York State Office of Mental Health that are convenient for them. For families unable to access services in clinics, providers must offer home-based telehealth services. Provider(s) will be responsible for hiring a clinical staff, as well as providing the technology, training, and technical support necessary to administer services through telehealth. The provider(s) will be responsible for coordinating with prevention services staff as needed to supply families with technology if they do not have it. ACS will work with providers to ensure they understand and can access technology to provide telehealth services in alignment with policy, confidentiality, and accessibility requirements.

“Telehealth” refers broadly to many types of technology-supported therapeutic services. These may include telephone and audio counseling, video and web conferencing, self-directed, web-based, or computer-based tools and programs, text-based communications, or mobile technologies. For the purposes of this Concept Paper, ACS is using telehealth to refer to video and web-based conferencing to deliver therapeutic services. Other types of technology may be used to supplement video or web-based conferencing.

Services provided through telehealth have been found, in large part, to be as effective as in-person treatment according to multiple meta-analyses. Client satisfaction and attrition are also comparable to in-person treatment. Moreover, these approaches have been used with a range of populations, including adults, parents of young children, seniors, preschool-age children (with their parents), school-age children, and adolescents. In addition, telehealth-delivered services are widely considered to be valuable tools in overcoming language, cultural, and logistical barriers to services. They may be used as stand-alone interventions or in conjunction with in-person treatment. There is significant literature on the use of telehealth to address PTSD. Research has also been done on the use of telehealth to address a range of other concerns/diagnoses, including depression and other mood disorders,
anxiety, panic disorders, behavioral and developmental issues, chronic illnesses, and substance use using a number of different clinical approaches.\textsuperscript{29} For families facing complex medical needs, telehealth can be a way to maintain contact with medical providers and receive support, care coordination, and monitoring between in-person visits.\textsuperscript{30}

Each of the clinical enhancement service options should be delivered over a period of less than one year. Providers can propose to implement one or more of the following service options:

A. **Trauma Treatment:**

1. **Prolonged Exposure** targets adults with a variety of traumas such as combat, sexual assault, car accidents, violent crimes, and acts of terrorism. It is an individual psychotherapy treatment that utilizes in vivo and imaginal exposure, psychoeducation about common reactions to trauma, and breathing exercises.

   For more information about Prolonged Exposure: [http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adults-pe-for-ptsd/](http://www.cebc4cw.org/program/prolonged-exposure-therapy-for-adults-pe-for-ptsd/)
   - Ages served: Adults and adolescents with trauma histories
   - Length of treatment: 8-15 sessions that are 60-90 minutes each

2. **Cognitive Processing Therapy** was developed for adults who have experienced a traumatic event and are currently suffering from the symptoms of PTSD and/or meet criteria for a diagnosis of PTSD.

   For more information about Cognitive Processing Therapy: [http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/](http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/)
   - Ages served: Adults with PTSD and related symptoms
   - Length of treatment: 12 sessions

3. **Child and Family Traumatic Stress Intervention (CFTSI)** is a brief early intervention model for children and adolescents that is implemented soon after exposure to a potentially traumatic event, or in the wake of disclosure of physical and sexual abuse.

   - Ages served: 7-18 years old
   - Length of treatment: 4-6 weeks

4. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events.


For more information about TF-CBT: http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/
- Ages served: 3-18 years old and their parents
- Length of treatment: 12-18 sessions

B. Mental Health Services:

1. **Cognitive Behavioral Therapy (CBT)** is a short-term, manualized, therapeutic intervention that is widely researched and used for mental health treatment. CBT has many iterations to address a wide range of issues including sleeping difficulties, relationship problems, drug and alcohol use, anxiety, and depression.

For more information about Coping Cat (CBT for child anxiety http://www.cebc4cw.org/program/coping-cat/ and CBT for adult depression http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/)
- Ages served: Children over age 7, adolescents, and adults
- Length of treatment: 12-20 weeks

2. **Interpersonal Psychotherapy (IPT)** is a time-limited, manualized treatment for adults with depression. The model is premised on the theory that symptoms of depression have multiple causes and are linked to interpersonal stressors. Treatment strategies include psychoeducation, assessment of relationships, and strategies to improve interpersonal functioning.

For more information about IPT: http://www.cebc4cw.org/program/interpersonal-psychotherapy/
- Ages served: Can be used with adults and adolescents ages 12-18 years old
- Length of treatment: 12-16 weeks

For the following sections (C) and (D), we are seeking provider feedback on promising models to serve families with intellectual and developmental disabilities and medical needs:

C. **Intellectual and Developmental Disability**

Interested providers should propose an approach to serving parents and/or children with intellectual and/or developmental disabilities that incorporates research-informed approaches and will provide assessments, care coordination, support, and monitoring.

D. **Medical**

Interested providers should propose an approach to serving both children and families with special medical needs that incorporates research-informed approaches and will provide assessments, care coordination, support, and monitoring.

**Target Population:** For families enrolled in prevention services, clinical enhancements will be available for children and adults. These services will include assessment, referral, care coordination, and ongoing therapeutic treatment. Additionally, clinical enhancements will be provided as a strategy to mitigate crises and alleviate trauma. The clinical enhancement provider(s) will be expected to coordinate with prevention providers to deliver follow-up services after a psychiatric hospitalization, overdose, suicide attempt or ideation, upon return from incarceration, or at times when high-intensity intervention has ended for a family member, but additional clinical
support would promote greater stability in the home. As needed, clinicians should also be available to develop safety plans with families receiving enhancement services. Interested providers should be able to bill Medicaid and/or other health insurance for relevant services to clients. For clients without Medicaid or other health insurance, ACS funding may be used to cover the cost of services. Services should be provided to adults and/or children, primarily to families enrolled in family support prevention programs, but where there is a significant need and with approval of ACS, may be accessed by families in therapeutic and treatment prevention programs.

**Anticipated Service Catchment Areas:** Clinical enhancement programs should offer full-time clinicians and medical staff who are available to provide clinic-based, in-home, as well as telehealth therapy to any family receiving prevention services. Service options are listed below. ACS anticipates making up to three contract awards to ensure all service options below are available to families Citywide. Potential applicants may propose programs for (a) trauma treatment, (b) mental health, and/or (c) parental intellectual or developmental disability (I/DD), special medical, and psychiatry; or a combination of (a), (b), and/or (c). Multiple services may be made available to families if needed and where model requirements do not prohibit engagement with multiple services (e.g., trauma treatment for a parent and developmental services for a child), but service models should not be combined or adapted beyond model fidelity standards.

<table>
<thead>
<tr>
<th>Service/Program</th>
<th>Clinical Enhancement Service Options</th>
<th>Anticipated minimum individuals served per year</th>
<th>Catchment Area</th>
<th>Anticipated Available Annual Funding</th>
</tr>
</thead>
</table>
| Clinical
Enhancements | Trauma treatment, which may include:  
- Prolonged Exposure[^31]  
- Cognitive Processing Therapy[^32]  
- Child and Family Traumatic Stress Intervention[^33]  
- Trauma-Focused Cognitive Behavioral Therapy[^34] | 1,500 | Citywide | $2,000,000 |
| | Mental Health, such as  
- Cognitive Behavioral Therapy for anxiety and depression[^35,^36]  
- Interpersonal Psychotherapy for depression[^37] | 500 | | |
| | Intellectual and Developmental Disability, Special Medical, Psychiatry:  
- Assessments  
- Care coordination, support, monitoring | 500 | | |

**VII. PROPOSED METHOD OF EVALUATING PROPOSALS**

[^34]: Trauma-Focused Cognitive Behavioral Therapy: [http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/](http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/)
[^35]: Cognitive Behavioral Therapy for Adult Depression: [http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/](http://www.cebc4cw.org/program/cognitive-behavioral-therapy-cbt-for-adult-depression/)
[^37]: Interpersonal Psychotherapy: [http://www.cebc4cw.org/program/interpersonal-psychotherapy/](http://www.cebc4cw.org/program/interpersonal-psychotherapy/)
The method of evaluating proposals for family support, therapeutic and treatment programs, and clinical enhancements is as follows:

- Upon receipt, all proposals will be reviewed for responsiveness.
- ACS will evaluate all responsive proposals based on criteria, which may include, but are not limited to:

<table>
<thead>
<tr>
<th>Program Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Capacity to support quality implementation and sustainability, including past performance delivering human services</td>
</tr>
<tr>
<td>Commitment to Family Voice, Inclusivity, and Social Justice</td>
</tr>
<tr>
<td>Connection to and history of serving the proposed community effectively</td>
</tr>
</tbody>
</table>

- Contracts will be awarded to the highest-ranked proposal until slots are exhausted in accordance with target slots per catchment area.

**VIII. PROPOSED TERM OF THE CONTRACTS**

ACS anticipates that the term of the contract(s) awarded from the upcoming RFP will be from July 1, 2020 through June 30, 2023, with an option to renew for two (2) additional three (3) year terms. Renewal is subject to availability of funds and evaluation of contractor performance.

**IX. TOTAL FUNDING AVAILABLE / ANTICIPATED PAYMENT STRUCTURE**

Building upon the recent Model Budget investments in prevention services in 2018, the total funding available for the contracts awarded from this RFP is approximately $227 million. For the Family Support and Therapeutic and Treatment contracts, ACS anticipates that reimbursement will largely be cost-based (that is, based on providers’ spending against approved line-item budgets), with a portion of payment driven by performance using utilization, quality, and outcome metrics. Such metrics may include staff training goals, client utilization and length of service targets, planned casework contacts, levels of parent engagement, increasing advocate cases, and community outreach, among other measures. For the Clinical Enhancements contracts, the payment structure will be cost-based, with contract funds supporting only services that cannot be billed to Medicaid or third-party insurance. All funding is subject to availability.

**X. PROCUREMENT TIMELINE**

ACS anticipates that the RFP will be released in the spring of 2019. A pre-proposal conference will be held shortly after the release of the RFP. The proposal due date will be approximately eight weeks after the release of the RFP. ACS anticipates that contractors will be selected before the end of the year.

**XI. CONTRACTOR PERFORMANCE REPORTING REQUIREMENTS**

Contractors will be required to submit for performance assessment all case- or program-related documentation, including but not limited to electronic case records, model fidelity reports, court reports and other documents, medical records, educational records, case conference reports, abuse/neglect reports, personnel files, program logs associated with facilities, supervision, or critical incidents or activities as requested by ACS, consistent with governing law.
XII. USE OF HHS ACCELERATOR

To respond to the forthcoming Prevention Services RFP and all other client and community services (CCS) Requests for Proposals (RFPs), vendors must first complete and submit an electronic prequalification application using the City’s Health and Human Services (HHS) Accelerator System. The HHS Accelerator System is a web-based system maintained by the City of New York for use by its Health and Human Service Agencies to manage procurements.

Only organizations with approved HHS Accelerator Business and Service application for one or more of the following will be eligible to propose:

- Community Engagement
- Language Skills
- Life Skills
- Recreational Services
- Child Care
- Parenting Services
- Diagnostic Testing
- Nursing
- Primary Care
- Mental Health Services
- Health Education and Supports
- Rehabilitation/Therapy
- Substance Abuse Services
- Home Attendant Services
- Drop-In Center
- Alternative Justice Management
- Discharge/Re-Entry
- Outreach
- Caregiver Support
- Case Management
- Conflict Resolution/Mediation
- Court Appointed Guardian Services
- Entitlements Assistance
- Preventive Services
- Respite Care
- Job Placement Services
- Work Readiness

To submit a Business and Service application to become eligible to apply for this and other ACS Client Service RFPs, please visit http://www.nyc.gov/hhsaccelerator.

XIII. CONTACT INFORMATION

All comments and feedback regarding this Concept Paper must be received no later than March 25, 2019 by 5:00 pm. Comments should be sent via email to: Prevention-CP@acs.nyc.gov.